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.