



Patient Information Sheet

PERSONAL INFORMATION

First Name	Middle Name	Last Name		
_____	_____	_____		
Nickname	Birth Date (mm/dd/yyyy)	Gender		
_____	_____/_____/_____	_____		
Social Security Number	Marital Status	Drivers License Number	State	Expiration
() _____	() _____	() _____	_____	_____
Home Telephone	Work Phone	Cell Phone/Other		
() _____	() _____	() _____		
Address	City	State	Zip Code	
_____	_____	_____	_____	
Email Address _____				

EMPLOYMENT / GUARANTOR

Employer	() _____		
_____	Phone _____		
Employer's Address	City	State	Zip Code
_____	_____	_____	_____
Guarantor's Name	Social Security #	Relationship to Patient	
_____	_____	_____	

INSURANCE

Insurance Company	() _____		
_____	Phone Number _____		
Policy Number	Group Number	Policy Holder	
_____	_____	_____	
Policy Holder's Address	City	State	Zip Code
_____	_____	_____	_____

EMERGENCY & PHARMACY INFORMATION

Emergency Contact (Name)	Relationship To Patient	() _____
_____	_____	Phone Number _____
Pharmacy Name	() _____	() _____
_____	Phone _____	Fax _____



Authorization to obtain, release or review protected health information

I, _____ hereby authorize Baldwin Park Family Practice to
Patient/Legal Representative

obtain copies of protected health information of: _____
Print Patient's Name

FROM: _____
Name of Individual, Healthcare Facility or Agency Phone Fax

Address City State Zip

PLEASE SEND RECORDS TO:

Baldwin Park Family Practice, P.A.
1040 Woodcock Road, Suite 200, Orlando, Florida 32803
PH: (407) 898-4550 | FAX: (407) 898-4842

Dates of services: From: _____ To: _____

Please place your initials by each item to be released:

_____ Complete Records _____ All Diagnostic Test _____ Consultation/Progress Notes
_____ Labs Only _____ Radiology Only Other (Specify) _____

Additionally, please specify by initials each/all applicable items:

_____ Mental Health _____ HIV Testing _____ Drug and/or Alcohol _____ AIDS Information

Date of Birth Social Security Number

Address City State Zip

Patient/Legal Representative/ Parent Signature Date

Witness



Financial Policy Statement

APPOINTMENT TIMES: We reserve your appointment time for you alone. Thus, we respectfully ask that you give us at least 24 hours notice prior to canceling or rescheduling your appointments so that we may offer your appointment to another patient who may need to see us. If not, you will be subject to a **\$25** charge.

HEALTH PLANS: All health plans are not the same and do not cover the same services. Patients are responsible for knowing the benefits of their individual insurance plans and also any referral requirements necessary to have coverage of any service rendered. Should you not know this, please contact your Health Plan using information usually provided on your insurance card.

INSURANCE COVERAGE:

1. Patients with insurance plans in which we participate:

Please verify your eligibility and benefits prior to your visit. Patients are responsible for deductibles, co-pays, non covered services, co-insurance, and items considered "not medically necessary" by your insurance company. **Payment of your co-pay and/or co-insurance is due at the time of service.** Any balance after insurance processing should be taken care of within thirty (30) days of notice from the insurance company. You are also responsible for ensuring that your insurance recognizes us as your new primary care physician, if required.

2. Patients with insurance plans in which we DO NOT participate:

Full payment is due at the time of service. We will file a claim for you within one week of the visit, but will not follow up on these claims. Should no reimbursement be made, patients will be responsible for communicating directly with their insurance company(s) to resolve these claims.

3. Private pay patients:

Full payment is due at the time of service. We will provide you with a receipt for your records.

OUTSTANDING BALANCES: We request that you remit all outstanding balances, including no-show charges, within thirty (30) days of date of service or charge date. If you are unable to meet this commitment please contact us promptly to discuss a payment plan option. If your account becomes severely delinquent and is referred to a collections agency, any charges and/or fees incurred will be added to your balance.

MINORS: Parents or guardians with custody must accompany all minors for their appointments and will also be responsible for remitting payment for all services rendered to the minor patient(s).

AGREEMENT: I have read and understand the financial policy of the practice and I agree to follow its terms. I also understand that this policy may be amended from time to time by the practice. If necessary, I have contacted my insurance company and verified that Priya Maharaj, DO is designated as my new primary care physician.

Patient/Responsible Party Signature

Date

Guardian/Other on behalf of the patient

Relationship to patient

Address

City / State / Zip

Phone (Include Area Code)



Patient Health History Form

Name: _____ Birthdate: _____

Drug Allergies YES NO (If "YES", please list)

Current Medications (please include non-prescription drugs and herbal remedies):

Name of Medication	Dosage	How Often Taken

Please provide details if you are a family member have had any of the following medical conditions:

Cancer (specify type) _____

Depression or Suicide _____

Diabetes _____

Heart Problems _____

High Blood Pressure _____

High Cholesterol _____

Lung Problems _____

Sickle Cell _____

Stroke _____

Thyroid Problems _____

Any Other Problem(s) _____

Females please indicate:

Number of pregnancies _____

Number of live births _____

First day of last period _____



Please list any surgeries you have had (use back of sheet if necessary)

(Continued on back of page)

Marital or Partnership Status: _____ **Occupation:** _____

I drink alcohol _____ times per day, _____ times per week.

I smoke _____ cigarettes (or cigars, pipes etc.) a day.

I exercise _____ minutes per day, _____ times per week.

Please indicate year of your last:

Tetanus Booster _____

DEXA Scan _____

Pneumonia Shot _____

Cholesterol _____

Colonoscopy _____

PAP smear _____

Mammogram _____

Complete Physical Exam _____



Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Baldwin Park Family Practice, P.A. (hereafter referred to as " the Practice") in order to carry out treatment, payment, or health care operations. (You should review and may request, at anytime, a copy of the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.).

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: *(list below)*

I agree that the Practice may also disclose the following types of information contained in my medical record:
(Please initial the appropriate categories listed below)

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Substance Abuse Information
- _____ Sexually Transmitted Disease Information
- _____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s)
(please initial the appropriate spaces below):

_____ **Via e-mail** to the Patient's designated e-mail address: _____
(I am responsible for notifying the practice of any changes to my e-mail address.)

_____ **Via postal mail** with any envelopes being marked personal and confidential and addressed to me.

_____ **Via telephone**, if I contact the Practice and provide the appropriate information *(Including my name, social security number and unique personal identifier)*.

_____ **Via fax** to my designated **secure** fax number: _____



At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM PM

Signature of Patient or authorized representative

Please print Name

- Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:



Patient Office Conduct Policy

I understand that I am fully responsible for my behavior and the behavior of anyone that accompanies me to Baldwin Park Family Practice, P.A. Any inappropriate behavior or language directed to the physician(s) and/or office staff within the office or during telephone conversations will not be tolerated and may result in my discharge from the practice.

I understand that as a patient of Baldwin Park Family Practice, P.A., I agree to abide by all office policies.

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or the patient's authorized representative, to release Dr. Priya Maharaj, D.O. and/or members of Baldwin Park Family Practice, P.A. staff from any and all liability which may arise from this action, whether or not foreseen at present.

Signature of patient/authorized representative

Date