MICHAEL FUNK, MD, FACP, FACC
CARDIOLOGY

Patient: ____
Last Name First Name M.I

Address: ____

____
City State Zip Code

Home phone: ____________ **Social Security Number:** ____________

Date of Birth ____________ **Age:** ______

Spouse's Name: ____________ **Spouse's DOB:** ____________

Spouse's Employer: ____________ **Phone #:** ____________

Emergency Contact: ____________ **Phone #:** ____________

Referred by: ____________ **Primary Physician:** ____________

Reason for Visit: ____

Medical Problems: ____

____

Past Surgery:

Surgery name with date (year) ____

____

Medications/Vitamins/Over the counter daily: ____

____

Drug Allergies ____

____

Phone: 954-840-0530 ~ Fax: 954-840-3570

3001 Coral Hills Drive ~ Suite 170 ~ Coral Springs, FL 33065

Tobacco Use:

Did you ever smoke cigarettes Yes_______ No_______ (If no, please skip to Alcohol use)

Current Every Day Smoker? Yes______ No_______ Current some day smoker? Yes_____ No_____

Former Smoker? Yes_______No______ When did you quit? _________Number of years smoking______

Smoke Socially? Yes_______ No_______ Smokeless tobacco use? Yes_______ No_______

Alcohol Use:

Do you drink alcohol? Yes______ No______ If yes, how much? ________________________

Never drinks alcohol? Yes______ No______ Quit drinking alcohol? Yes______ No If yes, when? _________

PLEASE READ AND SIGN

I authorize the release of my medical records or any other information necessary to process an insurance claim. I authorize payment of medical benefits to go directly to MultiSpecialty Healthcare, LLC, the office of Dr. Michael Funk, MD, FACP, FACC.

By signing below you are giving your permission to be contacted via interent or voicemail by MultiSpecialty Healthcare LLC, the office of Dr. Michael Funk MD, FACP, FACC.

Our office has a policy regarding "No Show" visits. There will be an automatic **$75.00 charge** applied to your account if we have no record of the appointment being rescheduled or canceled. The cancelation has to occur 24 hours prior to your appointment.

Patient Signature: ______________________________________ **Date:** ________________________________

CONSENT TO TREAT

In the course of your treatment as a patient of MultiSpecialty Healthcare LLC, the office of Michael Funk MD, FACP, FACC, there will be medical treatment plans, diagnostic tests and possibly minor procedures recommended or administered by the office physician or staff member. The doctors and staff will ensure that you have a complete understanding of your care and recommend that you ask questions. By signing below you are granting your permission for this office to proceed with providing the appropriate care:

Patient Signature: ______________________________

Print Name: __________________________________

Date: ____________________________

CONSENT TO NOTIFY

In the course of your treatment as a patient of Multispecialty Healthcare, LLC with Michael Funk MD, FACP, FACC, it may be necessary to contact you regarding your appointments, surgery or your medical condition. Please list family members or friends that you authorize us to speak with if we are unable to contact you.

Without this authorization we are prohibited by law to answer any questions regarding your appointments, surgery or medical condition. This rule applies to spouses, children, parents and any other immediate family members.

I, ____, hereby authorize the office of

MultiSpecialty Healthcare, LLC, the office of Michael Funk MD, FACP, FACC to contact:

Name:__________________________________ Telephone: ____________________

Name __________________________________ Telephone: ____________________

Name: __________________________________Telephone: ____________________

Name: __________________________________Telephone: ____________________

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Patient Signature: ____________________________________ **Date:** _______________

MEDICATION CONSENT FORM

I, ______________________________ hereby authorize the office of MultiSpecialty Healthcare, LLC, the office of Michael Funk MD, FACP, FACC to E-Prescribe medications as well as view my medication history. This authorization will last indefinitely unless this office is notified in writing about any changes.

Patient Signature: ________________________________ **Date:** __________

Print Name: ___________________________________

Witness: ____

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your care by providing the best treatment available. Our charges are usual and customary for our area. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor. Co-payments, co-insurance and deductibles are due at the time of service. We only accept cash, Visa, MasterCard, Discover or American Express.

WE DO NOT ACCEPT PERSONAL CHECKS

Should the account not be paid and a financial agreement is not in place, the account will be turned over to collections. You, the patient, will assume all cost of collection, including, but not limited to court costs, interest and legal fees.

Regarding Insurance

We will accept assignment of insurance benefits; however, we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you provide us with complete and accurate information. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. If your insurance company has not paid your account in full within 45 days, you will be responsible for the balance. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurance.

Referral / Authorizations

This is primarily the patient responsibility to obtain and provide to the office prior to services provided. The office will assist in obtaining authorizations for procedures. This is not a guarantee of payment by your insurance company.

Missed Appointments

Our office has a policy regarding **"NO SHOW"** visits. There will be an automatic **$75.00 charge** applied to your account if we have no record of the appointment being rescheduled or canceled. The cancelation has to occur 24 hours prior to your appointment.

Procedures

Once a date is set, the office requires that all cancellations are "prior to 24 hours" of the procedure. Failure to cancel within the appropriate amount of time will result in a **$150.00** fee being applied to your account.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and understand and agree to this Financial Policy.

____________________________________ _________________________

Signature of patient or responsible party **Date**

ACKNOWLEDGE OF RECEIPT OF THE PRACTICE'S NOTICE OF PRIVACY PRACTICES

Signature__________________________________

Name (Print) _______________________________**Date**______________________________________