OCALA INFECTIOUS DISEASE AND WOUND CENTER

Diabetes Clinic
Phone: 352-401-7552
Fax: 352-622-7945

Ocala Location:
2651 SW 32ND PLACE
OCALA, FL 34473

Lady Lake Location:
13940 N US 441, Suite 801
Lady Lake, FL 32159

PATIENT INFORMATION FORM

PATIENT INFORMATION:

LAST FIRST MIDDLE		SOCIAL SECURITY #	DATE OF BIRTH / /	SEX M / F
STREET APT		MARITAL STATUS	SPOUSE/SO-NAME	
CITY STATE ZIP		EMPLOYER	OCCUPATION	
HOME PHONE ( )	CELL PHONE ( )	BUSINESS PHONE ( )		
HOME STREET ADDRESS		EMAIL ADDRESS		
CITY STATE ZIP		PREFERRED LANGUAGE: (Medicare Requirement)		
RACE (CIRCLE): (Medicare Requirement) AFRICAN AMERICAN CAUCASIAN HISPANIC LATINO FILIPINO PACIFIC ISLANDER Other: _____				

EMERGENCY CONTACT:

LAST FIRST MIDDLE	RELATIONSHIP
STREET APT	HOME PHONE ( )
CITY STATE ZIP	DAYTIME PHONE ( )

INSURANCE INFORMATION

PRIMARY INSURANCE CO.	POLICY #	GROUP #	COPAY $	Is your plan a: (circle) Medicare Replacement HMO PPO
SECONDARY INSURANCE CO.	POLICY #	GROUP #	COPAY $	

PRIMARY CARE PHYSICIAN / RFERRING DOCTOR:

LAST FIRST MIDDLE	PHONE ( )
CITY STATE ZIP	

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PREFERRED PHARMACY

PHARMACY NAME	PHONE ( )
ADDRESS (or best description where located)	

HEALTH HISTORY QUESTIONAIRE

Patient Name: _____ Date: _____

Please tell us in your own words why you are here today and any symptoms you are experiencing:

_____

_____

PAST MEDICAL HISTORY - Please check all of the following which pertain to your medical history:

	CARDIAC		METABOLIC		SKIN DISORDERS
	Heart Disease		Thyroid Problems		Eczema
	Heart Attack		Diabetes Types I/II		Dermatitis
	Congestive Heart Failure		**VASCULAR SYSTEM**		Psoriasis
	Abnormal Heart Rhythm		Hypertension		Boils / Abscess
	High Cholesterol		Arteriosclerosis		Non-Healing Wound
	PULMONARY		Arterial Insufficiency		Cellulitis
	Lung Disease		Venous Stasis		**NEUROLOGICAL**
	Pneumonia		Leg Edema		Migraines
	COPD		Varicose Veins		Meningitis
	Emphysema		**MUSCULOSKELETAL**		CVA / Stroke
	Bronchitis		Arthritis		Neuropathy
	Asthma		Gout		Seizures
	GASTROINTESTIONAL		Osteomyelitis		Multiple Sclerosis
	Ulcers		Rheumatoid Arthritis		**MISCELLANEOUS**
	GI Bleed		Fibromyalgia		*Cancer:*
	Diverticulitis		Tendonitis		
	C-Diff		**BLOOD DISORDER**		Rheumatic Fever
	Crohn's Disease		Anemia		MRSA
	Liver Disease		Sickle Cell		Shingles
	Hepatitis		Blood Clots		Syphilis
	Pancreatitis		Leukemia		*Other:*
	RENAL / URINARY		HIV / AIDS		
	Kidney Disease		**PSYCHIATRIC**		

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	UTI		Anxiety		
	Urine Retention		Depression		
	Urine Incontinence		Alcohol / Drug Abuse		
	Enlarged Prostate				

PAST SURGICAL HISTORY - Please check all which pertain to your medical history:

	Abdominal Aneurysm Repair		Gallbladder Removal		Hysterectomy		Renal (Kidney) Stent
	Amputation		Graft Placement		Incision and Debridement		Surgery Related to Cancer
	CABG		Heart Catheterization		Infusa-port Placement		Spinal Surgery
	Appendix Removal		Hernia Repair		IVC Filter Placement		Splenectomy
	Bowel Resection		Hip Replacement		Kidney Surgery		Stomach Surgery
	Mastectomy		Prostate Surgery		Knee Surgery		Tonsils/Adenoids Removed
	Pacemaker Placement		Prosthetic Valve Placement		Lung Surgery		Thyroid Surgery

Patient Name: _____ Date: _____

ALLERGIES – List all medications you are allergic to and the reactions which you experience: **[ ]** ***No Known Allergies***

1)	4)	7)
2)	5)	8)
3)	6)	9)

MEDICATIONS – List your current medications: **[ ]** ***No current medications***

Name of Medication	Dose and Frequency	Why are you taking this?
Example: HCTZ	12.5mg Daily	High Blood Pressure
1)		
2)		
3)		
4)		
5)		

**PLEASE LIST ADDITIONAL MEDICATIONS ON THE BACK OF THIS PAGE*

FAMILY HISTORY – Check Box if your Mother, Father, Grandparents, or Brother/Sister have a history of:

	Diabetes		Heart Disease		Stroke		Thyroid Issues
	Hypertension		Autoimmune Disorders		Cancer: _____		Other: _____

IMMUNIZATIONS – Check box if you have had the following immunizations and enter the year as close as possible:

	Flu (Influenza)	Year-		MMR	Year-
	Pneumococcal	Year-		IPV	Year-
	Meningococcal	Year-		Hepatitis A	Year-
	Tetanus	Year-		Hepatitis B	Year-

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SOCIAL HISTORY

Do you smoke?		No		Yes		Quit _____(year)					
Do you drink Alcohol?		No		Yes		Quit _____(year)					
Do you use drugs?		No		Yes		Quit _____(year)					
Have you ever been tested for HIV		No		Yes	Results:		Positive		Negative		Unknown
Have you ever had needle exposure?		No		Yes							
Have you ever had sexual contact with someone known to be HIV positive?		No		Yes							
Have you ever received a blood transfusion?		No		Yes							
Have you ever had a tuberculosis (TB) skin test?		No		Yes							
Have you recently been exposed to mosquito bites?		No		Yes							
Have you recently been exposed to ticks or had a recent tick bite?		No		Yes							

What kind of pets do you have in your home?

_____

_____

Where have you traveled overseas in the last 5 years?

_____

_____

Financial Policy

Ocala Infectious Disease and Wound Center as well as Dr. Haris Mirza believe a good part of health care practice is to establish and communicate a financial policy to our patients. We are dedicated in providing the best possible care for you, and we want you to completely understand your financial policy prior to your visit.

VERIFICATION OF INFORMATION. By signing below, you have reviewed the above information which you entered into the PATIENT INFORMATION FORM and verify that all of your demographic information is correct. *You are also verifying that if health insurance is listed, it is current and there is valid coverage.*

PAYMENT is due at the time of your visit. We will accept cash, check, Visa, MasterCard, and any payments through your Health Savings Account. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance or your coverage is currently under a preexisting condition clause, your payment is due in full at the time of your visit.

ESTIMATED COST OF SERVICES We are happy to always provide an estimated cost of payment required with all services. As insurance policies continuously change their reimbursement rates, deductible on plans, and covered services, we will do the best we can to provide a close estimate of costs. However, this cannot be a guarantee of payment you may be responsible for.

INSURANCE We participate with many insurance plans. We will file all of these insurance claims. Feel free to verify with us that we accept your insurance company. Please also remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable time period, you will be billed.

Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy. Patients who insist on "day of" urgent/emergent care but have insurance coverage through a policy which needs preauthorization for visits may be billed the visit in full if the insurance denies payment. Please be aware of what your plan covers

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RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. All bad checks written to this office are subject to collections and will be prosecuted in Marion County.

ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Haris I Mirza MD/Ocala Infectious Disease and Wound Center LLC for charges not covered by the assignment of insurance benefits.

ASSIGNMENT OF INSURANCE BEBEFITS: I hereby assign, transfer, and set over directly to Haris I Mirza MD/Ocala Infectious Disease and Wound Center LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Haris I Mirza MD/Ocala Infectious Disease and Wound Center LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Haris I Mirza MD/Ocala Infectious Disease and Wound Center LLC. I authorize L Haris I Mirza MD/Ocala Infectious Disease and Wound Center LLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

RELEASE OF INFORMATION: I hereby authorize the and direct Haris I Mirza MD/Ocala Infectious Disease and Wound Center LLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

COLLECTION FEES: I understand that in the event I do not make a payment after three subsequent months of statements being sent, my account will be considered overdue and all outstanding fees will be sent to collections.

CONTINUITY OF CARE: I understand that Ocala Infectious Disease and Wound Center along with the physicians employed in this facility have the obligatory right to discontinue care if I "no show" to three appointments. Appointments cancelled within 24 hours of the scheduled appointment will be considered a "no show".

Signature of patient or guarantor: _____ **Date:** _____

Consent for Medical Care and Treatment

I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by my doctor, his consultants, associates and his assistants, or his designee. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me.

I authorize Dr. Haris Mirza and his assistants/designee to discuss my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse. I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time.

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I understand there are times when the law allows Dr. Haris Mirza and his assistants/designee to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, Dr. Haris Mirza and his assistants/designee may release information to doctors, nurses and others who provide me with health care or are prospective health care providers; to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

I also understand and acknowledge that Florida law provides if any health care worker is exposed to my blood or other bodily fluid, Dr. Haris Mirza and his assistants/designee may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Dr. Haris Mirza. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my medical record.

I acknowledge that it may be difficult for the physician(s), his/her assistants, or his/her designee to personally communicate with the patient regarding laboratory/diagnostic test results, etc. It is the policy of Dr. Haris Mirza's Office to leave this information on the patient's telephone answering machine.

NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that Dr. Haris Mirza has made no guarantees or warranties to me as to the result of treatments or examination.

_____ _____

Patient Name Date

_____

Patient / Legally Authorized Rep. Signature

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Intravenous Therapy Informed Consent

If I am ordered intravenous antibiotics by my physician, I also agree to insertion of appropriate venous access device for I.V. therapy administration. As needed, I agree to blood draws required to monitor my intravenous treatment. My prescribing physician has informed me of the purpose of the treatment, its desired effects, and the possibility of complications of this therapy which may include but are not limited to: discomfort, bruising, and pain at the site of injection, Inflammation of the vein used for injection, mild to severe allergic reactions including anaphylaxis, renal impairment, diarrhea, and other side effects caused by the medication I am prescribed.

I understand that I have the right to consent or refuse any proposed treatment at any time prior to the performance of the treatment. I also understand the information provided on this form and agree to Intravenous Therapy. I intend this consent for all future intravenous treatments.

Signature of patient or guarantor_____ **Date:** _____

Wound Care Informed Consent

By signing below, I agree to wound care as ordered by my physician. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of wound care. The description of wound care includes: dressing removal, cleansing of wound and surrounding skin, removal of necrotic tissue, application of new dressing (in the form of bandages, gauze, films, gels, or foams), whirlpool or negative pressure wound therapy. In some cases, dressings do not improve wounds as initially expected and dressing orders may need to be re-evaluated and changed. Wound treatment may be painful. Decreased blood supply to the area can lead to tissue death. In rare cases, muscles, blood vessels, and bones may be affected. A scar may form on your skin as the wound heals. The risk of infection may increase with hydrotherapy (whirlpool treatment) or negative pressure wound therapy (NPWT). There is also an increased risk for bleeding with negative pressure wound therapy.

I am also consenting to photography of my wounds to be used only for the purpose of clinical progression & documentation. This will remain a part of my chart and my privacy protected under HIPPA privacy act. I understand that I have the right to consent or refuse any proposed treatment at any time prior to the performance of the treatment. I also understand the information provided on this form and agree to Intravenous Therapy. I intend this consent for all future intravenous treatments.

Signature of patient or guarantor_____ **Date:** _____

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Authorization to Obtain/Release Medical Records

Patient Name: _____

DOB: ___/___/____ SSN# ***-**-_____

Address: _____

I hereby request and authorize: Ocala Infectious Disease and Wound Center to:

[ ] Obtain records from: _____
Address: _____
_____
_____

Phone: _____ Fax: _____

OR

[ ] Send records to: _____
Address: _____
_____
_____

Phone: _____ Fax: _____

The type and amount of information to be used or released is as follows:

	History and Physical	From (date)	/ /	To (date)	/ /
	Consultation	From (date)	/ /	To (date)	/ /
	Pathology Report	From (date)	/ /	To (date)	/ /
	Laboratory	From (date)	/ /	To (date)	/ /

(i.e. MRI/CT/US/CR and include body part)

	Radiology	From (date)	/ /	To (date)	/ /	Test Type:	
	Radiology on CD	From (date)	/ /	To (date)	/ /	Test Type:	
	Cardiac Reports	From (date)	/ /	To (date)	/ /	Test Type:	
	Entire Record	From (date)	/ /	To (date)	/ /	Test Type:	

[ ] Other: _____

Patient Signature: _____ Date: _____

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I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present to our receptionist. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I understand that I may be charged up to $1.00 per page for 25 pages and $0.25 per each additional page.

Photograph, Film, or Vocal Recording Release

Note: I authorize this release based on the following conditions:

- *These records become the property of Ocala Infectious Disease and Wound Center or its representatives*
- *This release is given without promise of compensation*
- *This release is effective until terminated by a retraction in writing from the person granting this authorization*
- *The legal guardian and the patient do release to Ocala Infectious Disease and Wound Center any right, title and/or interest of any kind they may have in the records produced.*

A. Release to photograph, film or record vocally for publicity purposes

I hereby grant to Ocala Infectious Disease and Wound Center the right and authority to photograph, film and/or record vocally: _____ *(Please Print Patient Name)*

These records may be used for promotional or publicity purposes and may be published in mass media publications, on the internet sites, or shown on television or movie presentations. The patient's and family's name may be used. This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records.

_____ _____

(Patient Signature) *(Date)*

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B. Release to photograph, film or record vocally for scientific purposes

I hereby grant to Ocala Infectious Disease and Wound Center the right and authority to photograph, film or record vocally: _____ *(Please Print Patient Name)*

These records may be used for purposes of study, research and teaching and may be published in scientific publications or on the intranet or internet. The patient's or family's name may not be used. This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records

_____ _____

(Patient Signature) *(Date)*

HIPAA Patient Consent Form

By signing this consent form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected Health Information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions.***

If you do not sign this consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this consent form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Name: _____ DOB: _____

Patient or Guarantor Signature: _____ Date: _____

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Patient Contact Information

I wish to be contacted in the following manner (check all that apply):

__ Home Telephone _____
- __ OK to leave a message with detailed information
- __ Leave message with call back number only

__ Work Telephone _____
- __ OK to leave a message with detailed information
- __ Leave message with call back number only

__ Cell Phone _____
- __ OK to leave a message with detailed information
- __ Leave message with call back number only

__ Written Communication
- __ OK to mail to my home address
- __ OK to fax to this number _____
- __ OK to email to my email address _____

__ Personal Contacts
- __ OK to release Protected Health Information to the following person(s)

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand it is my responsibility to change this information should circumstances change.

Patient or Guarantor Signature: _____ Date: _____