TRISTAR
WELLNESS

Patient Registration Form

Name: _____

Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____

Social Security Number: _____-_____-_____ Place of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Primary Language Spoken: _____

Name of Employer: _____

How did you hear about us: _____ Ethnicity: _____

Pharmacy Name: _____ City: _____ Zip Code: _____

Have you travelled outside of the US in the last six months? If yes, where to: _____

Insurance Information

Name of Primary Insurance: _____ Member ID Number: _____

Group Number (If Applicable): _____

Name of Secondary Insurance: _____ Member ID Number: _____

Group Number (If Applicable): _____

***If on a Family Plan the Name of the main Subscriber of the Policy*: _____**

Date of Birth of Subscriber: _____/_____/_____ Relationship to the Patient: _____

Consent and Signature

1. Payment for services is expected at the time of visit.

2. The insurance information stated above is true, and I authorize benefits to be paid directly to Tristar Wellness, LLC

3. I am responsible for the balance on my account, regardless, of insurance coverage. My failure to pay off outstanding balances may result in collection procedures.

4. I authorize Tristar Wellness, LLC to release any information requested in regard to the processing of my medical claims.

5. In case of an Emergency Please contact the individual below, I authorize any medical issues to be discussed with contact.

Name: _____ Phone Number: _____

Relationship to Patient: _____

Patient Signature: _____**Date:** _____/_____/_____

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Patient Financial Responsibility Agreement

A. Financial Responsibility. In consideration of Tristar Wellness, LLC "TSW" providing me with health care services, I agree as follows:

1. I will be responsible, either personally (for services not covered by my insurance) or through my insurance coverage, for payment to TSW for all services provided to me by TSW.

2. I hereby assign payment by any third party, including private insurance and credit card companies, for all services provided to me by TSW, directly to TSW. I understand and agree that I remain liable for all charges and/or applicable co-payments, co-insurance and deductibles are not covered by this assignment.

3. For services not covered by my insurance, I agree to pay TSW, within seven (7) days of the date of any invoice.

4. I understand that after 30 days of non-payment of any TSW invoice that TW may, in its sole discretion, stop providing services to me.

5. If my current insurance policy prohibits direct payment to TSW, I hereby authorize and instruct my insurance carrier to mail directly to TSW any check for any payment of benefits due to me.

a. Immediately upon TSW request, I will endorse such payment(s) over to TSW.

b. This is a direct assignment of my rights and benefits under my insurance policy.

c. Any payment made pursuant to this assignment will not exceed my indebtedness to TSW but I hereby agree to pay, in a current manner, any balance due to TSW over and above any insurance benefit payment received by TSW.

d. For purposes of carrying out the provisions of this assignment, a photocopy of this Agreement shall be treated as an original.

e. I hereby authorize TSW to initiate, on my behalf, any action it deems necessary to enforce the provisions of this assignment of benefits, including, but not limited to submitting a complaint to the appropriate Insurance Commissioner.

6. If I receive any payment of insurance benefits for services provided to me by TSW, I will immediately forward any and all such monies, along with the explanation of benefits to TSW.

7. I will notify TSW immediately upon my dis-enrollment from my current insurance carrier or any other change of benefit that could affect payment to TSW for its services.

8. I acknowledge that it is not the insurance company's responsibility to inform TSW of any change in my coverage, and the insurance company will not pay for non-covered services or for services I received after I am no longer covered.

9. I understand that I will be held liable for payment if I fail to notify TSW if I dis-enroll from or become ineligible for coverage under my current payer(s).

TRISTAR
WELLNESS

10. TSW will charge, and I agree to pay a 1.5% monthly finance fee on all outstanding balances over 30 days and, if necessary, collection and attorney fees.

11. I also agree to pay TSW $30.00 for any checks returned unpaid for any reason.

12. I must provider at least 24 hours' advance notice of cancellation of any appointment by calling 305-604-9595 or such other number as Tristar Wellness mandates. Tristar Wellness my charge me a cancellation fee of $50.00 if I do not cancel in a timely manner as required in this agreement.

B. **Release of Information**. I authorize:

1. Any health care insurer with whom I have or may have coverage to disclose to TSW any information regarding my coverage and any payments made directly or indirectly for services rendered to me by TSW;

2. any credit card company to which I charge fees for services provided to me by TSW to disclose to TSW any information regarding my account and any fees charged for services rendered to me by TSW.

3. TSW and its designees, to release to any public or private regulatory entity, accrediting entities and to any third-party insurer or other person or entity which provides insurance on behalf or for my benefit, information concerning my medical history, condition, lab and test results;

4. TSW and its designees, to conduct any credit and financial history check, inquiry or information gathering activities it feels, in its sole discretion, is or are necessary to verify my ability to pay for products or services provided by TSW.

I hereby release TSW, its designees and any person or entity providing information as contemplated above from any and all liability in connection therewith.

I have read and understand the provisions of this agreement, I have had a chance to ask questions about the agreement and I agree and acknowledge that I am financially responsible for services received from TSW. I acknowledge that this agreement binds me and my heirs, executors, administrators and assigns. I am signing this agreement of my own volition with full understanding of its meaning.

Patient Name: _____

Patient Signature: _____

Date: _____/_____/_____

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Authorization for Release of Confidential Medical Information

Attention to: _____

Date of Request: _____

I hereby authorize and request release for the following:

_____ A copy of the most **RECENT** Doctors Notes, Lab Results, Diagnostic and Procedure Results.

_____ **COMPLETE** Chart including reports, laboratory results, Diagnostic and Procedure Results.

MEDICAL RECORDS FROM:

Name of Facility or Doctor's Office:

_____

Phone: _____

Fax: _____

RELEASE MEDICAL RECORDS TO:

TRISTAR WELLNESS, LLC
ADDRESS: 400 WEST 41ST STREET, SUITE 402, MIAMI BEACH, FL 33140
Phone: 305-604-9595 Fax: 305-604-9257 Email: admin@tristarwell.com

TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Redisclosure is prohibited without the written permission of the patient/client/legal representative listed above.

NOTE: PATIENT/REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE:

Psychiatric/Psychological Information _____ (Initial)
Alcohol/drug/chemical information _____ (Initial)
HIV Tests and information pertaining to tests/treatment _____ (Initial)

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

Patient/Guardian Signature _____ Date: _____/_____/_____

Witnessed By: _____ Date: _____/_____/_____

TRISTAR
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Malpractice Insurance Notice

The doctor have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g) 1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

I have read and acknowledge the above statement and understand the statue stated above.

Patient Name

Patient Signature

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Date