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 / Unknown

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: ______________________

EMERGENCY CONTACT:

NAME: ______________________________ PHONE#: ________________________

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 CONDITION: ____

PAST HOSPITALIZATIONS: ____

PAST SURGERIES: ____

FAMILY MEDICAL HISTORY: ____

____

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

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.

____

Patient/Guardian

KAHLIL A. SHILLINGFORD, M.D., P.A.
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