[ ] Dr. Carlos E. Lara, MD [ ] Dr. Yoany Guia, MD [ ] Dr. Andrew Pogiatzis, MD [ ] Caris Barlatier, NP

New Patient Registration Form:

Patient's Name:	DOB:
	Age: Sex: (F) (M)
SSN:	Email:

Mailing address:

Home #	Work #
Cell #	
Marital Status:	Spouse's Name:
Employer:	Phone #

Emergency contact name and phone #

If patient is under 18 years old, please provide parent/guardian's information:

Name:	DOB:
SSN:	Relationship to patient:

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

[ ] Newspaper	[ ] Friend
[ ] Family [ ] Hospital	Insurance plan Other

Insurance Information:

Primary insurance:	Phone #
Policy:	Group:
Subscriber's name	Relationship to patient
Subscriber's DOB	Subscriber's SSN

Secondary insurance:	Phone#
Policy#	Group#
Subscriber's name	Relationship to patient:
Subscriber's DOB	Subscriber's SSN

*****Do you take controlled/narcotic medication ____Yes ____No**

If yes, please be aware that you will be referred to pain management. NO CONTROLLED OR NARCOTICS WILL BE PRESCRIBED AT THIS OFFICE

CONTROL MEDICATION:

Control medication NOT mentioned on new patient package medication list, will be prescribed by the physician according to the Florida State Law, for the current situation and then patients will be referred to the appropriate specialty for further care.

LARA MEDICAL AND ASSOCIATES

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 Practices (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 you information.
2. The right to request correction to your information.
3. The right to request that your information be restricted.
4. The right to report confidential communications.
5. The right to a report of disclosures of your information.
6. The right to paper copy of this notice.

We want to assure 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.

If you have any questions about this Notice, the names and phone number of our contact person is listed on this page.

Contact person: Alice Lucca	Phone number: 352-861-0043

Acknowledgement of Notice of Privacy Practice:

"I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices, 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 any way.

Patient or Representative Name (please print):
Patient or Representative Signature:
Patient Refuse to Sign:
Patient was unable to sign because:
Today's date:

PAST MEDICAL HISTORY
Please check off any medical history you have or have had

Diabetes	Coronary Artery Disease	Heart Attack	Stroke	High Blood Pressure
Asthma	High Cholesterol	Pneumonia	Hepatitis	Liver Disease
COPD	Reflux Disease	Gallbladder Disease	Bowel Irregularity	Diverticulitis
Kidney Disease	Stones	Prostate Disease	Depression	Headache
Urinary	Anxiety	Migraines	Breast Cancer	Seizures
Gastritis	Joint Disease	Others:		

Any past or recent surgery:

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

Family History (please check): Father

Living Age:	Deceased Age & Reason:

Heart Disease	High Blood Pressure	Cancer	Diabetes 1 or 2	
Others:				

Family History (Please check): Mother

Living Age:	Deceased Age & Reason:

Heart Disease	High Blood Pressure	Cancer	Diabetes 1 or 2		
Others:					

Habits:

Smoke Now:	Ever Smoked:	How Much:	How Long:	Alcohol:
Street Drugs:	Coffee Cups Per Day:	Other Caffeine:	Exercise:	Sleep Pattern:

Referral and Authorization Policy

Our referral department will assist you with referrals/authorizations.
Our referral department is dedicated in helping patients finding the right specialist. There are many things to consider:

- Your doctor's special orders
- Whether the specialist participates with your insurance company
- Getting an appointment schedule as soon as possible.

NOTE: This all depends on how long your insurance will take to complete approval

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 office 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/ authorization. We will have the specialist office contact you for an appointment. All other referral will take about 5 business days after your office visit.

All other referrals can take up to 7-10 business days depending on your insurance.

Please remember that if you have not received a call from the specialist after 7 business days IT IS YOUR RESPONSIBILITY to contact our referral department so that we can contact the specialist.

After you see the specialist he/she may request testing such as imaging they will fax us the request we will then send the request to your insurance company this process can take up to 10 business days depending on your insurance and how long they take to process the request.

If you have any questions or concerns please contact our referral specialists at
352-861-0043 option #3. Please leave a message and your call will be returned within 24 hours.

24 Hour Cancellation & " 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 reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointment which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

" No Show " fees 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 this policy.

Printed Name:
Date:
Signature:

MEDICAL RELEASE OF INFORMATION

(HIPAA RELEASE FORM)

Name:	**DOB:**

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:

( ) Child (ren):

( ) Other:

( ) MY INFORMATION IS NOT TO BE RELEASED TO ANYONE

MESSAGES: 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):

Signed:	**Date:**

Witness:	**Date:**

[ ] Dr. Carlos Lara [ ] Dr. Yoany Guia [ ] Dr. Andrew Pogiatzis [ ] Caris Barlatier N.P.
8599 Sw Hwy 200 Ocala, Fl 34481 Tel. 352-861-0043 Fax 352-861-8750
2760 Se 17th # 400 Ocala, Fl 34471 Tel. 352-245-1845 Fax 352-433-1381

Patient's Name:	**Date of Birth:**

I request and authorize Lara Medical and Associates to:

[ ] I request and authorize Lara Medical and Associates to :
[ ] Obtain records from:
Address:
Phone: **Fax:**

Or

[ ] Send records to:
Address:
Phone: **Fax:**

Healthcare information relating to the following: MOST <u>RECENT OFFICE NOTES, LABS, IMAGING, ETC</u>

The release of health information is at the request of the patient. By providing this authorization, I understand the following:

- I understand that this authorization is voluntary.
- I understand that I may revoke this authorization at any time by notifying provider in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
- I understand that the health information to be release may be subject to disclosure by the recipient of the health information and no longer protected by the federal privacy rules.

Yes___ No____ I authorize the release of my sexually transmitted diseases and HIV/AIDS results, whether negative or positive, to the person(s) listed above. I understand that disclosure of these results to anyone.

Yes___No___ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature:
Date signed:

<u>Preventive Care</u>

Last day of :	Colonoscopy	Endoscopy
Men Only	Last PSA:	Month: Year:
Women Only	Last PAP:	Last Breast Exam:
Last: Bone Density		

Immunization:	Hepatitis B	Flu	Pneumonia	Tetanus	Shingles

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 care in order to 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, MasterCard, Visa, American express, and Discover.

Checks are processed electronically.

Returned checks are subject to a $25.00 service fee and you will lose you 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 appointment/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 and results and refills on medication, regular follow up appointments must be kept.

Worker's compensation/Accident claims:

WE DO NOT TREAT WORK COMPENSATION/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 realize however that:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not 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 your 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 or government agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment and/or diagnosis.

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 XV111/X1X 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.

Medicap (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 any holder of medical information about me to be release to Lara Medical and Associates any information needed to determine 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 PHYICIAN'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 of payment. I understand it's 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 attorney's fee 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 P.A to provide whatever treatment they may deem necessary to the patient.

DATE:	
PATIENT'S SIGNATURE (parent or guardian if patient is under 18)	
PRINT NAME OF PATIENT AND RESPONSIBLE PARTY	