Family Practice of Suntree and Viera, P.A.

Frank G. Ditz, M.D.
2 Suntree Place Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

Patient demographic information

DATE: _____

LAST NAME: _____ FIRST: _____ MI: _____

DOB: _____/_____/_____ SOC SECURITY #: _____-_____-_____ SEX: MALE / FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: HOME: _____ CELL: _____
Number you prefer for us to contact you: _____ Home or _____ Cell

EMAIL: _____

ETHNICITY/RACE:
____ Caucasian
____ African American
____ Hispanic/Latino
____ Asian
____ Native American
____ Pacific Islander
____ Middle Easterner
____ Other

RETIRED / DISABLED / EMPLOYED: EMPLOYER: _____

OCCUPATION: _____ MARITAL STATUS: S / M / D / W / OTHER

EMERGENCY CONTACT: _____RELATION: _____ PHONE: _____

EMERGENCY CONTACT: _____RELATION: _____ PHONE: _____

PREFERRED PHARMACY(S): _____ CITY/PHONE: _____

PREFERRED PHARMACY(S): _____ CITY/PHONE: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Insurance Authorization/Financial Responsibility and patient notice

I hearby authorize payment directly to Family Practice of Suntree and Viera, P.A for services rendered and remain in effect until revoked in writing. I understand that my insurance policy is a contact between myself and my insurance provider and I agree to be financially responsible for non-covered services. I understand that I am ultimately responsible for ALL charges whether or not covered by my insurance company or policy and any co-payments, co-insurance or deductibles amounts not covered by my insurance is my financial responsibility. My insurance claim is billed by Family Practice of Suntree and Viera, P.A. as a courtesy and any of my financial responsibility is **due at the time of service.**

I understand that it is my responsibility to know and understand my benefits, coverage, participating labs, hospitals, diagnostic centers and pharmacies. I hereby authorize Family Practice of Suntree and Viera, P.A to release any information/medical records regarding my treatment to my insurance company to secure payment for services rendered. I have provided current and accurate information.

Signature: _____ Date: _____
(Patient, parent or legal guardian if minor)
Relationship to patient if signed by personal representative: _____

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HIPPA PRIVACY PRACTICES AND AUTHORIZATION FOR DISCLOSURE

I, _____ have been
(Please Print)

provided access to a copy of **Family Practice of Suntree and Viera, PA** for review. I give authorization and consent for the physician and staff of Family Practice of Suntree and Viera, PA to:

- **A.** Discuss my medical conditions, health care;
- **B.** Pick up prescriptions, medical procedure orders or x-rays;
- **C.** Payment/insurance information ;
- **D.** All of the above

with the following family members or friends. **Write N/A on 1st line if you not choose any person**

****PLEASE PICK A, B, C or D****

FULL NAME	**RELATION**	**A,B,C, or D**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further understand this authorization will remain in effect unless terminated with a personal dated signature.
My signature below indicates that I have read and agree to abide by the terms of this agreement.

_____ _____
Signature of patient or responsible party if minor Date

_____ _____
Signature of office staff/witness Date

I also authorize the release of information/medical records regarding my treatment and medical conditions to my insurance company to help secure payment for services rendered and to my health care providers. I understand that any **CO-PAYMENTS, CO-INSURANCE** and/or **DEDUCTIBLE** not covered by insurance will be due at the time of service.

_____ _____
Signature of patient or responsible party if minor Date