ANDREW E. NULLMAN, M.D.

VENTURE GASTROENTEROLOGY, LLC

NEW PATIENT REGISTRATION

Name (Last, First, Middle) ____
As written on your insurance card

Birth Date ____/_____/_____ Social Security #_____-_____-_____

Address ____

City ____________________________________ State ________________ Zip _______________

Home Phone ___________________________ Mobile Phone ___________________________________

*Email ____ No Email _______
*Required for www.drnullman.com online access (RX Refill, Appointments & Lab Results)

Contact Preference: Primary Home Phone |Mobile Phone| Email

Primary language spoken by the patient ___________________ Race _________________

Ethnicity _________________ Marital Status: Single |Married | Divorced |Widowed |Separated

Guardian (Last, First, Middle) ____

Emergency Contact (Last, First, Middle) ____

Relationship _______________________Phone _________________Mobile Phone _________________

Next of Kin Name (Last, First, Middle) ____

Relationship ___________________________Phone ____________ Mobile Phone __________________

Employer Name ____ Phone ___________________

Occupation _____________________________________

Patient's Relationship to Guarantor: Self _____ | Spouse _____ | Child ____| Other _________
Guarantor (Name to whom statements are sent)

Guarantor (Last, First, Middle) ____

Guarantor Date of Birth ____/____/____ Social Security # _____-_____-_____

Guarantor Address ____

City ________________________________State ________________________ Zip ______________

Guarantor Phone __________________________________Guarantor Email _______________________

Primary Insurance

Insurance Company ____Primary Insured ______________________________

Insurance ID # ____ Group # ____________________________________

Secondary Insurance

Insurance Company ____ Primary Insured ______________________________

Insurance ID # ____ Group #_____________________________________

Pharmacy Information

Pharmacy Name: Walgreens | CVS | Other ____

Address ____ City & State _________________________________

Pharmacy Telephone # _______________________________ Pharmacy Fax # _______________________________________

Preferred Lab

LabCorp | Quest | Other ____

Address ____ City & State ____________________

Referred by ____________________________________ PCP ____

ADVANCED DIRECTIVE STATEMENT – FLORIDA LIVING WILL

Do you have a Living Will? YES/NO If yes, please attach a copy

Do you have a Durable Power of Attorney? YES/NO If yes, please attach a copy

Have you completed a legal document designating anyone (other than your family or guardian) to make health care decisions for you, in the event you were incapacitated and could not make them yourself? YES/NO If yes, who?

Name: ____ Phone: ______________________________

Is this person aware of your choice? YES/NO

Patient Signature____ Date: _____________

MEDICATION HISTORY AUTHORITY

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care.

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Andrew E. Nullman, M.D., P.A. can request and use your prescription medication history from other healthcare providers, health plans and/or pharmacies for treatment purposes. Understanding all of the above, I hereby provide informed consent to Andrew E. Nullman, M.D., P.A. to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient ____Date _____________

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Referrals- If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have a referral, you will be required to reschedule your appointment until a referral can be obtained.

Co-Payments – By law we must collect your insurance carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

Co-Insurance and Deductibles- You are responsible for the payment of any amount that your insurance carrier deems to be co-insurance or deductible. Due to our contractual obligations with your insurance company, we are not able to write off co-insurance and deductibles.

Self-Pay Patients – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for all charges we incur as a result of your bad debt.

We accept cash, checks, and all major credit cards.

Signature of Patient ____Date ___________________

LIFETIME SIGNATURE AUTHORIZATION

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to Andrew E. Nullman, M.D., P.A. This Assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered an original.

Signature of Patient ____Date __________________

MEDICARE AND MEDICAID LIFETIME AUTHORIZATION

Medicare and Medicaid patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under the Title XVIII and/or Title XIX, of the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Signature of Patient ____Date ___________________

MEDIGAP BENEFICIARY SIGNATURE AUTHORIZATION (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medigap benefits be made on my behalf to Andrew E. Nullman, M.D. P.A. I authorize any holder of medical information about me to release to my Medigap Insurance Company any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient ____Date ___________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office staff or:

Dr. Andrew Nullman |1190 NW 95th Street | Miami, Florida 33150 | 305.534.4404

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature of Patient: ____ Date: ____________

RECORDS RELEASE AUTHORITY

To: ____

____

I, ____

Patient's Name

___________________________________ ___________________________________

Date of Birth Social Security Number

hereby request that you release to:

ANDREW E. NULLMAN, M.D., P.A

GASTROENTEROLOGY|LIVER DISEASE

1190 NW 95th Street, Suite 412 |Miami, Florida 33150

Phone: 305.534.4404 | Fax: 305.691.4449

A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to

your treatment of me from (date) _______________________to (date) ________________________

Include the following: (Indicate by Initialing)

______ Alcohol/Drug Treatment | ______Mental Health Information |______ HIV –Related Information

____ ____________________________

Signature of patient or representative authorized by law Date

____ ____________________________

Please print name signed above Relationship to Patient

____ ____________________________

Witness Date

Please consider the environment before mailing confidential health information. Send records via fax: 305.691.4449