Orlando Medical Group

Dear Patient:

Thank you for choosing Orlando 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: MaryP@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:
Address: Phone:
City: State: Zip Code:

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

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: **Orlando Medical Group:**

Wasim Ahmar, MD, FACC/ Khalid Yaqoob, MD/Edwin Martinez, MD/Ayesha Ahmar, 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 Orlando 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 Orlando Medical Group and /or it 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 Orlando 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 Orlando 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 Orlando 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 Orlando 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 Orlando 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 compete 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: _____
_____
_____
_____
_____
_____

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? Pleas mark yes or no. If yes please provide a brief explanation.

System	Yes	No	Explanation
Cardiovascular			
Chest Pain or Angina	☐	☐	
Irregular heart rhythm	☐	☐	
Swelling of the feet, ankles, or hands	☐	☐	
Constitutional			
Good general health lately	☐	☐	
Recent weight changes	☐	☐	
Extreme Fatigue	☐	☐	
Frequent nausea and /or vomiting	☐	☐	
Difficulty sleeping	☐	☐	
Hematology/Lymphatic			
Easy bruising	☐	☐	
Frequent bleeding	☐	☐	
Musculoskeletal			
Leg muscle stiffness or pain	☐	☐	
Weakness of leg muscles	☐	☐	
Difficulty in walking	☐	☐	
Neurological			
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
Respiratory			
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: _____