Premier Internal Medicine
Of Ocoee

Patient Name: _____
Last First MI

Sex: M/F Marital Status: _____ Date of Birth:_____ SS#:_____

Address: _____
Street City Stare Zip Code

Home phone #:_____ Cell phone #_____ Work #_____

Occupation: _____ Employer: _____

Name of Ins Co: _____

Policy #: _____ Group #:_____

Guarantor's Name: _____ Relationship to Pt._____

Guarantor's SS#: _____ Sex:_____ Date of Birth: _____

Insured's Employer: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

I certify that the information I have provided is correct. I authorize the release of the medical information necessary to process insurance claims (for the purpose of filing and payment of medical claim). I authorize payment of medical benefits to the provider. I acknowledge that I am responsible for any co-payments and balances not paid by the insurance company. I certify that a photocopy of these assignments shall be as valid as the original.

Patient signature: _____ **Date**_____
Guardian for minor

HIPAA PATIENT PHI COMMUNICATION REQUEST

I hereby Authorize my insurance company,attorney or any other third party payer to pay directly Premier Internal medicine Of Ocoee all charges submitted for services incurred by me. I understand that I will be responsible for any and all charges not paid by my insurance company or third party payer. I authorize Premier Internal Medicine Of Ocoee to release information concerning my medical condition to my insurance company,employer,hospital,physician or attorney for the purpose of a claim. I assign payment directly to Premier Internal Medicine Of Ocoee which may be due from the medicare program or any other insurance company,including supplemental insurance, which may cover in whole or part of the medical services that I have received. The authorization and assignment shall be valid until I notify Premier Internal Medicine of Ocoee in writing of a cancellation. A photocopy of this authorization shall be as valid as the original.

I hereby acknowledge that I have read the HIPAA Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Premier Internal medicine Of Ocoee with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the HIPAA Privacy Policy.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Premier Internal Medicine
Of Ocoee
Financial Policy

In order for us to be able to continue to deliver high quality care, it is necessary to provide a financial policy. Please read all the information and acknowledge by signing below.

Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct information so that we may submit your insurance. Failure to do so may make you liable for denied claims.

1. We will collect your co-payment, deductible, co-insurance cost, payment for non-covered services or any patient balance at the time of your visit. We accept cash, personal checks, and credit cards (Visa, MasterCard and Discover).
2. If we do not participate with your insurance, we ask that you pay for your services at the time of the visit. You will be responsible to file your claim and your insurance company will reimburse your expense.
3. **MEDICARE PATIENTS:** We will submit to Medicare all your covered services. If you have a supplemental insurance, we will also submit that for you as a courtesy. If payment is not received from your supplemental insurance within 30 days of being submitted, we will ask for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your deductible is met.
4. **MEDICAID PATIENTS:** We are not participating providers with Medicaid. We ask that you pay for your services at the time of your visit.
5. **HMO/PPO PLANS:** If we participate in your plan, we will submit claims for the service that you received to your insurance for you. Your co-payment will be collected at the time of service – no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure that your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have prior authorization to see a specialist, you will need to obtain that from our office prior to your visit with the specialist. 72 hours notice is required to obtain all referrals. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits and file the claim for your service; however, we expect payment for your portion of the services at the time of your visit.
6. **SELF-PAY PATIENTS:** Patients without insurance coverage will be expected to pay at the time of service. If you are not able to pay in full, you must contact our billing service to set up payment arrangements.

NO SHOW OR MISSED APPOINTMENTS: We understand there may be times when you are unable to keep an appointment. 24 hours notice must be provided to prevent incurring a cancellation fee. If two appointments are missed without proper notice you will be charged a $25 cancellation fee.

Remember, whether you have insurance or not, you are ultimately responsible for payment on services that you incurred. If you have any questions regarding our financial policy please contact our practice manager.

I have read and acknowledge the above Financial Policy of Premier Internal Medicine of Ocoee

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Premier Internal Medicine Of Ocoee
Notice Of Privacy Practices
Acknowledgment Form

Premier Internal Medicine Of Ocoee Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our notice. You have the right revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

I have read the Premier Internal Medicine Of Ocoee Notice of Privacy Practices.

_____ _____

Signature Of Patient or Authorized Representative Date

_____

Print Name

_____ _____

Print Name of Patient Patient Date of Birth

PREMIER INTERNAL MEDICINE OF OCOEE CARE USE ONLY

Patient declined signing this acknowledgment form

Reason Given:_____

Staff Member Name:_____

Date:_____

Last Colonoscopy: _____ **Last Stress Test:** _____

List any operations that you have had (including approximate age): _____

Female Patients – do you have any problems with:
(please circle all that apply)

Menstrual Cramps: No/Yes Heavy Bleeding No/Yes Painful Intercourse No/Yes
Irregular Periods: No/Yes Abnormal discharge No/Yes

When was your last menstrual period (Last Known Menstrual Period)? _____
Last Breast Exam/Mammogram: _____ Last PAP Smear: _____ Last Bone Density Scan: _____
# of Pregnancies/Complications: _____

Do any of your family member have or have had:

Cancer: No/Yes
Heart Attacks: No/Yes
High Blood Pressure: No/Yes
Strokes: No/Yes
Thyroid disease: No/Yes
Diabetes: No/Yes
Anemia: No/Yes
Kidney Disease: No/Yes
Ulcers: No/Yes
Other: No/Yes

Family History:	**Age**	**Illness**
Father	____	_____
Mother	____	_____
Brothers	____	_____
Sisters	____	_____
Sons	____	_____
Daughters	____	_____
Other	____	_____

Habits:

Tobacco use? No/Yes Amount: _____
Illicit Drug use? No/Yes Amount: _____
Alcohol? No/Yes Amount: _____
Coffee, tea or soda? No/Yes Amount: _____
Do you exercise regularly? No/Yes How often? _____

List any medications (and dosages) you are currently taking (include over-the-counter drugs): _____

List medication allergies: _____

Please list any other doctors you currently see: _____

_____
Patient Signature **Date**

Patient Name _____ Today's Date _____

Race_____ Sex: M/F Age_____ Height_____ Weight_____ Handedness: R/L

Present Concerns: _____

Past Medical History

Have you ever been treated for:
(please circle all that apply)

Asthma:	No/Yes	Diabetes	No/Yes	Kidney Disease:	No/Yes
Anemia	No/Yes	Emphysema:	No/Yes	Pneumonia:	No/Yes
Arthritis	No/Yes	Epilepsy (seizures):	No/Yes	Psychiatric Disorder:	No/Yes
Abnormal Cholesterol:	No/Yes	Gall Bladder Disease:	No/Yes	Rheumatic Fever:	No/Yes
Blood Clots:	No/Yes	Glaucoma:	No/Yes	Stroke:	No/Yes
Blood Transfusions:	No/Yes	Gout	No/Yes	Thyroid Disease:	No/Yes
Cancer:	No/Yes	Heart Disease	No/Yes	Tuberculosis:	No/Yes
Chronic Allergies:	No/Yes	Hepatitis	No/Yes	Ulcer Disease:	No/Yes
Colon Polyps:	No/Yes	High Blood Pressure:	No/Yes		

Please give details: _____

Other conditions not listed above: _____

Review of Symptoms:
(please circle all that apply)

Skin Rashes or Discoloration:	No/Yes	Loss of Consciousness (Fainting):	No/Yes
Abnormal Lumps/Glands:	No/Yes	Vision Problems:	No/Yes
Nausea or Vomiting:	No/Yes	Hearing Problems (Earaches):	No/Yes
Belly Pain:	No/Yes	Headaches:	No/Yes
Constipation	No/Yes	Frequent or Persistent Cough:	No/Yes
Diarrhea:	No/Yes	Hoarseness:	No/Yes
Bloody/Tarry Stools:	No/Yes	Frequent Colds/Allergies:	No/Yes
Excessive/Constant Worrying:	No/Yes	Feeling Lonely/Depressed:	No/Yes
Abnormal Tiredness:	No/Yes	Inability to Sleep Well:	No/Yes
Shortness of Breath:	No/Yes	Mood Swings:	No/Yes
Wheezing:	No/Yes	Changes in Appetite:	No/Yes
Chest Pain:	No/Yes	Difficulty Swallowing:	No/Yes
Skipped/Irregular Heartbeat:	No/Yes	Hemorrhoids:	No/Yes
Ankle Swelling:	No/Yes	Trouble Urinating:	No/Yes
Pain in your legs when you walk:	No/Yes	Arthritis:	No/Yes
Morning Stiffness:	No/Yes	Fever or Chills:	No/Yes
Loss of Sensation (numbness):	No/Yes	Impotence/Sexual Difficulty:	No/Yes
Lightheadedness:	No/Yes	Bruises:	No/Yes
Night Sweats:	No/Yes	Weight loss/Gain:	No/Yes
Changes in glove or shoe size:	No/Yes		

Please give details: _____

Advanced Directives – The Patient's Right to Decide

All adult individuals in heath care facilities such as hospitals, nursing homes, hospice, home health agencies, and health maintenance organizations, have certain rights under Florida law.

Your have a right to fill out a paper known as an "advance directive." The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions – conditions that would stop you from telling your doctor how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment?

What is an Advance Directive?

An advance directive is a written or oral statement, which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made. Two forms of advance directive are:

- A "Living Will"
- Health Care Surrogate Designation

An advance directive allows you to state your choices about health care or to name someone to make those choices for you, if you become unable to make decisions about your future medical treatment.

What is a Living Will?

A living will generally states the kind of medical care you want or do not want if you become unable to make you own decisions. It is called a "Living Will" because it takes effect while you are still living. Florida's law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wishes will be understood.

What is a Health Care Surrogate Designation?

A "health care surrogate designation" is a signed, dated, and witnessed paper naming another person such as a husband, wife, offspring, or close friend as your agent to make medical decisions for you, if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form for designation of a health care surrogate. You may use it or some other form. You may wish to name a second person to stand in for you, if your firs choice is not available.

Which is better?

You may wish to have both or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you should you be unable to make decisions for yourself.

Do I have to write an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive or designated a health care surrogate, health care decisions may be

made for you be a court appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a proxy.

Can I change my mind after I write a living will or designate a health care surrogate?

Yes, you may change or cancel these documents at any time. Any change should be written, signed and dated. You can also change an advance directive by oral statement.

What if I have filled out an advance directive in another state and need treatment in a health care facility in Florida.

An advance directive completed in another state, in compliance with the other state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

Make sure that someone such as your doctor, lawyer, or family member knows that you have an advanced directive and where it is located. Consider the following:

- If you have a designated health care surrogate, five a copy of the written designation form or the original to that person.
- Give a copy of your advance directive to your doctor for your medical file.
- Keep a copy of your advance directive in a place where it can be found easily.
- Keep a card or note in your purse or wallet, which states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your doctor, lawyer and /or family member has the latest copy.
- For further information ask those in charge of your care.

Please note you have a right to choose a new health care provider in situations when a health care provider cannot honor the advance directive wishes of his/her patients due to objectives of conscience. For further information, ask those in charge of you care or contact your Member Relations Department.

For More information:

American Association of Retired Persons
1-800-424-3410
To order publications #D155294 and #D15529 write to:
AARP Fulfillment
606 E. Street NW
Washington, DC 20049

Choice in Dying
200 Varick Street
New York, NY 10014
212-366-5540