Central Florida Pulmonary Group, P.A.
Patient Information & Authorization of Treatment Form

Office Use Only		
Account	Date	☐Hospital ☐Mills ☐East ☐North

Please Print

Patient Information

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Phone: Home _____ **Cell** _____ **Work** _____

Email: _____ **Social Security Number:** _____

Gender: ☐ **Male** ☐ **Female** **Language:** _____ **Race:** _____ **Ethnicity:** _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____ **Marital Status:** ☐ **S** ☐ **M** ☐ **W** ☐ **D**

Spouse/Guardian: _____ **Social:** _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Pharmacy Information

Pharmacy Name: _____ **Phone:** _____ **Fax:** _____

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

Referring Physician Information

Physician Name: _____ **Phone:** _____ **Fax:** _____

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

Primary Care Physician Information

Physician Name: _____ **Phone:** _____ **Fax:** _____

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

If my insurance requires an authorization and it has NOT been obtained, I realize I may be responsible for services rendered. I understand that I am financially responsible for charges rendered and that filing my insurance is a courtesy performed by this office.

Primary Insurance Information

Insurance Name: _____ **Phone:** _____ **Is the patient retired?:** ☐ **Y** ☐ **N**

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

Policy No.: _____ **Group Name/No.:** _____ **Effective Date:** _____

Employer Name: _____ **Policy Holder's Name:** _____

Policy Holder's: Social _____ **Birth Date** _____ **Relationship to Patient** _____

Secondary Insurance Information

Insurance Name: _____ **Phone:** _____ **Is the patient retired?:** ☐ **Y** ☐ **N**

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

Policy No.: _____ **Group Name/No.:** _____ **Effective Date:** _____

Employer Name: _____ **Policy Holder's Name:** _____

Policy Holder's: Social _____ **Birth Date** _____ **Relationship to Patient** _____

Central Florida Pulmonary Group, P.A.
Patient Authorization For Use & Disclosure of Protected Health Information

Please Print

Patient Information

Patient Name: _____ **Birth Date:** _____ **Social:** _____

Authorization

By signing this authorization, I authorize *Central Florida Pulmonary Group, P.A.* to ***obtain/release*** certain protected health information (PHI) about me from or to:

_____

(Name and address of entity being asked to release or to obtain information from)

The information requested to be obtained from the entity listed above should be sent to:

Attention: Medical Records, Central Florida Pulmonary Group

- ☐ *326 North Mills Avenue, Orlando, Florida 32803*
- ☐ 10916 Dylan Loren Circle, Orlando, Florida 32825
- ☐ 610 Jasmine Road, Altamonte Springs, Florida 32701

This authorization permits the following individually identifiable health information about me to be **obtained/released** for the specified date or period:

Records obtained/released are for the date(s) of _____ or the period from _____ to _____

☐ My complete medical record ☐ Other _____

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____(date supplied by patient); (3) under the following condition(s): _____

_____

When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the federal Privacy Rule.

My written revocation must be submitted to the Privacy Officer at:

Central Florida Pulmonary Group, P.A.
326 North Mills Avenue
Orlando, Florida 32803

I understand and agree that I am financially responsible for appropriate fees associated with my request in accordance with Florida Administrative Code, Rule 64B-10.003 which states that "(1) Any person licensed pursuant to Chapter 458, Florida Statutes, required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records. (2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: (a) For the first 25 pages, the cost shall be $1.00 per page. (b) For each page in excess of 25 pages, the cost shall be 25 cents. (3) Reasonable costs of reproducing X-rays, and other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication."

The cost of postage related to mailing is a separate fee that may be charged and is unrelated to the costs of reproduction.

Signature of Patient : _____ Print Name: _____ Date: _____

Signed by Personal Representative/Guardian: _____ Print Name: _____ Date: _____

Description of personal representative/guardian authority to act on behalf of the patient: _____

Witness Signature: _____ Print Name: _____ Date: _____

For Internal Purposes Only

Completed by: _____ Date completed: _____ ❒Fax ❒Pick-up ❒Mailed ❒Other: _____

Central Florida Pulmonary Group, P.A.
Financial Policy Disclosure & Assignment of Benefits

Welcome to Central Florida Pulmonary Group. We are committed to providing you with the most efficient and reasonable health care services. Therefore it is necessary for us to have a Financial Disclosure stating our requirements for payment of services rendered to our patients.

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to the specifics of your contract. **Please note it is your responsibility to know the specific regulations or limitations of your plan such as referrals, pre-certifications and network participation**. If your plan is not one in which we participate, you will be responsible for payment in full for any out-of-network amounts.
- Any required referrals or authorizations should be furnished to our office no less than two days in advance of your appointment or your appointment may require rescheduling. CFPG will assist you in requesting these as a courtesy, however it is ultimately your responsibility and **you will be responsible for the cost of services rendered without proper authorization required by your plan.**
- It is your responsibility to notify CFPG of any changes in health care coverage. As a courtesy to you, we will bill your insurance company directly for services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to involving your intervention or making it your responsibility. Please be advised that you are ultimately financially responsible for payment of medical services rendered.
- Balances owed for services rendered are due at the time of service unless prior payment arrangements have been approved by our billing department. Co-payments will be collected at the time of check-in. We accept cash, checks and most major credit cards**. Failure to pay co-payments or balances due upon check-in may result in non-emergent appointments being rescheduled**. Self-pay patients should be prepared to pay in full the self-pay rate at the time of each visit. Failure to pay in full or make payment arrangements may risk negative credit ratings and possible dismissal from the practice. Past due balances may hinder your ability to have appointments scheduled.
- There are miscellaneous fees associated with your care at CFPG. If you need to miss a scheduled appointment, notice is required to our office 48 hours in advance. Failure to provide proper notice or failure to keep your scheduled appointment may result in a charge of $40.00. Returned checks will result in a $25.00 fee and your account will be flagged as “cash only”. We will accept payments only by cash or credit card for future services. There is an administrative fee for completing forms such as DMV, FMLA, disability, etc. Most forms require 5 to 7 days to research your information and complete.
- If your plan has a preferred drug listing and requires prior-authorization, it is your responsibility to provide the office with a covered drug listing to assist in expediting receiving necessary medications.
- Please note your Providers are here to provide you with the best medical care therefore they are not involved in the day to day financial operations. **We ask that you <u>do not</u> discuss your account balance or financial aspects with the physician(s) or medical staff.** Please discuss any account information with the front desk or billing office.

I authorize release of any medical information necessary to determine benefits payable for services furnished to me. I authorize direct payment from my health insurance plan to Central Florida Pulmonary Group for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A copy of this authorization may be used in place of the original. This serves as a lifetime authorization unless revoked in writing by me. I certify that I have read this agreement and my signature indicates my understanding and consent.

_____ _____

Responsible Party’s Signature Date

_____ _____

Patient Name (Please Print) Date of Birth

CFPG Consent Form

Consent For Treatment

The patient and/or authorized representative of the patient whose signature is affixed below does hereby consent to medical treatment which may be deemed advisable by the physician/provider. The intention, hereof, being to grant authority to administer and perform all examinations, treatment, and diagnostic procedures which may now or during the course of my care be deemed necessary.

Patient or Authorized Signature: _____ Date: _____

Printed Name and Relationship if other than patient: _____

Patient Permission To Communicate Medical Information

The patient and/or authorized representative of the patient whose signature is affixed below does hereby permit and does not object to the communication of medical information related to care and condition to the following individuals (e.g. spouse, child, friend, etc.)

Name of Individual: _____ Relationship:_____ Phone: _____

Name of Individual: _____ Relationship:_____ Phone: _____

Name of Individual: _____ Relationship:_____ Phone: _____

Patient or Authorized Signature: _____ Date: _____

Printed Name and Relationship if other than patient: _____

CFPG Patient Medical History Form

Office Use Only		
Account	Date	☐ Hospital ☐ Mills ☐ East ☐ North

Please Print

Patient Information

Patient Name: _____ **Age:** _____ **Today's Date:** _____

Current Occupation: _____ **If retired, previous occupation:** _____

Today's Visit

What is the main reason for today's visit, and when did you first notice this problem?

Current Problems

Please check any current problems you are having. If yes, please explain.

☐ Shortness of breath	☐ Yes ☐ No	
☐ Wheezing	☐ Yes ☐ No	
☐ Hay fever (allergies)	☐ Yes ☐ No	
☐ Cough ☐ with phlegm ☐ with blood	☐ Yes ☐ No	Color:
☐ Fevers	☐ Yes ☐ No	
☐ Recent weight change	☐ Yes ☐ No	
☐ Sleeping disorder	☐ Yes ☐ No	
☐ Difficulty swallowing	☐ Yes ☐ No	
☐ Chest pain	☐ Yes ☐ No	

Medications

Prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: _____

Allergies

Please check any current allergies you have.

☐ Ace Inhibitors	☐ Anesthesia	☐ Antihistamines	☐ Aspirin	☐ Codeine
☐ Dairy Products	☐ Iodine	☐ Latex	☐ Mold	☐ Penicillin
☐ Pet Dander	☐ Prednisone	☐ Sulfa Drugs	☐ X-ray Dye	☐ No Known Allergies

Other Allergies: _____

Immunizations

Date of your most recent IMMUNIZATION: Influenza (flu shot) _____ **Pneumovax (pneumonia)** _____ **Other:** _____

CFPG Patient Medical History Form – Page 2

Patient Information

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Testing

Please check any recent testing you had.

Type of Test	When	Where	Results (If Known)
TB Skin Test			
Chest X-ray/CT Scan			
Pulmonary Function Test (PFT)			

Past Surgical/Hospitalization History

Please list all prior operations/hospitalization (with dates).

Type of Surgery/Hospitalization	Where (e.g. name of hospital or facility)	Date

Past Medical History

Please check if you have ever been diagnosed with any of the following.

☐ Allergies	☐ Alzheimer's	☐ Anemia	☐ Aneurysm	☐ Anxiety
☐ Arrhythmias	☐ Arthritis	☐ Aspirations	☐ Asthma	☐ Bronchiectasis
☐ Bronchitis	☐ Cancer	☐ Cardiac Arrest	☐ Cardiac Arrhythmias	☐ Cardiac Disease
☐ Colitis	☐ Congestive Heart Failure	☐ COPD	☐ Coronary Artery Disease	☐ Chronic Cough
☐ Cystic Fibrosis	☐ Diabetes	☐ Emphysema	☐ Fissure	☐ GERD/Heart Burn
☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ HIV/AIDS	☐ Hodgkin's Disease
☐ Hyperactive Airway	☐ Hypertension	☐ Hyperthyroidism	☐ Hypothyroidism	☐ Incontinence
☐ Irregular Heart Beat	☐ Kidney Stones	☐ Leukemia	☐ Lung Cancer	☐ Melanoma
☐ Migraines	☐ Neuropathy	☐ Non-Hodgkin's Lymphoma	☐ Obesity	☐ Parkinson's Disease
☐ Pleural Effusion	☐ Pleurisy	☐ Pneumonia	☐ Pneumothorax	☐ Pulmonary Emboli
☐ Pulmonary Fibrosis	☐ Pulmonary Hypertension	☐ Raynaud's Phenomenon	☐ Renal Failure	☐ Rheumatic Fever
☐ Sarcoidosis	☐ Scleroderma	☐ Scoliosis	☐ Seizures	☐ Sinus Condition
☐ Sleep Disturbance	☐ Stridor	☐ Stroke, TIA, CVA	☐ Stomach Ulcers	☐ Thyroid Disorder
☐ Tuberculosis (TB)	☐ Other: _____			

Exposures

Have you ever been exposed to any of the following?

☐ asbestos	☐ carpenter's wood dust	☐ dust	☐ radiation
☐ ammonia	☐ chemical/toxin	☐ feathers	☐ silica
☐ agent orange	☐ chemical fumes or gases	☐ fiberglass	☐ soldering/welding
☐ animals/pets	☐ chlorine	☐ mold growing in house	☐ tobacco exposure
☐ burns wood in home	☐ coal dust	☐ oil or kerosene burning heater in home	☐ UV overexposure

CFPG Patient Medical History Form – Page 3

Patient Information

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Family History

Please indicate the current status of your immediate family members. Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

Addison's disease		High cholesterol	
Alcoholism		Hypertension	
Alzheimer's disease		Kidney disease	
Asthma		Lupus	
Autoimmune disorder		Obesity	
Cancer (list type)		Osteoporosis	
Cardiovascular		Respiratory disease	
COPD		Rheumatoid arthritis	
Cystic fibrosis		Schizophrenia	
Diabetes		Sickle cell disease	
Emphysema		Stroke	
Fibromyalgia		Thyroid disease	
Heart problems		Tuberculosis	
Hepatitis		Other:	

Tobacco Use

Cigarettes:

- ☐ Never Smoked
- ☐ Former Smoker: ☐ Quit Date _____. Packs per day _____ for _____ number of years
- ☐ Current Every Day Smoker. Packs per day _____ for _____ number of years
- ☐ Current Some Day Smoker. Packs per day _____ for _____ number of years
- ☐ Current Status Unknown

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes, number of drinks/week _____ ☐ No

Drug Use

Do you use recreational drugs? ☐ Yes ☐ No

Caffeine Use

Do you drink/use caffeine (Coffee/tea/soda)? ☐ Yes, number of cups/day _____ ☐ None