Jupiter Family Healthcare
www.jupiterfamilyhealthcare.com

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4600 Military Trail, Suite 115, Jupiter, FL 33458
Phone (561) 776-5252 Fax (561) 776-5255

PATIENT REGISTRATION—PLEASE PRINT

Today's Date: _____ **Referred by:** _____

Patient's Name: _____
Last **First** **M.I.**

_____ _____ **M or F**
Patient's Date of Birth **Patient's Social Security Number** **Sex**

Primary Address: _____
Street **Apt/Unit #**

_____
City **State** **Zip Code**

Secondary Address: _____
(if have, Northern) **Street** **City** **State** **Zip Code**

_____ _____ _____
Home Phone **Cell Phone** **Work Phone**

_____ _____
Employer **Email address (for use of patient portal)**

_____ _____
Marital Status **Spouse's Name**

_____ _____
Primary Insurance **Secondary Insurance**

_____ _____ _____
Subscriber's Name (relationship of other than self) **DOB** **Social Sec No.**

_____ _____ _____
Emergency Contact person **Relationship to Patient** **Phone Number**

_____ _____
Local Pharmacy **phone number** **Mail Order Pharmacy** **Phone Number**

Race: (circle one): African American Hispanic White Other Race_____
(insurance request)
Ethnicity: (circle one) Hispanic or Latino Non Hispanic or Latino Refuse to report

Primary Language: _____ (2/17)

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Consent for Purposes of Treatment, Payment and Healthcare Operations

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I consent to the use or disclosure of my protected health information by Jupiter Family Healthcare / Richard A. DeLucia, Jr, MD PA (hereafter referred to as "Jupiter Family Healthcare") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Jupiter Family Healthcare. I understand that diagnosis or treatment of me by any of the providers may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Jupiter Family Healthcare is not required to agree to the restrictions that I request. However, if Jupiter Family Healthcare agrees to a restriction that I request, the restriction is binding on behalf of Jupiter Family Healthcare and our physicians and practitioners.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jupiter Family Healthcare or its practitioners have taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician(s), another healthcare provider, a health plan, my employer, or a healthcare billing clearinghouse. This protected healthcare information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Jupiter Family Healthcare Notice of Privacy Practices prior to signing this document. The Jupiter Family Healthcare Notice of Privacy Practices has been provided to me. It describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Jupiter Family Healthcare. The Notice of Privacy Practices for Jupiter Family Healthcare is also provided at the front desk. This Notice of Privacy Practices also describes my rights and Jupiter Family Healthcare duties with respect to my protected healthcare information.

Jupiter Family Healthcare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices.

If you want your health information / billing information discussed with anyone, please indicate their name and relationship below.

Print Name _____ **Relationship** _____

Signature of Patient, Parent or Guardian _____ **Date** _____