KAHLIL A. SHILLINGFORD, M.D., P.A.
9960 CENTRAL PARK BLVD., N.
Suite 235
BOCA RATON, FL 33428
PHONE: (561) 483-8840
FAX: (561) 483-3342

PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____

SS#: _____ D.O.B. _____ AGE: _____

RACE: Asian / Caucasian / Black or African American / Hispanic / Other _____

LANGUAGE: _____

E-MAIL Correspondence (?): _____YES or _____ NO

E-MAIL ADDRESS: _____

S M D PARTNER/SPOUSE NAME: _____

HEIGHT: _____ WEIGHT: _____ BMI: _____

EMPLOYER INFORMATION:

EMPLOYER: _____

ADDRESS: _____

WORK PHONE: _____

POSITION: _____

PRIMARY INSURANCE INFORMATION:

INSURANCE NAME: _____ ADDRESS _____

ID # _____ GROUP # _____

PHONE # _____ SUBSCRIBER'S NAME _____

SUBSCRIBER SS# _____ D.O.B. _____

SECONDARY INSURANCE:

INSURANCE NAME: _____ ADDRESS _____

ID # _____ GROUP # _____

PHONE # _____ SUBSCRIBER DOB: _____

REFERRED BY: _____

FAMILY DR: _____ PHONE: _____

ADDRESS: _____ FAX: _____

HOW DID YOU HEAR ABOUT DR. SHILLINGFORD??? PLEASE CHECK ALL THAT APPLY:

____ INTERNET _____ SOCIAL MEDIA _____FRIENDS/FAMILY _____PHYSICIAN _____ HOSPITAL _____ OTHER

Assignment of Benefits/Medical Information Release: I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Kahlil A. Shillingford, M.D. for any services furnished to me. I authorize any holder of medical information regarding me to release any information needed to determine the benefits payable for related services.

I hereby authorize Medicare to furnish to the above-named Doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. I hereby assign benefits to Kahlil A. Shillingford, M.D. / group indicated on this claim. Having insurance is not a substitute for payment. I understand, I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: _____ Date: _____

- Name:
  Phon #
- RELATIONSHIP TO PATIENT :

- **PATIENT MEDICAL INFORMATION :**

- REASON FOR CURENT VISIT :
- ALLERGIES: LIST ALL ALLERGIES AND REACTION :

- **ALLERGIC TO LATEX?**

- ☐ Yes
  ☐ No

- Reaction

- **SMOKER?**

- ☐ Yes
  ☐ No

- HOW MUCH?

- **ALCOHOL?**

- ☐ Yes
  ☐ No

- HOW MUCH?

- **ILLICIT DRUGS?**

- ☐ Yes
  ☐ No

- WHAT?
- CURRENT MEDICATIONS: LIST ALL AND DOSE AND HOW TAKEN:

current medical conditions?

- PHARMACY INFORMATION/PHONE NUMBER:
- PAST HOSPITALIZATIONS:
- PAST SURGERIES:

- FAMILY MEDICAL HISTORY:

- I am choosing to take part in medical services with Kahlil A. Shillingford, M.D., P.A.
- As my appointment time has been set aside exclusively for me, I understand that I am responsible for the appointment fee, or a $25 cancellation fee if I fail to cancel a scheduled appointment at least 24 hours in advance. I understand that my insurance company will not pay for missed visits.
- I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. I understand the billing department will be glad to file my insurance claims for me: however, payment cannot be guaranteed. I will be responsible for any unpaid balances not covered by my insurance company.
- Any balance overdue more than thirty days will be subject to a $25 late fee per month. I agree to pay the cost of any delinquent bill, including a reasonable attorney's fee and/or collection agency fee and interest fee. I understand my account may be sent to a collection agency or court if fees are not paid in a timely manner.
- I fully understand and agree to the above policies and conditions. A copy of this signature is as valid as the original

Kahlil A. Shillingford, M.D., P.A.
9960 Central Park Blvd., N.
Suite 235
Boca Raton, FL 33428
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Patient/Guardian

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9960 CENTRAL PARK BLVD., N.
SUITE 235
BOCA RATON, FL 33428
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EFFECTIVE JULY 1, 2018

Under Florida law, Dr. Shillingford is unable to prescribe pain medication past 7 days postop, without a new hospitalization. **No exceptions to this law.**

If you believe you need further medications beyond the 7 days, we must refer you to a Pain Management physician.

Thank you.

_____ _____

Patient/Guardian Date

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ATTENTION:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE. This notice is provided pursuant to statute 458.320 Florida law."

_____

Patient/Guardian

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MEDICAL RECORDS RELEASE FORM

DATE: _____/_____/_____

To Whom It May Concern:

I hereby authorize any physician, hospital or medical facility the release of any information acquired over the course of my treatment or examination to Kahlil A. Shillingford, M.D.

Please fax all recent labs, test results and H & P including diet and exercise history to (561) 483-3342.

_____ _____

Patient Name (PRINT) Patient/Guardian Signature

Patient D.O.B. ____/____/_____

FMLA / DISABILITY FORMS

If you have FMLA forms or any other forms that need to be filled out by our office, please drop them off and they will be completed **AFTER** you have had your procedure as FMLA will not accept the forms prior to your surgery date. Please have your portion of the forms completed. Thank you.

_____ _____

Signature **Date**

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All Inclusive Bariatric Patients Regarding Pre-Op Testing Fee:

If you have completed your pre-op tests and you decide to cancel and do not reschedule within 30 days of completed tests, you may receive an invoice from the facility for $250.00 or higher, depending on the tests performed, if you did not pay prior to Dr. Shillingford's office, however, if you have paid toward your procedure, you will receive a refund minus the pre-op testing fee.

_____ _____

Patient/Guardian Signature Date

*** STAR MEDICAL BILLING RESOURCES, INC.***

P.O. Box 970528 * Coconut Creek, FL 33097 * Phone (954)227-8224 * Fax (954)227-7442

Assistant Service Patient Disclosure Form

During your surgical procedure Dr. Shillingford may require the use of a surgical assistant. A surgical Assistant will be used on those procedures where he believes an assistant to be medical necessary, and required to provide adequate care to you during your surgical procedure. Your surgeon may select a surgical assistant because of his confidence in their ability and because surgical assistants provide quality cost effective care. There will be a SEPARATE FEE from that of the surgeon for this service.

When Tiffany Morello PA-C participates in your surgery, she will file a claim with your insurance carrier on your behalf. Although your surgeon may be a participant in your insurance network, the charges for the assistant may or may not be considered as a participating provider when the claim is processed for payment. If the surgical assistant is not covered under your insurance plan, a maximum amount of $200.00 will be your responsibility to pay for their services.

In the event your insurance company sends a payment directly to you for these services, please contact us for full forwarding instructions.

In many cases insurance benefit statements can be confusing. The only charges you may be responsible for, would be itemized in the final invoice to you from Star Medical Billing resources, Inc. If you have any questions, please contact our billing office at (954)227-8224. We would be happy to assist you in any way possible.

Patient Name: _____ D.O.B. _____

Patient Signature:_____ Date:_____

KAHLIL A. SHILLINGFORD, M.D.

Medical Information Release Form (HIPPA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] Email: _____

[ ] _____

The best time to reach me is (day) _____ between (time) _____

- I understand that Kahlil A. Shillingford, M.D., P.A. will not condition treatment, Payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that signing tis form is voluntary and that I may revoke this authorization by sending a written request for revocation to this office. I understand that my revocation of this authorization will not apply to disclosures already made in reliance on my authorization.
- I understand that the PHI used, disclosed, or released pursuant to this authorization may be subject of redisclosure by the recipient of my PHI and will no longer be protected by state or federal privacy regulations.
- I understand that Kahlil A. Shillingford, M.D. may charge a fee for copying and sending my records.
- I understand that I am entitled to a copy of this authorization

_____ _____

Signature of Patient Date

_____ _____

Signature of Authorized Representative Relationship to Patient (must provide legal authority)

Kahlil A. Shillingford, M.D.

INSURANCE REFERRAL AND FINANCIAL RESPONSIBILITY WAIVER

Insurance Referral: If your insurance policy requires a Primary Care Physician referral, prior approval or other pre-authorization, in order for you to receive services from Kahlil A. Shillingford, M.D. **It is your responsibility (patient/guardian) to see that the necessary referral is current, and any necessary prior approval or other pre-authorization has been presented to Kahlil A. Shillingford, M.D. prior to receiving said services.** If no required referral, prior approval or other pre-authorization is present in advance, you will be personally responsible to pay for any services rendered to you by Kahlil. A. Shillingford, M.D.
Please note that Kahlil A. Shillingford, M.D. will use its best efforts to assist you in obtaining the necessary referrals, approvals and pre-authorizations.

_____ _____

Patient/Guardian signature Date

Kahlil A. Shillingford M.D.

Attention: All Self-Pay Bariatric Patients:

Dr. Shillingford will require labs after your surgery at 6 months and 1 year or as medically necessary. This is not included in our all-inclusive bariatric package. Any tests that may be required after you are discharged will be your responsibility which may include X-rays, IV Hydration, ER visits, CT scans, etc.

_____ _____

Patient signature Date