☐ Carlos E. Lara MD, ☐ Yoany Guia MD, ☐ Andrew Pogiatzis MD, ☐ Eldere Germain MD,
☐ RobertoAlvarez Garcia ARNP

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

NEW PATIENT REGISTRATION FORM:

Patient's Name:	DOB:
Age: Sex: ☐ Male ☐Female	SSN:
Email:	

Mailing Address:

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

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

Name:	**DOB:**
SSN:	**Relationship to patient:**

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

☐ **Family**	☐ **Friend**
☐ **Newspaper** ☐ **Insurance Plan**	☐ **Hospital** ☐**Other**

Insurance Information:

Primary Insurance:	**Phone:**
Policy #:	**Group #:**
Subscribers Name:	**Relationship to patient:**
Subscribers DOB:	**Subscribers SSN:**

Secondary Insurance:	**Phone#:**
Policy #:	**Group #:**
Subscribers Name:	**Relationship to patient:**
Subscribers DOB:	**Subscribers SSN:**

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

☐ Diabetes	☐Coronary Artery Disease	☐ Heart Attack	☐ Stroke
☐ High blood pressure	☐ High Cholesterol	☐ Asthma	☐ Pneumonia
☐ Hepatitis	☐ Liver Disease	☐ COPD	☐ Reflux Disease
☐ Gallbladder Disease	☐ Bowel Irregularity	☐ Diverticulosis	☐ Kidney Disease
☐ Stones	☐Prostate Disease	☐ Urinary Problems	☐ Depression
☐ Anxiety	☐ Migraines	☐ Headaches	☐ Gastritis
☐ Joint Disease	☐ Breast Cancer	☐ Seizures	☐ 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.

FAMILY HISTORY

FATHER:

Deceased Age: Reason:
☐Heart Disease ☐High Blood Pressure ☐Cancer ☐ Diabetes 1 or 2 ☐ Other:

MOTHER:

Deceased Age: Reason:
☐Heart Disease ☐High Blood Pressure ☐Cancer ☐ Diabetes 1 or 2 ☐ Other:

□Smoke How much:_____ How Long:_____ □ Never Smoked □ Alcohol
□ Street Drugs □ Coffee-How many cups per day_____□Other Caffeine_____
□Exercise _____ Sleep Pattern:_____

PREVENTIVE CARE LAST DATE PROCEDURE WAS DONE

MEN:

□Colonoscopy Date:_____ □Endoscopy Date:_____ □PSA Date_____

WOMEN:

□ Pap Date:_____ □Breast Exam Date:_____ □Bone Density Date:
□ Mammogram Date:_____□Colonoscopy Date:_____□Endoscopy_____

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
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.

If you have any questions about this notice, the name and phone number in your contact person is listed on this page.

Contact: Alice Lucca Phone: (352) 861-0043

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:

□ Carlos E. Lara MD., □ Yoany Guia MD, □ Andrew Pogiatzis, □ Laura Zambrana- Morales MD,
□ Eldere Germain MD
8599 SW HWY 200 Ocala, Fl 34481 Tel # 352-861-0043 Fax# 352-861-8750
2760 SE 17th St #400 Ocala, Fl 34471 Tel# 352-245-1845 Fax# 352-433-1381

MEDICAL RELEASE FORM

Patients Name:	DOB:

I request and authorize Lara Medical and Associates to obtain medical records:

Physician/Office Name	Specialty	Phone Number
1)		
2)		
3)		
4)		

Send records to:	**Lara Medical & Associates**
Address:	**8599 SW HWY 200 Ocala, Fl 34481**
Phone: 352-861-0043	**Fax: 352-861-8750**

Healthcare information relating to the following: Most Office Notes, Labs, Imaging, Etc.
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 released may be subject to disclosure by the recipient of the health information and no longer protected by the federal privacy rules.

□ YES □N O I authorize the release of my sexually transmitted disease and HIV/Aids results whether negative or positive, to the person(s) listed above

□ YES □ NO I authorize the release of any records regarding drug,alocohol or mental health treatment to the person(s) listed above

Patient Signature:	**Date:**

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:	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):

Signature:	**Date:**
Witness:	**Date:**

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 $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 feed 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.

PRINTED NAME:
SIGNATURE:
DATE:

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 _____