618 13th St. STE 101
St. Cloud, FL 34769
(407) 556-3999

New Patient Information

NAME: _____ _____ _____ **DOB:** _____ /_____ /_____
(First) (Middle) (Last) DD MM YYYY

HOME ADDRESS: _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

PHONE: _(_____)_____-_____ _(_____)_____-_____ **EMAIL:** _____
(Primary) (Work/Alt)

MAILING ADDRESS: _____ _____ _____ _____
(If different) (Street Address) (City) (State) (Zip Code)

SSN: _____-_____-_____ **DRIVER'S LICENSE:** _____

RACE: _____ **GENDER:** M / F **PRIMARY LANGUAGE:** _____**INTERPRETER NEEDED?**: Y / N

MARITAL STATUS: _____ **EDUCATION LEVEL:** _____ **STUDENT: F/T P/T N/A**

EMPLOYER: _____ **JOB TITLE:** _____ **PHONE:** _(_____)_____-_____

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

PRIMARY DOCTOR NAME: _____ **PHONE:** _(_____)_____-_____

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

REFERRING DOCTOR NAME: _____ **PHONE:** _(_____)_____-_____

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

REFERRING DOCTOR'S SPECIALTY: _____

PHARMACY NAME: _____ **PHONE:** _(_____)_____-_____

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

Insurance Information

PRIMARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ **DOB:** ____/_____/_____

RELATION TO PATIENT: SELF / SPOUSE / DEPENDANT / OTHER

ID #: _____ **GROUP #:** _____

START DATE:____/_____/_____ **END DATE:** ____/_____/_____ **COPAY AMOUNT:** _$_____

Oscceola Women's & Family Medicine Specialists
Faith & Healthy Life

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SECONDARY INSURANCE NAME: _____

SUBSCRIBER NAME: _____ **DOB:** ____/_____/_____

RELATION TO PATIENT: SELF / SPOUSE / DEPENDANT / OTHER

ID #: _____ **GROUP #:** _____

START DATE:____/_____/_____ **END DATE:** ____/_____/_____ **COPAY AMOUNT:** $_____

IF PATIENT UNDER 18, PARENT/GUARDIAN NAME_____ RELATION _____

CONTACT IN CASE OF EMERGENCY

NAME_____

PHONE NUMBER_____ RELATION TO PT_____

NAME_____

PHONE NUMBER_____ RELATION TO PT_____

PATIENT HAS GIVEN PERMISSION FOR MEDICAL AND BILLING INFORMATION TO BE GIVEN VIA:

___Home Voice Mail ___Cell Voice Mail ___Work Voice Mail ___E-mail ___Affiliated Facilities re: procedures/tests

___Other:_____

Please list names and their relations to you that are authorized to speak w/our staff on behalf of you(the patient), or to leave detailed messages regarding medical care, results, procedures, billing, and any other important information regarding your treatment:

_____

_____

_____

I authorize OSCEOLA WOMEN & FAMILY MEDICINE SPECIALISTS and staff to release to my insurance carrier and its agents any healthcare information regarding my treatment needed to determine benefits or the benefits payable for related services. I authorize my insurance company or any other party to make payable directly to Osceola Women and Family Medicine Specialists for any services rendered. By signing below, I am responsible for charges incurred for services rendered that are not covered. These charges are to be paid within 30 days unless other arrangements have been made. This consent will remain in force for a reasonable period of time in order to collect for office and hospital charges.

Patient/Custodian Signature _____ **Date**_____

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

____Accepted _____ Denied

Signature_____

Date: _____

Oscceola Women's & Family Medicine Specialists
Faith & Health 1st

618 13th St. STE 101
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HIPAA/ DISCLOSURE OF HEALTH INFORMATION POLICY

HIPAA POLICY - This office will NOT disclose information to any party without signed consent from the patient. If you do not write in name of person on HIPPA paperwork, NO medical issues will be discussed with them. NO EXCEPTIONS.

I authorize the disclosure of health information about me from the Osceola Women & Family Medicine Specialist to be disclosed to myself or Spouse or Guardian _____ _____ regarding my in office consult and/or treatment (i.e. progress notes, lab and radiology results, medication, patients plans, referral information.) This information is to be used for my personal use.

I wish to be contacted in the following manner (check all that apply):

_____ Home telephone _____

_____OK to leave message with detailed information
_____Leave message with call-back number only

_____Work telephone _____
_____OK to leave message with detailed information
_____Leave message with call-back number only

_____Other instructions
_____
_____

This authorization can only be revoked with written authorization.

Print Patient Name_____

Signature_____ Date_____

618 13th St. STE 101
St. Cloud, FL 34769
(407) 556-3999

Request for Medical Records

To: _____
_____
_____
Fax_____ Date Requested:

Reason for Request:

I hereby request that my medical records be released to:

Tanya M. Medina, MD
Osceola Women & Family Medicine Specialists
618 13th Street, Suite 101
St. Cloud, FL 34769
Phone: (407)-556-3999 Fax: (407)-556-3933

This authorization will expire on the following date_____. If I fail to specify an expiration event or condition the authorization will expire in one year. I understand that this is revocable upon written notice to the office where original authorization is retained, except to the event that the action ahs already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Further request that no generic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this rule. I further understand that Osceola Women & Family Medicine Specialists may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization

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_____
Patient Name (Please Print)

_____
Patient Address

_____ _____ _____
City State Zip

_____ _____ _____
Date of Birth Social Security Number Phone

Please send records to Physician listed above.

If I have had a screening for Human Immunodeficiency virus (HIV), I request that those test results be included with my medical records.
_____Yes _____No Patient initials: _____

Patient Signature_____

PLEASE MAIL IF MORE THAN 15 PAGES

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Osceola Women & Family Medicine Specialists

PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I, undersigned patient, permit parent or legal guardian do hereby present myself (or the patient) for care or treatment at Osceola Women & Family Medicine Specialists, and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures, I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician, All physicians expect payment in full upon a receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service or treatment plane.

ASSIGNMENT OF BENEFITS: I HERBY ASSIGN PAYMENT DIRECTLY TO Osceola Women & Family Medicine Specialists, the physician accepting the assignment, of all medical benefits applicable and other wise payable to me. I understand that I am financially responsible to Osceola Women & Family Medicine Specialists for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, THE UNDERSIGNED PATYIENT, PARENT, OR LEGAL GUARDIAN, DO HERREBY AUTHORIZE Osceola Women & Family Medicine Specialists, the practice's officers and her employees, to release to any third party payer (such as an insurance company or Government agency; example: Blue Cross/Blue Shield of Florida or Medicare) any medical psychiatric, alcohol, drug abuse and/or HIV (Aids or Aids related complex) treatment information and records, in accordance with the policy of Osceola Women & Family Medicine Specialists and any applicable State or Federal Statues, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment, and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Osceola Women & Family Medicine Specialists from liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statues, stipulates that nay person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS- CERTIFICATION AND AUTHORIZATION TO REALEASE INFORMATION AND PAYMENT REQUESTS: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Osceola Women & Family Medicine Specialists. I understand that I am responsible for any health insurance deductibles and coinsurance.

_____ **MEDICAL BENEFICIARY NOTICE OF NON-COVERED SERVICES:** Medicare does not cover some inpatient, (initials) outpatient and emergency services. Items not included, but are limited to, medications typically self-administered, annual testing and physicals

AKNOWLEDGMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Osceola Women & Family Medicine Specialists as dated below and does not waive any of my right to request a review or make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH MAY BE ON FILE AT THE OFFICE of Osceola Women & Family Medicine Specialists.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she individually hereby obligates himself/herself to pay the account of Osceola Women & Family Medicine Specialists in accordance with the regular rates and terms of the physicians. The undersigned will pay all costs and expenses including reasonable collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint Osceola Women & Family Medicine Specialists and/or her successor /designee as my attorney-in-fact to take measures in my behalf as may necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance by signing my name as attorney-in-fact for me to any such checks and/or insurance claim forms.

_____ _____

Patient's signature **Patient's representative/policy holder or spouse**
Indicate relationship;_____

_____ **Date:_____**

Witness

Patient unable to sign due to:_____