PLEASE NOTE: This form has interactive fields.
You may type your information directly into most fields; however it CANNOT be submitted electronically. Once you have completed the form it should be printed, then signed.

Baldwin Park Family Practice, P.A.
Promoting Healthy Lifestyles
1040 Woodcock Road, Suite 200
Orlando, Florida 32803
Tel: 407-898-4550
Fax: 407-898-4842
Email: info@baldwinparkfp.com

Patient Information Sheet *(Please fill completely)*

PATIENT INFORMATION

Last Name | First Name | Middle Name

Nickname | Birth Date *(mm/dd/yyyy)* | ☐ Male ☐ Female Gender

Social Security Number | Choose one Marital Status | Driver's License Number | FL - Florida State | Expiration*(mm/dd/yyyy)*

Home Telephone | Cell Phone | Work/Other/Alternate

Address | City | FL - Florida State | Zip Code

Email Address

Is Patient a Minor (Under 21)? ☐ Yes ☐ No
If Yes, you must also complete the Guarantor Information

GUARANTOR INFORMATION *(when applicable)*

Last Name | First Name | Middle Name

Guarantor's Address | City | FL - Florida State | Zip Code

Social Security Number | Home Telephone | Cell Phone | Work/Other/Alternate

INSURANCE INFORMATION

Insurance Company | Phone Number

Policy Number | Group Number | Policy Holder's Name

Claims Address (located at the back of your insurance card) | City | FL - Florida State | Zip Code

EMERGENCY CONTACT & PHARMACY INFORMATION

Emergency Contact (Full Name) | Relationship To Patient | Phone Number

Pharmacy Name | Phone | Fax

REQUIRED DEMOGRAPHICS INFORMATION:

As part of the new healthcare reform act, **The US Department of Health and Human Services** has embarked on an initiative to standardize the collection of data on race and ethnicity in an effort to produce better reporting on treatment and standards. As part of this initiative, the **information we are requesting is now mandatory** for the Standardization for Health Care Quality Improvement. For complete information on Standardization for Health Care Quality Improvement, please visit the following webpage at the US Department of Health and Human Services: http://www.ahrq.gov/research/iomracereport/reldatasum.htm .

What is required?

The Practice is REQUIRED to collect this information form patients and to use it solely for reporting purposes *(Please ask a member of staff or visit www.BaldwinParkFP.com for Race and Ethnicity Collection Policy.)*

The Patient is REQUIRED to select an option provided - even if this option is "Declined".

Please Complete the Sections Below Fully:

RACE: *(Please check ONE Box)*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Declined

ETHNIC GROUP: *(Please check ONE Box)*

☐ Hispanic or Latino | ☐ NON Hispanic or Latino | ☐ Declined

PREFERRED LANGUAGE: *(Please check ONE Box)*

☐ English	☐ Arabic	☐ Chinese	☐ French	☐ German
☐ Japanese	☐ Russian	☐ Spanish	☐ Vietnamese	☐ Other

_____
Patient Name Printed

_____ _____
Signature Date

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Financial Policy Statement

APPOINTMENT TIMES: We reserve your appointment time for you alone. Thus, we respectfully ask that you give us at least 24 hours notice prior to canceling or rescheduling your appointments so that we may offer your appointment to another patient who may need to see us. If not, you will be subject to a **$25** charge.

HEALTH PLANS: All health plans are not the same and do not cover the same services. Patients are responsible for knowing the benefits of their individual insurance plans and any referral requirements necessary to have coverage of any service rendered. Should you not know this, please contact your Health Plan using information usually provided on your insurance card.

INSURANCE COVERAGE:

1. **Patients With Insurance Plans In Which We Participate:**
   Please verify your eligibility and benefits prior to your visit. Patients are responsible for deductibles, co-pays, non covered services, co-insurance, and items considered "not medically necessary" by your insurance company. **Payment of your co-pay and/or co-insurance is due at the time of service; if you are not able to remit payment, we may request you to re-schedule your appointment.** Additionally, any balances due after your insurance processes your claim will be due within thirty (30) days of notice from the insurance company. You are also responsible for ensuring that your insurance recognizes us as your new primary care physician, if required.

2. **In-Network/Out Of Network Verification:**
   Patients are advised to contact their insurance companies before-hand if you would like to verify whether your provider/providers are in network. Our office will use tools available to us to determine, in good faith, if your insurance plan is in network with our provider/providers. If, on filing your claim, your insurance plan determines our provider/providers are out of network, any balances that have been placed as your responsibility for payment will be due in full within 30 days or will be subjected to the terms of our outstanding balance policy (see below).

3. **Patients With Insurance Plans In Which We DO NOT Participate:**
   Full payment is due at the time of service. Upon request, we may provide you with your visit information from which you can file a claim on your own behalf.

4. **Private Pay Patients:**
   Full payment is due at the time of service. We will provide you with a receipt for your records.

OUTSTANDING BALANCES: We request that you remit all outstanding balances, including no-show charges, within thirty (30) days of date of service or charge date. If you are unable to meet this commitment your account will be considered delinquent. If your account becomes severely delinquent, it will be referred to a collections agency and any charges and/or fees incurred in this process will be the responsibility of the patient.

MINORS: Parents or guardians with custody must accompany all minors for their appointments and will also be responsible for remitting payment for all services rendered to the minor patient(s) upon being due.

AGREEMENT: I have read and understand the financial policy of the practice and I agree to follow its terms. I also understand that this policy may be amended from time to time by the practice. If necessary, I have contacted my insurance company and verified that Priya Maharaj, DO is designated as my new primary care physician.

_____ _____
Patient (or Guarantor, if applicable) Signature Date

_____ _____
Guarantor or Responsible Party for the patient (PRINT) Relationship to patient

_____
Address (If Guarantor for patient) City / State / Zip Phone (Include Area Code)

IMPORTANT:
Forms must be filled out COMPLETELY to be valid:
ALL fields are required.

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Authorization to obtain, release or review protected health information

I, _____ hereby authorize Baldwin Park Family Practice to
Patient/Legal Representative

obtain copies of protected health information of: _____
Print Patient's Name

FROM: _____
Name of Individual, Healthcare Facility or Agency **[PRIOR PCP ONLY]** Phone Email or Fax **[REQUIRED]**

_____ **FL - Florida** _____
Address City State Zip

PLEASE SEND RECORDS TO:

Baldwin Park Family Practice, P.A.
1040 Woodcock Road, Suite 200, Orlando, Florida 32803
PH: (407) 898-4550 | FAX: (407) 898-4842

Dates of services: From: _____ To: _____

Please place your INITIALS by each/all item to be released:

_____ All Chart / Visit Notes _____ Consultations

_____ Labs _____ Radiology Other *(Specify)* _____

Additionally, please specify by INITIALS each/all applicable items:

_____ Mental Health _____ HIV Testing _____ Drug and/or Alcohol _____ AIDS Information

_____ _____
Date of Birth Social Security Number

_____ **FL - Florida** _____
Address City State Zip

_____ _____
Patient/Legal Representative/ Parent Signature Date

_____
Witness

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Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Baldwin Park Family Practice, P.A. (hereafter referred to as " the Practice") in order to carry out treatment, payment, or health care operations. (You should review and may request, at anytime, a copy of the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.).

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: *(list below)*

_____

_____

I agree that the Practice may also disclose the following types of information contained in my medical record:
(Please initial the appropriate categories listed below)

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information

_____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s)
(please initial the appropriate spaces below):

_____ **Via e-mail** to the Patient's designated e-mail address: _____
(I am responsible for notifying the practice of any changes to my e-mail address.)

_____ **Via postal mail** with any envelopes being marked personal and confidential and addressed to me.

_____ **Via telephone**, if I contact the Practice and provide the appropriate information *(Including my name, social security number and unique personal identifier).*

_____ **Via fax** to my designated ***secure*** fax number: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ ☐ AM ☐ PM

_____
Signature of Patient or authorized representative

_____
Please print Name

- Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

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Patient Health History Form

Name:_____ Birthdate: _____

Drug Allergies ☐ YES ☐ NO (If "YES", please list)

Current Medications (please include non-prescription drugs and herbal remedies):

Name of Medication	Dosage	How Often Taken

Please provide details if you or a family member have had any of the following medical conditions:

Cancer (specify type) _____

Depression or Suicide _____

Diabetes _____

Heart Problems _____

High Blood Pressure _____

High Cholesterol _____

Lung Problems _____

Sickle Cell _____

Stroke _____

Thyroid Problems _____

Any Other Problem(s) _____

Females please indicate:

Number of pregnancies _____

Number of live births _____

First day of last period _____

Please list any surgeries you have had (use bottom box if necessary)

☐ *(Continued on bottom box)*

Marital or Partnership Status: _____ **Occupation:** _____

I drink alcohol _____ times per day, _____ times per week.

I smoke _____ cigarettes (or cigars, pipes etc.) a day.

I exercise _____ minutes per day, _____ times per week.

Please indicate year of your last:

Tetanus Booster _____

Pneumonia Shot _____

Colonoscopy _____

Mammogram _____

DEXA Scan _____

Cholesterol _____

PAP smear _____

Complete Physical Exam _____

Surgeries and other procedures *(continued)* **:**

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This form MUST be completed PRIOR to your treatment

Complete Physical Exams or Well Woman Exams

Please be advised that I, the undersigned, am aware that I am here for a Complete Physical Exam or a Well Woman Exam (regular yearly exam).

- Most insurance plans allow only ONE physical or well woman exam per year.
- Our office will not be aware if this exam was done elsewhere, unless you inform us.
- If you are unsure of your last exam, please speak with the front office.

I understand that if my insurance does not cover this preventative exam, I may be responsible for a portion the cost of this visit. Additionally, Dr. Maharaj cannot re-file this claim with a change in diagnosis code in an attempt to be reimbursed.

Statements of Financial Responsibility

1. If you have health insurance we will file a claim on your behalf with the information in your chart.
2 You must ensure that we have your current insurance information on file or inform us of changes to your plan or policy prior to being treated.
3. All deductibles, copays and outstanding balances are your responsibility and must be remitted at time of service or due upon receipt.
4. Patients without insurance will be required to pay for service in full at time of service.

Patient Name (Print) _____

Patient Signature _____ DATE: _____

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Patient Office Conduct Policy

I (PRINT YOUR NAME:) _____ **understand** that I am fully responsible for my behavior and the behavior of anyone that accompanies me to Baldwin Park Family Practice, P.A. Any inappropriate behavior or language directed to the physician(s) and/or office staff within the office or during telephone conversations will not be tolerated and may result in my discharge from the practice.

I understand that as a patient of Baldwin Park Family Practice, P.A., I agree to abide by all office policies.

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or the patient's authorized representative, to release Dr. Priya Maharaj, D.O. and/or members of Baldwin Park Family Practice, P.A. staff from any and all liability which may arise from this action, whether or not foreseen at present.

_____ _____

Signature of patient/authorized representative Date

Print Form Now