



PATIENT'S NAME		DATE OF BIRTH: / /	AGE:
EMAIL ADDRESS:		CELL PHONE #:	
MAILING ADDRESS:		HOME PHONE #:	
CITY:	STATE:	ZIP CODE:	
PATIENT'S EMPLOYER:		OCCUPATION:	
Race: <i>Please circle</i> Asian, Black, Indian, White, More than 1 race, Refuse, Other		Ethnicity: Hispanic, Not Hispanic	
SOCIAL SECURITY #:		CIRCLE MARITAL STATUS: M S D W	
SPOUSE'S NAME:	DOB: / /	SPOUSE'S SOCIAL SECURITY #:	
EMERGENCY CONTACT:		RELATIONSHIP:	
ADDRESS:		PHONE #:	
PRIMARY CARE PHYSICIAN:		REFERRING PHYSICIAN:	
ONSET OF ILLNESS (DATE):			
<u>INSURANCE INFORMATION</u>			
PERSON RESPONSIBLE FOR PAYMENT:		HOME PHONE #:	
MEDICARE #:			
OTHER MEDICAL INSURANCE:			
INSURED'S NAME:	INSURED'S ADDRESS:	DOB: / /	
GROUP #:	CERTIFICATE #:	PHONE #:	
How did you hear about our office? <i>Please circle.</i> Magazine Ad, Friend, Doctor, Newspaper, Other: _____			

WE ARE PARTICIPATING WITH MEDICARE. IF YOU HAVE A SUPPLEMENTAL INSURANCE THAT CROSSES OVER FROM MEDICARE AND PAYS THE DOCTOR, THEN WE WILL NOT COLLECT THE 20%. IF IT DOES NOT CROSS OVER OR YOU HAVE NO SECONDARY INSURANCE, THEN WE WILL COLLECT THE 20% PLUS DEDUCTIBLE AT THE TIME OF SERVICE. PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR APPOINTMENT. AN INSURANCE RECEIPT WILL BE GIVEN TO YOU TO SEND TO YOUR INSURANCE COMPANY. THIS OFFICE WILL FILE FOR PROCEDURES AND HOSPITALIZATION.

I GUARANTEE PULMONARY GROUP OF CENTRAL FL PAYMENT ALL CHARGES FOR THE ABOVE NAMED PATIENT IN ACCORDANCE WITH THEIR REGULATION AND CHARGES. IN THE EVENT THAT PULMONARY GROUP OF CENTRAL FL CHOOSES TO BILL MY INSURANCE COMPANY. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THEM ALL MEDICAL BENEFITS DUE ME UNDER THIS POLICY, IF THE SERVICES ARE NOT COVERED BY MEDICARE OR THE OTHER INSURANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND AND AGREE THAT ANY OUTSTANDING BILLS WILL BE MY RESPONSIBILITY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS TO MEDICARE OR ANY OTHER INSURANCE OF WHICH I AM A BENEFICIARY; I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS FROM AN OUTSIDE FACILITY THAT MAY BE REQUESTED TO THE OFFICE.

SIGNED: _____

DATE: / /

WITNESS: _____

DME Company: _____

Pharmacy Name and Number: _____

MEDICATION ALLERGIES: _____

OTHER ALLERGIES: _____

PAST MEDICAL HISTORY – Do you have or have you ever had the following:

	Yes	No		Yes	No
Measles	___	___	GERD (reflux)	___	___
Mumps	___	___	Hiatal Hernia	___	___
Whooping Cough	___	___	Anemia(type)	___	___
Scarlet Fever	___	___	Kidney Disease	___	___
Rheumatic Fever	___	___	Ulcer	___	___
Poliomyelitis	___	___	Hypothyroidism	___	___
Tuberculosis	___	___	Osteoarthritis	___	___
Pneumonia	___	___	Rheumatoid Arthritis	___	___
Asthma	___	___	Cataracts	___	___
Bronchitis	___	___	Glaucoma	___	___
Emphysema	___	___	Hepatitis	___	___
Hay fever/Sinusitis	___	___	Cancer	___	___
Hypertension	___	___	Type of Cancer	_____	
Coronary Disease	___	___	Other:	_____	
Diabetes (type)	___	___		_____	

SURGERIES – Please list type of surgery and your age at time of surgery:

FAMILY HISTORY:

Father: If Living Age and Health status: _____

 If Deceased Age at death and cause of death: _____

Mother: If Living Age and Health Status: _____

 If Deceased Age at death and cause of death: _____



Jose L. Diaz, MD, FCCP
Marjery N. Lopez, MD

HIPAA COMPLIANT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ ACCT# _____

I request and authorize medical records from the following facility:

I authorize to release information to the following person:

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

To release healthcare information of the patient named above to:

Pulmonary Group of Central Florida, LLC
1038 West North Blvd., Suite 102
Leesburg, FL 34748
Phone#352-315-1627
Fax # 352-326-8744

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information: _____

Other: _____

CONDITIONS OF AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION IN WRITING. IF I DO, IT WILL NOT AFFECT ANY PREVIOUS ACTIONS ALREADY TAKEN IN RELEANCE UPON MY AUTHORIZATION. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF ITS PURPOSE WAS TO OBTAIN INSURANCE. I MAY REVOKE THIS AUTHORIZATION BY WRITING A LETTER AND MAILING IT CERTIFIED MAIL, RETURN RECEIPT REQUESTED, TO THE PRIVACY OFFICEER AT THE HEALTHCARE PROVIDER LISTED ABOVE. INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.

THIS AUTHORIZATION IS VALID FOR 1 YEAR FOR THE RELEASE OF INFORMATION AS INDICATED ABOVE. ONLY RECORDS FROM THIS FACILITY CAN LEGALLY BE RELEASED. ANY RECORDS FROM OTHER PHYSICIANS MUST BE OBTAINED FROM THEM.

Patient Signature & Date

Guardian Signature & Date

Witness Signature & Date



OUR NOTICE OF PRIVACY PRACTICES

This Notice describe how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge regarding your Health Information

We understand that medical information about you and health is personal. We create a record of the care and service you receive from us. We need this record to provide you with quality care, obtain payment for the service we provide, and to comply with legal requirements. This notice applies to all of the records of your care generated by us, whether made by your personal doctor, other Practice doctors, or Practice staff. We are required by law to 1) make sure that medical information that identifies you is kept private; 2) give you this Notice of our legal duties and privacy practices; and 3) follow the terms of the Notice that is currently in effect. The professional and non-professional staff at each of our Practice sites will follow the terms of this notice. Each of our Practice sites may share medical information with each other for treatment, payment, or practice operations purposes described in this Notice.

How We May Use and Disclose Medical Information About You

The following categories and examples describe the different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Category:	Description and Examples:
Treatment	We may share medical information about you with another physician, a hospital, or other health care provider involved in your care. For example, a hospital may need to see a part of your medical record before you have surgery.
For Payment	We may share medical information with Medicare or other health plan to obtain payment for services provided to you, to verify insurance coverage, or to obtain authorization for further treatment. For example, an insurance company may need to see part of your medical record before they will pay for the services.
For Practice Operations	We may share medical information as necessary to manage the medical, legal, and financial affairs of the practice and to monitor the quality of services provided to our patients. For example, our attorney or accountant may need patient information in order to provide legal and financial services to the Practice. Any business associate with whom we share medical information will agree in writing to protect your privacy.
Appointment Reminders	We may disclose medical information to remind you of an appointment. We will disclose only the date, time, and location of the appointment.
Family members and friends	We will share medical information with a friend or family member who is involved in your care or payment of your bill. We will give you an opportunity to agree or object to these disclosures unless it is clear from the circumstances that you do not object.
Worker Compensation	We may report a work-related injury to a worker compensation carrier or to advise your employer about a work-related injury.
To meet legal requirements and for public health activities	We may disclose medical information to a government agency that oversees medical practice in the State such as the Florida Agency for Health care Administration on the Board of medicine, We are also required to report certain diseases and conditions to the local unit of the department of Health for its public health activities.
Law enforcement lawsuits, disputes, and reports of abuse or neglect	We may disclose medical information to an attorney or a law enforcement official to comply with a court order, subpoena, discovery request, or other legal mandate. We may also disclose medical information to assist law enforcement with investigating crime. For example, we are required to report wounds resulting from violence and incidents of abuse or neglect.
To avert a serious threat to health or safety	We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure, however, would only be to someone able to respond to the threat.
For special government functions	We may be required to disclose medical information to a government agency for national security purposes, a correctional facility in which you may be incarcerated, or to a military authority if you are in the service or a veteran

