Aida M. Murko, M.D.
Zoran Murko, M.D.

21301 Powerline Rd. Suite 302
Boca Raton, FL 33433

PATIENT REGISTRATION

Patient Last Name: _____ *Patient First Name:* _____ *M.I.:* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Social Security Number: ___ - ___ - ___ *DOB:* ___/___/___ *Age:* _____ *Gender: M ( ) F ( )*

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Home Phone: (___) _____ *Work Phone: (___)* _____

Employer: _____ *Occupation:* _____

Emergency Contact Name: _____ *Phone: (___)* _____

Responsible Party Name: _____ *Relationship:* _____ *Phone #:* _____

Who may we thank for referring you? _____

E-mail Address _____

PRIMARY INSURANCE INFORMATION: This information is required

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ *Name of Insured:* _____

Insured's Date of Birth: ___/___/___ *Social Security Number:* ___ - ___ - ___ *Sex: ( ) M ( ) F*

Insured's ID Number: _____ *Group Policy Number:* _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Physician/Company name here.** I authorize the release of any medical records for treatment, payment or healthcare operations.

INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE.

Authorized Signature: _____ **Date:** _____

All Co-pays, Co-insurances and Deductibles must be paid at time of service

Initial _____

There is a $75 charge for missed appointments without a 24 hour cancellation

Initial_____

Aida M. Murko, M.D., P.A.
Zoran Murko, M.D., P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I read and understand your *Notice of Privacy Practices*, hanging in the office, containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

_____	_____	_____
Date	**Initials**	**Reason**

Aida M. Murko, M.D., P.A.
Zoran Murko, M.D., P.A.

PATIENTS NAME:_____

FINANCIAL AGREEMENT:

The undersigned agrees he/she is hereby obligated and agrees to pay Dr. Murko's charges for services rendered. I further agree that the payment is due upon receipt of statement. **I understand that unpaid accounts will be considered in default after 90 days and then will be turned over to a collection agency. I also understand that once an account is turned over to collections, I will be responsible for any collection costs occurred while my account is in collections.**

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment to be made directly to Dr. Murko of all benefits which may be due and payable under insurance coverage of the named patient. Where Medicare and Medicaid benefits are applicable, I hereby certify that the information given by me for payment under Title XVIII and XIX of the Social Security Act is correct, and request that said payment be authorized benefits be made payable on my behalf of the Doctor. I authorize utilization of this application or copies therefore for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of any liability and I will remain financially responsible to Dr. Murko.

AUTHORIZATION TO RELASE MEDICAL RECORD INFORMATION:

Dr. Murko is hereby authorized to disclose all or any part of the medical record on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services.

FEES FOR SERVICE:

The fees for professional service at this office are payable at the time services are rendered. All appointments require a 24 hour cancellation notice. **THERE IS A $75 CHARGE FOR MISSED APPOINTMENTS OR CANCELATIONS WITHOUT A 24 HOUR NOTICE.**

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

_____

Signature of responsible party Date

Child, Adolescent, Adult and Geriatric Psychiatry Patient Care Guidelines

Welcome to the office

Family Psychiatry offers a range of outpatient psychiatric and mental health services designed to improve the quality of life and expand functional abilities. Our faculty and staff are committed to quality patient care and education. The following is a statement of our policies. Please read and sign prior to evaluation and/or treatment.

First appointments: evaluation differs from treatment

All first appointments are evaluations of your needs. During this evaluation information is gathered to determine a diagnosis and treatment options.

- We routinely provide second or consultative opinions. In these cases, on-going care is the responsibility of your local doctor or health care professional. We will communicate our recommendations to your referring care provider.
- In some cases we are not able to provide for your needs. In these cases we will assist in identifying healthcare providers who can better address your needs.

Confidentiality

Our staff is legally required to protect the privacy of your health information and to provide you with a notice about our legal obligations and privacy practices. For specific details, please refer to the HIPPA policies posted in our office. If you have any questions or want more information please inform your clinician. Except in special circumstances, information regarding your treatment will not be released without your written authorization. These exceptions include:

- Significant risk of harm to self or others.
- Mandatory reporting requirements for child abuse concerns.
- To be reimbursed by the insurance company, if you choose to use your insurance.
- Release of information requested by the court.

Treatment policy

The goals of treatment - medication and psychotherapy - vary according to the patient's or family's needs. Once goals have been agreed upon it will be important to cooperate with treatment recommendations. If you question any aspect of the treatment - please discuss this with your clinician. All of our counseling and medication management services are designed to be time limited with an emphasis upon specific treatment goals.

Medication policy

Prescriptions are only provided to patients in active treatment with our office. Your prescribing clinician will review the possible risks and benefits of a medication treatment. It is important that

you take the medication as directed or as a parent give and monitor the medication to your child. All medications should be kept in a safe place.

Patients seen for consults or second opinions and are returning to their local doctor will not be issued prescriptions. The referring physician will determine whether or not to follow our recommendations.

Refill policy

Active patients will have refills coordinated with scheduled return appointments. If you do not have enough medication until your child's next appointment, **PLEASE CONTACT THE OFFICE AT LEAST TWO BUSINESS DAYS IN ADVANCE TO REQUEST RENEWAL OF PRESCRIPTION(S)**. You can also call your Pharmacy and have them fax us a refill request which is subject to the two day policy as well.

Some prescriptions cannot be called into pharmacies. These will require advance notice to coordinate pick up. If a prescription must be mailed, you will need to contact the office a minimum of 1 week in advance to allow adequate time for mail delivery. If it is more convenient for you, you may arrange to pick up the prescription(s) from the office during regular business hours. We ask that you do not arrive without advance notification to pick up prescriptions.

Urgent and After Hours Care

If you feel your are having an emergency, contact our office at (561)852-2525 Monday through Friday, 8 to 5 pm, your call will be returned as soon as possible that same day. After 5pm on weekdays, weekends and holidays, you will probably be directed to the nearest Emergency Room. After hour care is typically reserved for those circumstances that may require an inpatient admission. If you request a phone consult outside of your regular office visit, please be aware phone calls lasting longer than 10 minutes will be subject to an additional charge. Phone consults cannot be billed to your insurance.

Cancellations

Each appointment is a special time reserved for you. Please notify our office 24 hours in advance in the event that you cannot keep your appointment. If you arrive 15 minutes or more late we may not be able to meet with you. **MISSED APPOINTMENTS AND APPOINTMENTS NOT CANCELED 24 HOURS IN ADVANCE ARE SUBJECTED TO A $75 CANCELLATION FEE.**

Termination of care

If a patient or family decides to refuse treatment without notification, this may be considered a violation of the treatment agreement and could be considered as a reason for termination of treatment. If a patient misses 3 appointments within a 12-month period and there is no timely notification, this is considered as a failure to meet the obligations of treatment and could be considered as a reason for termination of treatment.

Patients under the age of 18

Patients under the age of 18 with divorced parents or in the case of a legal appointed guardian of a minor, the adult bringing the child for their appointment must possess legal documents giving them permission to authorize treatment. In the case of divorced parents sharing joint custody, both parents must (in writing) give permission for the child to be treated.

Complaints

It is our responsibility to listen to patient concerns or the concerns voiced by the patient or parent/guardians. In the event that you are dissatisfied, feel free to discuss your concerns with your treating clinician. If you have concerns unrelated to therapeutic matters please discuss these with the office manager. The doctors do not discuss financial matters pertaining to the office under any circumstances. It is our goal to make sure the patient receives the best care possible.

Fees and Insurance

Your personal financial responsibility will vary depending on the type of service, type of professional providing the service, and your health insurance plan. Most insurance carriers provide some coverage for behavioral health services. Consult your insurance provider to verify your plan's specific coverage. You may be responsible for pre-authorization of services provided. Failure to authorize may result in the denial of payment by your insurance. If your insurance does not approve payment you will be responsible for payment in full. If you use your health insurance we are required to provide some information regarding your child's diagnosis and/or treatment. For this reason, some patients, parents/guardians prefer not to use their insurance.

Payment or insurance co-payment is expected at the time the service is provided. Patients may have their treatment interrupted if their account balance becomes delinquent. Only emergency treatment will be provided until the balance is paid in full. Arrangements can be made to assist in meeting your financial obligations. We accept cash, checks, MasterCard and Visa, American Express, and Discover.

The signatures below verify that I have read, understand and agree to the policies presented above.

Name of patient _____

Signature of patient or responsible party _____

Date _____

Witness _____

Date _____

Aida M. Murko, M.D., P.A.
Zoran Murko, M.D., P.A.
Dimitra Theoharis, PsyD, LMHC, P.A.
RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE DR. MURKO TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
SCHOOLS	☐ YES	☐ NO	_____
PHYSICIANS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____
THERAPISTS	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

We ask if you have any change in this request that you please inform the receptionist.

DR MURKO MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, RECORDS, ETC....

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT DR MURKO WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

Health History Form

Name: _____ **Age:** _____ **Date:** _____

Home Phone: _____ **Pharmacy:** _____ **Sex: ( ) Male ( ) Female**

Work Phone: _____ **Pharmacy Phone:** _____ **Date of Birth:** ___-___-___

Referring Physician: _____ **Phone Number: (____)** _____

Height: _____ **Weight:** _____ **Reason for visit:**_____

_____

Allergies to Medications: ☐ None 1. _____ Reaction: _____

Current Medications: ☐ None 1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Aspirin/Motrin/Advil	☐ Yes ☐ No	Birth Control Pills	☐ Yes ☐ No	Are you pregnant	☐ Yes ☐ No
Coumadin	☐ Yes ☐ No	Are you breast feeding	☐ Yes ☐ No	Plan on becoming pregnant	☐ Yes ☐ No

Review of Systems Screen *(Current or past problems with)*

	Yes	No		Yes	No		Yes	No
Blood/Bleeding Disorders	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Diabetes (sugar)	☐	☐	Immunologic Disease	☐	☐
Kidney Disease	☐	☐	High Blood Pressure	☐	☐	Latex/Rubber/Nickel/Food	☐	☐
Liver Disease or Hepatitis	☐	☐	Infectious Disease (TB, HIV)	☐	☐	Skin Disease	☐	☐
Lung Disease	☐	☐	Received Blood Transfusions	☐	☐	Skin Cancer	☐	☐
Thyroid Disease	☐	☐	Psychological Disorders	☐	☐	Melanoma	☐	☐

Do you:	Yes	No		Yes	No
Have a pacemaker or defibrillator	☐	☐	Have an artificial joint or heart valve	☐	☐

List surgeries:

1. _____ 2. _____ 3. _____

Family Psychiatric History (*Check the following psychological conditions which have occurred in your family)*

Disease	Mother	Father	Disease	Mother	Father
Depression	☐	☐	Bipolar Disorder	☐	☐
Obsessive/Compulsive	☐	☐	Dementia	☐	☐
Anxiety Disorder	☐	☐	Alzheimer's	☐	☐
Schizophrenia	☐	☐	Panic Disorder	☐	☐
Mood Swings	☐	☐	Eating Disorder	☐	☐
ADHD	☐	☐	Aggression	☐	☐

List any medical health conditions which occur in your family_____

_____

Social History

	Yes	No		Yes	No		Yes	No
Do you live alone?	☐	☐	Do you drink alcohol?	☐	☐	Do you use recreational drugs?	☐	☐
			Frequency _____			Frequency _____		

Occupation _____ Hobbies/Leisure activity _____

Patient Signature: _____

Why Some Patients Decide NOT to Use Their Mental Health Insurance

When you seek professional medical services of any kind, it makes sense to find out whether your health insurance will pay for the services involved. But there are many reasons why you may NOT want to seek reimbursement for psychological and or psychiatric services.

Real and substantial privacy issues can occur when you choose to use your insurance.

Any professional you meet with is legally and ethically bound to maintain strict confidentiality. When you use your insurance this is no longer the case.

- Information regarding you and the services you receive will be shared with the insurance company by way of the case manager.
- Private information can find its way into medical databases, other physician records, legal court proceedings, employer records, and simple gossip.
- Insurance companies often request that therapists and psychiatrists share information with your primary care doctor. Once part of your medical record it becomes available to life insurance and disability companies. This could negatively affect your ability to qualify for insurance.
- Confidentiality and privacy cannot be guaranteed by your provider once information is transmitted to an insurance company.

Receiving reimbursement from your insurance company requires that you be diagnosed with a psychiatric disorder.

Therapists and psychiatrists struggle with the decision of whether to describe an ordinary life problem or situation as a "psychiatric disorder" in an effort to facilitate reimbursement. Many people are adamant about avoiding such a "label" for themselves and their loved ones.

The choice of a therapist is usually limited and controlled by the insurance company.

With many insurance plans this may not be possible because you must make your selection from the company's provider list. You should choose your own therapist based upon expertise, recommendations, or comfort level.

The most positive and valuable services are usually not covered under health insurance.

Services related to personal growth, learning, advancement, happiness, enrichment, fulfillment, and achievement are usually never covered by insurance. Because of this many people whose lives could be dramatically improved with effective professional help never even try to find out what help is available, how valuable it might be, and whether they can afford it.

Effective personal services can be affordable without using your insurance.

Let the administration staff know that you prefer not to use your insurance, and discuss the options. You will most likely discover that you can get the help you need, at a price you can afford, without the need to disclose personal information or be diagnosed with a psychiatric disorder as is required by insurance companies.