ALL ABOUT MEDICINE

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Please Print

PATIENT INFORMATION

Patient's Last Name, First Name, Middle	[ ] Mr. [ ] Mrs. [ ] Miss. [ ] Mrs.	Marital Status: Single / Married / Divorced / Seperated / Widowed			
If this is not, what is your legal name?	Former/Maiden Name:	Social Security #	Date of Birth	Age:	Sex: [ ] Male [ ] Female
Home Phone Number:	Cell Phone Number:	Preferred Contact Method: [ ] Home [ ] Cell [ ] Other [ ] Work			
Email Address:					
Street Address:		City:		State:	ZIP Code:
Occupation (if student, please specify):	Employer:			Employer/Work Phone	
Referred to clinic by: [ ]Our website, [ ]Other Webpage, [ ]Friend/Family, [ ]Yellow Pages, [ ]Newspaper, [ ]Insurance Company, [ ]Dr._____					
Preferred Language: [ ] English, [ ] Spanish, [ ] Hindi, [ ] Other (Please Specify):					

FINANCIAL INFORMATION

(Please give your insurance card(s) and identification card/driver's license to the receptionest)

Person responsible for bill:	Date of Birth:	Address (If Different)	Home Phone Number:
Is this person a patient here? [ ] Yes [ ] No			
Occupation:	Employer:	Employer address:	Employer Phone#:

INSURANCE INFORMATION

Is patient covered by Insurance? [ ] Yes [ ] No		Primary Insurance Company:		
Subscriber's Name:	Subscribers Social Security #:	Date of Birth:	Group Number:	Policy Number:
Patient's Relationship to Subscriber: [ ]Self [ ]Spouse [ ]Child [ ]Other:				

IN CASE OF AN EMERGENCY

Name of local friend or relative to contact in case of an emergency:	Relationship to patient	Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance owed.

Patient/Guardian Signature:	Date:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In the event you must be contacted by phone with regards to appointments, test results, referrals, or any other reason, please indicate how you wish to be contacted.

	ORDER OF PREFERENCE	OK TO LEAVE VOICEMAIL?	PHONE NUMBER
HOME PHONE	[ ]1 [ ]2 [ ]3 [ ]4	[ ] YES [ ] NO	
CELL PHONE	[ ]1 [ ]2 [ ]3 [ ]4	[ ] YES [ ] NO	
WORK PHONE	[ ]1 [ ]2 [ ]3 [ ]4	[ ] YES [ ] NO	
ALTERNATE PHONE	[ ]1 [ ]2 [ ]3 [ ]4	[ ] YES [ ] NO	

You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	NAME	RELATIONSHIP	PHONE NUMBER
[ ] FINANCIAL [ ] MEDICAL CARE			
[ ] FINANCIAL [ ] MEDICAL CARE			
[ ] FINANCIAL [ ] MEDICAL CARE			
[ ] FINANCIAL [ ] MEDICAL CARE			

PATIENT'S PRINTED NAME DATE OF BIRTH

PATIENT/LEGAL REPRESENTATIVE SIGNATURE DATE

RELATIONSHIP TO PATIENT

NEW PATIENT

NAME:	DOB:
If minor, accompanying Adults Name:	Todays Date:

REASON FOR TODAYS VISIT:

Please list your CURRENT MEDICATIONS:		
Name of Medication	**Dosage (ie, milligrams)**	**Frequency of Dose**

Please list any ALLERGIES to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea)

Please provide your **IMMUNIZATION HISTORY:**

Tetanus-Diphtheria Booster [ ] Y [ ] N	**Date**	**Hepatitis A Vaccine [ ] Y [ ] N**	**Date**
Influenza Vaccine (Flu Shot) [ ] Y [ ] N		**Hepatitis B Vaccine [ ] Y [ ] N**	
Pneumococcal [ ] Y [ ] N		**Human Papilloma Virus (HPV) [ ] Y [ ] N**	
Tuberculosis (TB) Skin Test [ ] Y [ ] N		**Varicella Vaccine [ ] Y [ ] N**	

Please provide your **PAST MEDICAL HISTORY**:

___Allergies
___Anemia
___Angina (chest pain)
___Anxiety
___Arthritis
___Asthma
___Atrial Fibrillation
___BPH (enlarged prostate)
___Blood Clots
___Cancer, Type:_____
___CVA (stroke)
___COPD (emphysema)
___CAD (heart disease)
___Crohn's Disease
___Depression
___Diabetes
___Gallbladder Disease
___GERD (reflux)
___Hepatitis C
___High Cholesterol
___High Blood Pressure
___Irritable Bowel Disease
___Liver Disease
___Migraine Headaches
___MI (heart attack)
___Osteoarthritis
___Osteoporosis
___Peptic Ulcer Disease
___Renal Disease (kidney)
___Seizure Disorder
___Thyroid Disease

Please tell us about any **SURGERIES** you have had; you may indicate the **DATE/YEAR if known:**

___Angioplasty
___Angioplasty with Stent
___Arthroscopy (Knee)
___Back Surgery
___CABG (open heart)
___Carpal Tunnel Release
___Cataract
___Cholecystectomy
___Colectomy (colon removal)
___Colostomy
___Gastric Bypass
___Hernia Repair
___Hip Replacement
___Knee Replacement
___LASIK
___Liver Biopsy
___ORIF (broken bone repair)
___Pacemaker
___Small Bowel Resection
___Thyroidectomy
___Tonsillectomy

Gender Specific Male:
___Prostatectomy
___TURP
___Vasectomy

Gender Specific Female:
___Breast Augmentation
___Bilateral Tubal Ligation
___Breast Biopsy
___Cesarean Section
___D & C
___Hysterectomy
___Breast Reduction

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:**

_____

Please provide your **FAMILY HISTORY:**

	Mother	Father	Sister	Brother	Other
ADD/ADHD	[ ]	[ ]	[ ]	[ ]	[ ]
Alcoholism	[ ]	[ ]	[ ]	[ ]	[ ]
Allergies	[ ]	[ ]	[ ]	[ ]	[ ]
Alzheimer's Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]
Blood Disease	[ ]	[ ]	[ ]	[ ]	[ ]
CAD (heart)	[ ]	[ ]	[ ]	[ ]	[ ]
Premature Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer, Type:_____	[ ]	[ ]	[ ]	[ ]	[ ]
CVA (stroke)	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Developmental Delay	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]

	Mother	Father	Sister	Brother	Other
Hearing Deficiency	[ ]	[ ]	[ ]	[ ]	[ ]
High Cholesterol	[ ]	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]
Irritable Bowel Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Learning Disability	[ ]	[ ]	[ ]	[ ]	[ ]
Mental Illiness	[ ]	[ ]	[ ]	[ ]	[ ]
Migraines	[ ]	[ ]	[ ]	[ ]	[ ]
Obesity	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoarthritis	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	[ ]	[ ]
Peripheral Vascular Dis.	[ ]	[ ]	[ ]	[ ]	[ ]
Renal (kidney) Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Seizure Disorder	[ ]	[ ]	[ ]	[ ]	[ ]

Social HISTORY

Do you Smoke?
_____

Type of Tobacco:
_____

Packs Per Day:
_____

 # Years Smoking?
_____

Have you tried quitting?
_____

Years Quit:

Do you drink Alcohol?

[ ] Yes [ ] No [ ] Former
Type of alcohol: _____
Frequency: _____
Amount: _____
When was your last drink?
_____

For Females ONLY:

Age at first Period:_____, Last Menstrual Period: _____, Last Mammo: _____, Last PAP Smear: _____, Abnormal PAP: _____, When: _____,
Are Periods regular? [ ] Yes [ ] No
Do you have pain with periods? [ ] Yes [ ] No
Is flow: [ ]Normal [ ]Heavy [ ]Light [ ]Spotting
#Pregnancies: _____, #Miscarriages: _____, #Abortions: _____,

Hospitalization within the past 1 Year:

Name of Hospital	Reason for hospitalization	month/year

Past Surgical History:

Operation type	month/year	Operation type	month/year

Preventative Health Measures:

Please list the most recent dates for the mentioned Health Screening tests:

Vaccine	month/year	screening	month/year	screening	month/ year
Flu		Mammogram		PSA	
Pneumonia		Bone Density (DEXA)		Pap Smear	
Shingle's		**Colorectal Cancer Screen:**		Eye Exam	
Tetanus		Colonoscopy		ECHO	
		Cologuard		PFT	
		FOBT		EKG	
				CXR	

Other Physicians/Specialists:

Type of Doctor	Name of Doctor	Phone #	Type of Doctor	Name of Doctor	Phone #
Cardiology			Ophthalmology		
Dermatology			Orthopedics		
ENT			Psychiatry		
Gastro (GI)			Pulmonology		
Nephrology			Urology		
Hematology			Rheumatology		
Oncology					
Infect Dis.					

ALL ABOUT MEDICINE

HIPPA PRIVACY AUTHORIZATION FORM

The individual signing this form agrees and acknowledges as follows:

I hereby give my consent for ALL ABOUT MEDICINE to use and disclose my Protected Health Information to carry out treatment, payment, and Healthcare operations (TPO). The Notice of Privacy practices provided by ALL ABOUT MEDICINE describes such uses and disclosures more completely.

With this consent, ALL ABOUT MEDICINE may send me emails, text messages, call my home, send mail to my home or other alternative locations and to leave a message on voicemail, or in person in reference to any items that assist the practice in carrying out the TPO, such as appointment reminders, insurance related info or any calls pertaining to my clinical care including laboratory test results among others.

- **Voluntary Authorization**: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- **Effective Time Period:** This authorization shall be in effect until two (2) years after the death of the patient for whom this authorization is made for.
- **Right to Revoke**: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

This authorization may include disclosure of information relating to drug, alcohol & substance abuse, mental health information, confidential HIV/AIDS information, and genetic information. In the event the health information described above includes any of these types of information I specifically authorize release of such information to the person or entity indicated herein.

-Signature Authorization: I have read this form and agree with the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: Date:

If Legal Representative, relationship to patient:

ALL ABOUT MEDICINE

AUTHORIZATION TO REQUEST MEDICAL RECORDS

I hereby authorize ALL ABOUT MEDICINE to request all my medical records from my previous Healthcare providers (Primary Care Provider and Specialists). Medical Records can be faxed, emailed or mailed:

FROM:

Former Practice Name: _____

Former PCP Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

TO:

ALL ABOUT MEDICINE

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Phone: (407)777-2503

Fax: (407)777-2523

e-mail: info@allaboutmedicine.com

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Patient Name and Signature: _____ Date:_____

ALL ABOUT MEDICINE

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, however,that the contract regardingyour health care benefitsisbetweenyou, your employer, and your insurance company. The obligation you have with our practice isto pay for treatment, regardless ofthe amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

• Although we are willingto complete insurance information forms and submit a claimonyour behalf,we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

• We requireyoutosignthisformand/or any other necessary assignment documentsthat may be required by your insurance company. This instructs your insurance company to make payment directly to ouroffice.

• We requireyou to pay the co-payment, which isthe amount not covered by yourinsurance company, atthe time we provide service to you.

• Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

• Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billingprocedures uponverification of coverage. However, ifyour claim is denied, you will be responsible for payingthe full amount atthat time.

• Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THEABOVE TERMSAND CONDITIONS. IAUTHORIZE MY INSURANCE COMPANY TO PAYMYHEALTHBENEFITSDIRECTLYTOTHEDOCTOR.

Signature of Patient/Responsible Party: _____

Date: _____

I AUTHORIZE YOU TODEBIT MY CREDIT CARDIFYOU HAVENOT RECEIVED PAYMENT FROM MY INSURANCE COMPANY WITHIN 60DAYSOF RECEIVINGTREATMENT.

Print Name:_____ Credit Card# (Optional): _____

Expiration Date: _____ V-Code: _____

ALL ABOUT MEDICINE

PATINENT FINANCIAL AGREEMENT

By signing this I hereby authorize ALL ABOUT MEDICINE to release to any insurance company/Medicare or its carriers any information needed to process and pay my claims. I approve payment by medical insurance and medical benefits to be made directly to ALL ABOUT MEDICINE. I understand it is mandatory to inform my healthcare provider of any other party who may be responsible for paying any other deductible amount, co-pay, or any percentage fees not paid by the insurance company of 3rd party within reasonable time which is not to exceed 60 days. I also authorize payment of my insurance/Medicare benefits to be made directly to ALL ABOUT MEDICINE for my treatment. I also understand that it is my responsibility to pay any unpaid amounts not paid by the insurance company/Medicare.

Insurance regulations suggest that we inform you in advance if we believe a service may not be covered or fully re-imbursed by your insurance. In the doctor's professional judgement certain services needed to provide high quality healthcare and to help formulate a diagnosis may not be reimbursed by the insurance. Such services include but are not limited to EKGs, labs, biopsies, etc. We will only perform these services when required and only to optimize the care provided to you.

Patient Agreement:

I hereby certify that I have read and fully understand the above information and that I understand I will be responsible for payment of any medically necessary services should they be denied by my insurance. I also understand that I have the right to accept or refuse medical treatment.

Lastly, I understand and have been informed about my right to implement Advanced Directive. An Advanced Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and are unable to communicate your wishes. Our office requires a copy of such documents (Advanced Directives, Living Will, Durable Medical Power of Attorney, DNR/DNI forms)

Name and Signature of Patient: Date:

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE MEDICATIONS

Controlled substance medications (i.e., narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, reduce stress, and assist in sleep; thus improving function and/or ability to work. Our physicians are dedicated to improving the quality of living for their patients; however, every care is taken to maximize the safety and well-being of the patients by implementing strict rules and controls over the prescribing of narcotics. Failure to abide by these regulations could lead to discharge from the practice.

1. Prescriptions for narcotics will only be given during an office visit and we will not be able to accommodate your request after hours or on weekends. Should you need a prescription or refill other than during office hours, you may need to be seen in an emergency room and evaluated by the attending physician.

2. Refills of controlled substance medications will not be made if you "run out early", "lose a prescription", or "spill or misplace" your medication. You are responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

3. You are responsible for the controlled substance medications prescribed to you. If your prescription is lost, misplaced, or if you "run out early", please understand that medication will not be replaced. If your medication is stolen it will only be replaced if a police report is provided.

4. It may be deemed necessary by your doctor that you see a pain specialist or other specialist at any time while you are receiving controlled substance medications. Please understand that if you do not attend such an appointment, your medications may be discontinued or may not be refilled beyond a tapering dose to completion. Also understand that if the specialist feels that you are at risk for psychological dependence (addiction), your medications will no longer be refilled.

5. Driving a motor vehicle may not be allowed while taking controlled substance medications and it is your responsibility to comply with the laws of the state while taking the prescribed medications.

6. If you violate any of the above conditions, your prescription for controlled substance medications may be terminated immediately.

7. If you are involved in obtaining controlled substance medications from another individual, forging or altering a controlled substance prescription, or using non-prescribed illicit (illegal) drugs, your prescription for controlled substance medications will be terminated immediately and you may also be reported to all of your physicians, medical facilities, and appropriate authorities. Please understand that these actions are grounds for the termination of your relationship with Altamonte MD.

8. You are subject to random drug testing either using urine or blood at our discretion. Testing may not be covered by your insurance and may be charged directly to you. Unless otherwise indicated you will not be screened more than 2 times per year. If you refuse to be screened we retain the right to refuse to prescribe the medication. I, the patient, understand and agree to adhere to the above terms for receiving controlled substances.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ALL ABOUT MEDICINE

24 Hour Cancellation & "No Show" Policy

At ALL ABOUT MEDICINE, we are dedicated to providing high-quality, timely care to every patient. Your scheduled appointment time is reserved specifically for you, and missed appointments or late cancellations limit our ability to serve others who may be waiting for care.

Missed Appointments & Cancellations

We kindly ask that you notify us at least **24 hours in advance** if you are unable to attend your appointment. This allows us the opportunity to offer the time to another patient in need.

- Appointments that are **missed without notice**, or **cancelled with less than 24 hours' notice**, may incur a **$35.00 fee**.
- This fee is **not covered by insurance** and must be paid **prior to scheduling your next appointment**.

Late Arrivals

We understand that delays happen. However, if you arrive **15 minutes or more after your scheduled appointment time**, we may need to **reschedule your visit** to ensure we remain on time for all patients.

- While we will do our best to accommodate you the same day, this may not always be possible.

We truly value your time and your health, and we thank you for helping us maintain a schedule that benefits all of our patients.

By signing below, you acknowledge that you have **read and understand** ALL ABOUT MEDICINE's policies regarding missed appointments and late arrivals.

Patient Signature: _____ Date: _____

Printed Name: _____