PREMCARE FAMILY MEDICAL CENTER, INC.
4501 S. Semoran Boulevard
Orlando, FL 32822
(407) 380-1428

ABID RASOOL, M.D.
M. A. AWAN, M.D.

PATIENT INFORMATION

PLEASE PRINT

TODAY'S DATE

LAST NAME	FIRST NAME	M.I.	HOME PHONE	WORK PHONE
STREET ADDRESS			SOCIAL SECURITY #	D.O.B.
CITY/STATE/ZIP			MARITAL STATUS ☐S ☐M ☐W ☐DIV ☐SEP	SEX ☐ M ☐ F
EMPLOYER NAME	ADDRESS			OCCUPATION

HOW DID YOU LEARN ABOUT PREMCARE? ☐ YELLOW PAGES (Southern Bell) ☐ FRIEND ☐ SIGN (Outdoor) ☐ DONNELLY DIRECTORY ☐ M.D. ☐ OTHER

EMERGENCY INFORMATION

NAME—NOT LIVING WITH YOU	RELATIONSHIP	HOME PHONE	WORK PHONE
STREET ADDRESS	CITY/STATE/ZIP		

CONSENT TO TREATMENT

I hereby give consent to Premcare to provide whatever treatment they may deem necessary to the patient above.

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE

PAYMENT AGREEMENT & INFORMATION RELEASE

I understand that I am responsible for charges incurred for service and that payment is due at time of service. It is my responsibility to bill my insurance company for these fees. I understand I am responsible for charges not covered by the insurance policy, and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, interest, collection costs, and attorney's fees. I authorize Premcare and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me, needed to determine these benefits or the benefits payable for related services.

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE

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BRIEF HISTORY

In an effort to serve you better, we request that you provide us with the following information.

LAST NAME:	FIRST:	AGE:	SEX:

PRESENTING PROBLEM OR PROPOSED SURGERY:

ILLNESS / INJURY: Please check if you have ever had:

YES	NO		YES	NO	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain / tightness			Lung problems / asthma
		History of heart murmur			Shortness of breath
		Stroke			Accidents or broken bones (list)
		Cancer			Gallstones
		Hepatitis			
		Yellow jaundice			

OPERATONS: List the names and dates of all operations you have had ☐ NONE

YEAR	Name of Operation	Type of Anesthetic, if Known	Complications

Have you ever had a blood transfusion? ☐ YES ☐ NO Date: ______________
List any hospital admissions or medical conditions not listed above:

FEMALES ONLY: Are you pregnant? ☐ YES ☐ NO

DRUGS: Please list all drugs you take and their dosages. ☐ NONE

Drug	Dosage	Drug	Dosage

ALLERGIES: Please list type and reaction ☐ NONE

Name of Drug	Reaction	Name of Drug	Reaction

Do you now or have you ever smoked? ☐ Yes ________ / Day # Years ______________
☐ No ________ / Wk. Quit ______________

Do you drink alcohol? ☐ Yes ________ / Day # Years ______________
Type: __________ Ounces: __________ ☐ No ________ / Wk. Quit ______________

The above information is true and accurate.

Patient Signature (parent if patient is a minor) ______________________________

Doctor Notes
(please do not write in this area)

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A WRITTEN POLICY

Dear Patient:

We are pleased you have chosen Premcare Family Medical Center for your medical needs. As the physician provides the medical care you need, we, the members of his staff, will be available to help you understand our office procedures. The following information concerning the financial policy of the practice is important.

PAYMENT IS COLLECTED AT THE TIME SERVICE IS RENDERED FOR SELF PAYS. We do not bill. Our office visit for a new patient starts between $75.00 - $115.00. The charge is determined by the amount of time the doctor spends with the patient and the complexity of the problem and decision making. Follow-up visits are determined in the same manner.

INSURANCE

We will file your claim with your insurance company only after you have met your deductible for the calendar year. If your deductible has not been met, you will be given all the necessary paperwork to file the claim yourself. NO insurance will be file din the evening hours or on the weekend since we cannot verify coverage. Once we have verified that your deductible has been satisfied, your percentage of co-payment will need to be paid at the time service is rendered. We will file your insurance claim only once. If payment is not received within 30 days, the amount will be due from the patient within 10 days of being notified.

MEDICARE PATIENTS

We will file your Medicare and secondary insurance at the time of your visit. You will be responsible for any services or supplies that are not covered by Medicare. You will receive a statement for these charges, your 20% co-pay and your deductible, if not met for the current year.

MEDICAID PATIENTS

We are not providers for the Genesis or Century Medicaid programs. If you are a Medicaid patient, you must present your Medicaid card at each visit. Without your card, we cannot perform services for you under the Medicaid program. If you are 21 years of age or older, you will be asked to pay $2.00 at the time of your visit as required by Medicaid.

If you are covered under a PPO contract, your co-payment will be due at the time of service and cannot be billed.

To assist you in meeting our financial policies, we accept VISA, MasterCard and Discover. Thank you for your support of this policy

Sincerely,

Premcare Family Medical
Center Staff

Date ____________________

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

Print Name ______________________________

Signature X______________________________

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PATIENT CONSENT FORM / PRIVACY NOTICE
CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we request your consent to the following possible scenarios. It is our office policy to require your reading and signing this consent form prior to treatment or medical services in our office. If you have any questions, please ask a staff member for clarification.

EVENTS OF DISCLOSURE: Please initial and date your consent to authorize us to relay any information about you to receive benefits, payment or other information to benefit you, your healthcare/medical services or account with our office.

_________ (1) In the event my insurance company requests a copy of my medical records for clarification to receive payment on my account, I authorize Premcare Family Medical Center to relay such information as deemed necessary.

_________ (2) In the event Dr. Awan or Dr. Rasool needs to refer me to another physician for further treatment or consultation, I authorize either one of them to relay information as deemed necessary.

_________ (3) In the event a hospital needs any part of my records faxed to their facility for clarification or history of treatment, I authorize the relaying of any such information as deemed necessary.

_________ (4) In the event my pharmacy calls or faxes a request for information to fill a prescription for me, I authorize this office to relay any such information as deemed necessary.

_________ (5) In the event another physician requests copies of my medical records for the purpose of treatment, I authorize Premcare Family Medical Center to relay any such information as deemed necessary.

_________ (6) In the event that Dr. Awan or Dr. Rasool needs to discuss my medical status/treatment and /or history with a physician involved in my care, I authorize either of them to relay any such information via telephone, fax or mail as deemed necessary.

_________ (7) In the event a Lab or Diagnostic Center requires a faxed order for a test to be performed, I authorize the faxing of such order deemed as necessary.

_________ (8) In the event that a family member needs to be involved in my care or treatment at Premcare Family Medical Center, I authorize the communication of any information as deemed necessary (to the following family member only:_________________________________).

I understand that I have the right to revoke this consent in writing, at any time, and that any revocation will become effective on the date it has been received by this office and will apply to the specific uses and disclosures as addressed above.

Patient Name ____ Date ____/____/____

Patient Signature (or parent, if a minor) **X** ____

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Acknowledgment of Privacy Notice

I, ______________________________, hereby acknowledge that a copy of the Notice of Privacy Practices is available upon request to me by Premcare Family Medical Center.

Signed: X _________________________ Date: ____________