LAKESIDE MEDICAL, L.L.C.
600 N. Hiatus Road ❖ Suite 203 ❖ Pembroke Pines ❖ Florida 33026

WELCOME TO OUR OFFICE

Please complete this form. If you need assistance, please feel free to ask. We are happy to help you.

Your Provider: ☐ Armando De Feria, M.D. ☐ Tyesha Bowen, D.N.P. ☐ Lisset Gonzalez Perez, A.P.R.N.

Date (Fecha): _____ Tel (Telefono): _____ Cell (Celular): _____

Work (Trabajo): _____ Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work

Email Address: _____

Patient: _____
Last Name (Apellido) First Name (Nombre) Middle Initial (Inicial)

Street Address: _____
Direccion

City: _____ State: _____ Zip: _____
(Ciudad) (Estado) (Codico Postal)

Sex: ☐ M ☐ F Date of Birth: _____ Social Security #: _____
(Sexo) (Fecha de nacimiento) (Seguro Social)

Race: _____ Ethnicity: _____

Marital Status (Estado Civil): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By: _____ Occupation: _____
(Empleo) (Ocupacion)

Responsible Party: _____ Relation: _____ Phone: _____
(Persona responsable) (Relacion) (Telefono)

Emergency Contact: _____ Phone: _____
(Persona en caso de emergencia) (Telefono)

Primary Language Spoken: _____
(Idioma Principal)

Whom May We Thank For Referring You To Our Practice? _____
(Referido Por)

Please give your insurance ID card(s) to the receptionist so we may make a copy. Thank You!

ADVANCE DIRECTIVES
A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a Living Will? ☐ No ☐ Yes (If Yes, Please provide us with a copy.)

CONSENT FOR TREATMENT

I, hereby authorize **Lakeside Medical, LLC** to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the physician, including but not limited to, medications, blood samples, urine samples and other therapies. I hereby authorize any and all pharmacies to disclose my patient prescription record, reflecting my prescription history and any other pharmacy services I have received. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment. I hereby certify that I understand the above authorization.

_____ _____
Patient/Guardian Signature (Firma del Paciente) Date (Fecha)

FINANCIAL POLICIES

We will be sure to discuss our fees prior to the beginning of your treatment. Payment of fees for services rendered is expected at the time services are provided. We file insurance as a courtesy to our patients. However, we do require co-payments to be paid at the time of service. We accept cash, checks, and most major credit cards (Visa, MasterCard, American Express). Returned checks are subject to a $25 fee.

I acknowledge and understand the above-stated Policy.

_____ _____
Initials Date

OFFICE PHILOSOPHY

We would like to take this opportunity to inform you that we will spend as much time as necessary with you to fully address your medical problems. This enables us to explain our suggestions and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly and we try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassured that we value your time. However, given the unpredictable nature of our work, it is not uncommon to have a prolonged waiting period. On many occasions, we are delayed for such matters as patients' medical problems that require immediate attention, hospital calls, physician calls, and/or emergencies. These issues are unforeseen and need to be addressed appropriately. We do not leave this office until all patients are seen and all their medical problems are addressed.

We encourage your comments and suggestions. Thank you.

_____ _____
Initials Date

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to **LAKESIDE MEDICAL, LLC** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I am responsible for any fees or legal fees that **LAKESIDE MEDICAL, LLC** incur for the full collection of payments.

_____ _____
Patient/Guardian Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **LAKESIDE MEDICAL, LLC** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

LAKESIDE MEDICAL, LLC

PRESCRIPTION REFILL POLICY

Prescription refill requests will ONLY be handled at the time of the office visit. We will no longer process requests over the phone or fax. We are empowering you with the responsibility of making sure you have enough refills to last until your next appointment. If for some reason you find yourself without refills, we will accommodate you with a same day appointment so you may then obtain a prescription that will last until your next office visit. This new policy is a result of an unmanageable amount of calls and faxes for refill requests on a daily basis.

I acknowledge and understand the above-stated Policy.

_____ _____

Initials Date

MISSED/CANCELED APPOINTMENTS

Since our profession is based on an appointment schedule, our policy is to charge for missed appointments, unless your appointment is cancelled within 24–48 hours in advance. Your physician may recommend future appointments to follow up on your medical care. The appointment includes medication management, the discussion of test results, new test orders, and/or your recent visits with other health care providers. It is your responsibility to make sure you keep your appointment and obtain the test results for all tests ordered. If you are unable to keep your appointment, it is imperative you reschedule the appointment.

Please be advised repeated checks of your health are required due to the possibility of an adverse outcome. Failure to keep appointments poses risks to our ability to properly treat you and may jeopardize your health.

I acknowledge and understand the above-stated Policy.

_____ _____

Initials Date

LAB FEE

It is our policy to charge a $25 convenience fee to have lab work drawn in the office.

I acknowledge and understand the above-stated Policy.

_____ _____

Initials Date

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

I, _____, understand that as part of my health care, LAKESIDE MEDICAL, LLC originates and maintains paper and/or electronic 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 following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that LAKESIDE MEDICAL, LLC 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 also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that LAKESIDE MEDICAL, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should LAKESIDE MEDICAL, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

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

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Check if applicable: ☐ This authorization permits LAKESIDE MEDICAL, LLC to disclose my protected health information to the following person(s):

_____ Name

_____ Relation

I fully understand and accept / decline the terms of this consent.

_____ Patient Name

_____ Date

_____ Signature of Patient/Guardian

_____ If Guardian, Guardian Name (Please Print)

_____ Relation to Patient