

Patient Information Form

Last Name		First Name		Middle/Maiden Name		Date of Birth		Sex (circle): M - F	
Mailing Address			Apt./Lot		City		State/Zip		How did you hear about us?
Marital Status (circle): Married - Single - Divorced - Widowed - Separated				Mother's Name if Minor Patient			Father's Name if Minor Patient		
Home Phone () ()		Work Phone () ()		Mobile Phone () ()		Email Address			
Race (circle): Black - White - Asian - Hispanic - Other: _____				Ethnicity (circle): Hispanic - Non-Hispanic - Unknown			Preferred Language		
Spouse/Parent Name		Do you have a Living Will or Medical Advance Directive?					Yes - No		
Emergency Contact if different than parent or spouse list above		Emergency Contact Address			City		State/Zip		
Emergency Contact Phone Numbers:		Home Phone () ()		Work Phone () ()		Mobile Phone () ()			

Insurance Information

Primary Carrier Insurance Company		Effective Date		Primary Carrier Insurance Company		Effective Date				
Insurance Carrier Mailing Address		City		State/Zip		Insurance Carrier Mailing Address		City		State/Zip
Policy Holder's Name				Policy Holder's Name						
Policy #		Group #		Policy #		Group #				

Responsible Party Information

If other than parent/spouse listed above

Head of Household or Parent with Custody of Minor				Relationship to Parent					
Mailing Address		Apt./Lot		City		State/Zip		Phone #	
								Home () ()	
								Work () ()	
								Mobile () ()	

Authorization for Treatment

I authorize Physician Associates, LLC to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse - to include alcohol & drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Physician Associates, LLC in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Physician Associates, LLC. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Physician Associates, LLC.

Patient/Legal Guardian Signature

Date

Patient/Legal Guardian Print



Dr. Robert Duggan, DPM, FACFAS
Foot & Ankle Surgeon, Board Certified

7404 Red Bug Lake Rd, Oviedo FL 32765 - 7472 Doc's Grove Circle, Orlando, FL 32819 - 3300 W. Lake Mary Blvd., Ste 100, Lake Mary, FL 32746

HISTORY AND PHYSICAL FORM

Name: _____ Date: ____/____/____

HISTORY

Chief Complaint: _____

History of illness:

Onset: _____
Location: _____
Duration: _____
Changes: _____
Prior Treatment: _____
Family Physician: _____

Past Medical History:

Check all that apply

- Diabeties, Skin Problems, Hepatitis, Hypertension, Hypotension, Bleeding Disorder, Nervous Conditions, Heart Disease, Rheumatic Fever, Stroke, Fainting Spells, Other/Explain: _____, Sickle Cell Anemia, Seizure Disorders

Past Surgical History:

Table with 4 columns: Hospitalizations/Surgeries, Date, Hospitalizations/Surgeries, Date

Allergies:

Check all that apply

- Penicillin, Food, Other/Explain: _____, No Known Allergies, Codeine, Clothing, Asprine, Iodine, Tape, Sulphur, Sulfites, Local Anesthetics

Medications:

Table with 6 columns: Name, Illness, Physician, Name, Illness, Physician

Family History: Check all that apply

- Diabeties, Hypertension, Bleeding disorders, Circulatory, Problems w/Anesthesia

Social History: Check all that apply

- Tobacco (pkg/day), Coffee (cups/day), Alcohol, Substance Abuse

By signing this form you agree that all information is correct and up to date. Please fill out form entirely.

Patient / Legal Guardian Signature

PHYSICIAN ASSOCIATES
Notice of Privacy Practices Acknowledgment Form

Physician Associates' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician's office or by visiting our Web site at www.paof.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Physician Associates Notice of Privacy Practices

Signature of Patient or Authorized Representative

Date Signed

Print Name

Print Name of Patient

Patient Date of Birth

PHYSICIAN ASSOCIATES USE ONLY

Patient declined signing this acknowledgement form

Reason given: _____

Staff Member Name: _____

Office Location: _____ Date: _____



FINANCIAL AGREEMENT

In consideration of the patient receiving services from Physician Associates, LLC, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of charges is due at the time of the appointment.
- If Physician Associates files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.

Patient Signature

Responsible Party's Signature (Parent/Guardian of Minor)

Printed Name

Printed Name

Date

Date

AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS

I authorize Physician Associates, LLC to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to Physician Associates, LLC for covered medical and/or surgical services.

Patient Signature

Responsible Party's Signature (Parent/Guardian of Minor)

Printed Name

Printed Name

Date

Date

PHYSICIAN ASSOCIATES, LLC

Authorization for the Use and Disclosure of Protected Health Information (Medical Record)

_____ hereby authorizes the use or disclosure of the individually
Print Patient/Legal Representative or Parent/Legal Guardian Name

identifiable health information of _____ **as described herein.**
Print Patient Name Date of Birth

Person/organization authorized to use/disclose the information:	Person/organization authorized to receive the information:
Name/organization _____	Name/organization _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

For the purpose of: Legal Request Moving out of Area New Local Physician Other (please specify)

Date(s) of Service: From: _____ **To:** _____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Physician Associates, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

- | | | |
|-------------------------|------------------------------------|------------------------------------|
| ____ Complete Record | ____ All diagnostic test results | ____ Pathology/Operative Report(s) |
| Or | ____ Consultation/Progress Note(s) | ____ Lab only |
| ____ Abstract of Record | ____ Radiology only | ____ Other (please Specify) _____ |

In addition, place your initials by each specific item: (if applicable)

- | | | |
|--------------------------|-----------------------|---|
| ____ Mental Health | ____ HIV Testing | ____ Genetic Counseling/Testing Information |
| ____ Drug and/or Alcohol | ____ AIDS Information | |

Patient/Legal Representative or Parent/Legal Guardian **Signature Required** Date of Authorization

Patient Date of Birth Social Security Number (optional) Identification Shown

Translator or Interpreter's Name Telephone Number

Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information Date