Family Care Specialists, Inc.

PLEASE PRINT CLEARLY DATE: ____________________

PATIENT NAME____ DOB_____/_____/_____ AGE_______ SEX_______

PHONE NUMBER (_______)____SS#____

PERMANENT ADDRESS____CITY_________________ STATE_____ ZIP________

LOCAL ADDRESS____ CITY_________________ STATE FL ZIP________

MARITAL STATUS: ____MARRIED ____SINGLE ____OTHER SPOUSE'S NAME_____________________________________

EMPLOYED: (PLEASE LIST EMPLOYER)____ PHONE # (______) _______________

CHECK THE FOLLOWING IF APPLICABLE: _____FULL-TIME STUDENT _____PART-TIME STUDENT

NAME OF SCHOOL:____

WHERE AND WHEN HAVE YOU LIVED AND TRAVELED OUTSIDE THE U.S. AND CANADA?: ______________________________

____

LIST ANY ILLNESSES FOR WHICH YOU WERE HOSPITALIZED:____

____

HAVE YOU HAD ANY SERIOUS INJURIES, BROKEN BONES, ETC.:____

____

PREVIOUS OPERATIONS:____

____

PLEASE LIST ANY MEDICATIONS YOU MAY BE ALLERGIC TO: ____

____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ____

____

CIRCLE ANY DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED:

1. MMR 2. TETANUS 3. POLIO 4. OTHER

DO YOU HAVE A LIVING WILL / ADVANCED DIRECTIVE
(Circle One)
YES NO

In case of emergency please notify (Someone who does not live in your home): Relationship: ______________________________

Name:____ PHONE: ________________________

ADDRESS: ____

If patient is a minor: Guarantor's SSAN: _______________________________ Guarantor's DOB: _____________________________

CHECK ILLNESS THAT HAS OCCURRED IN *ANY OF YOUR BLOOD RELATIVES*: ☐ Diabetes ☐ Cancer
☐ Bleeding Tendency ☐ Kidney Disease ☐ Tuberculosis ☐ Heart Disease ☐ Stroke ☐ High Blood Pressure
☐ Nervous Illness ☐ Allergy ☐ Other

CHECK ANY ILLNESS OR CONDITION *YOU* HAVE HAD: ☐ Diabetes ☐ Glaucoma ☐ Heart Trouble ☐ Syphilis
☐ Vein Trouble ☐ Cancer ☐ Asthma ☐ Jaundice ☐ Gonorrhea ☐ Bleeding Tendencies ☐ Tuberculosis ☐ Pneumonia
☐ Kidney Disease ☐ Rheumatic Fever ☐ Nervous Disorder ☐ Arthritis ☐ Allergies ☐ Hypertension ☐ Other

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HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received Family Care Specialists, Inc.'s HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

1. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or 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.

III. 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 XVII/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 carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. The assignment will remain in effect until revoked by me in writing.

V. CONSENT FOR TREATMENT – I, the below named patient, hereby give my consent for treatment to all physicians associated with Family Care Specialists, Inc.

VI. CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Family Care Specialists to discuss my medical condition with , or release my medical records to, the below named person(s):

Name____ Relationship to Patient ______________________

Name____ Relationship to Patient______________________

Please remember that insurance in 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 it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If the amount 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.

DATE________________________PATIENT____
(Signature)

SUBSCRIBER (if different from patient)____
(Signature)

PLEASE PROVIDE US WITH COPIES OF YOUR INSURANCE CARDS

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

____ ____
NAME OF BENEFICIARY HEALTH INSURANCE COMPANY

____
MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on my behalf to Family Care Specialists, Inc. for any services furnished to me

by my physician. I authorize any holder of medical information about me to release to ________________________________
Insurance Company

any information needed to determine these benefits or the benefits payable for related services.