FLORIDA ATLANTIC UNIVERSITY
MEDICAL GROUP

PATIENT INFORMATION FORM

Last Name: _____ **First Name:** _____ **Prefix** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
Middle Name: _____ **Preferred Name:** _____
Date of Birth:_____/_____/_____ **Age:** _____ **SSN:** _____ - _____ - _____
Address: _____ **City:** _____ **County:**_____ **State:** _____ **Zip:** _____
Email: _____ **Home:** ( )_____ - _____ **Cell:** ( )_____ - _____

Alternate Contact: **If you want us to contact you at an alternate address or telephone number, please provide below:**
Alt. Address: _____ **City:** _____ **State**: ____ **Zip**: _____ **Phone**: ( ) _____-_____

Marital Status: ◯ Married ◯ Single ◯ Separated ◯ Divorced ◯ Widowed ◯ Partner ◯ Unknown
Ethnicity: ◯ Not Hispanic / Latino ◯ Hispanic / Latino ◯ Declined to Specify

Race: ◯ White ◯ Black / African American ◯ Asian ◯ American Indian / Alaska Native ◯ Native Hawaiian / Other Pacific Islander ◯ Declined to Specify ◯ Other Race

Birth Sex: ◯ Male ◯ Female **Gender Identity (optional):** _____

Primary Language: ◯ English ◯ Spanish ◯ French ◯ Other: _____

Student Status: ◯ N/A ◯ Full-time ◯ Part-time **Employment Status**: ◯ N/A ◯ Full-time ◯ Part-time **Employer:**_____

Name of Pharmacy: _____ **Address**: _____ Phone: ( )_____-_____

Emergency Contact Name: _____ **Relationship**: _____ Phone: ( )_____-_____

Guarantor/ Person Financially Responsible For the Payment If Other Than The Patient

Last Name: _____ ◯ Mr. ◯ Mrs. ◯ Miss ◯ Other: _____ Sex: ◯ Male ◯ Female

First Name: _____ Date of Birth: _____/____/_____ Age:____ SSN: _____–_____–_____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: ( )_____ - _____ Cell: ( )_____ - _____

Email Address of Guarantor/ Person Financially Responsible: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

Consent for Treatment, Mediation, and Assignment of Benefits

NOTICE OF LIMITED LIABILITY: I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that: I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida Atlantic University Board of Trustees (hereafter referred to as "FAU") at this facility. The FAU employees and/or agents providing this medical care and treatment may include, but are not limited to: physicians, residents, fellows, healthcare students, physician assistants, advanced registered nurse practitioners, perfusionists, nurses, pharmacists, and technicians, who will at all times be under the exclusive supervision and control of FAU. I, on behalf of myself, my child, and/or my ward, understand that the employees of FAU are not employees or agents of any entity other than FAU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, which may arise from the care rendered by FAU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

Signature of Patient (or Authorized Personal Representative) _____ Date _____

Print Name of Patient (or Authorized Personal Representative) _____ Authority of Personal Representative (e.g., parent, legal guardian, healthcare surrogate) _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been provided a copy of the Florida Atlantic University Notice of Privacy Practices and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

CONSENT FOR TREATMENT: I hereby consent to any and all diagnostic procedures, tests and medical treatment required in the diagnosis of my illness and course of treatment by the physician or his/ her designee; other agents, and/or employees of the Florida Atlantic University. I recognize that FAU is a teaching and research facility and that my treatment and care may be observed and, in some instances, aided by residents, medical students and students from other allied health professions in their course of training. I hereby authorize FAU to retain, preserve, and use for scientific, educational, or research purposes, or to otherwise dispose of, any specimens, tissues, or medical devices removed from my body during treatment**.** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered. I consent to FAU taking photographs and/or video/audio recordings of me in the course of and related to my care, and to their use of such photographs or videos and my medical data for educational and research purposes within FAU.

CONSENT FOR TELEMEDICINE: I understand and agree that my providers may utilize telemedicine (the electronic communication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs as part of my care. Except in emergency circumstances, my providers will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek care elsewhere in lieu of a telemedicine encounter.

AGREEMENT TO MEDIATION: In accepting care at this facility where FAU employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the FAU Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FAU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights and allow payment to be made directly to FAU for all medical or surgical benefits otherwise payable to me under terms of my insurance. I further understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for payment purposes.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by FAU, including charges for services not covered by my insurance. I consent and authorize FAU and third-party agents of FAU to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein. A signed copy shall be as valid as the original.

Signature of Patient (or Authorized Personal Representative) _____ Date _____

Print Name of Patient (or Authorized Personal Representative) _____ Authority of Personal Representative (e.g., parent, legal guardian, healthcare surrogate) _____