# ASSOCIATES IN MEDICINE & SURGERY

Patient Last Name: _____, First: _____, MI:_____ D.O.B. _____

☐ Home Phone _____ ☐ Cell Phone _____
Check Box If Preferred Contact Number Check Box If Preferred Contact Number

May we leave you a message: Yes No Marital Status: _____

Social Security: _____ Email: _____

Mailing Address: _____ City: _____ State:_____ Zip:_____

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

Northern Address: _____City: _____ State: _____ Zip: _____

Type of Residence You Live In: ☐ Private Home ☐ Assisted Living Facility ☐ Nursing Home ☐ Group Home

Race:_____ Ethnicity: _____ Preferred Language: _____

How did you hear about our office? _____

**EMERGENCY CONTACT:** Name: _____ Phone: _____ Relation: _____

**Employer Information:** Name _____ Occupation: _____

Address:_____ Phone: _____

**Pharmacy Information:** Name: _____ Phone: _____

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

**I herby authorize the physician and/ or representative to communicate via electronic submission with the pharmacy of my choice. This can and may include electronic submission of new prescriptions, authorizations of refills, and inquiry as to current medications.**

**Signature of Patient or Authorized Representative:** _____**Date:** _____

**Insurance Information:**

**(Primary)** _____ Phone Number: _____

Subscriber ID: _____ Group Number: _____

Subscriber SS: _____Subscriber D.O.B. _____

**(Secondary)** _____ Phone Number: _____

Subscriber ID: _____ Group Number: _____

Subscriber SS: _____ Subscriber D.O.B. _____

***Assignment of Benefits:***

**I herby authorize direct payment for all valid insurance benefits including all major medical benefits, be made on my behalf to Associates In Medicine & Surgery. I understand I will be financially and legally responsible for charge(s) not covered by assignment.**
**I certify that I have read the above authorizations and understand and agree to same, and also certify no guarantee or assurance has been made as to the results that may be obtained.**

**Signature of Patient or Authorized Representative:** _____ **Date:** _____

***Authorization For Release of Information:***

**I request the services of the Physicians of Associates In Medicine & Surgery, duly licensed physicians in the state of Florida, and all personnel, the consent to examination, diagnostic procedures and treatment which may need to be performed on my behalf. Also, I authorize the release of any medical information to any person or corporation, necessary to process my claim.**

**Signature of Patient or Authorized Representative:** _____ **Date:** _____

# ASSOCIATES IN MEDICINE & SURGERY

As a patient, it is your responsibility to verify that we are indeed a participating provider with your insurance company/ network and what services are or are not covered.

Patient Initials _____

Please be advised that you are ultimately responsible for any and all balances incurred, regardless of insurance coverage. As a courtesy to you, our valued patient, our office will file to your primary and secondary insurance, as well as call your insurance carrier for eligibility verification and procedure pre-certification, when necessary. However, it is the responsibility of the patient to be aware of their insurance benefits. **It is our office policy to collect any co-pays and deductibles at the time of check in (Exception: Medicare Deductible, Co-Insurance if owed will be billed.)** Please be aware that a $10.00 processing fee may be charged for each co-pay not paid at the time of service and/ or your appointment rescheduled.

Patient Initials _____

Be advised that should you cancel your appointment with less then 24 hours notice or no-show for your appointment, it is up to the discretion of the physician to reserve the right to access a $50.00 cancellation fee.

Patient Initials _____

Please be aware that although your insurance carrier might state that some procedures are “eligible” for payment, or are a “covered benefit” that does not mean that there will be no financial obligation by you, the patient. Many times a deductible is withheld, or there may be a separate co-payment withheld, depending on your specific carrier. Again, it is ultimately the responsibility of the patient to know and understand their policy.

Patient Initials _____

ALL INSURANCE COMPANIES STATE A DISCLAIMER: THERE IS NO GUARANTEE OF PAYMENT. EVERY CLAIM IS SUBJECT TO MEDICAL NECESSITY AND THE TERMS OF YOUR CONTRACT AT THE TIME SERVICES ARE RENDERED. Once we receive the “Explanation of Benefits” (EOB) we must abide by their payment and/or denial; therefore any remaining balance will be billed to you, the patient. Any disputes of the benefits should be addressed to your insurance company. Your account will be considered delinquent if payment is not made in a timely manner.

Patient Initials _____

In addition any co-insurance that is owed by you will be collected by the receptionist at subsequent appointments once your insurance carrier has processed the claim, or you will be sent a statement.

Patient Initials _____

By my signature below, the undersigned patient assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by the providers of Associates In Medicine & Surgery. I hereby direct the benefits be paid directly to the physicians on my behalf for any services furnished to me by the providers of Associates In Medicine & Surgery. By my signature below I hereby certify that I have read and fully understand all of the words and information contained intros form and reaffirm my consent to the examination, diagnostic procedures and/or care, treatment, therapy or remedy proposed.

By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

Please feel free at any time to discuss any concerns or questions you may have with our Billing Specialists.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

# ASSOCIATES IN MEDICINE & SURGERY

**CONSENT TO USE AND DISCLOSE HEALTH INFORMATION PRIVACY NOTICE ACKNOWLEDGEMENT**

Patient Name: _____ Date of Birth: _____

By signing this consent, you authorize Associates In Medicine & Surgery to use and/or disclose your health information for treatment, payment, or health care operations. You have the right not to sign this consent. If you refuse to sign this consent Associates In Medicine & Surgery has the right to refuse to treat you.

**Your Rights with Respect to this Consent:**

- **Right to review notice of Privacy Practices** - You have the right to review a copy of our Privacy Practices before signing this consent. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the notice from time to time. A copy of the Notice is posted in your office. Any revisions made to the Notice will be posted as soon as feasible.

- **Right to Request Restrictions on Use/ Disclosure**- You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services , and/or conducting healthcare operations. Such requests must be made in writing. Please note that we are NOT required to agree to any restriction that you request. If, however, we decide to agree to a restriction you have requested, we must restrict use and disclosure of your health information in the manner described in your request.

- **Right to Revoke Consent**- You have the right to revoke this consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact the Administrator of this practice to obtain a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse further treatment if you revoke this consent.

- **Right to Receive a Copy of this Consent Form**- You have the right to receive a copy of this consent form after you sign it.

- **Effective Period-** This consent is effective unless and until you revoke it in writing.

**I give my authorization for my Healthcare Provider to discuss my care and treatment with the following individuals:**

1. Name: _____ Relation: _____
2. Name: _____ Relation: _____
3. Name: _____ Relation: _____

**I have an ADVANCED DIRECTIVE (LIVING WILL) and the following individual is able to make decisions regarding my Healthcare if I am unable**

**(I will provide a copy of this document for the office)**

Name of Individual: _____ Relation: _____

**I hereby authorize Associates In Medicine & Surgery to use and/or disclose my health information for treatment, payment, or health operations.**

**Patient Signature: _____ Date: _____**

**If a personal representative on behalf of the individual signs this authorization, please complete the following:**

Personal Representative Name: _____

Relationship; _____ Reason patient cannot sign: _____

Authority of Personal Representative: _____

**Patient Consent To Treatment**

Patient Name: _____ Date of Birth:_____

Patient hereby voluntarily consents to treatment by Physician, Physician Assistant, Advanced Practicing Registered Nurse, their representatives, and affiliated companies. Patient understands that this consent form will be valid and remain in effect from the date of signature, as long as patient receives care, treatment and services at Associates In Medicine and Surgery. A new consent form will be obtained when a patient is discharged and returns for care, treatment or services. Patient has the right to give or refuse consent to any propose procedure or treatment at any time prior to its performance.

**General Description of Diagnostic Testing:** Testing may include, but shall not be limited to: X-rays, MRI, Ultrasound (Diagnostic and Needle Guided), Arterial and Venous Doppler studies, Autonomic Nerve studies, Dexascan and EKG. As well as point of care lab testing such as: HgA1c, urine drug screen, urinalysis, blood glucose, flu and pneumonia testing, PT/INR, COVID-19 antibody testing and pregnancy testing.
Patient acknowledges that Physician will allow the patient the opportunity to ask all questions regarding testing that may be provided.

**General Description of Treatment:** Treatment may include, but shall not but limited to: physical examinations and evaluations, injections, nerve blocks, strapping, physical therapy, casting/bracing, lesion and/ or nail debridement, Routine foot care (if patient qualifies) and administration of medications prescribed by a physician.

Patient acknowledges that the Physician will allow the Patient the opportunity to ask all questions regarding the treatments that may be provided.

**Agree to Disclose Information:** The patient agrees to disclose any and all information to enable the provider to render appropriate care. I understand that failure to disclose pertinent information could result in compromise of care.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

The undersigned Physician has explained to the patient ( or his or her legal representative ), in layman's terms, the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patients goals, complications and consequences which are/ or may be associated with the treatment or procedure (s).

_____ _____
Physician Signature Date

# Patient Medical Information

Patient Name: _____ Date: _____

**PRIMARY CARE PHYSICIAN:** (First and Last Name) _____ Phone: _____

**CONCERNS:** (& Duration)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**PRIOR TREATING PHYSICIAN: (First and Last Name)** (& Treatment)

1. _____ _____
   Physician Date Treatment
2. _____ _____
   Physician Date Treatment
3. _____ _____
   Physician Date Treatment

**MEDICATIONS:** (Dose and Directions)

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Non Prescription: _____

**ALLERGIES: (**Describe Reactions)

1. _____ Reaction: _____ 3. _____ Reaction: _____
2. _____ Reaction: _____ 4. _____ Reaction: _____

**PAST SURGERIES** (Including year performed)

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

**DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR?** ☐ **YES** ☐ **NO** **If yes, Date Performed:** _____

**FEMALES:** ☐ Pregnant Last Period: _____ ☐ Menopausal ☐ Hysterectomy

# of Pregnancies: _____ Last PAP: _____ Last Mammogram: _____

**SOCIAL HISTORY:**

Smoking _____ cigarette(s) a day x _____ years. / Alcohol _____ per week / Coffee _____ cups/day

Routine Exercise _____x per week / Do you feel you are overweight? ☐ Yes ☐ No

**HIV/ AIDS** ☐ **Yes** ☐ **No**

Have you had any falls in the past year? ☐ Yes ☐ No If YES, How Many? _____ Injuries ☐ Yes ☐ No

**FAMILY HISTORY:**

| | | | | AGE / | Diabetes / | High BP/ | Heart Disease/ | Stroke/ | Mental Illness/ | Cancer |
|---|---|---|---|---|---|---|---|---|---|---|
| Mother | ☐ Living | ☐ Deceased | | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ Living | ☐ Deceased | | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Siblings | ☐ Living | ☐ Deceased | | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children | ☐ Living | ☐ Deceased | | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

How Many/ Age: Brother(s) _____Sister(s) _____Son(s) _____ Daughter(s) _____

**DISEASE PREVENTION AND HEALTH MAINTENANCE:**

*Please list below the most recent dates of your vaccines and health screening tests*

Flu Vaccine _____ Month/Year  Pneumonia 13 Vaccine _____ Month/Year  Pneumonia 23 Vaccine _____ Month/Year  Tetanus Vaccine_____ Month/Year

Shingles _____ Month/Year  Colonoscopy _____ Month/Year  Bone Density _____ Month/Year  EKG _____ Month/Year  Heart Stress Test _____ Month/Year

Diabetic Foot Exam _____ Month/Year  Eye Exam _____ Month/Year

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several Days | Nearly every Day |
|---|---|---|---|
| 1. Little interest or pleasure in doing things | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed or hopeless | ☐ | ☐ | ☐ |

**MEDICAL HISTORY:**

**Do you have, or had in the past, any of the following?**

- ☐ Fever/Chills
- ☐ Hearing Loss
- ☐ Frequent Sore Throat
- ☐ Ringing in Ears
- ☐ Chest Pain
- ☐ Foot/ Ankle Swelling
- ☐ Heart Valve Problems
- ☐ Diarrhea
- ☐ Loss of Appetite
- ☐ Nausea/ Vomiting
- ☐ Weight Gain/ Loss
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Menopausal
- ☐ Nocturia
- ☐ Decreased Urine Stream
- ☐ Burning, Tingling, Numb
- ☐ Blurred Vision
- ☐ Infection
- ☐ Callous
- ☐ Wound
- ☐ Rash/ itching
- ☐ Change in Mole
- ☐ Deformed Nails
- ☐ Balance Problems
- ☐ Headaches
- ☐ Joint Stiffness
- ☐ Joint Pain
- ☐ Weakness
- ☐ Bowel/Bladder Problems
- ☐ Frequency in Urination
- ☐ Fatigue

**Past Medical History**

- ☐ Diabetic
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Hypertension
- ☐ PVD
- ☐ Stroke
- ☐ Raynauds Disease
- ☐ Minieres Disease
- ☐ Dialysis
- ☐ Phlebitis
- ☐ Venous Insufficiency
- ☐ Respiratory Disease
- ☐ Alzheimers Disease
- ☐ Parkinsons Disease
- ☐ Hepatitis
- ☐ Fibromyalgia
- ☐ RSD/CRPS
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Cirrhosis
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Neuropathy
- ☐ Cancer
- ☐ Pancreatitis
- ☐ Hypercholesterolemia
- ☐ Osteomyelitis
- ☐ Sciatica
- ☐ Arthritis
- ☐ Fractures

ASSOCIATES IN MEDICINE & SURGERY, LLC
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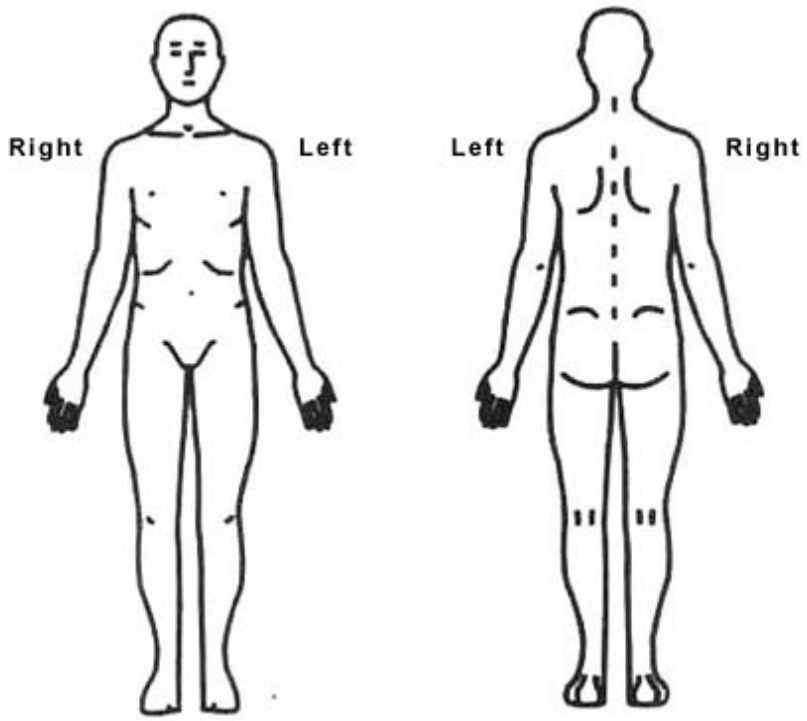
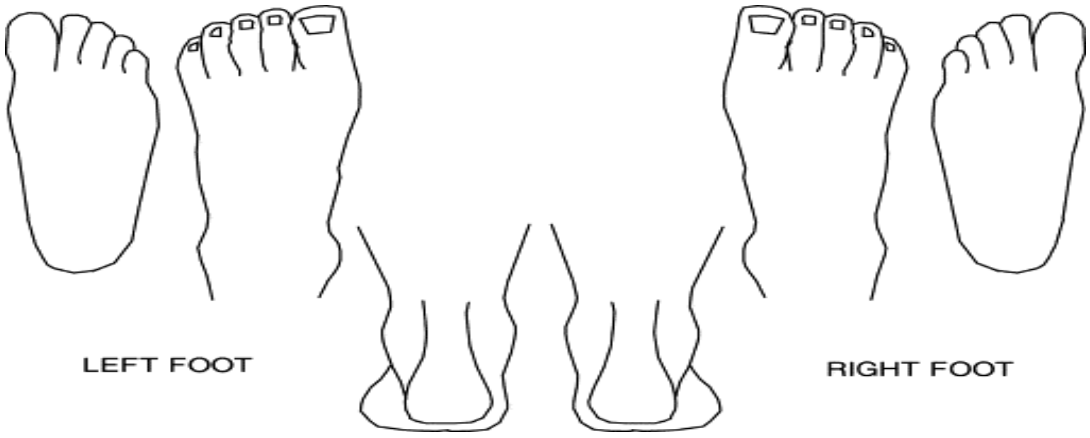
Specializing in Podiatry, Family Practice, Internal Medicine, Interventional Pain Management

Please mark an **X** indicating the area of injury or discomfort on the chart below.




0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible

Current pain level:_____ Worst pain level:_____

Patient Name:_____ Date:_____