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**\*\*\*\*PLEASE USE BLACK INK TO FILL OUT \*\*\*\***

**NEW PATIENT REGISTRATION FORM:**

Patient's Name:	DOB:
Age:                      Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:
Email:	

Mailing Address:
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Home Phone #	Cell #
Work#	
Marital Status:	Spouse Name:
Employer:	Phone#
Emergency Contact Information:	

**Patient is under 18 years old, pleas provide parent/guardians information:**

<b>Name:</b>	<b>DOB:</b>
<b>SSN:</b>	<b>Relationship to patient:</b>

**How did you hear about us? Please check one of the following:**

<input type="checkbox"/> <b>Family</b>	<input type="checkbox"/> <b>Friend</b>
<input type="checkbox"/> <b>Newspaper</b> <input type="checkbox"/> <b>Insurance Plan</b>	<input type="checkbox"/> <b>Hospital</b> <input type="checkbox"/> <b>Other</b>

**Insurance Information:**

<b>Primary Insurance:</b>	<b>Phone:</b>
<b>Policy #:</b>	<b>Group #:</b>
<b>Subscribers Name:</b>	<b>Relationship to patient:</b>
<b>Subscribers DOB:</b>	<b>Subscribers SSN:</b>

<b>Secondary Insurance:</b>	<b>Phone#:</b>
<b>Policy #:</b>	<b>Group #:</b>
<b>Subscribers Name:</b>	<b>Relationship to patient:</b>
<b>Subscribers DOB:</b>	<b>Subscribers SSN:</b>

**Do you take controlled or Narcotic Medication  Yes  NO**

**If yes, please be aware that you will be referred to pain management.**

**\*NO CONTROLLED OR NARCOTICS WILL PRESCRIBED AT THIS OFFICE\***

**LIST OF MEDICATIONS**

- 1. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 2. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 3. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 4. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 5. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 6. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 7. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 8. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 9. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 10. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 11. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 12. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 13. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 14. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 15. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 16. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 17. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 18. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 19. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_
- 20. Name: \_\_\_\_\_ Miligrams \_\_\_\_ How many daily \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

**Phone # for Pharmacy:** \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**Please circle any medical history you have or have had**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> COPD	<input type="checkbox"/> Reflux Disease
<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Bowel Irregularity	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Stones	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Migraines	<input type="checkbox"/> Headaches	<input type="checkbox"/> Gastritis
<input type="checkbox"/> Joint Disease	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other:

**ANY PAST OR RECENT SURGERY**

What Type: _____	Date: _____
What Type: _____	Date: _____
What Type: _____	Date: _____
What Type: _____	Date: _____

**ALLERGIES**

**Please list any allergies and your reaction to them, if you have no allergies please write N/A.**

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**FAMILY HISTORY**

**FATHER:**

Deceased Age: _____	Reason: _____
<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes 1 or 2 <input type="checkbox"/> Other: _____	

**MOTHER:**

Deceased Age: _____	Reason: _____
<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes 1 or 2 <input type="checkbox"/> Other: _____	

<input type="checkbox"/> Smoke   How much: _____   How Long: _____ <input type="checkbox"/> Never Smoked <input type="checkbox"/> Alcohol
<input type="checkbox"/> Street Drugs <input type="checkbox"/> Coffee-How many cups per day _____ <input type="checkbox"/> Other Caffeine _____
<input type="checkbox"/> Exercise _____   Sleep Pattern: _____

**PREVENTIVE CARE LAST DATE PROCEDURE WAS DONE**

**MEN:**

<input type="checkbox"/> Colonoscopy Date: _____	<input type="checkbox"/> Endoscopy Date: _____	<input type="checkbox"/> PSA Date _____
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**WOMEN:**

<input type="checkbox"/> Pap Date: _____	<input type="checkbox"/> Breast Exam Date: _____	<input type="checkbox"/> Bone Density Date: _____
<input type="checkbox"/> Mammogram Date: _____	<input type="checkbox"/> Colonoscopy Date: _____	<input type="checkbox"/> Endoscopy _____

<b><u>Immunization:</u></b>	<b>Hepatitis B</b>	<b>Flu</b>	<b>Pneumonia</b>	<b>Tetanus</b>

**FINANCIAL POLICY:**

Financial policy/lifetime authorization for insurance assignments and release of information:  
As your physician, we are committed to providing you with the best possible  
achieve this goal. We need your assistance and your understanding of our payment policy.

**Payment for service is due at the time service is rendered:**

We accept cash, personal checks, Master card, Visa, American Express and Discover.  
Checks are processed electronically.

Returned checks are subject to a \$25.00 service fee and you will lose the privilege of writing checks in our office.  
Patient will be responsible for a service charge of \$20.00 or 25% whichever is more for accounts sent to collection  
agency.

**Follow up appointments and no show appointment policy:**

Patients who do not cancel 24 Hours in advance, will be charged a \$25.00 No Show fee. In order to receive test  
results and refills on medications, regular follow up appointments must be kept.

**Workers Compensation and Accident Claims:**

WE DO NOT TREAT WORK COMPENSATION OR ACCIDENT CLAIMS.

**Disability:**

We do not make disability determination.

**Financial agreement:**

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your  
insurance. You must however realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party  
to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain  
services they will not cover.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health,  
not insurance company. All charges are your responsibility from the date of service is rendered. On any balance on your  
account after 90 days where payment has not been made by either the insurance company or yourself as agreed, collection  
action may be taken.



Patients will be responsible for service charge of \$20.00 or 25 % whichever is more, **for accounts sent to the collection agency.** We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account. Lara Medical and Associates will NOT be responsible for paying hospital bills, outside labs, pathology reports, x-ray readings etc. that may be incurred for your care during your office visit.

**Release of information:**

I, the below named patient, do hereby authorize any physician examining and or treating me to release to any third payer(such as an insurance company , government agency, pharmacy and other health care provider that is participating in my care any medical condition and records concerning diagnosis and treatment.

**Physician insurance assignment:**

I, the below named subscriber, hereby authorize payment directly to any physician examining or treating my of many group and or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary for these service.

**Medicare:**

Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare claim. I hereby verify all insurance pertaining to treatment shall be assigned to the physician treating me.

**Medigap (secondary insurance):**

I, the below request that payment of authorized MEDIGAP benefits be made on my behalf to Lara Medical and Associates for any services furnished by Lara Medical and Associates. I authorize an y holder of medical information about me to release to Lara Medical and Associates any information needed to determine the benefits of the benefits payable for related services. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS AT THE PHYSICIAN'S OFFICE.

This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand its my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and or suit the prevailing party shall be entitled to reasonable attorneys feed and costs of collections.

**Consent for treatment:**

**I agree to be treated by Lara Medical and Associates, I hereby give consent to Lara Medical and Associates PA to provide whatever treatment they may deem necessary to the patient.**

I am aware that if I change providers, it is up to the discretion of Lara Medical and Associates to accept patient back if patient wants to re-establish.

DATE: \_\_\_\_\_

Patients Signature: (parent or guardian if patient is under 18): \_\_\_\_\_

Print Name of patient and responsible party: \_\_\_\_\_



**THIS NOTICE DESCRIBES HOW MEDICAL PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.**

**Summary:**

By law, we are required to provide you with Notice of Privacy Practice (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to report of disclosure of your information.
5. The right to a report of disclosure of your information.
6. The right to a paper copy of this notice.

We want to ensure you that your medical protected health information is secure with us. This notice contains information about how we will ensure that your information remains private.

How we use your patient health information (PHI) This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

**Treatment:** We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care.

**Acknowledgment of Notice of Privacy Practices:**

“I hereby acknowledge that I have received a copy of this practices Notice of Privacy Practice. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice Will offer me updates to this Notice of Privacy Practices should it be amended, modified or changed in anyway.”

Patient or Representative Name (please print):
Patient or Representative (signature):
Date:

Patient refuse to sign:
Patient was unable to sign because:





**MEDICAL RELEASE OF INFORMATION  
(HIPAA RELEASE FORM)**

<b>Name:</b>	<b>DOB:</b>
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**RELEASE OF INFORMATION:**

Authorize the release of information, including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse:	Phone:
Children:	Phone:
Other:	Phone:

**MY INFORMATION IS NOT TO BE RELEASED TO ANYONE**

**This release of information will remain in effect until terminated by me in writing.**

Please call home:	My work:
Best time to reach me(Day):	Between (time):

<b>Signature:</b>	<b>Date:</b>
<b>Witness:</b>	<b>Date:</b>

## Referral and Authorization Policy

Our Referral Department will assist you with referral and authorizations.

Our Referral Department is dedicated to helping patients find the right specialist. There are many things to consider: your doctors special orders, whether to specialist participates with your insurance company and getting an appointment schedule as soon as possible.

If you have a STAT Referral (emergency referral) and have NOT received a phone call from the specialist office within 2 business days from your visit with us please contact the referral Department at our office they will contact the specialist office and confirm that they have received your information Referral and Authorization. We will have the specialist office contact you for an appointment. All other referrals take about 10 business days after your office visit.

Please remember after 10 business days if you have not heard from the specialist office for an appointment it **is your responsibility to contact our referral Department** so they can contact the specialist office to find out why you have not received an appointment.

\*\*\*\*STAT REFERRALS 2 BUSINESS DAYS TO PROCESS\*\*\*\*

\*\*\*\*REGULAR REFERRALS 7 TO 10 DAYS BUSINESS DAYS TO PROCESS\*\*\*\*

If you have any questions or concerns, please contact our Referral coordinator at 352-861-0043 Ext 206.

Please leave a message and a coordinator will return your call within 24 hours.



## **24 HOUR CANCELLATION AND NO SHOW FEE POLICY**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore Lara Medical and Associates reserves the right to charge a fee of \$40.00 for all missed appointments (no shows) and appointment which absent a compelling reason are not cancelled with a 24 hour advance notice.

NO SHOW fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Three no shows in any 12 month period will result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand the policy.

<b>PRINTED NAME:</b>
<b>SIGNATURE:</b>
<b>DATE:</b>

## Patient Portal – Consent Form

**Lara Medical & Associates** West Marion Family Practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff **Healow**. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

### How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

### Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: 1) the secure message must reach the correct email address, and 2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

### Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone.

### Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal. I understand the risks associated with online communications between my physician's office and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician's office may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided and am aware I may refuse to disclose my email address.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient or Responsible Party's Email Address for use with

Patient Portal \_\_\_\_\_