# Patient Information

| Patient Demographics/Information | | |
|---|---|---|
| **Name:** | | **Today's Date:** ______________________ |
| **Address:** | **City, State, Zip:** | |
| **Home # (     )** | **Cell # (     )** | **Work # (     )** |
| **Date of Birth:** | **Social Security #:      -      -** | |
| **Sex:** ☐ **Male** ☐ **Female** | **Marital Status:** | **Race:** |
| **Employer:** | **Occupation:** | |
| **Employer Address:** | | **Active Employee:** ☐ **Yes** ☐ **No** |

| Responsible Party (if other than patient) | | |
|---|---|---|
| **Name:** | | |
| **Address:** | **City, State, Zip:** | |
| **Home # (     )** | **Cell # (     )** | **Work # (     )** |
| **Date of Birth:** | **Social Security #:      -      -** | **Race:** |
| **Sex:** ☐ **Male** ☐ **Female** | **Marital Status:** | |
| **Employer:** | **Occupation:** | |
| **Employer Address:** | | **Active Employee:** ☐ **Yes** ☐ **No** |

| Emergency Contact Information | | |
|---|---|---|
| **Name:** | **Relationship:** | |
| **Address:** | **City, State, Zip:** | |
| **Home # (     )** | **Cell # (     )** | **Work # (     )** |
| **Is emergency contact aware of your medical condition?** ☐ **Yes** ☐ **No** | | |
| | **If yes, may we discuss your care with this person?** ☐ **Yes** ☐ **No** | |

| Primary Care Physician | |
|---|---|
| **Physician Name:** | |
| **Address:** | **City, State, Zip:** |
| **Phone # (     )** | **Fax # (     )** |

| Referring Physician | |
|---|---|
| **Physician Name:** | **Specialty:** |
| **Address:** | **City, State, Zip:** |
| **Phone # (     )** | |

| Reason for visit |
|---|
| **Medical condition for which you are being referred to our office:** |
| **Reason for Visit:** |
| **Symptoms:** |
| **Date symptoms began:** |

| Insurance | | | |
|---|---|---|---|
| Please provide the following information in order for the Practice to file your Insurance. It is your responsibility to provide the Practice with the most recent and updated information concerning your medical insurance coverage. | | | |
| **Primary Insurance** | | | |
| **Subscriber Name** (if other than patient): | | **DOB: ____/____/______** | |
| **Insurance Company Name:** | | | |
| **Policy #:** | | **Group #:** | |
| **Mail claims to:** | | | |
| **Phone #: (    )** | | **Fax #: (    )** | |
| **CoPay: $** | **Co-Insurance: %** | **Deductible met?** ☐ **Yes** | ☐ **No** |
| **Secondary Insurance** | | | |
| **Subscriber Name** (if other than patient)**:** | | **DOB: ____/____/______** | |
| **Group Name:** | | | |
| **Policy #:** | | **Group #:** | |
| **Mail claims to:** | | | |
| **Phone #: (    )** | | **Fax #: (    )** | |
| **CoPay: $** | **Co-Insurance: %** | **Deductible met?** ☐ **Yes** | ☐ **No** |

| Pharmacy Coverage | |
|---|---|
| **Subscriber Name** (if other than patient)**:** | **DOB: ____/____/_____** |
| **Group Name:** | |
| **Policy #:** | **Group #:** |
| **Mail claims to:** | |
| **Phone #: (    )** | **Fax #: (    )** |
| | |
| **Preferred Pharmacy** | |
| **Pharmacy Name:** | **Phone # (    )** |
| **Location:** | |
| **Phone #: (    )** | **Fax #: (    )** |

Patient Name: ___________________________________ Patient #: ____________________

INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

1. **Release of Information –** I understand and acknowledge that all records concerning my health, treatment and diagnosis are the property of Center for Prevention and Treatment of Infections, (herein after referred to as the "Practice") I hereby authorize the release of my confidential medical (including HIV status, mental health condition, alcohol or drug related) information and/or demographic information to the following parties for purposes of medical treatment, payment or operational purposes. Such parties include, but are not limited to: insurance company or third party payer, governmental agency (including Center for Medicare and Medicaid Services, Florida Medicaid, Social Security Administration, Florida Department of Children and Families), and any treating/referring physician/facility, in accordance with State and Federal laws.
2. **Assignment of Benefits –** I assign payment of all insurance benefits, governmental payments or other third parties, for services related to my medical condition to the Practice.
3. **Financial Agreement -** The undersigned agrees to pay the Practice for all charges not covered by insurance or other third parties for services provided. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party payer within a reasonable period of time. I request that payment of authorized Medicare/Medicaid benefits be made to the Practice for services rendered. I authorize the holder of medical or other information to be released to the Center for Medicare and Medicaid Services, or state Medicaid agency or its agents any information needed to determine benefits for related services. Should it become necessary to enforce collection of any unpaid balance for services rendered, the undersigned will pay all collection and legal expenses incurred by the Practice, including reasonable attorney's fees, which shall include, but not be limited to, such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings.
4. **Authorization for Medical Care and Treatment –** I recognize that a condition is present requiring medical care and I voluntarily consent to such medical care and treatment, diagnostic procedures or therapy as prescribed by the Practice physicians, providers, staff and its agents as deemed necessary. I am aware that the practice of medicine and the administration of medical care are not exact sciences and I acknowledge that no guarantees have been made to me as a result of diagnostic procedures, treatments, examinations or care undertaken with the Practice.
5. **Acknowledgement of Health Information Practices –** The Practice has provided information regarding the HIPAA, and the use and disclosure of medical, demographic and financial information. I have been provided an opportunity to review said information prior to signing this consent. I understand that the information may change periodically, and that updated information will continue to be made available to me by the Practice. By signing this form, I acknowledge that I have been offered and/or received information regarding Health Information Practices.
6. **Acknowledgement of Photography** – There may be instances when the Practice deems it is necessary to take a photograph as part of your confidential medical records to help with the assessment and formulation of your treatment. Every patient has the right to refuse to be photographed or withdraw consent at any time.
7. **Original signature -** I permit a copy of this authorization to be used in place of the original that is on file at the Practice. This assignment will remain in effect until revoked by me in writing.
8. **Release of Information -** I, the below named patient, do hereby authorize Edgardo E. Li-Espino, MD and/or Ronaldo R. Patiag, MD to release to any third payor [such as an insurance company(ies) or governmental agency(ies), example: Blue Cross of Florida or Medicare] and to any treating/referring physician(s) any medical records, HIV results and status, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party(ies) for its(their) use in connection with my ongoing medical treatment and/or in connection with determining a claim for payment for such treatment and/or diagnosis.

Patient Name: ________________________________ Patient #: ____________________

9. **Physician Insurance Assignment -** I, the below named subscriber, hereby authorize payment directly to Edgardo E. Li-Espino, MD and/or Ronaldo R. Patiag, MD individual medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

10. **Medicare/Medicaid - Patient's certification, authorization to release information, and payment request:** I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to Edgardo E. Li-Espino, MD and/or Ronaldo R. Patiag, MD.

11. **I permit a copy of this authorization to be used in place of the original which is on file at the physician's office.** This assignment will remain in effect until revoked by me in writing.

12. The contents of this form have been fully explained to me, and I have been given the opportunity to ask questions. Any questions asked have been answered to my satisfaction. I certify that I understand the contents of this form.

**Note to Patient:** Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Patient ________________________________________ Date_______________

or

Authorized Representative ____________________________________________

Relationship______________________________________________