



Dear Patient:

Thank you for choosing Longwood Medical Group as your health care provider. Welcome to our practice! We look forward to providing you the best care.

Please plan on arriving 30 minutes prior to your appointment time to ensure that all required paperwork is completed. Due to the complexity of your comprehensive office visit, it is reasonable to allow for up to two hours for your appointment time. In order to expedite this process, you will need to bring with you the following:

- All enclosed forms, completed, signed and dated.
- Your insurance card(s)
- Photo ID
- Your referral or authorization from your primary care physician (if needed)
- Your medications and a listing of your medications
- Any pertinent medical records (including past hospitalizations, surgeries, recent lab work, specialist reports, medical records, etc.)

**Medical records MUST be obtained at least 48 hours prior to your appointment date.**

Please be advised that your office visit may be rescheduled if your records have not arrived to our office by the time of your appointment. You may request your records to be sent to us by completing the "Authorization For Use of Disclosure of Health Information" form and fax, email or hand carry it to your PCP, Specialist, Hospital or other medical provider. They will then fax or email your records to us.

It is imperative that you bring your pertinent medical records sent to us at least 24 hours prior to your appointment. Without this information, your chart will not be complete and our providers need your full chart to provide you with a comprehensive new patient office visit. Please assist us in making this possible.

Today's Date: \_\_\_\_\_

Please fax to: 407-339-1200

or e-mail to: [LC@Longwoodmedicalgroup.com](mailto:LC@Longwoodmedicalgroup.com)

## PATIENT DEMOGRAPHIC INFORMATION

Last Name:		First Name:		Middle:
Mailing Address:				
City:		State:	Zip Code:	
Home Phone:		Cell Phone:	Work Phone:	
E-mail Address:				
Sex: Male:		Female:		
Date of Birth (mm/dd/yyyy):			Social Security #	
Marital Status: Single:		Married:	Divorced:	Widow/Widower:
Spouse's Name (if applicable):			Spouse's DOB:	
Spouse's Social Security #:				
Spouse's Contact number:			Home:	Cell: Office:
Emergency Contact Name:				
Phone:				
In the event I am not available, I authorize the verbal release of my medical condition and/or status, over the telephone to the authorized members listed below:				
1:		2:		
3:		4:		

## EMPLOYMENT INFORMATION

Patient's Company Name:		Phone:	
Address:		Zip Code:	
City:	State:		
Spouse/Parent's Company Name:		Phone:	
Address:		Zip Code:	
City:	State:		

## AUTHORIZATION FOR RELEASE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient:

Date of Birth:

Social Security #

## USE AND DISCLOSURE OF HEALTH INFORMATION

To:

(Name of healthcare provider)

(Street address, City, State, Zip)

I hereby authorize release to: **Longwood Medical Group:**

**Wasim Ahmar, MD, FACC/ Khalid Yaqoob, MD**

*(Persons/Organizations authorized to receive the information)*

The following information:

Complete records:

All Diagnostic test results:

Lab only:

Operation Reports:

Consultation/Progress Notes:

Other:

Authorization will not expire unless a written notice is submitted to our office.

Date:

Patient Signature:

**SIGNATURE**

If signed by other than patient, indicate relationship:

Print name: (Legal Representative):

## **Release Record**

### **Medicare Benefits to Provider, Physicians and Patient**

I certify that the information given by me in applying for payment under file XVIII of the social security act is correct. I authorize any holder of medical information or other information or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment.

### **Authorization for Medical and Diagnostic Treatment**

I, the undersigned, as the patient of his/her authorized representative, hereby authorize Longwood Medical Group, their employees and agents, to treat the condition(s) which appear indicated by the admission complaints and findings. I will be informed of the modes of treatment, risks involved, and the nature of the procedure(s) to be done. No guarantee has been made that my present condition will be cured.

### **Release of Medical Records**

Release of medical records and medical information; I, the undersigned, as the patient or his/her authorized representative, hereby authorize Longwood Medical Group and /or its representative(s) to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim.

### **Assignment of Insurance and Financial Responsibility**

Assignment of insurance and financial responsibility; I hereby authorize payment to Longwood Medical Group for benefits otherwise payable to me, including major medical insurance. I understand that I am financially responsible for all charges incurred during this treatment program, whether or not paid by said insurance. It is my responsibility to pay any deductible(s) amount or any other balance not paid by my insurance in 45 days.

### **I Agree...**

I agree to pay Longwood Medical Group any monies owed if a referral form authorizing the visit is not brought in at the time of the visit or within 10 days after the visit.

I agree to authorize the release of my health information to other physicians and/or specialist if needed for treatment or further medical necessity.

### **The Undersigned ...**

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Longwood Medical Group or its employees, from any and all liability which may arise from this action, whether or not foreseen at present.

Signature of Patient or Responsible Party

Date:

Patient's name printed

## Financial Policy

Thank you for choosing Longwood Medical Group as your health care provider. Because of the many changes in insurance companies and the requirements of referrals/authorizations by Primary Care Physicians, we are requesting that our patients sign this Financial Policy stating that their insurance company has not changed from the prior visit and that we have the correct insurance information.

It is also a requirement of your insurance plan to know where your Laboratory work will be sent. Please select the lab corresponding to your insurance plan.

Quest Diagnostics: \_\_\_\_ Florida Pathology \_\_\_\_ LabCorp \_\_\_\_ Other \_\_\_\_

### Participating HMO, PPO, POS and Indemnity plans:

- Your deductible is your responsibility according to your insurance plan.
- Your copay / coinsurance is your responsibility according to your insurance plan.
- If you have any questions regarding this please call your insurance company prior to your visit or procedure. Any other questions call Longwood Medical Group at 407-767-8200.
- Please understand that it is the patient's responsibility to understand the rules and regulations of their policy. If we are not a participating physician, you may be responsible for charges incurred.
- If applicable, please obtain required referral/authorization from your Primary Care Physician prior to your visit. You may be rescheduled if no authorization has been obtained.
- Please call your insurance company prior to your visit to make sure our Physicians participate with your insurance plan and that your services are a "covered" benefit.
- If your insurance requires a co-pay, this will be collected at the time of your appointment.

We will file your insurance claims as a courtesy. If your claims have not been paid within a timely manner, you may receive our billing statement notifying you of these circumstances. At the time you will be asked to call you insurance carrier to check claim status first and then call our Billing Department at 407-767-8200 to assist you.

### Self-Pay and Non-Participating Insurance:

- Any and all past due to patient's balances will be collected before your appointment.
- Cancellations will need to be arranged **24 hours in advance**.
- Returned checks are subject to **a \$25.00 service fee**.
- Fees for medical records and forms vary, please call 407-767-8200 for pricing.
- This Financial Policy Statement must be signed prior to any treatment.

We thank you for your understanding.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date:

Patient's name printed

## Insurance Information

### Primary:

Insurance Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Other: \_\_\_\_\_

### Secondary:

Insurance Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship: Self \_\_\_\_\_ Spouse: \_\_\_\_\_ Other: \_\_\_\_\_

## Referring Physician

Did another Physician refer you? Yes \_\_\_\_\_ No: \_\_\_\_\_

If yes, please complete the following information so we can send a report to your referring physician.

Referring Physician Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

If you have a primary care physician OTHER than your referring physician please complete the following information so we can send a report to your primary care physician.

Primary Physician's Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Office phone: \_\_\_\_\_

What is your chief complaint or reason for your appointment? \_\_\_\_\_.

\_\_\_\_\_  
\_\_\_\_\_

## ALLERGY HISTORY

Have you ever had an allergic reaction to any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list medication and the reaction: \_\_\_\_\_

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## CURRENT MEDICATIONS

Please list any medications (Prescription and nonprescription) you are currently taking, including vitamins and aspirin. Please use separate sheet if necessary.

Medication	Dosage	Number taken daily

## Past Medical History

	Yes	No	Onset Date	Notes
Heart Attack				
Coronary Artery Disease				
Stent(s)				
Hypertension				
Stroke				
Arrhythmias ie: Afib				
Elevated Cholesterol				
Diabetes				
Renal Disease/Renal Stent				
Cancer				

Pulmonary Disease				
Substance Dependency				
Thyroid Disease				
GERD				
Peripheral Vascular Disease				
Rheumatology				
Valvular Disease				
Mental Illness				

### Cardiac and Social History

Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widow/Widower: \_\_\_\_\_  
 How many children do you have? \_\_\_\_\_  
 Who currently lives with you at home? \_\_\_\_\_  
 Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_  
 Do you have any dietary restrictions: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes what type? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	Yes	No	Date	Notes
Arterial Ultrasound				
Cardiac Catheterization				
Cardioversion				
Carotid Ultrasound				
Echocardiogram				
Event Monitor				
Holter Monitor				
Stress Echo				
Stress Test				
Pacemaker/Defibrillator				
Venous Ultrasound				



### Family History

	Age (or age at death	Significant Health Problems		Age	Significant Health Problems
Father			Children		
Mother					
Sibling					
			Maternal Grandmother		
			Maternal Grandfather		
			Paternal Grandmother		
			Paternal Grandfather		

### Tobacco History

Have you ever smoked cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how much do you currently smoke per day? None \_\_ ½ pack \_\_ 1 pack\_\_>1 pack\_\_

If you have previously smoked, how long ago did you quit? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

### Substance History

Have you had significant exposure to: Pesticides\_\_\_\_\_ Toxic Waste \_\_\_\_\_ None \_\_\_\_\_

Do you drink Alcohol? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Type: \_\_\_\_\_

How much per week: \_\_\_\_\_

Have you or do you take street drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which kind: \_\_\_\_\_

## Review of Systems

Have you experienced any of the following symptoms? Please mark yes or no. If yes please provide a brief explanation.

System	Yes	No	Explanation
<b>Cardiovascular</b>			
Chest Pain or Angina			
Irregular heart rhythm			
Swelling of the feet, ankles, or hands			
<b>Constitutional</b>			
Good general health lately			
Recent weight changes			
Extreme Fatigue			
Frequent nausea and /or vomiting			
Difficulty sleeping			
<b>Hematology/Lymphatic</b>			
Easy bruising			
Frequent bleeding			
<b>Musculoskeletal</b>			
Leg muscle stiffness or pain			
Weakness of leg muscles			
Difficulty in walking			
<b>Neurological</b>			
Headaches			
Numbness or tingling sensation			
Weakness or paralysis			
Convulsions or seizures			
Loss or blurring of vision			
Blackouts or dizziness			
Memory loss or confusion			
Other neurological problems			

System	Yes	No	Explanation
<b>Respiratory</b>			
Breathing problems/shortness of breath			

By signing below you are verifying that above stated information is true.

Patient signature: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Date of signature: \_\_\_\_\_