Advanced Bay Area Medical Associates

Infectious Disease & Internal Medicine

Jeffrey R Levenson, M.D., P. A.
Infections Disease

Denisse Balcacer, M.D.
Infectious Disease & Internal Medicine

Margaret Lalor, APRN

Evan Thomas, PA-C

Last Name:_____ **First Name:**_____ **MI:**___

Social Security #:_____-_____-_____ **Date of Birth:**_____/_____/_____ **Age:**_____

MAILING ADDRESS:

CONTACT INFORMATION:

_____ _____ _____
Street address, apartment/unit# **Home Phone** **Cell Phone**

_____ _____ _____
City, ST and ZIP Code **Work Phone** **Email Address**

Race:_____ **Ethnicity**:_____ **Sex:** Male

Preferred Language:_____ **Marital Status:**_____

Spouse/Partner Name:_____ Spouse/Partner Phone#:_____

Employer Name:_____ **Employer Phone #:**_____

Person responsible to pay bill:_____
Name **Phone #**

Primary Insurance Name:_____ **ID #:**_____

Secondary Insurance Name:_____ **ID #:**_____

Emergency Contact Name:_____

Emergency Contact Phone #:_____ **Relation to You:**_____

Authorization for Treatment and Insurance:

I hereby authorize such treatment and procedures performed by the physician and staff and understand that no guarantee or assurance has been made as to the results that may be obtained.

Signed: _____ Date: _____

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Patient Self-Determination Act Questionnaire

To comply with the Omnibus Budget Reconciliation act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to decline Life-Prolonging Procedure (LIVING WILL)

- ☐ I have such a declaration
- ☐ I have NOT made such a declaration

Health Care Surrogate

- ☐ I have a designated healthcare surrogate
- ☐ I have NOT designated a healthcare surrogate

Durable Power of Attorney

- ☐ I have appointed a durable power of attorney
- ☐ I have NOT appointed a durable power of attorney

_____ / /

Signature of patient (or legal guardian) Date

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Consent to Release Information

Instructions

Please provide names and phone numbers of persons who will be able to receive information about you and/or your care and treatments. Only the people you designate below will be able to receive information on your behalf, apart from other uses/disclosures outlined in our HIPAA Privacy Practices Notice.

Consent

By signing below, I authorize all Advanced Bay Area Medical Associates representatives to discuss any information in my medical records with the following persons. Additionally, I acknowledge that I am responsible for contacting Advanced Bay Area Medical Associates to update this approved list of persons shall I wish to add, revoke, or modify my approval(s).

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Signature of patient (or legal guardian) Date

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Office Policy Acknowledgement

By signing this form, you acknowledge the following policies:

1) Co-payment must be made at the time of your office visit. Patients without their co-payment will have to reschedule their appointment.

2) Referrals require a 48-hour advanced notice.

3) Patients should bring all their medication bottles to each appointment.

4) Our office requires 3 business days' notice for all prescription refill requests. Additionally, we do not process refill requests on Fridays, after hours, on weekends, or on holidays. Patients with an urgent medical need requiring medication outside of these constraints should visit their nearest walk-in clinic or urgent care facility. Patients are advised to plan accordingly.

5) Cancellations require notice via telephone call to our office at least 24 hours prior to the scheduled appointment time. If you miss an appointment or fail to provide 24-hour advanced notice, a **$25.00** charge will be applied to the patient's account. This fee will be the responsibility of the patient/guarantor and will not be paid by insurance.

6) If a patient acquires a balance due with us, a mandatory payment will need to be made to resolve the balance prior to being seen by a provider. If payment cannot be made, the appointment will be rescheduled for a later date.

Signed: _____Date:_____

Guardian Signature (if other than patient):_____

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Billing Practices Policy Acknowledgement

1) **Payment for service is due at the time services are rendered.** We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover, AMEX). Returned checks are subject to a service charge of $25.00 or 20% of the value of the check, whichever is greater. We will no longer accept future check payments if a check is returned for any reason.

2) **Your insurance policy is a contract between you and the Insurance company.** Not all services are a covered benefit in all insurance plans. Some insurance companies arbitrarily _select certain services they will not cover. Any items not covered by insurance may be the financial responsibility of the patient or their guardian.

We must emphasize that as your medical providers, our relationship and concern are with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATES SERVICES ARE RENDERED. Collection action may be taken on any delinquent balances owed on your account after 60 days, including those that insurance has not paid. We will file claims with your primary insurance based on the information that was provided by you. You agree to keep us updated of any changes to your insurance coverage. Also, as a courtesy, we will file any secondary claims on your behalf. **You will be responsible for negotiating any unpaid or disputed claim.** If it becomes necessary to collect any sum through an attorney, the patient agrees to pay all reasonable costs of collection, including attorney fees.

3) **Our office accepts Medicare.** Since we are a Medicare provider, we will file your Medicare claims. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. If you have secondary insurance, please also present the insurance card when checking in. Failure to do so will result in you receiving a bill/invoice.

4) **For worker's compensation visits, you are required to provide necessary information including claim number, date of the incident, and authorization from your worker's comp insurance at least 24 hours prior to your office visit.** Failure to do so will result in the cancellation of your appointment. In the event, you fail to provide the claim for Worker's Compensation for this illness or condition or it is declined by the Worker's Compensation case, you agree to pay the fee for services rendered to you.

Signed: _____Date:_____

Guardian Signature (if other than patient):_____

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Patient Name:_____ Date of Birth:_____

Medications List

Please make a list of all medications and supplements that you are currently taking. Be sure to include the name and dosage. If you need more room, please add and write on an additional blank sheet of paper.

Medication Name	Dosage
Example: Aspirin	*200mg 4 times per day*

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Patient Name:_____ Date of Birth:_____

Allergies

Please make a list of all known allergies and the reaction(s) you experience. If you need more room, please add and write on an additional blank sheet of paper.

Allergy	Reaction
Example: Codeine	*Hives/Fever*

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Patient Name:_____ Date of Birth:_____

Hospitalizations/Surgeries

Please make a list of all hospitalizations or surgeries. If you need more room, please add and write on an additional blank sheet of paper.

Hospital Name / Surgery & Reason	Date
Example: Northside Hospital ER, broken arm	*Feb, 2008*

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Patient Name:_____ **Date of Birth:**_____

Family History

Please indicate if you have any family history of the following medical conditions.For each selected condition, please indicate the blood relative(s) with history of that condition.

CONDITION	RELATIVE (Mother, Father, Sibling, Grandparent, Etc)
☐ Alcoholism	
☐ Cancer	
☐ Heart Disease	
☐ Depression	
☐ Genetic Disorder	
☐ Diabetes	
☐ High Cholesterol	
☐ Hypertension	
☐ Stroke	
☐ Bleeding/Clotting Disorder	
☐ Asthma or COPD	
☐ OTHER (please specify)	

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Protected Health Information Policy

By signing this form, you are consenting to Advanced Bay Area Medical Associates to use and disclose your Protected Health Information (PHI) to carry out treatment, payment, and operations as described in the Notice of Privacy Practices form. Advanced Bay Area Medical Associates may also obtain your information from other providers for those purposes. Your PHI may be used by and shared within Advanced Bay Area Medical Associates, as well as outside providers and other entities as explained in the Notice.

Health Information Exchange (HIE)

Advanced Bay Area Medical Associates participates in a Health Information Exchange (HIE) electronic records system which enables your healthcare providers to access your healthcare records quickly and securely, saving time and enhancing the quality of care we provide. These HIE systems include, but are not limited to, regional and state health information exchanges, accountable care organizations (ACOs), regional health information organizations, hospital systems, other practices' software management platforms, and other systems used to exchange PHI electronically. This includes all PHI contained in your electronic medical record, including medical history, diagnosis, treatment, examination, laboratory tests, and medications. By signing this form, you specifically authorize the exchange and disclosure of your Sensitive Information outside Advanced Bay Area Medical Associates via electronic medical records through secure HIE systems. Sensitive Information includes particularly confidential conditions such as mental health/psychological/psychiatric conditions, genetic information and related tests, drug/alcohol/substance abuse, HIV/AIDS (including tests for such conditions), sickle cell anemia, hospice care, birth control & family planning, and sexually transmissible diseases. Psychotherapy notes and certain information from federally regulated substance use disorder programs will be shared only as allowed by law. Even if you do not provide your consent below, Advanced Bay Area Medical Associates may release your PHI electronically to treat an emergency medical condition when the healthcare provider is unable to obtain consent, or the situation requires immediate medical attention. Advanced Bay Area Medical Associates providers also share Sensitive Information internally only as needed for treatment, payment, and health care operations.

You may revoke your consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent. You may withdraw consent at any time by contacting us in writing by email to office@abamamd.com , or by postal mail to 1700 66th St N, Suite 510, St. Petersburg, FL 33710.

Signed: _____Date:_____

Guardian Signature (if other than patient):_____

UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: Advanced Bay Area Medical Associates Phone: (727) 384-2479

Address: 1700 66th St N, Suite 510, St. Petersburg,FL 33710 Fax: (727) 345-2300

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.