Patient Registration
Karen F. Kuhns, M.D., F.A.C.O.E.M.
Michelle Supraski, PA-C
Internal Medicine

Demographics

Name(Last, First, MI): _____

Sex: M F Date of Birth:_____

Address: _____

_____

Social Security Number: _____

Primary Phone:_____ Home Cell Work

Secondary Phone:_____ Home Cell Work

Emergency Contact name and phone: _____

Insurance Information

Name of Insurance:_____

Subscriber name:_____ Date of Birth:_____

Guarantor Information: (the person responsible for payment, if self please leave this section blank)

Name:_____ Date of Birth:_____

Relationship to patient:_____

Address (if different from patient):_____

_____

I hereby authorize Dr. Kuhns and her associates to release any medical information required in the course of examination and treatment and permit payment directly to them for services rendered. I recognize and accept responsibility regardless of insurance coverage. My doctor and her associates will attempt to let me know if a certain procedure will not be covered by insurance, but I understand that I am ultimately responsible for any charges incurred. This includes, but is not limited to, co-insurance, co-payment, deductible and any non-covered services.

Signature:_____ Date:_____

PEDIATRICS by the sea

Bradley J. Bradford, M.D.
Karen F. Kuhns, M.D.
Kenia Martinez, M.D.
285 SE Fifth Avenue
Delray Beach, FL 33483
(561) 272 - 8991

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Pediatrics by the Sea** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatrics by the Sea's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatrics by the Sea reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatrics by the Sea's Privacy Officer at 285 SE 5th Ave., Delray Beach, FL 33483.

With my consent, Pediatrics by the Sea may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatrics by the Sea may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Pediatrics by the Sea may e-mail to my appointment reminder cards and patient statements. I have the right to request that Pediatrics by the Sea restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Pediatrics by the Sea's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatrics by the Sea may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date