Medical Associates OF CENTRAL FLORIDA


Amy Davis, MSN ARNP
Primary Care


Mahesh G Allam, MD
Internal & Pulmonary Medicine
Sleep Disorders


Nakisha Watson, ARNP
Primary Care

Your Health Care Partner in Primary Care

Welcome to Medical Associates of Central Florida. Please complete this form.

Email Address: _____

Patient's Name:_____ Age:_____ Date of Birth:_____

Patient's Social Security Number:_____ Cell Phone: _____

Address:_____ City:_____ State:___ Zip:_____

Out of State Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Sex:_____ Height:_____ Weight:_____ Race:_____ Married:___ Single:___

Employer:_____ Phone:_____

Responsible Party (If Minor) Father:_____ Mother:_____

Resp Party Address:_____ City:_____ State:___ Zip:_____

Patient Referred By:_____ Family Physician:_____

Spouse's Email Address:_____

Spouse's Name:_____ Spouse's Date of Birth: _____

Spouse's: Social Security Number:_____ Spouses Cell Phone: _____

Spouses' Employer:_____ Employe Phone:_____

Employer Address:_____ City:_____ State:___ Zip:_____

Name of Nearest Relative:_____ Relationship:_____ Phone:_____

Address:_____ City:_____ State:___ Zip:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Allam/Dr Nelson/Nakisha Watson and Medical Associates of Central Florida for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Allam/Amy Davis, ARNP/Nakisha Watson, ARNP and Medical Associates of Central Florida, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE - MEDICAID - MEDIGAP

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

PATIENT SIGNATURE:_____ DATE:_____

rev 12/17/20

A photocopy of these assignments shall be valid as the original.

Lake Wales Office
1110 Druid Circle
Lake Wales, FL 33853

Office (863) 877-2411
Fax (863) 354-6617
www.macfdoc.com

Haines City Office
31810 US 27
Haines City, FL 33844

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Health Information - Page 1

Today's Date: _____

Patient Name: _____ DOB: _____

Welcome to Medical Associates of Central Florida. Please complete Page 1 and 2.

Heart Disease	Yes	No	If yes, explain:
Lung Disease	Yes	No	If yes, explain:
Kidney Disease	Yes	No	If yes, explain:
Bowel Problems	Yes	No	If yes, explain:
Urine Problems	Yes	No	If yes, explain:
Weight Loss	Yes	No	If yes, explain:
Bleeding Problems	Yes	No	If yes, explain:
Sexual Problems	Yes	No	If yes, explain:
Cancer Anywhere	Yes	No	If yes, explain:
High Blood Pressure	Yes	No	If yes, for how long?:
Diabetes	Yes	No	If yes, for how long?:
High Cholesterol	Yes	No	If yes, for how long?:
Anxiety/Depression	Yes	No	If yes, for how long?:
Thyroid Problems	Yes	No	If yes, for how long?:
Tobacco	Yes	No	If yes, for how long?:
Alcohol	Yes	No	If yes, for how long?:

Past Surgeries/Hospitalizations: _____

_____

_____

_____

_____

_____

_____

Family Medical History (Cardiac Disease, Stroke, Diabetes, etc.): _____

_____

_____

_____

_____

_____

Allergies (List All): _____

_____

_____

Medications (including over the counter medications): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Illicit/Recreational Drug Use (Name or Type of Drugs Used): _____

_____

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Authorization For Release Of Information

I,_____ hereby give my consent of release to/from:

1. Information to be released from

Doctor/Facility:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____Date:_____

2. Information to be released from to:

Doctor/Facility:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____Date:_____

3. Information to be released on the following patient:

Name of Patient:_____

Date of Birth:_____Social Security No.:_____

4. Date(s) of treatment: (__) All Dates (___) Specific Dates _____

5. Information to be released (including STD, HIV, Drugs, HepB and HepC, Psychiatric/Psychology):
(__) All Records (__) Progress Notes (__) Labs (__) Radiology (__) Operative

6. Purpose of Disclosure: (__) Medical Records (__) Other _____

This authorization shall be in effect for 90 days following the date of signature below. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A photocopy of this authorization shall constitute a valid authorization.

The facility, its employees, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient or Representative:_____

Relationship to Patient:_____

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PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask our privacy officer, Tania Allam, who can be reached at 863-877-2411.

Information We Collect About You

We collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your company. This personal information includes items such as your name, address, phone number, birthday, social security number, employer, health history, insurance policy and coverage information and any other information you may provide to us. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information is Used

The personal and health information gathered may be used and disclosed with your general consent for purpose of treatment, payment or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other use of your information requires a signed authorization by you, the patient or guardian. Medical Associates of Central Florida, PA does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. Medical Associates of Central Florida, PA maintains physical, electronic and procedural; safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Medical Associates of Central Florida, PA.

Changes to Our Privacy Policy

All new patients will receive a copy of our privacy policy. Medical Associates of Central Florida, PA occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be posted at our office and copies available at the reception desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatments. 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 procedural 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 copy of the Privacy Policy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will provide a copy of any revised notice. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization 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 taken action in reliance thereon.

I AGREE THAT A COPY OF MY MEDICAL NOTE MAY BE SENT TO MY INSURANCE COMPANY, IF THEY SO REQUIRE. (Please initial to show your agreement): _____.

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

_____

I give my consent to speak to the following persons about my medical care: _____

_____

(Circle One) I fully understand and **Accept** / **Decline** the terms of this consent.

_____ _____

Signature of Patient or Patient's Legal Representative Signature Date

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