Mid-Florida Rheumatology
1743 Park Center Drive, Suite 400
Orlando, FL 32835

Phone: 407-598-7603 or **Fax**: 407-598-7584

PATIENT INFORMATION

Last Name:	First Name: M.I.:	Previous Name (if applicable)
Mailing Address: Apt#		
City/State/ZIP:		
Home Phone:	Cell Phone:	Work Phone:
Are we allowed to leave a voicemail if so : (Please select only one option) ☐ Yes ☐ No		
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:
Marital Status:	Social Security#:	
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone#:	Relationship to Patient:	

ADDITIONAL INFORMATION

Additional Information (**PLEASE FILL OUT ALL SECTIONS BELOW**)

Email Address:	Can we leave message regarding your medical care and test results? ☐ Yes ☐ No
Race (Please select): ☐ White ☐ American Indian or Alaska ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity (Please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Pharmacy Name and Location:	

INSURANCE INFORMATION

	PRIMARY MEDICAL INSURANCE	**SECONDARY MEDICAL INSURANCE**
Ins. Co. Name:		
Policy Holder Name:		
Policy Holder's Date of Birth:		
Policy Holder's Social Security#:		
Patient's Relationship to Policy Holder:		

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Assignment of Benefit

Release of information /authorization for treatment Prescription (RX) History consent

I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance, major medical benefits and any other health plan to the assigned physician. This assignment will remain in effect until revoke by me in writing. I understand that **I am financially responsible** for all charges whether or not paid by said insurance. I hereby authorize the said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

Consent of Treatment: The patient and/ or authorized representatives does hereby consent to any or all medical treatments which may deem advisable by Mid-Florida Rheumatology .

RX Consent: I give Mid-Florida Rheumatology to send and receive my pharmacy history.

Patient or Responsible Party:_____ Date:_____

I have read and agreed the copy of Mid-Florida Rheumatology's Privacy Notice. ☐ (Initials)

I have read and agreed the patient portal user agreement. ☐ (Initials)

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

Patient Consent

Please give us your contact information below

Patient Name: I _____, agree that Mid-Florida Rheumatology may contact me or the following individuals that I have designated in the following alternative manners for the following reasons.

Appointments Reminders:

Leave a message / Voice Mail _____ Home Phone_____ Cell Phone_____

Work Phone_____ Telephone Number_____

Results:

Results may be given to the Designated Person(s) _____ Or patient ONLY_____

Leave a message / Voice Mail at contact number provided_____

Medicine Prescriptions/Orders:

Scripts/Orders may be given to the following_____ patient ONLY_____ patient and/or designated person(s)

_____

Designated Person(s)

_____

Print name and relationship

_____

Patient or Guardian Signature

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Patient's Name: _____ Date: _____

Reason for visit _____

Name of your Primary Care Doctor (PCP) _____

Does (Did) any family member have this condition:

History of Gout_____ Psoriasis _____ Rheumatoid Arthritis _____ Sjogren Syndrome _____

Scleroderma _____ Myositis _____ Tuberculosis _____

List of any Surgeries you had:

_____

_____

Social History: Single _____ Married _____ Divorced _____ Widow(er) _____

Are you smoker? Yes _____ No _____ If yes, how much Cigarettes per day? _____For how long? _____

If you ever smoked, when did you quit _____

Do you drink alcohol? Yes _____ No _____ If yes, how much_____

Do you/have you ever illicit drugs? Yes _____ No_____ If yes, what drugs are/have you used? _____

Do any of your family members have any of the following illnesses?

Diabetes _____Heart Disease _____ Heart Attack _____

High Blood Pressure_____ Stroke _____ High Cholesterol Levels _____

List any medication allergies you have and your reaction to them _____

_____

Please list all medication that you take, both prescription and non-prescription:

Medication	Dose	How often	Medication	Dose	How often
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

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Patient's Name: _____ **Date:** _____

Review of Systems:

Please state YES or NO if you have experienced any or all of the following recently:

Fevers	_____	Chills	_____	Sweats	_____	Weight Loss	_____
Rashes	_____	Photosensitivity	_____	Mouth Sores	_____	Chest Pain	_____
Vomiting	_____	Nausea	_____	Constipation	_____	Abdominal Pain	_____
Dark/Bloody Stools	_____	Diarrhea	_____	Numbness	_____	Blood in Urine	_____
Sleeping Problems	_____	Fatigue	_____	Anxiety	_____	Depression	_____

Past Medical History:

Please state YES or NO if you have ever experienced any of the following:

Stomach Ulcers	_____	Hepatitis	_____	Reflux Disease	_____	HIV	_____
Crohn's Disease	_____	Lyme disease	_____	Kidney Disease	_____	Psoriasis	_____
Thyroid Disease	_____	Asthma	_____	Gout	_____	Glaucoma	_____
Heart Attack	_____	Osteoporosis	_____	Tuberculosis	_____	Anemia	_____
High Blood Pressure	_____	High Cholesterol	_____				

Vaccination Status :

Please list the date of your last vaccination:

Shingles_____ FLU _____ Hepatitis _____ BCG _____ Pneumonia _____

Other _____, if so please list_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

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OUR OFFICE POLICIES

1. Appointments are necessary at all times. No walk-ins please. It disrupts the patient care. You are welcome to call and discuss your questions.

2. All medical record requests for personal use will require 48 hours' notice and the patient will be charged a fee of .15 cents per page. If you are requesting records to be mailed there might be an additional charge.

PLEASE NOTE: if records are for another doctor's office and not for the personal use, we will **fax** them over **free of charge**.

3. **ALL REFILLS** must be requested by your pharmacy 48 hours in advance. No refills will be given without being seen by our office within a 4-month time period. All refills guidelines must be up to date before any refills will be given by our office. If you are requesting a mail order prescription, this requires a 48-72 hour notice. This takes time to acquire a signed prescription from the doctor since he travels to different offices. Your patience in this matter is greatly appreciated.

4. **ALL REFERRALS** are the responsibility of the patient!!! Please make sure you have a valid referral on file, if necessary with our office before each appointment. If you fail to do so, you will be responsible for the charges incurred for that date of service or you may be rescheduled. It is the sole responsibility of the patient to know their insurance.

5. **PLEASE NOTE**: MID-FLORIDA RHEUMATOLOGY reserves the right to discharge you from the practice for frequent missed or cancelled appointment without informing our office 24 hours in advance. Any missed appointments without a 24 hour advance notice will be also require to pay a $25.00 cancellation fee for follow up and $50.00 for new patients. We may dismiss you from our practice for inappropriate comments or behavior.

6. $35.00 service charge will be applied to your account if a check is returned from your bank.

7. **Self-Pay** patients are required a $50.00 deposit to be kept on their account.

I understand the above policies and procedures of Mid-Florida Rheumatology

Patient Signature _____ Date _____

Print Name _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understood Mid-Florida Rheumatology's Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that Mid-Florida Rheumatology may update its Notice of Privacy Practices at any time and that I may receive an updated copy of Mid-Florida Rheumatology's Notice of Privacy Practices by submitting a request in writing for a current copy of Mid-Florida Rheumatology's Notice of Privacy Practices.

Copy of Mid-Florida Rheumatology's Notice of Privacy Practices.

Print Name _____

Patient Signature _____ Date _____

If completed by patient's personal representative, please print name and sign below.

Printed

Patient Personal Representative Name_____ Date _____

Patient Personal Representative Signature_____ Date _____

Mid-Florida Rheumatology Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Mid-Florida Rheumatology made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign

☐ Patient or patient's personal representative unable to sign

☐ Other_____

Employee Name (Printed) _____

Employee Signature _____ Date _____

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CONSENT TO HIV TESTING

GENERAL INFORMATION

The Human Immunodeficiency Virus, the causative agent of Acquired Immunodeficiency Syndrome (HIV) and related clinical manifestations, has been shown to be spread by sexual contact; by parenteral exposure to blood and rarely, by other exposures to blood, and from an infected woman to her fetus or infant.
Once the virus enters the bloodstream, it seeks out the particular form of white blood cell that is essential to the working of human immune system. This particular cell is called T-helper cell lymphocyte and one of its functions is to orchestrate the immune system in the event of attack from foreign particles.

As the virus continues its reproduction, the body loses an increasing number of lymphocytes, thereby slowly diminishing the ability of the immune system to function properly. A number of diseases are known to take advantage of the opportunity presented by the damaged immune systems. These are frequently referred to as opportunistic diseases. The most well-known are Kaposi's Sarcoma, a form of skin cancer, and pneumocystis pneumonia, a lung infection caused by a protozoa. It is the presence of these opportunistic diseases that signal; a diagnosis of AIDS.

Persons exposed to the Human Immunodeficiency Virus visually develop detectable levels of antibodies against the virus within 6 to 12 of infection. The presence of antibodies indicates current infection, though many infected persons may have minimal or no clinical evidence of disease for years.

TEST

The Human Immunodeficiency Virus Antibody Test (HIV Antibody Test) is a simple blood test that detects the antibody produced by the body following infection with the Human Immunodeficiency Virus. The HIV Antibody Test is not the test for the disease, AIDS, instead it is the test to show whether an individual is infected with the Human Immunodeficiency Virus which, in turn, can cause AIDS.
The HIV Antibody Test is done by drawing approximately 5cc's (1 teaspoon) of blood from the arm. When the blood sample is drawn, the individual may experience some discomfort at the site of the needle stick and a small bruise may develop. Otherwise there is no risk of physical injury.

A test of HIV antibody is considered positive when a sequence of tests, starting with a repeatedly reactive enzyme immunoassay (EIA) and including an additional, more specific essay, such as Western Blot, are consistently reactive. A false- negative test is remote except during the first weeks after an infection, before antibodies are detectable. The antibody test is a tool to aid the medical team in diagnosing and managing an individual's medical care.

RISKS

As reflected above, the HIV Antibody Test poses a negligible physical risk; however, because of early uncertainty and fears about the transmission of AIDS, persons who test positive for the virus, if the results of the test are made public, may experience difficulties in regard to employment, housing, insurance needs, and other activities normally obtained and enjoyed by public.

ALTERNATIVES

There are no known alternatives other than the HIV Antibody Test for determining the presence or absence of the HIV antibody.

CONSENT

I understand that the blood test for the virus which is the causative agent of Acquired Immunodeficiency Syndrome is not 100% accurate, and that these blood tests sometimes produced false positive or false negative test results. I further understand that a positive antibody test means a person probably has been infected with HIV, but does not necessarily mean that a person will develop AIDS.
An explanation of the HIV Antibody Test (including but not limited to), the purpose of the test, the potential use of the test, its limitation and meaning of the results have been supplied to me and I have been given the opportunity to ask questions about the test.

I understand that the results of the HIV tests will be made available to me and that at the time or immediately thereafter, upon request, I will be given the opportunity to obtain counseling which will assists me understanding the test results, the possible need for additional testing, measures for the prevention of the transmission of the Human Immunodeficiency Virus, the availability of appropriate health care and support services, the advisability of locating individuals who may have either exposed to me or that I may have exposed to the Human Immunodeficiency Virus and the services of the public health authorities that are available to assist me locating/ notifying said individuals.

CHECK ONE

( ) I authorize the hospital, physician, and/or laboratory to furnish my insurance company(s) and other third party payers with any and all the information it has or may have hereafter, either written or oral, pertaining to or in any manner connected with the tests authorized herein, that may aid in the payment of any account presented to me or a third party, on my behalf, and I further agree that no person, firm or corporation shall be held liable in any manner for furnishing or having furnished such information.

( ) I do not consent to the release of the nature of the test(s) to my insurance company(s) or medical assistance program. I will pay the bill for the test myself.

I understand that the test results will be confidential and only those directly involved in my care, or as required by law will know the results.

On this basis, I authorize my physician and anyone authorized by him or her to perform the blood tests for the Human Immunodeficiency Virus antibody.

_____ _____

Date Patient Signature

_____ _____

Witness Signature of Authorized Representative

If the person on whom the teats is to be performed is not the person executing the consent to the HIV antibody Test, the person who signs the form, on behalf of said individual, should include, next to their signature, their relationship to the individual being tested.