
**1132 Cypress Glen Circle Kissimmee, FL 34741**
**Phone: 407-343-4700 Fax: 407-343-8500**

## PATIENT INFORMATION:

**TODAY'S DATE**_____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: _____Male _____Female SS#:_____ Marital Status: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone:_____ Mobile Phone: _____Email: _____

**Contact Preference**: ____ Home Phone ____ Mobile Phone ____ Email ____ Text message

## AUTHORIZATION:

I authorize you to leave automated reminder calls on my mobile device ____YES ____NO

**Race:** _____ (Arab) _____ (Asian) _____ (Black or African American) _____ (White) _____ (Other) _____

**Preferred Language:** _____English _____Spanish or other _____

**Ethnicity:** _____ Hispanic or Latino _____ Not Hispanic or Latino _____Other: _____

## EMERGENCY CONTACT INFORMATION:

Last Name: _____ First Name: _____Phone:_____Relationship:_____

## PRIMARY INSURANCE INFORMATION:

*Please bring insurance card(s) to the visit*

Insurance Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

## SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

## CLINICAL INFORMATION:

Preferred Pharmacy: _____Phone: _____ Fax: _____

Preferred Laboratory: _____Quest Diagnostic _____ Labcorp _____Other: _____

**Protected Health Information Authorization:**

**Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.**

| **Name** | **Relationship to Patient** | **Type of information** |
|---|---|---|
| _____ | _____ | **_____All _____Schedule _____Medical _____Billing** |
| _____ | _____ | **_____All _____Schedule _____Medical _____Billing** |

**Specific Instructions or Limitations:** _____

**We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.**

**Signature of Patient:** _____ **Date:** _____

**To revoke this authorization, please send a written request to our office.**

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Date _____ D.O.B. _____ Age _____ Patient Name _____

**PAST MEDICAL HISTORY (Have you had these?) Please do a checkmark (√).**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | High Blood Pressure | ___ | ___ | Peptic Ulcer | ___ | ___ | Arthritis |
| ___ | ___ | Gallbladder Disease | ___ | ___ | Diabetes | ___ | ___ | Bowel/Colon disorder |
| ___ | ___ | Pneumonia | ___ | ___ | Liver disease | ___ | ___ | Thyroid disease |
| ___ | ___ | Kidney stones | ___ | ___ | High cholesterol | ___ | ___ | Kidney disease |
| ___ | ___ | Asthma/emphysema | ___ | ___ | Stroke | ___ | ___ | Heart disease |
| ___ | ___ | Epilepsy/seizures | ___ | ___ | Bleeding disorder | ___ | ___ | Cataracts |
| ___ | ___ | Radiation treatment | ___ | ___ | Gout | ___ | ___ | Tuberculosis |
| ___ | ___ | Anemia | ___ | ___ | Cancer | ___ | ___ | Bladder infections/UTI |
| ___ | ___ | Glaucoma | ___ | ___ | Depression | ___ | ___ | Psychiatric disorder |
| ___ | ___ | | ___ | ___ | | ___ | ___ | |

**FAMILY MEDICAL HISTORY (Have any blood relative ever had?) Please do a checkmark (√).**

| Yes | No | | Who | Yes | No | | Who |
|---|---|---|---|---|---|---|---|
| ___ | ___ | Diabetes | _____ | ___ | ___ | Cancer | _____ |
| ___ | ___ | Thyroid disease | _____ | ___ | ___ | Hepatitis | _____ |
| ___ | ___ | High blood pressure | _____ | ___ | ___ | HIV | _____ |
| ___ | ___ | Heart disease | _____ | ___ | ___ | Abnormal bleeding | _____ |
| ___ | ___ | High cholesterol | _____ | ___ | ___ | Dementia | _____ |
| ___ | ___ | | _____ | ___ | ___ | | _____ |

**SOCIAL HISTORY. Please do a checkmark (√).**

Married ____ Single ____ Divorced ____ Widowed ____ Separated ____

Have you used tobacco? Yes___ No___ # of packs/day _____ For how many years? _____
Have you used alcohol? Yes___ No___ How much/daily_____ For how many years? _____
Have you used any drugs? Yes___ No___ What kind? _____ For how many years? _____

- If yes, have you ever received any counseling or entered a Rehab. Program.
- Program Name/Location Date
- _____

Do you use caffeine? Yes___ No___ Coffee/day _____ Cola/day _____ Tea/day _____
Do you exercise regularly? Yes___ No___ Are you on a regular diet? _____
Is sex satisfactory? Yes___ No___ Recent changes in sex life? _____

**LIST OF CURRENT MEDICATIONS**

| Name of Medication | Dose/ frequency | Reason for taking medication |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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D.O.B. _____ Patient Name _____

**ALLERGIES: Yes ____ No ____ Medications: Penicillin ____ Sulfa _____ Aspirin _____**
**Any other allergies? _____**

**PREVIOUS SURGICAL HISTORY**

_____ Date_____ _____ Date _____
_____ Date_____ _____ Date _____

**REVIEW OF SYSTEMS (In last 6 months) Please do a checkmark (√).**

**GENERAL**

| | | |
|---|---|---|
| Weight change | Yes___ | No___ |
| Extreme fatigue | Yes___ | No___ |
| Fainting | Yes___ | No___ |
| Dizziness | Yes___ | No___ |
| Excessive bruising | Yes___ | No___ |
| Impaired sight | Yes___ | No___ |
| Nose bleeds | Yes___ | No___ |
| Anxiety | Yes___ | No___ |

**SKIN**

| | | |
|---|---|---|
| Dry | Yes___ | No___ |
| Moist | Yes___ | No___ |
| Rash | Yes___ | No___ |
| Normal | Yes___ | No___ |
| Open wounds | Yes___ | No___ |

**CARDIAC/RESPIRATORY**

| | | |
|---|---|---|
| Shortness of breath | Yes___ | No___ |
| Chest pain | Yes___ | No___ |
| Heart palpitations | Yes___ | No___ |
| Persistent cough | Yes___ | No___ |
| Edema | Yes___ | No___ |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Ulcers | Yes___ | No___ |
| Liver disease | Yes___ | No___ |
| Diarrhea | Yes___ | No___ |
| Constipation | Yes___ | No___ |
| Blood in stool | Yes___ | No___ |
| Nausea/vomiting | Yes___ | No___ |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Severe headaches | Yes___ | No___ |
| Confusion | Yes___ | No___ |
| Tingling | Yes___ | No___ |
| Numbness | Yes___ | No___ |

**ENDOCRINOL.**

| | | |
|---|---|---|
| Excessive thirst | Yes___ | No___ |
| Increased urination | Yes___ | No___ |
| Rising to void more than once a night | Yes___ | No___ |

**FEMALE REPRODUCTIVE**

Age of menstruation ____ Is it regular? Yes___ No___
No. of pregnancies _____ Children born alive _____
Date last menstrual period _____
Date of last pap-smear_____
Last breast exam _____

**MALE REPRODUCTIVE**

| | | |
|---|---|---|
| Prostate problems | Yes___ | No___ |
| Testicular Mass | Yes___ | No___ |
| Impotence | Yes___ | No___ |

If taking any medications for impotence list below:
_____

**KIDNEYS**

| | | |
|---|---|---|
| Stones | Yes___ | No___ |
| Kidney infections | Yes___ | No___ |
| Bladder infections | Yes___ | No___ |
| Blood in urine | Yes___ | No___ |

**VACCINATIONS**

| | | |
|---|---|---|
| PNEUMONIA | YES___ | NO____ |
| TETANUS (last 10 yrs) | YES___ | NO____ |
| FLU | YES___ | NO____ |

Completed by: Patient_____ Office nurse/M.A_____Physician_____
Patient Signature _____ Date reviewed by Md with patient
____/____/_____Physician Signature _____

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# HIPAA
# PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. 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 shall honor that 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. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Protected health information may be disclosed or used for treatment, payment or health care Operation
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practice
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restriction
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

**This Consent was signed by**: _____
Printed Name - Patient or Representative

_____**Date**:_____
**Signature**

Relationship to Patient (if other than patient):_____

**Witness:** _____
Printed Name - Practice Representative

_____**Date**:_____
**Signature**

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## CONSENT AND AUTHORIZATION

- **MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. We do not give one year prescription refills. The practice is closed on weekend and refill requests will not be accepted. Please contact our office to confirm that we have received the refill request.

- **PAYMENTS & CREDIT CARD ON FILE:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. All patients are required to leave a credit card on file. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

- **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

- **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or any other applicable forms, there is a fee starting at $35. Fees are due when forms are drop off. Please allow 7 to 20 business days for us to completed forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

- **APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals later than 15 minutes will require appointment rescheduling.

- **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

- **CANCELLATION/NO SHOWS:** If you need to cancel your appointment, we ask that you give us 24 hours notice. If you fail to notify us and miss your appointment, there will be a $35 fee and possible termination from the office if excessive. There will also be a fee of $35 if you cancel your appointment on the same day.

- **LAB & RADIOLOGY RESULTS:** Once reports are received, the physician will review the results and have our clinical staff contacts you within 10 business days.

- **Terminating Patient Relationships reasons:** Treatment nonadherence, Follow-up nonadherence, Office policy nonadherence, Verbal abuse and Nonpayment.

- **Office visits:** At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require **multiple visits.**

- **Health Care Services Agreement:** I understand that I will be responsible for any additional costs to collect my past dated account, but also any additional cost that may incur for the collection of my account, such as (interest, litigation cost and attorney's fees) if so necessary.

By signing below, you acknowledge having read, understood and are in agreement with the information and expectations.
*The practice may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form.*

**Signature of Patient: _____ Date: _____**


**AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION**

I, **_____,** hereby authorize
**Print Patient Name**

**G & G Medical Group, Inc.**
**1132 Cypress Glen Circle**
**Kissimmee, Florida 34741**
**Tel: (407) 343-4700 Fax: (407) 343-8500**

Permission to release and/or obtain:

_____ Copy of the most recent Office notes, labs, ultrasounds and/or scans from the organization listed below.

_____ Complete chart which includes all office notes, labs, diagnostic test, psychiatric drug/alcohol and AIDS information.

_____ I hereby authorize G & G Medical Group to obtain Medication History related to the patient above, from pharmacies for the purpose of continued treatment.

_____ Speak/Write a letter to the person/organization listed below:

I authorize and request the release or request of all medical records regarding my medical history, treatment and results of any testing done, including HIV, for the purpose of ongoing medical care. I understand that my records are protected under the Notice of Privacy Act. My records cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time by so informing the above name parties in writing: however such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year from the date of signature.

_____

(Name of hospital, agency, or individual receiving information)

_____

(Address, phone and/or fax number)

**Address: _____Apt\Unit#_____**

**City: _____ State_____ Zip: _____**

**Date of Birth:_____ SSN: _____ Phone\Cell#: _____**

_____ _____
**Patient / Representative Signature** **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
**Print Name** **Relationship to patient**

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# Acknowledgement for Advanced Directives

Patient Acknowledgment: I understand I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. “Advance Directive” refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes.

*Please check the following statements that apply:*

_____ I Have Not executed an Advance Directive

_____ I Have executed an Advance Directive Location of Form: _____

_____ Living Will

_____ Durable Power of Attorney

_____ Do Not Resuscitate (DNR) Order

_____ Designation of health care surrogate form Designee/Guardian: _____

**Signature: _____ Witness: _____ Date: _____**

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**Insurance Assignment Release Form:** I hereby authorize my Insurance Benefits to be paid directly to G & G Medical Group, Inc. I also authorize the physicians to release any information required and /or requested by my insurance carrier.

**Signature of Patient: _____ Date: _____**

**A. Notifier:**

**B. PatientName:** **C. IdentificationNumber:**

# Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't payfor **D.**_____below, you may have topay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay forthe**D.**_____below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about yourcare.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receivethe**D.**_____listedabove.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box foryou.**

☐ **OPTION 1.** I wantthe**D.**_____listed above. You may ask to be paid now,but I also want Medicare billed for an official decision on payment, which is sent to me on aMedicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays ordeductibles.

☐ **OPTION2.** Iwantthe **D.**_____listed above, but do not bill Medicare.Youmayask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is notbilled**.

☐ **OPTION 3.** I don't wantthe**D.**_____listed above. I understand with thischoicel am **not** responsible for payment, and **I cannot appeal to see if Medicare wouldpay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

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