ALTAMONTE MEDICAL ASSOCIATES P.A.

631 Palm Springs Drive # 117
Altamonte Springs, FL. 32701
Ph. 407 339 5600 Fax 407 339 5602

PATIENT INFORMATION FORM

DATE. _____
□ NEW PATIENT
□ CHANGE OF INFORMATION

PERSONAL DATA:

NAME. _____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL . SEC. # : _____

_____ HOME PHONE # : _____

_____ CELL PHONE # : _____

GENDER: □ FEMALE □ MALE EMAIL ADDRESS (OPTIONAL) _____

EMPLOYER DATA:

EMLOYER NAME: _____ WORK # : _____

ADDRESS: _____

INSURANCE DATA:

□ CIGNA PRIMARY / SECONDARY □ AETNA PRIMARY / SECONDARY
□ BCBS PRIMARY / SECONDARY □ MCR PRIMARY / SECONDARY
□ UHC PRIMARY / SECONDARY □ OTHER : _____ _____ PRIM / SECD

PRIM. CLAIMS ADDRESS: _____ _____ _____
(PO BOX, STREET) (CITY,STATE) (ZIP)

TELEPHONE # : _____ POLICY # : _____ GROUP # : _____

SECD. CLAIMS ADDRESS: _____ _____
(PO BOX, STREET) (CITY,STATE) (ZIP)

TELEPHONE # : _____ POLICY #: _____ GROUP #: _____

EMERGENCY CONTACT

NAME. _____ RELATIONSHIP: _____ PHONE # : _____

I authorize Altamonte Medical Associates to release Any medical information necessary to process claims, Coordinate care, and for quality management, and / or Utilization activities.

_____
(SIGNATURE) **(DATE)**

I authorize payment of medical benefits to Altamonte Medical Associates for service rendered.

_____
(SIGNATURE) **(DATE)**

Altamonte Medical Associates

PATIENT DATA SHEET

Name: _____ Date of birth_____ Sex_____ Race____

Marital status: Single, Married, Divorced, Widowed, Separated.

Of children _____ # of persons in household _____ Education/grade _____

Patient History

Last Medical exam _____ Last eye exam _____

Present Medical Conditions:

____ High blood Pressure ___Lung Disease other _____
____ Diabetes ___ Cancer of _____ _____
____ Heart Disease ___ Depression _____

List all past Major illnesses/
Hospitalizations/Surgeries Year

_____
_____
_____
_____
_____
_____
_____
_____
_____

Immunizations: Date of injection

Tetanus_____

Pneumovax _____
Hepatitis B _____
_____

List all Drug and Food Allergies and type of reaction: _____
_____
_____

List all current medications, vitamins, over the counter drugs, birth control, including name, strength and dosing frequency.

_____ _____

_____ _____

_____ _____

Family History

List any significant Family Medical History (e.g., diabetes, high blood pressure, cancer)
Father _____
Mother_____
Brothers/Sisters_____
_____
_____

Children
_____
_____

Current Lifestyle

Current Occupation_____
Name any chemical or other hazards on your job_____
1. Do you drink alcohol? NO YES; How Much? _____
2. Do you feel you have been exposed to AIDS? NO YES
3. Do you smoke or chew tobacco? NO YES How much and how long? _____
4. Do you ever use illicit drugs? NO YES_____
5. Do you have any sexual concern? NO YES
Name any major hobbies and recreational activities _____

Patient Signature_____
Date_____

ALTAMONTE MEDICAL ASSOCIATES

Notice of Privacy Practices Acknowledgment Form

Altamonte Medical Associates' Notice of privacy Practices provides information about how we use and disclose protected health information about you. You have a right to review our notice before signing this form We reserve the right to change the privacy practices outlined in the notice You may obtain a copy by contacting us

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment or for health care operations. We are not required to agree to this restriction. but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and operations as described in our notice You have the right to revoke this consent, in writing Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected

I have read the Altamonte Medical Associates Notice of Privacy Practices

Name: _____

Signature: _____ **Date:** _____

PF-1000 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service the services provided, and the medical condition being treated

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Altamonte Medical Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting Your health information may be disclosed to public health agencies as required by law For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

l und raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box

[ ] Please do not use my information for fund raising purposes

Individual Rights

You have certain rights under the federal privacy standards These include:

- ❑ the right to request restrictions on the use and disclosure of your protected health information
- ❑ the right to receive confidential communications concerning your medical condition and treatment
- ❑ the right to inspect and copy your protected health information
- ❑ the right to amend or submit corrections to your protected health information
- ❑ the right to receive an accounting of how and to whom your protected health information has been disclosed
- ❑ the right to receive a printed copy of this notice

Altamonte Medical Associates Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionist or Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Altamonte Medical Associates
499 East Central Parkway #115
Altamonte Springs,FL 32701

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is: As stated above.

Effective Date
This Notice is effective on or after APRIL 14, 2003