2022

CHANGE OF INSURANCE FORMS PACKET

ASSOCIATED FAMILY PHYSICIANS
OF BOCA RATON, P.L.

MARILYN B. CABRAL
Administrator

MEDICAL STAFF

LYNDA ALTMAN, M.D., F.A.A.F.P.
Board Certified in Family Medicine

OWEN A. BARRUW, M.D., F.A.C.P.
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D., PA.
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.
Board Certified in Endocrinology

TABITHA M. DUGAL, FNP-C
Nurse Practitioner

Date: _____

Patient's Name : _____ Marital Status : _____

Address : _____ Date of Birth: _____

City: _____ Age : _____ Sex : M F

State: _____ Zip Code : _____-- _____

Race: O Caucasian O Black O Hispanic O Asian O Native American O Asian Pacific American O Pacific Islander O Subcontinent Asian American O American Indian or Alaskan Native O Native Hawaiian O Black Non-Hispanic O White Non-Hispanic O Other Race or Ethnicity

Ethnicity: O Latino / Hispanic O Other O Not Reported / Refused

Home Phone : ( ) _____--_____

Cell Phone: ( ) _____--_____

Referred By : _____ Employed : Y / N Student : Y / N Retired: Y / N

Drivers License
(Please give drivers license to receptionist)

Employer: _____

Address: _____

_____--_____
City State Zip Code

Other Address: _____
(if applicable)

City: _____ State: _____ Zip Code: _____--_____

==========

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

Please Present Card To Receptionist

Below information is relating to **subscriber** (insured, not necessarily patient):

CHECK BOX IF SAME AS ABOVE

Relationship to subscriber: _____ self _____ spouse _____ child _____ other (pls. explain)

NAME OF SUBSCRIBER: _____

DATE OF BIRTH : _____

SUBSCRIBER'S ADDRESS: _____

_____ _____--_____
City State Zip Code

SUBSCRIBER'S EMPLOYER : _____

EMPLOYER'S ADDRESS: CHECK BOX IF SAME AS ABOVE

_____

_____ _____--_____
City State Zip Code

9910 SANDALFOOT BLVD., SUITE 1, BOCA RATON, FLORIDA 33428-6692
TELEPHONE (561) 883-3030 • FACSIMILE (561) 852-7611
www.afpdocs.org

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Patient's Name : _____

SECONDARY INSURANCE (if applicable)
INSURANCE COMPANY NAME: _____
Please Present Card To Receptionist
Below information is relating to **subscriber** (insured, not necessarily patient):
CHECK BOX IF SAME AS ABOVE

Relationship to subscriber: _____ self _____ spouse _____ child _____other (pls. explain)

NAME OF SUBSCRIBER: _____

HOME # ( ) _____ -- _____ DATE OF BIRTH : _____

SUBSCRIBER'S ADDRESS : _____

_____ _____--_____
City State Zip Code

SUBSCRIBER'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

_____ _____--_____
City State Zip Code

==========

PLEASE BE CONSIDERATE. FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF APPOINTMENT TIME WILL RESULT IN A $ 25.00 FEE.
Do you have a Health Care Surrogate? Y / N **If yes please furnish a copy for your medical record.**
Do you have a living will? Y / N **If yes, please furnish a copy for your medical record. If you would like literature on Advance Directives please ask your Health Care Provider.**
Primary Language Spoken: ( ) English ( ) Spanish ( ) French ( ) Other _____

Name of an emergency contact:_____

Phone number ( )_____-- _____

Relationship _____

Payment is required at the time services are rendered.

==========

LIFETIME AUTHORIZATION
I, authorize the healthcare providers and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary. I guarantee payment of any and all charges for services provided.

_____
SIGNATURE OF PATIENT (authorized person if minor) DATE

Relationship if Minor: _____

VISIT OUR WEBSITE: www.afpdocs.org
Patient Demographic Form master file

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Today's date _____ **2022**

PLEASE LET US KNOW HOW YOU WOULD LIKE CONFIDENTIAL MEDICAL INFORMATION CONVEYED TO YOU?

☐ Call home phone ( ) _____
Can we leave medical information on your answering machine / voicemail? Yes or NO

☐ Call cell phone ( ) _____
Can we leave medical information on your answering machine / voicemail? Yes or NO

☐ Can we leave medical information with a designated person? Yes or NO
If yes, please give us the individual's complete name, date of birth and relationship:

_____
Name date of birth Relationship

By signing, below I understand this authorization form to release confidential information will remain in effect until I revoke the authorization in writing.

_____
Patient's Name (Guardian if minor)

_____
Patient's Signature (Guardian if minor) Date

LOCAL PHARMACY

NAME: _____ PHONE # ( ) _____

MAIL ORDER PHARMACY

NAME: _____ PHONE # ( ) _____

Confidential medical information form.docx

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Only complete if you are on Medicare or Medicare Advantage

To Our Valued Patients:

Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers, and doctors continually undergo training so t hat they may understand and comply with government rules and regulations regarding Medicare. We strive to achieve the very highest standards of ethics and integrity in performing services for our Medicare patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Medicare expenditures. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any Medicare service or billing errors.

Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION
(SIGNATURE ON FILE)

_____ _____
NAME OF BENEFICIARY (PATIENT) MEDICARE NUMBER

"I request that payment of Medicare benefits be paid on my behalf to the Provider of medical services, for services provided to me. I authorize the release of medical information about me to the Health Care Financing Administration and it's agents, any information needed to determine benefits payable for these services.

I understand my signature requests that payment be made directly to the Provider of medical services. I authorize the release of medical information necessary to pay the claim. In Medicare assignment cases, I understand that I am responsible for my annual deductible, Co-insurance (20% of the approved amount), and any non-covered services provided to me. All other charges will be adjusted off. I understand the amount of payment I'm responsible for is due at the time services are rendered."

_____ _____
PATIENT'S SIGNATURE DATE

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LIFETIME AUTHORIZATION

" I authorize the release of any medical information necessary to process a claim or any insurance related claim made on my behalf. I assign the benefits payable for services to the healthcare provider furnishing the services. I authorize such healthcare provider to submit a claim to my insurance company on my behalf." I authorize the healthcare provider and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____
PATIENT'S NAME

X_____
PATIENT'S SIGNATURE (authorized person if minor) DATE

Authorization forms

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Dr. Radhika P. Phadke * Tabitha M. Dugal, FNP-C * Gabriela Lopez Botero, PA-C

Patients: By dating and signing below this will help us coordinate your health care with other health care providers.

I, authorize any Physician, Hospital, Diagnostic Facility, Health Provider, or Insurance Carrier to release any information on my behalf to Associated Family Physicians of Boca Raton, P.L.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Patient's Signature (Guardian if minor) Date

I, authorize Associated Family Physicians of Boca Raton, P.L. to release any information on my behalf to any Physician, Hospital, Diagnostic Facility, Health Provider, or Insurance Carrier.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Patient's Signature (Guardian if minor) Date

I, authorize Associated Family Physicians of Boca Raton, P.L., their doctors and employees to release any medical information on my behalf to the following: (e.g. family members)

_____ _____
1. Print Name Relationship

_____ _____
2. Print Name Relationship

_____ _____
Print Patient's Name Date of Birth

_____ _____
Patient's Signature (Guardian if minor) Date

file: release of medical information

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Name_____ Date_____

Do I Need a Test For PAD?

'eripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? ☐
4. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? ☐
5. Do you have diabetes and unusual hair loss or skin discoloration in your legs? ☐
6. Do your fingers or toes feel numb or cold in response to temperature changes or stress? ☐
7. Have you suffered a severe injury to your leg(s) or feet? ☐
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? ☐
9. Have you had blockages in your coronary or heart arteries? ☐

Other Comments or Notes: _____

_____

_____

Patient Signature:_____ Date:_____

Note: *Providers are advised that insurance carriers have policies regarding when diagnostic services are considered medically necessary. These policies may vary between carriers and are subject to change at any time. Providers should check coverage requirements with specific insurance plans before testing.*

ALLERGY PROFILE

Name: _____ Phone: _____ DOB: _____ Date: _____

Please check all symptoms that you experience occasionally or more than once a day:

☐Sneezing ☐Runny Nose ☐Postnasal Drip ☐Hives/Rash ☐Vomiting
☐Headaches ☐ Itchy/Watery eyes ☐ Wheezing ☐ Cough ☐Diarrhea
☐Nasal Congestion ☐Shortness of Breath ☐ Itching ☐ Swollen lips, tongue, face, etc.

Have you tired over the counter allergy medication(s)? (Antihistamines, Decongestants):

☐Yes ☐No Which medications have you tried? _____

Have you ever been allergy tested? ☐Yes Date: _____ ☐No

----------**PHYSICIAN USE ONLY**----------

Physician Recommendations: ☐ Allergy Testing ☐ No recommendation

☐ **Allergic Rhinitis Unspecified** j30.9 ☐ **Allergic Conjunctivitis** H10.45 ☐ **Asthma Mild Persistent** J45.30
☐ **Chronic Rhinitis** j31.0 ☐ **Rash** R21 ☐ **Asthma Mild Intermittent** J45.20
☐ **Urticaria – Idiopathic** L50.1 ☐ **Atopic Dermatitis** L20.81 ☐ **Asthma Moderate Persistent** J45.40
☐ **Urticaria – Allergic** L50.0 ☐ **Angioedema** T78.3 A D S ☐ **Asthma Other** J45.998
☐ **Sinusitis Chronic (NOS)** J32.9 ☐ **Allergic Gastro** K52.2

☐ Lynda Altman, M.D., F.A.A.F.P ☐ Debra A. Costantino, ANP-BC ☐ Gabriela Lopez Botero, PA
☐ Owen A. Barruw, M.D., F.A.C.P ☐ Tabitha M. Dugal, FNP-C ☐ Other: _____
☐ Dushyant J. Utamsingh M.D.
☐ Radhika Phadke, MD

X_____ X_____

Provider Signature **Documented in Chart**