ASSOCIATES IN MEDICINE & SURGERY

Patient Last Name: First: Middle:

Mailing address

Street Address: (If different from above)

Type of Residence you live in: □ Private Home □ Assisted Living facility □ Nursing Home □Group Home

Home Ph#: Cell Ph#:

Ok To Leave a Message: □ YES □ NO Email:

Date of Birth: Social Security#: Marital Status:

Race: Ethnicity: Language Preference:

Emergency Contact: Contact Ph#: Rel:

Pharmacy Information:

Pharmacy Name: Pharmacy Ph#:

Location:

Seasonal Residents:

Northern Address:

Ph #: When do you go North:

Insurance Information:

Primary Insurance: Phone Number:

Subscriber ID: Group Number:

Subscriber Name:

Subscriber SS#: Subscriber Date of Birth:

Secondary Insurance: Phone Number:

Subscriber ID: Group Number:

Subscriber Name:

Subscriber SS#: Subscriber Date of Birth:

Employer Information:

Employer Name:

Address:

Phone Number: OK to leave message: □ YES □ NO

AUTHORIZATION FOR COMMUNICATION WITH PHARMACY

I herby authorize the physician and /or representative to communicate via electronic submission with the pharmacy of my choice. This can and may include electronic submission of new prescriptions, authorizations of refills, and inquiry as to current medications.

Signature of patient or authorized person Date

PREGNANCY DISCLAIMER *(FEMALE PATIENTS ONLY)*

I understand that if I am pregnant, I should not have any diagnostic x-rays or elective surgery without first checking with my obstetrician.

I am **NOT** pregnant. My last period was _____.
If during the course of my treatment I become pregnant, it is my responsibility to inform the doctor and avoid x-rays and elective surgery.

Signature of patient or authorized person Date

Staff Witness Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I request the services of the Doctors of Associates in Medicine & Surgery, duly licensed physicians in the state of Florida, and all personnel, the consent to examination, diagnostic procedures and treatment which may need to be performed on my behalf. Also, I authorize the release of any medical information to any person or corporation, necessary to process my claim.

Signature of patient or authorized person Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment for all valid insurance benefits including all major medical benefits, be made on my behalf to Associates in Medicine & Surgery. I understand I will be financially and legally responsible for charge(s) Not covered by assignment.
I certify that I have read the above authorizations and understand and agree to same, and also certify no guarantee Or assurance has been made as to the results that may be obtained.

Signature of patient or authorized person Date

New Policy Effective July, 2016

Please be aware that effective October 1, 2010, Associates in Medicine & Surgery will have a new billing and collection policy.

As a patient, it is your responsibility to verify that we are indeed a participating provider with your insurance company/network and what services are covered. **_____ (patient initial)**

Please be advised that you are ultimately responsible for any and all balances incurred, regardless of insurance coverage. As a courtesy to you, our valued patient, our office will file to your primary and secondary insurance, as well as call your insurance carrier for eligibility verification and procedure pre-certification, when necessary. However, it is the responsibility of the patient to be aware of their insurance benefits. **It is our office policy to collect any co-pays and deductibles at the time of check in (Exception: Medicare deductible/Co-insurance if owed will be billed.)** Please be aware that a $10.00 processing fee may be charged for each co-pay not paid at the time of service and/or, your appointment rescheduled.

_____ (patient initial)

Be advised that should you cancel your appointment with less than 24 hours notice or no-show for your appointment, it is up to the discretion of physician to reserve the right to assess a $50.00 cancellation fee. **_____ (patient initial)**

Please be aware that although your insurance carrier might state that some procedures are "eligible" for payment, or are a "covered benefit" that does not mean that there will be no financial obligation by you, the patient. Many times a deductible is withheld, or there may be a separate co-payment withheld, depending on your specific carrier. Again, it is ultimately the responsibility of the patient, to know and understand their individual policy. **_____ (patient initial)**

All insurance companies state a disclaimer: There is no guarantee of payment. Every claim is subject to medical necessity and the terms of your contract at the time services are rendered. Once we receive the "explanation of benefits" (EOB) we must abide by their payment and/or denial; therefore any remaining balance will be billed to you. Any disputes of the benefits should be addressed to your insurance company. Your account will be considered delinquent if payment is not made in a timely manner.

_____ (patient initial)

In addition any co-insurance that is owed by you will be collected by the receptionist at subsequent appointments once your insurance carrier has processed the claim, or you will be sent a statement. **_____ (patient initial)**

By my signature below, the undersigned patient assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by the providers of the Associates in Medicine & Surgery. I hereby direct the benefits be paid directly to the physicians on my behalf for any services furnished to me by the providers of Associates in Medicine & Surgery. By my signature below I hereby certify that I have read and fully understand all the words and information contained in this form and reaffirm my consent to the examination, diagnostic procedure and/or care, treatment, therapy or remedy proposed.
By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

Please feel free at any time to discuss any concerns or questions you may have with our Billing Specialists.

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION
PRIVACY NOTICE ACKNOWLEGEMENT

PATIENT NAME:_____ Date of Birth:_____

By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment, or health care operations. You have the right not to sign this consent. However, if you refuse to sign the consent, we have the right to refuse to treat you.

Your Rights with Respect to This Consent:

- **Right to review notice of Privacy Practices** – You have the right to review a copy of our Privacy Practices before signing this consent. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the Notice from time to time. A copy of the Notice is posted in your office. Any revisions made to the Notice will be posted as soon as feasible.
- **Right to Request Restrictions on Use/Disclosure** – You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are NOT required to agree to any restriction that you request. If, however, we decide to agree to a restriction you have requested, we must restrict use and disclosure of your health information in the manner described in your request.
- **Right to Revoke Consent** – You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact the administrator of this practice to obtain the revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse further treatment if you revoke this consent.
- **Right to Receive a Copy of This Consent Form** – You have a right to receive a copy of this consent after you sign it.
- **Effective Period** – This consent is effective unless and until you revoke it in writing.

I give my authorization for my healthcare provider to discuss my care and treatment with the following individuals:

1. Name:_____ Relation:_____
2. Name:_____ Relation:_____
3. Name:_____ Relation:_____

I have an ADVANCED DIRECTIVE (LIVING WILL) and the following individual is able to make decisions regarding my healthcare if I am unable. (I will provide a copy of this for the office)

Name of Individual:_____ Relation**:_____**

I hereby authorize Associates in Medicine & Surgery to use and/or disclose my health information for treatment, payment, or health care operations.

_____ _____
Patient Signature **Date**

If a personal representative on behalf of the individual signs this authorization, please complete the following:
Personal Representative Name:_____

Relationship:_____ Reason patient could not sign:_____

Authority of Personal Representative:_____

What is the problem/ condition you are having? _____

1. Is the condition a result of an injury? Yes No **If Yes**, is this work related? Yes No

   How long have you been having this problem? _____

2. Have you seen a physician for this condition? Yes No **If Yes**, Whom and when? _____

   Treatment: _____

3. Are you Diabetic?Yes No **If Yes**, Name of physician monitoring Diabetes: _____

   Controlled By: Diet Oral Medications Insulin Last Blood Sugar:_____

4. Current Medications & Dosage: _____ _____ _____

   _____ _____ _____

   _____ _____ _____

5. Allergies & Reactions: _____ Reaction: _____

   _____ Reaction: _____

   _____ Reaction: _____

6. Surgical History & Dates: _____Date:_____

   _____Date:_____

   _____Date:_____

   _____Date:_____

7. Prior Hospitalizations: _____

8. Current or Previous Primary Care Physician: _____Phone:_____

9. Name of any Specialists your are currently under care with:

   Dr._____ Phone: _____

   Dr._____ Phone:_____

   Dr._____ Phone:_____

Date of Last Flu Shot: _____ Shoe Size: _____

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR Yes No If Yes, Date Placed:_____

Print Name: _____ Date: _____

Social History:

Do you use recreational drugs? O Yes O No

Do you exercise routinely? O Yes O No

HIV/ AIDS O Yes O No

Do you use caffeine? O Yes O No **If Yes,** How much daily? _____

Do you use tobacco? O Yes O No O If Yes, How Long? _____

Former user **If Former**, how long ago did you quit? _____

Type of Tobacco: O Pipe O Cigar O Cigarettes O Chew

Amount: O Less than 1 pack per day O 1 pack per day O More than 1 pack per day

Have you had a drink containing alcohol in the past year? O Yes O No

If YES, How often did you have 6 or more drinks on one occasion in the past year?

O Never O Less Than Monthly O Monthly O Daily or Almost Daily

How may drinks did you have on a typical day when you were drinking in the past year?

O 1-2 O 3-4 O 5-6 O 7-9 O 10 or More

How often did you have a drink containing alcohol?

O Never O Monthly O 2-4 Times Per Month O 2-3 Times Weekly O 4+ Times Weekly

Family History:		**Age**	**Diabetes**	**High BP**	**Heart Disease**	**Stroke**	**Mental Ill.**	**Cancer**
Mother	O Living O Deceased	_____	☐	☐	☐	☐	☐	☐
Father	O Living O Deceased	_____	☐	☐	☐	☐	☐	☐
Siblings	O Living O Deceased	_____	☐	☐	☐	☐	☐	☐
Children	O Living O Deceased	_____	☐	☐	☐	☐	☐	☐

How many/ age: Brother(s)_____ Sister(s) _____ Son(s)_____ Daughter(S)_____

Have you had any falls in the past year? O Yes O No

If Yes, How many? _____

Any injuries caused by falls? O Yes O No

PRINT NAME: _____ Date:_____

Do you have, or had in the past, any of the following?

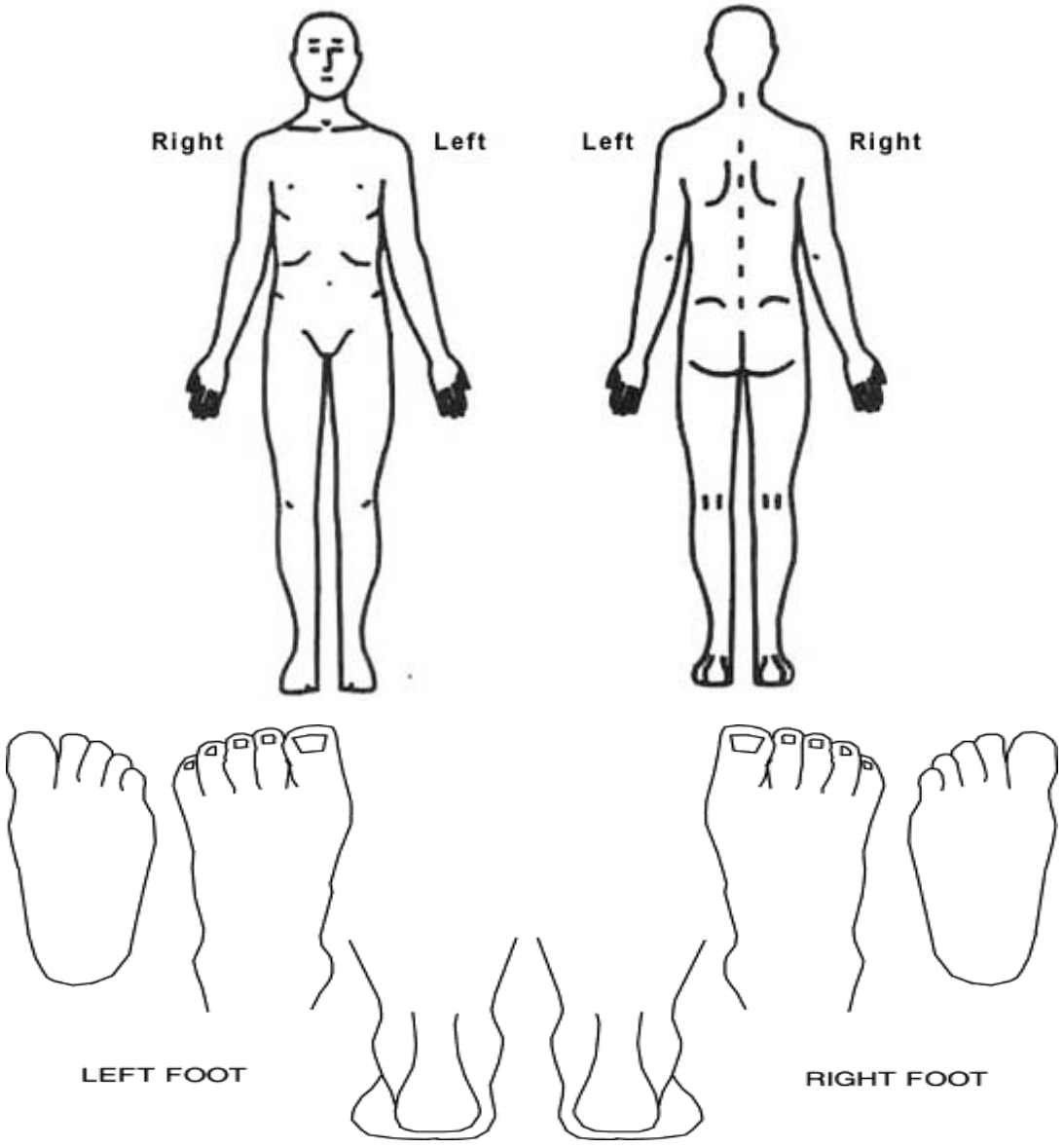
Fever/ Chills	O Yes O No	Burning/Tingling/Numbness	O Yes O No
Hearing Loss	O Yes O No	Blurred Vision	O Yes O No
Frequent Sore Throat	O Yes O No	Infection	O Yes O No
Ringing In Ears	O Yes O No	Callous	O Yes O No
Chest Pain	O Yes O No	Wound	O Yes O No
Foot/ Ankle Swelling	O Yes O No	Rash/ Itching	O Yes O No
Heart Valve Problems	O Yes O No	Change in Mole	O Yes O No
Diarrhea	O Yes O No	Deformed Nails	O Yes O No
Loss of Appetite	O Yes O No	Balance Problems	O Yes O No
Nausea/ Vomiting	O Yes O No	Headaches	O Yes O No
Weight Gain/ Loss	O Yes O No	Joint Stiffness	O Yes O No
Shortness of Breath	O Yes O No	Joint Pain	O Yes O No
Chronic Cough	O Yes O No	Weakness	O Yes O No
Menopausal	O Yes O No	Bowel/ Bladder Problems	O Yes O No
Nocturia	O Yes O No	Frequency in Urination	O Yes O No
Decreased Urine Stream	O Yes O No	Fatigue	O Yes O No

Past Medical History

Diabetic	O Yes O No	Crohn's Disease	O Yes O No
Heart Disease	O Yes O No	Hiatal Hernia	O Yes O No
Heart Murmur	O Yes O No	Colitis	O Yes O No
Mitral Valve Prolapse	O Yes O No	Cirrhosis	O Yes O No
Hypertension	O Yes O No	Thyroid Problems	O Yes O No
PVD	O Yes O No	Liver Disease	O Yes O No
Stroke	O Yes O No	Carpal Tunnel	O Yes O No
Raynauds Disease	O Yes O No	Neuropathy	O Yes O No
Minieres Disease	O Yes O No	Cancer	O Yes O No
Dialysis	O Yes O No	Pancreatitis	O Yes O No
Phlebitis	O Yes O No	Multiple Sclerosis	O Yes O No
Venous Insufficiency	O Yes O No	Hypercholesterolemia	O Yes O No
Respiratory Disease	O Yes O No	Osteomyelitis	O Yes O No
Alzheimers Disease	O Yes O No	Sciatica	O Yes O No
Parkinsons Disease	O Yes O No	Arthritis	O Yes O No
Hepatitis	O Yes O No	Fractures	O Yes O No
Fibromyalgia	O Yes O No	Hip Replacement	O Yes O No
RSD/ CRPS	O Yes O No	Knee Replacement	O Yes O No

PRINT NAME_____ Date_____

Please mark an **X** indicating the area of injury or discomfort on the chart below.



0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible

Current pain level:_____ Worst pain level:_____

Patient Name:_____ Date:_____