

Medical Associates of Tamarac, P.A.  
7875 West Commercial Boulevard  
Tamarac, Florida 33351  
(954) 726-0099 . Fax (954)726-0047

**WELCOME TO OUR OFFICE:**

Please complete the attached forms and return them to the receptionist with a picture ID and your insurance card ( if you have insurance)

**ADDITIONALLY:**

If you are referred by a primary doctor to see Rheumatologist, Kristin Chai, MD, please also attach the Script from your primary doctor so that we will have the reason for your visit and where we should send your reports .

Thank You

**MEDICAL ASSOCIATES OF TAMARAC, P.A.**  
Everold Haffizulla, MD   Jason Haffizulla, MD   Nigam Parikh, MD   Kristin Chai, MD  
Katrina Wright, PA-C

**PATIENT REGISTRATION INFORMATION**

Date: \_\_\_\_\_

**\*\*Race and Ethnicity questions are required to be asked of the Patient by the Federal Government\*\***

Please complete this form and return it to the receptionist with you ID and Insurance Card

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M   F

Address: \_\_\_\_\_  
Street City State Zip Code

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Please check your preference on how to contact you: Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Marital Status: S   M   D   W   Other \_\_\_\_\_ Primary Language: \_\_\_\_\_ SS# \_\_\_\_\_

Please check appropriate response for **BOTH** \*\*Race and \*\* Ethnicity

\*\*Race:   American Indian/ Alaska Native \_\_\_\_\_   Asian \_\_\_\_\_   Black/African American \_\_\_\_\_  
White \_\_\_\_\_   Native Hawaiian/Pacific Islander \_\_\_\_\_   Declined to answer \_\_\_\_\_

\*\* Ethnicity: Hispanic or Latino \_\_\_\_\_   Not Hispanic or Latino \_\_\_\_\_   Declined to answer \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Address: \_\_\_\_\_ Phone# \_\_\_\_\_

Responsible Party/Guarantor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

**PAYMENT IS DUE WHEN SERVICES ARE RENDERED**

**HOW WILL YOU BE PAYING TODAY? CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD \_\_\_\_\_**

**CONSENT TO TREATMENT and ASSIGNMENT OF INSURANCE BENEFITS and INFORMATION RELEASE**

I hereby consent to medical treatment by the medical providers of MEDICAL ASSOCIATES OF TAMARAC for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance company for the purpose of filing my medical claim. I authorize payment on behalf of myself, and/or my dependent to be made directly to MEDICAL ASSOCIATES OF TAMARAC for services rendered to me, and/or my dependent. I further understand that I am financially responsible for all charges incurred, including any services deemed Non Covered by my insurance company. I also understand that any deductibles, co-pays, and co-insurance are due at the time of service..

Health information can be left on answering machine \_\_\_\_\_, given to \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature of Patient/Subscriber

\_\_\_\_\_  
Date



# NOTICE OF PRIVACY PRACTICES

## ACKNOWLEDGEMENT OF NOTICE RECEIPT

Medical Associates of Tamarac  
7875 W. Commercial Boulevard  
Tamarac, FL 33351  
954.726.0099  
[www.meditam.net](http://www.meditam.net)

I acknowledge that I have received this office's Notice of Privacy practices which describes the ways in which the office may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the privacy officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

If completed by a patients personal representative, please print and sign your name in the space below.

\_\_\_\_\_  
Personal Representative (Print)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Relationship

### CONSENT FOR HEALTHCARE COMMUNICATIONS

#### Consent to email or text usage for appointment reminders or other healthcare communications.

Patients in our practice may be notified by email, text or telephone to remind you of an appointment, to provide general health reminders/information and to obtain feedback on your experience. By signing this form, you consent to receiving information in this way as provided by Privacy Rule Section 164.522(b).

#### *Please initial each that apply.*

\_\_\_\_\_ OK to leave message with detailed information

\_\_\_\_\_ OK to send text messages \*

\_\_\_\_\_ OK to Leave message with call back numbers only

\_\_\_\_\_ OK to E-mail me at: \_\_\_\_\_

\_\_\_\_\_ OK to leave a message with (specify relationship) \_\_\_\_\_

\_\_\_\_\_ OK to mail to address listed below

\_\_\_\_\_ OK to Fax to the number listed below

Home Telephone Number: \_\_\_\_\_

Written Communication Address: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Cellular Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

\* The practice does not charge for this service, but standard text messaging rates apply as provided in your wireless plan. (Contact your carrier for pricing plans and details)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

#### FOR OFFICE USE ONLY

We have made a good faith effort to obtain a written acknowledgement of receipt of this office's Notice of Privacy Practices but was unable to for the following reason:

- ☐ patient refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ Patient unable to sign
- ☐ Other (please specify) \_\_\_\_\_

Employee Name \_\_\_\_\_

Date \_\_\_\_\_

**MEDICAL ASSOCIATES OF TAMARAC, P.A.**  
**7875 WEST COMMERCIAL BLVD.**  
**TAMARAC, FL. 33351**  
**954-726-0099**

Due to the many constant changes in insurance policies, we are not able to predict what an insurance company will or will not cover. Many insurances only allow members to use a particular "in network" lab, have tests done at special "in network" facilities and go to "in network" specialist doctors.

Your contract is between you and the insurance company. Please call your insurance and learn more about your coverage. Make sure that the lab work or tests to be done are covered by your insurance. It will save a lot of confusion. Failure to do this could result in your being responsible for all cost incurred (doctor visit, lab work, tests) during your visit with our office or other office/facility.

You signature below acknowledges that you have read the above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

If completed by patient's personal representative, please print and sign your name in the space below

\_\_\_\_\_  
Personal representative (Print)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Relationship