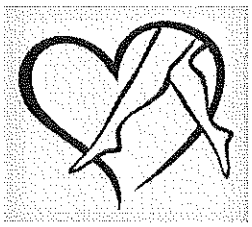

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Patient Registration Information

Patient Name: _____ Date of Birth: _____ Age: _____

Sex Assigned at birth: (Male / Female) Gender :_____Pronouns:_____

S.S. #:_____Marital Status: _____ E-Mail Address: _____
Address:

_____
(Street) (City) (State/Zip Code)
Home Phone: ( ) _____Mobile Phone: ( ) _____Primary Language: _____

Emergency Contact: _____Relation to Patient: _____

Emergency Contact Phone#: ( ) _____

Pharmacy: _____Phone#:_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin

Patient Employer Information

Patient's Employer: _____ Occupation: _____
Employer's Address: _____Phone: ( ) _____
Spouse's Name: _____Spouse's Employer: _____
Primary Care Physician: _____ Phone#: ( ) _____
Referring Physician: _____Phone#: ( ) _____

Insurance

*Insurance Information **(PLEASE PROVIDE COPIES OF INSURANCE CARD(S)**
Primary Ins. Company Name: _____Primary Insured's Name: _____ Date of Birth: _____
Insurance ID#: _____Plan#: _____ Group#: _____

Circle all that apply:

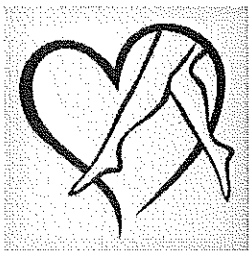
Do you have Chest pain, Shortness of breath, Palpitations, Dizziness, Swelling, High/Low Blood pressure, Tingling or numbness?

Have you been in the hospital since your last visit? Yes or No If yes for what?

_____

_____

***Email addresses are used as an emergency contact and newsletter regarding our practice.**



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Current Medications

Name	Strength	Frequency	Name	Strength	Frequency

Medical History

Diagnosis	Year	Diagnosis	Year

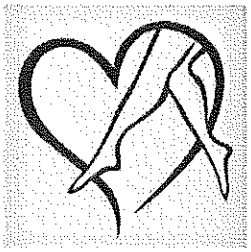
***** ALLERGIES: _____

Surgical History

Year	Type

Hospitalizations

Reason	Name of Hospital	Location	Date



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Family History

Father: ☐ Alive ☐ Deceased	**Mother**: ☐ Alive ☐ Deceased	**Siblings**: ☐ Alive ☐ Deceased
Medical History:	Medical History:	Medical History:
☐ Cancer	☐ Cancer	☐ Cancer
Type: _____	Type: _____	Type: _____
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Stroke	☐ Stroke	☐ Stroke
☐ High Cholesterol	☐ High Cholesterol	☐ High Cholesterol
☐ Other: _____	☐ Other: _____	☐ Other: _____

Social History

Tobacco	**Alcohol**	**Exercise**	**Illicit Drug Use**
☐ Yes ☐ No ☐ Former	☐ Yes ☐ No	☐ Sedentary	☐ Yes ☐ No
Type: _____	☐ Social	☐ Occasional	Type of Drug: _____
Years Smoked_____			
Year Quit: _____	☐ Daily	☐ Regular	
Packs/Day: _____	☐ Weekend		

AADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS: This form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. This form also lets you express an intention to donate your bodily organs and tissues following your death. Lastly, this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named.

I, _____, being of sound mind and at least 18 years of age declare that:

(1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Initial only one box)

- [__] (a) Choice NOT To **Prolong Life.** I do not want my life to be prolonged if within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain my consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

- [__] (b) Choice **To Prolong Life.** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

_____

_____

(3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(4) PRIMARY PHYSICIAN: (OPTIONAL)

- I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____
(address) (city) (state) (zip code) (phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

- _____
(name of physician)

_____ _____
(address) (city) (state) (zip code) (phone)

(5) DONATION OF ORGANS AT DEATH: (OPTIONAL)

Upon my death: (mark applicable box)

- [___] (a) I give any needed organs, tissues, or parts, OR
- [___] (b) I give the following organs, tissues, or parts only.
- [___] (c) My gift is for the following purposes: (strike any of the following you do not want)
    - (1) Transplant
    - (2) Therapy
    - (3) Research
    - (4) Education

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment , and I accept the consequences from such refusal.

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

I execute this declaration, as my free and voluntary act, on this _____ day of _____, 20__, in the City of _____, Country of _____, State of _____.

_____
(signature)

(INSTRUCTIONS: This advance health care directive will not be valid for making health care decisions unless it is either: (1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (2) acknowledged before a notary public.)

I declare under penalty or perjury under the laws of the state of (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community health care facility, the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under the laws of penalty of perjury of the state of that I am neither related to the patient by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to ant portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law.

Signed at _____ on this _____ day of _____, 20___.

_____

(name and address of first witness)

_____

(name and address of second witness)

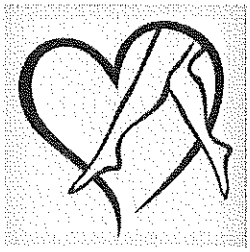
State of _____	)
Country of _____	)

On this the _____ day of _____, 20__, before me, the undersigned, a notary public in and for said County and State, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____

Signature of Notary



Cardiac & VeinwoRx
DBA Functional MedWoRx

Please Read This Form Carefully And Completely Before Signing It

I, _____, understand that I may require medical treatment depending on my examinations done in office.

I authorize the physicians of Cardiac & VeinwoRx DBA Functional MedWoRx to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include x-rays, blood tests, urine analysis, blood pressure tests, or other routine tests. I understand that if my doctor advises a more complex test, or one which has special risks, that it will be explained to me. Further, I authorize the personnel of Cardiac & VeinwoRx DBA Functional MedWoRx to assist in giving, or to give, the tests which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health. Additionally, I authorize the personnel of Cardiac & VeinwoRx to assist in the giving, or to give, the therapy which my doctor will order. I fully understand that medical tests or treatments may involve certain unavoidable risks.

If part of my treatment is very complex or carries special risks, it will be explained to me.

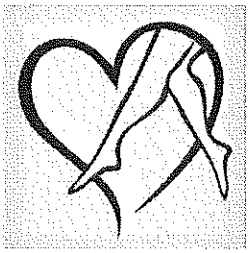
I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer any questions I might have. I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as to the results of treatments or examination.

I certify that I have read this form, and had it explained to me, and I certify that I fully understand its contents.

➡ _____ _____
Patient Signature Date

FOR PATIENTS UNABLE TO SIGN

➡ _____ _____
Signature of Legal Representative Witness



Cardiac & VeinwoRx
DBA Functional MedWoRx

Patient Agreement to Pay for Medical Services

I hereby authorize Cardiac & VeinwoRx, DBA Functional MedWoRx to furnish my insurance carrier all information concerning my illness. I also authorize benefits under this claim to be made payable directly to the physician. I understand that I am responsible financially to the physician for charges not covered by my insurance company, I, the patient or the guardian of the patient, will be responsible in full in payment.

I also understand that all co-payments and / or deductibles are to be paid at the time services are rendered. I also understand that physician charges may occur if I am in the hospital and I will responsible for those charges as well. I agree to assist Cardiac & VeinwoRx DBA Functional MedWoRx in any collection efforts to receive payment from my insurance company providing the office with any information that may be necessary for the physicians to receive payment. If any insurance changes I will notify the office right away or I will be responsible for any unpaid claims.

I understand that by signing this agreement I agree to make all payments to Cardiac & VeinwoRx DBA Functional MedWoRx that I am responsible for, and that if the insurance denies a claim for any reason that I am responsible ultimately for payment in full to the physicians.

By not signing this agreement, services may be denied.

➡ **Signature:** _____ **Date:** _____

Print: _____ **Date:** _____

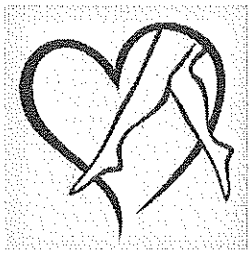
Please give the receptionist your insurance card and driver's license to be photocopied. Thank you.

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in the place of the original.

➡ **Signature:** _____ **Date:** _____

I hereby authorize Cardiac & VeinwoRx DBA Functional MedWoRx to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Cardiac & VeinwoRx DBA Functional MedWoRx (or to the party who accepts the assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

➡ **Signature:** _____ **Date:** _____



Cardiac & VeinwoRx
DBA Functional MedWoRx

OUR NO-SHOW POLICY IS AS FOLLOWS.....

**Please note that if you need to cancel or reschedule, please call 24 hours

in advance to avoid a "No Show" fee. (Please see fees below)**

Exercise/Monitor/Ultrasound(s) _____ No Show Fee $50.00

EVLA/EVLT/VenaSeal(s) _____ No Show Fee $200.00

Loop/Nuclear Study/Tilt Table _____ No Show Fee $200.00

Follow Up _____ No Show Fee $50.00

Procedures_____ No Show Fee $200.00

Patient Name: _____ Date of Birth: ___/___/_____

Patient's Signature: _____ Date: _____

Cardiac & VeinwoRx
DBA Functional MedWoRx

Medical Records Release Form

Today's Date: _____

Check as appropriate:

____X___ All progress notes for the past 3 years

____X____ All laboratory tests for the past 12 months

____X____ All consultation, emergency room and hospital reports, including but not limited to inpatient and outpatient reports, inpatient history and physicals, and inpatient discharge summaries for the past 24 months

____X____ All EKG's and imaging reports including but not limited to mammography, X-ray, CT, ultrasound, and MRI for the past 5 years

____X____ All surgical and pathological reports including, but not limited to, surgery, colonoscopy, bronchoscopy, endoscopy, biopsy, cardiac catheterization, and interventional radiology irrespective of the date of the procedure

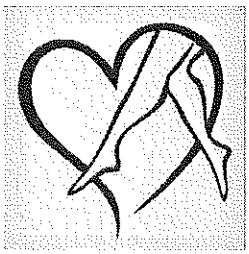
____X____ All Mental Health, HIV/AIDS,Substance Abuse, Psychiatric/Psychologic treatment, and Contagious disease.

Patient Name (**Printed**) _____

Date of Birth _____ Soc Sec No. ____ - _____- _____

Signature: _____ Date: _____

To:	**From:Dr. Cohen, Dr.Eric Rosen and Dr.Beatrice Grumberg**
	954-983-8910 phone
	954-985-5781 fax



Cardiac & VeinwoRx
DBA Functional MedWoRx

HIPAA
(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)
EFFECTIVE APRIL 9, 2003

Due to new federal and state mandates, please note the following important information.

Cardiac & VeinwoRx DBA Functional MedWoRx is committed to maintaining and protecting the confidentiality of our patients' personal and confidential information. We are required by federal and state law to protect the privacy of our patients' health and personal information. Therefore, we have instituted the following changes to ensure compliance with these laws.

We are no longer permitted to leave detailed messages on an answering machine or with family members. We must speak directly with the patient.

****Please provide our office with 4 digit pin # for your identification****
*** This is requested when you contact the office by telephone for your protection***

In order for any personal information to be given out to any other person(s) other than the patient the following release must be filled out: **Please initial next to the option(s) you choose.**

1.) I _____ authorize Cardiac & VeinwoRx, DBA Functional MedWoRx to release my medical information and will accept responsibility for the loss of privacy. You may leave a message for me at my contact number on file.
2.) I authorize release of any and all of my medical information whether verbally or in writing to the following person(s):

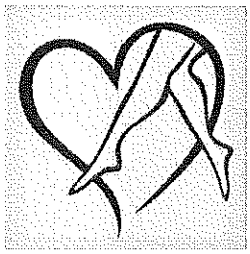
Name: **Relationship:**

1 _____ _____

2 _____ _____

_____ _____

Patient Name Patient Signature & Date



Cardiac & VeinwoRx
DBA Functional MedWoRx

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

Telephone: ( ) _____ Social Security: _____

SECTION B: To the Patient- Please read the following statements carefully

Purpose of Consent, by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices, You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read your Notice of Privacy Practices posted in your waiting room and that I may request a copy of this form. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

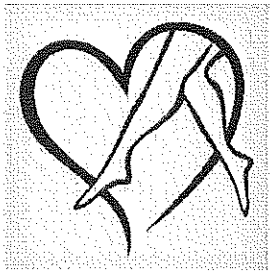
➡ Signature: _____ Date: _____

I consent permission to view my prescription listing from external sources ➡ _____Initial

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other _____



Cardiac & VeinwoRx

DBA Functional MedWoRx
Dr. Yale Cohen Dr.Beatrice Grumberg Dr.Eric Rosen
3702 Washington St. Suite 305
Hollywood, Fl 33021
954-983-8910 Phone
954-985-5781 Fax

How were you referred to us?

PCP Name_____

Hospital_____

Insurance_____

Friend/Family_____

Newspaper/Internet_____