Jorge L. Florin, MD, FACS
Christopher J. Johnson, DO, FACOS, FACS
Jason A. Boardman, MD, FACS
Alexander D. Schroeder, MD
Owen R. Kieran, DO, FACOS, FACS
Lucille E. Woodley, MD
Amy E. Diehl, PA-C
Sarah M. Ramos, PA-C
Bailey E. Florin, PA-C

___MFSA Winter Garden Clinic
2000 Fowler Grove Blvd
3rd Floor
Winter Garden, FL 34787
T: 407.521.3600
F: 407.521.3603

___MFSA Clermont Clinic
1919 E Hwy 50
Suite 201
Clermont, FL 34711
T: 352.243.2622
F: 352.243.6277

___MFSA Apopka Clinic
2100 Ocoee Apopka Rd
Suite 240
Apopka, FL 32703
T: 407.521.3600
F: 407.521.3603

For Your Appointment

Appointment Date: _____/_____/_____ Time: _____ Provider: _____

Enclosed are our patient forms for your scheduled appointment. Please completely fill out and bring with you. You will also need to bring the following information with you. **Failure to do so will result in your appointment being rescheduled.**

- Current insurance card(s) and valid ID
- If your insurance requires a referral for your visit, please obtain this from your primary care doctor and bring it with you to your appointment or have them fax it to our office. ****If we do not have the referral at the time of your visit, your appointment will be rescheduled.**
- We will need all medical records pertaining to your visit with the surgeon. These may be faxed prior to your appointment, or you may bring them with you. You will need to bring your mammogram, sonogram, MRI and CT disk and reports to your appointment. Please notify the facility where your test was done at least 72 hours prior to pick up so that they may have these items ready for you. ****Failure to have these items will result in your appointment being rescheduled.**
- Payment is due at the time services are rendered. This includes copay, co-insurance, and deductibles. ****Failure to bring payment with you will result in your appointment being rescheduled.**
- Please bring a list of your medications (with the correct spelling) and dosage. If this is not available, medication bottles will be needed.
- Please arrive 20 minutes early for your appointment (unless told otherwise).
- If you are unable to keep your appointment, 48-hour notice is needed. Failure to do this will result in a cancelation fee of $50.00.
- If you have a living will or medical advance directive, please bring this with you as it is needed for your chart.

Thank you for your cooperation and we look forward to seeing you soon. Please call our office with any questions: Winter Garden/Apopka @ 407.521.3600 or Clermont @ 352.243.2622.

Mid-Florida Surgical Associates

Patient Information

(Please complete the entire form)

MID-FLORIDA SURGICAL ASSOCIATES

First_____ **MI**_____ **Last**_____

Sex (Circle One) **M** **F** **DOB** _____/_____/_____ **Marital Status**_____

Race (Circle One) **Black** **White** **Asian** **American Indian** **Ethnicity** (Circle One) **Hispanic** **Not Hispanic** **Decline**

Language (Circle One) **English** **Spanish** **Other** _____ **SS#** _____/____/_____ (Required)

Do you have a living will or medical advance directive? ___**Yes** ___**No** (if yes, copy mandatory)

Address_____ **Apt/Unit/Lot #** _____

City_____**St**_____**Zip**_____**Email**_____

Home#_____ **Cell#**_____**(text__Y__N___)** **Work#**_____

Employer_____ **Occupation**_____

EMERGENCY CONTACT _____**RELATION TO PATIENT**_____

HOME#_____**WORK#**_____ **CELL#**_____

Primary Insurance _____ **Copy of Card Provided** ___**Yes** ___**No**

Policy Holder's Name_____ **DOB** _____/_____/_____

Policy Holder's SS# _____/____/_____ **Policy Holder's Relation to Patient**_____

Secondary Insurance _____ **Copy of Card Provided** ___**Yes** ___**No**

Policy Holder's Name_____ **DOB** _____/_____/_____

Policy Holder's SS# _____/____/_____ **Policy Holder's Relation to Patient**_____

Primary Care Physician_____**Phone**_____

I have received the Notice of Privacy Practices and hereby request and consent to examination and/or medical treatment by the providers of Mid-Florida Surgical Associates.

Patient Signature_____ Parent/Power of Attorney Signature_____

Date_____/_____/_____ Parent/Power of Attorney Print_____

Patient Authorization for Practice to Release Protected Health Information to Third Parties

MID-FLORIDA SURGICAL ASSOCIATES

By signing this authorization, I authorize Mid-Florida Surgical Associates to use and/or disclose certain Protected Health Information (PHI) pertaining to me to the party or parties listed below either in person or via phone or fax.

Please list any individuals you authorize Mid-Florida Surgical Associates to speak to below

Name: _____ Relation: _____

____medical information ____financial information ____anything ____emergency only

Name: _____ Relation: _____

____medical information ____financial information ____anything ____emergency only

Name: _____ Relation: _____

____medical information ____financial information ____anything ____emergency only

Can we speak to your employer? _____**YES** _____**NO** Name of Employer: _____

____medical information ____financial information ____anything ____emergency only

This authorization will remain effective unless notified by you in writing (please initial) _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization. My written revocation must be submitted to Mid-Florida Surgical Associates' Privacy Officer at: 1804 Oakley Seaver Drive Suite A Clermont, FL 34711

Signature _____
Patient or Legal Guardian

Print _____
Patient or Legal Guardian

Relationship to Patient _____
If Self, Disregard

Patient's Name_____
If Self, Disregard

Date _____/_____/_____

Updated:

Initial_____Date_____/_____/_____

Initial_____Date_____/_____/_____

Initial_____Date_____/_____/_____

Patient Consent for Use and Disclosure of Protected Health Information

MID-FLORIDA SURGICAL ASSOCIATES

With my consent, Mid-Florida Surgical Associates may use and disclose **P**rotected **H**ealth **I**nformation (PHI) about me to carry out **T**reatment, **P**ayment, and healthcare **O**perations (TPO). Please refer to Mid-Florida Surgical Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mid-Florida Surgical Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Mid-Florida Surgical Associates
Privacy Officer
1804 Oakley Seaver Drive
Suite A
Clermont, FL 34711

With my consent, Mid-Florida Surgical Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Mid-Florida Surgical Associates may email, mail or fax to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked Personal and Confidential. I have the right to request that Mid-Florida Surgical Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mid-Florida Surgical Associates' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Mid-Florida Surgical Associates may decline to provide treatment to me.

Signature _____ Date_____/_____/_____
Patient or Legal Guardian

Print _____ Patient's Name_____
Patient or Legal Guardian If same, disregard

Lifetime Insurance & Policy Authorization

(Please sign appropriate sections as they apply to your insurance)

MID-FLORIDA SURGICAL ASSOCIATES

MEDICARE

I request that payment of authorized Medicare benefits be made on my Behalf to Jorge L. Florin, MD, PA DBA Mid-Florida Surgical Associates for any services furnished to me by any of the above providers. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature_____ **Date**_____/_____/_____

MEDICARE REPLACEMENT/SUPPLEMENT, MEDICAID AND/OR COMMERICAL INSURANCE

I request that payment of authorized insurance benefits be made on my behalf to Jorge L. Florin, MD, PA DBA Mid-Florida Surgical Associates for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company to determine the benefits payable for the services rendered by any of the above providers.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY HEALTH BENEFITS (COPAYS, DEDUCTIBLES, COINSURANCES, etc.) AS STATED IN POLICY. THIS WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED. IN SOME CASES, THE EXACT INSURANCE BENEFITS CANNOT BE DETERMINED UNTIL THE INSURANCE COMPANY RECEIVES AND PROCESSES THE CLAIM. IT IS MY RESPONSIBILITY TO NOTIFY MID-FLORIDA SURGICAL ASSOCIATES OF ANY CHANGES IN MY HEALTHCARE COVERAGE.

Patient Signature_____ **Date**_____/_____/_____

SELF-PAY or NON-INSURED PATIENTS

If you do not have insurance or if we are not a participating provider for your insurance, you will be responsible for services as they are rendered. If services were provided emergently, please set up a payment plan for the care you received in good faith.

Patient Signature_____ **Date**_____/_____/_____

CANCELLATION POLICY

Patients who fail to show for scheduled appointments or did not notify the office within 48 hours of their appointment time, will be charged a no-show fee of $50.00 for office appointments and/or $300 fee for surgery appointments. In the event of an actual emergency and prior notice cannot be given, consideration will be given and a one-time exception may be granted. Please contact the office for cancellations/re-schedules during regular business hours. Do not call the answering service for this, as the answering service should only be used to reach the physcian after hours for emergencies only. We appreciate your cooperation with this policy.

Patient Signature_____ **Date**_____/_____/_____

30-DAY FACILTY POLICY

I understand if my surgery is more than 30 days from my office visit and is scheduled at a hospital or surgery center that I may require a follow up visit. This will result in additional charges that will be my responsibility, such as co-pays, deductibles, co-insurances, etc which will be due at the time of service. Mid-Florida Surgical Associates must comply with this requirement as this is a hospital/surgery center-based policy.

Patient Signature_____ **Date**_____/_____/_____

MID-FLORIDA SURGICAL ASSOCIATES

Patient Name: _____

Date of Birth: ____/_____/_____

***Local* Pharmacy Name:** _____ **Pharmacy Phone #:** _____

I authorize Mid-Florida Surgical Associates to download my medication history from my pharmacy portal: Y____N____

Vaccines: Flu: Yes____ No____ Date: _____/____/_____

Pneumonia: Yes____ No____ Date: _____/_____/_____

COVID-19: Yes____ No____ **Pfizer**____ **Moderna**____ **Johnson & Johnson's**____

Date: _____/_____/_____ Date: ____/_____/_____

Booster date: ____/_____/_____ Booster date: ____/_____/_____

Allergies: Contrast Dye: Yes____ No____

Medication Allergies ☐ No Known Medication Allergies

	Reaction

Food Allergies ☐ No Known Food Allergies

	Reaction

Environmental Allergies ☐ No Known Environmental Allergies

Examples: (latex, tape, seasonal, dust, grass, pets, etc....)

	Reaction

List of Current Medications: Prescription, Over-The-Counter Medications or Supplements and/or Vitamins

Name of Medication	**Strength**	**Dosage**

*Additional medications can be listed on the back of sheet

Date	**Patient Signature**	**Date**	**Patient Signature**
/ /		/ /	
/ /		/ /	
/ /		/ /	