Jorge L. Florin, M.D., F.A.C.S.
Christopher J. Johnson, D.O., F.A.C.O.S., F.A.C.S.
Jason A. Boardman, M.D., F.A.C.S.
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Owen R. Kieran, D.O.
Amy E. Diehl, PA-C
Sarah M. Ramos, PA-C
Courtney Beville, PA-C

__10,000 West Colonial Dr
Suite 288
Ocoee, FL 34761
Ph. 407.521.3600
Fx. 407.521.3603

__1804 Oakley Seaver Dr
Suite A
Clermont, FL 34711
Ph. 352.243.2622
Fx. 352.243.6277
Arrive 30 mins early

__2000 Fowler Grove Blvd
3rd Floor
Winter Garden, FL 34787
Ph. 407.521.3600
Fx. 407.521.3603

What you need 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 I.D.
- If your insurance requires a referral for your visit, please obtain this from your primary care doctor and bring 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, the medication bottles will be required.
- Please arrive 20 minutes early for your appointment (unless stated otherwise).
- If you are unable to keep your appointment, a 48-hour notice is required. 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 required for your chart.

Thank you for your cooperation and we look forward to seeing you soon.

Mid-Florida Surgical Associates

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Patient Information

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, must provide a copy)

Address____________________________________ Apt/Unit/Lot # ______________

City________________St_____Zip___________Email_______________________

Home#_______________Cell#____________________ 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

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: 10000 West Colonial Drive Suite 288 Ocoee, FL 34761

Signature ______________________________ Print ______________________________
Patient or Legal Guardian Patient or Legal Guardian

Relationship to Patient ______________________________ Patient's Name______________________________
If Self, Disregard If Self, Disregard

Date _____/_____/________

updated:
initial______________Date____
initial______________Date____
initial______________Date____

patautPHI

Patient Consent for Use and Disclosure of Protected Health Information

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 anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Mid-Florida Surgical Associates
Privacy Officer
10000 West Colonial Drive
Suite 288
Ocoee, FL 34761

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 as long as 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 Authorization

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

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 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 in order 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 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 could not 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_____/_____/____________

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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: __YES __NO

Vaccines: Flu: Yes____No____ Date: ____/___/_____
Pneumonia: Yes____No____ Date: ____/___/_____
COVID-19: Yes____No____ Date: ____/___/_____ Pfizer Moderna Johnson & Johnson's
Date: ____/___/______ Date____/___/_____
Booster date if applicable: ____/___/_____

Medication Allergies ☐ No Known Medication Allergies

	Reaction

Food Allergies ☐ No Known Food Allergies

	Reaction

Environmental Allergies ☐ No Known Environmental Allergies
Examples: (latex, seasonal, pets…)

	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
/ /		/ /	
/ /		/ /	
/ /		/ /	