

Please have your insurance card and one other ID available at our front desk.													
PATIENT INFORMATION													
Last Name:				First Name:				Middle Name:					
Previous Last Name:				Suffix:									
Address:													
City:				State:			Zip:			Postal Code (non-US):			
Home #:				Work#:			Alt		Alter	ernate Home#:			
Mobile#:				E-mail Address:			Con			tact Preference: _HomeWorkMobile			
DOB: Social Sec			urity #: Sex:					Country: Language:					
/ / -						_FemaleMale							
Race:				Marital Status: Single Married Divorced Widowed					Citizen of:				
PATIENT'S EMPLOYER OR GUARANTOR INFORMATION													
Name:				Phone #:					Occupation:				
MAILING ADDRESS : (if different from the above)													
Address:													
City:				State	:		Zip:			Postal Code (non-US):			
PATIENT'S O	CEAN REEF	STATUS :	(circle ONE	E catego	ory)								
1- Patron 2- Equity 3-Legacy			4- Social 5- Family			of Member	uest of Member 7- Meeting Attendee			Neeting Attendee			
8-Associate of Ocean 9- Associate of Reef Club Sound			iate of Care	rd 10- Associate of Anglers			11- Associate Other OR Ven		12- Resigned13- Family MemlMemberEmployee				
MEDICAL CEI	NTER FOUN	IDATION S	SUPPORT L	EVEL: (d	circle)								
	1-Guardian Trustee 2-Guardian					or 5	5-Super Founder		Found	er 7-Membe	er 8	-None of the Above	
EMERGENCY	CONTACT	INFORMA	TION					-					
Name:				Phor	ne#:				Relati	onship:			
PRIMARY CA	RDHOLDER	INFORM	ATION: (P	ERSON	WHO THE PLA	N IS LI	STED UNDER)						
Last Name:			First	Name:				Middle Name:					
DOB: Social S				Security	/ #:			Empl	oyer:			State:	
SECONDARY CARDHOLDER INFORMATION													
Last Name:				First Name:			M		Midd	Middle Name:			
DOB: Social S			Security #:			Employe		oyer:	r:		State:		
INSURANCE INFORMATION													
Primary :							Member # or ID #:						
Secondary :					Member # or ID #				<i>t</i> :				
How did you hear about us?													

PAYMENT METHOD									
Ocean Reef Club Card # :	Authorization Signature:								
Credit Card # : Visa or Master Card	Exp Date:	Security Code:	Authorization Signature:						
*Please stop at the check-out counter before lea	• …								
rendered. As part of our service, we will submit your insurance claims. Insurance/financial arrangements including any required pre-									
authorization should be made prior to services. RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION									
I hereby authorize release of any medical information necessary to process my insurance claim and also assign to the doctor all payments									
from my Insurance Company for services rendered. I understand and agree to the above conditions.									
Print Name of Patient or Parent/Guardian	Signat	ure of Patient o	r Parent/Guardian Date						
MEDICATION HISTORY AUTHORITY									
I hereby authorize release of any medication history information from my pharmacy to the doctor. I understand and agree to the above conditions. Print Name of Patient or Parent/Guardian Signature of Patient or Parent/Guardian Date									
CONSENT TO CONTACT	Jigilat								
I hereby authorize The Medical Center to leave a detailed message via :CallText Email									
(Initials) (Initials) (Initials) (Initials) (Initials) (Initials)									
This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104- 191), 42 U.S.C. Section 1320d, et. Seq., and regulations promulgated there under, as amended from time to tome (collectively referred to as "HIPPA").									
This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.									
The Medical Center at Ocean Reef, Inc. will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.									
By signing this authorization you acknowledge and agree that The Medical Center at Ocean Reef, Inc. may use or disclose your medical information for the purpose(s) of continuous care.									
Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand The Medical Center at Ocean Reef's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While The Medical Center at Ocean Reef, Inc. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy as amended are available from The Medical Center at Ocean Reef, Inc. at any of its offices or by sending a written request with return address to: 50 Barracuda Lane Key Largo, Florida 33037.									
In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy you PHI on the designated record set maintained by The Medic al Center at Ocean Reef, Inc. for as long as the PHI is maintained in the designated record set.									
You have the right to revoke this authorization, writing, at any time, except to the extent that The Medical Center at Ocean Reef, Inc. has taken action in reliance on it. A revocation is effective upon receipt by The Medical Center at Ocean Reef, Inc. of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.									
The authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of The Medical Center at Ocean Reef, Inc., or (d) six years from the date this authorization was executed.									
By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.									
The Medical Center at Ocean Reef, Inc. will provide you with a copy of this signed authorization.									
Acknowledged and agreed to by:									
I certify that I have received written documentation of my Patient Rights and Responsibilities. (Initials)									