

# Robert S. Tomchik, M.D., P.A.

3161 Dykes Road, Miramar, FL 33027

Phone: (954) 450-3550

Fax: (954) 450-3557

MiramarMedicine.com

## Patient Information Sheet

### PERSONAL INFORMATION:

Patient Name: \_\_\_\_\_  
Last First Middle

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:  M  F

Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

\*Home Phone: (\_\_\_\_) \_\_\_\_\_ \*Cell Phone: (\_\_\_\_) \_\_\_\_\_ \*Work Phone: (\_\_\_\_) \_\_\_\_\_  
\*At Least 2 Phone Numbers Please

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Spouse's Name: \_\_\_\_\_  
Last First Middle

Spouse's Birth Date: \_\_\_\_\_ Employed by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

How did you hear of us (optional): \_\_\_\_\_

### If someone other than the patient is responsible for payment, please complete this section:

Name of Responsible Party: \_\_\_\_\_  
Last First Middle

Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

### **Medical Authorization and direction to pay:**

I do hereby authorize the doctors/providers of care to furnish you, my insurance company, with the above referred, concerning the examination, diagnosis, treatment, progress, etc., of myself in regard to the accident or illness for which I received treatment. I hereby authorize and direct you, my insurance company, to pay the said doctors/providers of care such sums as may be due and owing them for services rendered to me by reason of this accident or illness. Under no circumstances is this agreement revocable, nor can it be changed unless proof of payment in full of the bill is provided to him/her for services rendered to me. And, I further understand that such payment is not contingent on any insurance policy, settlement, judgment, or verdict by which I may eventually recover said fee. I hereby agree to pay for the services rendered, including attorney's fees, collection charges, and court costs necessary to affect payment of this account. I understand that interest charges of 1-1/2% per month may be charged should my account become delinquent. I will also pay you an additional fee for each dishonored check or similar instrument received by you in payment on this account. A photocopy of this is as valid as the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review

**1. CONTITUTIONAL SYMPTOMS**

Good general health lately..... No Yes  
 Recent weight change..... No Yes  
 Fever..... No Yes  
 Fatigue..... No Yes  
 Headaches..... No Yes

**2. INTEGUMENTARY (skin, breast)**

Rash of itching..... No Yes  
 Change in skin color..... No Yes  
 Varicose veins..... No Yes  
 Breast pain..... No Yes  
 Breast lump..... No Yes  
 Breast discharge..... No Yes

**3. NEUROLOGICAL**

Frequent or recurring headaches No Yes  
 Light headed or dizzy..... No Yes  
 Convulsions or seizures..... No Yes  
 Numbness or tingling sensations..... No Yes  
 Tremors..... No Yes  
 Paralysis..... No Yes  
 Stroke..... No Yes  
 Head injury..... No Yes

**4. HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts..... No Yes  
 Bleeding or bruising tendency..... No Yes  
 Anemia..... No Yes  
 Phlebitis..... No Yes  
 Past transfusion..... No Yes  
 Enlarged glands..... No Yes

**5. PSYCHIATRIC**

Memory loss or confusion..... No Yes  
 Nervousness..... No Yes  
 Depression..... No Yes  
 Insomnia..... No Yes

**6. ENDOCRINE**

Glandular or hormone problem..... No Yes  
 Thyroid disease..... No Yes  
 Diabetes (insulin or non insulin – circle one)..... No Yes  
 Excessive thirst or urination..... No Yes  
 Heat or cold intolerance..... No Yes  
 Skin becoming dryer..... No Yes  
 Change in hat or glove size..... No Yes

**7. Eyes, Ear, Nose, Mouth**

Hearing loss or ringing..... No Yes  
 Earaches or drainage..... No Yes  
 Chronic sinus problem or rhinitis..... No Yes  
 Nose bleeds..... No Yes  
 Mouth sores..... No Yes  
 Bleeding gums..... No Yes  
 Sore throat or voice change..... No Yes  
 Swollen glands in neck..... No Yes

**8. CARDIOVASCULAR**

Heart trouble..... No Yes  
 Chest pain or angina pectoris..... No Yes  
 Palpitation..... No Yes  
 Shortness of breath while walking..... No Yes  
 Swelling of feet, ankles or hands..... No Yes

**9. RESPIRATORY**

Chronic or frequent coughs..... No Yes  
 Spitting up blood..... No Yes  
 Shortness of breath..... No Yes  
 Asthma or wheezing..... No Yes

**10. MUSCULOSKELETAL**

Joint pain..... No Yes  
 Joint stiffness or swelling..... No Yes  
 Weakness of muscles or joints..... No Yes  
 Muscle pain or cramps..... No Yes  
 Back pain..... No Yes  
 Cold extremities..... No Yes  
 Difficulty in walking..... No Yes  
 Sports injury..... No Yes

**11. GASTROINTESTINAL**

Loss of appetite..... No Yes  
 Change in bowel movements..... No Yes  
 Nausea or vomiting..... No Yes  
 Frequent diarrhea..... No Yes  
 Constipation..... No Yes  
 Rectal bleeding or blood in stool..... No Yes  
 Abdominal pain..... No Yes  
 Peptic ulcer (stomach or duodenal)..... No Yes

**12. GENITOURINARY**

Frequent urination..... No Yes  
 Burning or painful urination..... No Yes  
 Blood in urine..... No Yes  
 Incontinence or dribbling..... No Yes  
 Kidney stones..... No Yes  
 Sexual difficulty..... No Yes  
**Male** – Testicle Pain..... No Yes  
**Female** – Pain with period..... No Yes  
 Use douche..... No Yes  
 Irregular periods..... No Yes  
 Vaginal discharge..... No Yes  
 Age at the onset of menstruation..... No Yes  
 Number of days menstruation lasts..... No Yes  
 Date of last pap smear..... No Yes  
 Date of last menstrual period..... No Yes

List all pregnancies with dates, weights, and problems (Please include miscarriages, terminations, and pre-term): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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## Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing our insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the balance of a claim.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

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Signature of patient or responsible party

Date

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## LIVING WILL

This Declaration is made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_. I, \_\_\_\_\_, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medicine or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this declaration:

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

Note 1: At least one of the above witnesses is neither a spouse nor a blood relative of the Declarant.

Note 2: It is the responsibility of the Declarant to provide for notification to his attending physician that this Declaration has been made.

## HIPPA Notice of Privacy Practices

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PII) to carry out treatment, payment or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health conditions and related health care services.

### Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed to your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Or, for example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of a medical student, licensing, and conducting or arranging for other activities. For example, we may disclose your protected health information to medical school students that are volunteering at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroner's, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, required uses and disclosures. Under the law we must make disclosures to you, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following record: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask or request us not to use any part of your protected health information. For example, to not disclose to family members or friends who be involved in your care or for notification purposes as described in this Notice of Privacy Practice. Your request must state the specific restriction to apply.

Your Physician is not required to a restriction that you request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications for us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have accepted this notice alternatively, i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement for disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have had, if any, of your protected health information.

We receive the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

#### Complaints

You may complain, to us or to the Secretary of Health and Human Services, if your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

The notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of individuals, and to provide them with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgment, that you have received this Notice of our Privacy Practices:

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

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

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## Patient Bill of Rights

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.



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## Patient Bill of Rights

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_