West Orlando Internal Medicine
Dr. Osama Ansari, MD
1551 Boren Drive, Suite B, Ocoee, FL 34761
(P) 407.338.3939 (F) 407.395.2480

Appointment Date:____/____/_____
Time:____:____ AM/|PM

PLEASE COME IN 30 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT AND BRING IN *ALL* PRESCRIPTION BOTTLES.
THANK YOU.

Welcome!

Thank you for choosing us to serve your health care needs. You can trust that we will work extraordinarily hard to provide you with the absolute best in health care services and support. Our goal is simple - to help you feel as good as you can and be as healthy as you can be!

➢ **Osama Ansari, MD**
Internal Medicine

We have designed a number of tailored programs and solutions to deliver a true patient-centered medical home experience just for you:

➔ Our schedules are open when you need to be seen - just call us!
➔ Annual wellness and comprehensive health review program
➔ Screening Test Evaluation Program (STEP) - for early detection of disease
➔ Post- hospital admission follow-up program
➔ In House services, and many more!

If you have not already done so, please call our office to schedule your first appointment and get you started on your road to better health!

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PATIENT REGISTRATION FORM

Last Name:_____ First Name:_____ MI:_____

DOB:_____ Sex: Male / Female/

Social Security Number:____-____-____ DL / State ID #:_____

Physical Address: _____

City:_____ State: _____ Zip Code:_____

Mailing Address: _____
(If different from physical address)

City: _____ State: _____ Zip Code:_____

Home Phone: (___) ____-____ Cell Phone: (____) _____-_____

Email Address: _____@_____.com

Race: _____ Ethnicity: _____ Preferred Language: _____

Marital Status: Single / Married / Divorced / Widowed
Spouse's Name: _____ Phone Number: (____) ____- _____

Emergency Contact (Person who does not live in your home):
Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) ____- _____

Primary Insurance: _____Policy Number :_____Group Number_____
Secondary Insurance: _____ Policy Number: _____Group Number_____

Authorization and Assignment:
I hereby authorize my insurance carrier, attorney or any third-party to pay directly to West Orlando Internal Medicine (WOIM) all charges submitted for services incurred by me. I understand I will be responsible for any and charges not paid for by my insurance company. I authorize West Orlando Internal Medicine to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the providers at WOIM which may be due for me from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or in part medical services which I have received. This authorization and assignment shall be valid until I notify West Orlando Internal Medicine in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature: _____ Date: _____/_____/_____

HEALTH QUESTIONNAIRE

Patient Name:_____ Date of Birth: ____/____/_____

Name of your pharmacy-		
Address of your pharmacy-		
List any Allergies to Medications and reactions-		

Past Medical History / Family History

Condition	Self	Mother	Father	Siblings	Children
High Blood Pressure					
Heart Disease /Heart Attack					
Diabetes					
Stroke					
Cancer					
Thyroid Problems					
Asthma					
COPD/ Lung Disease					
High Cholesterol					
Anemia					
Liver Disease					
Kidney Problems					
Migraines					
Alcohol / Drug Abuse					
Seizures / Epilepsy					
Arthritis					
Depression/ Mental Illness					

Social History

(Please circle you response)

Do you smoke? **Yes / No**. If yes, How many a day? ____;

If not, are you a former smoker? **Yes / No** When did you quit? ____/____

Do you use illegal drugs? **Yes / No.** If yes, What substance? _____

Do you drink alcohol? **Yes / No.** If yes, How many cups a day? _____

Do you drink water? **Yes / No.** If yes, How many cups a day? _____

Do you exercise? **Yes / No**. If yes, How many times a week? _____

Are you on a low fat diet? **Yes / No**

Are you currently employed? **Yes / No.** If yes, Occupation? _____

Disabled / Retired/ Semi- Retired/

Have you ever been a victim of abuse? **Yes / No**

Please place a checkmark next to any symptom that you are currently having or had in the past.

General ❑ Fever ❑ Night Sweats ❑ Weight Loss/ Gain ❑ Fatigue ❑ Weakness ❑ Headaches	**Heart** ❑ Chest Pain ❑ Palpitations ❑ Heart Murmur ❑ Pacemaker ❑ Swelling in ankles ❑ Blood clots	**Lungs** ❑ Cough ❑ Shortness of breath ❑ Wheezing ❑ Congestions ❑ Asthma ❑ Phlegm	**Gastrointestinal** ❑ Nausea/vomiting ❑ Ulcers ❑ Heartburn ❑ Blood in stool ❑ Change in bowel movements ❑ Abdominal pain
Skin ❑ Rashes ❑ Cancers ❑ Change in hair,skin, or nails ❑ Breast nodule /lumps ❑ Breast tenderness ❑ Breast discharge	**Musculoskeletal** ❑ Muscle weakness ❑ Joint pain/stiffness ❑ Back Pain ❑ Injuries ❑ Joint swelling	**Neurological** ❑ Seizures ❑ Hand Tremors ❑ Paralysis ❑ Tingling/ numbness ❑ Slurred speech ❑ Loss of sensation	**Psychiatric** ❑ Depression ❑ Poor Sleeping ❑ Anxiety ❑ Panic attacks ❑ Suicidal Thoughts ❑ Obsessiveness ❑ Mania
Eyes ❑ Glasses ❑ Contact Lenses ❑ Pain ❑ Change in vision ❑ Discharge ❑ Glaucoma / Cataracts ❑ Double Vision	**Ears** ❑ Hard of hearing ❑ Deafness ❑ Ringing ❑ Ear ache ❑ Wax ❑ Room spinning	**Nose** ❑ Nose bleeds ❑ Pain ❑ Nasal Drip ❑ Runny Nose ❑ Sinus Congestion ❑ Polyps	**Mouth / Throat** ❑ Bleeding ❑ Ulcers ❑ Sore Throat ❑ Hoarseness ❑ Hard to swallow ❑ White Spots ❑ Loss of taste ❑ Gum problems
Genitourinary ❑ Blood in urine ❑ Painful/ frequent urination ❑ Incontinence ❑ Kidney stones ❑ Flank pain ❑ Bed wetting ❑ Urgency	**Gynecological Women** ❑ Vaginal Discharge ❑ Hot flashes ❑ Painful intercourse ❑ Post Menopausal ❑ Sexually Transmitted Disease	**Gynecological Men** ❑ Testicular Pain ❑ Decreased urinary stream ❑ Penile Discharge ❑ Change in sexual function ❑ Sexually Transmitted Disease	**Endocrine** ❑ Diabetes ❑ Hypoglycemia ❑ Heat/ Cold intolerance ❑ Loss of hair ❑ Erectile dysfunction

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SCREENING FORM

Patient Name: _____ Date of Birth: ____/____/_____

Please check the corresponding answers:

Do you use any of the following -

- ❑ Oxygen
- ❑ CPAP
- ❑ BIPAP
- ❑ Nebulizer

Do you have any of the following -

- ❑ Living Will
- ❑ Advanced Directive
- ❑ Power of Attorney

Do you need aide with walking -

- ❑ Walker
- ❑ Cane

Do you need help with daily living activities?

- ❑ Yes
- ❑ No

How are your senses -

Vision - Good / Fair / Poor / Glasses / Contact Lenses

Hearing - Good / Fair / Poor / Hearing Aides

Touch - Good / Fair/ Poor

Taste - Good / Fair / Poor

Smell - Good / Fair / Poor

Is there any pain that you have all the time, or often?

- ❑ Yes - Where? _____
- ❑ No

Pain Scale

- ❑ Mild (1-3)
- ❑ Moderate (4-6)
- ❑ Heavy (7-8)
- ❑ Severe (9-10)

Please list any surgeries/hospitalizations below:	Date (Month/Year)
_____	_____
_____	_____
_____	_____
_____	_____

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Please fill in below to the best of your knowledge so we may obtain your medical records.

When was your last:	Date?	Where?
Mammogram ❑ Normal ❑ Abnormal		
Bone Density (DEXA)		
Colonoscopy / EGD		
Stool Card		
Eye Exam		
Pap Smear ❑ Normal ❑ Abnormal		
PSA		
Stress Test / EKG		
Labs		

Immunizations

When was your last	Date?	Where?
Influenza (FLU) Vaccine		
Shingles (Zoster) Vaccine		
Pneumonia Vaccine		
Tetanus Vaccine		
Tuberculosis (PPD) Test		

Women ONLY:
Date of first day of last menstrual period: _____/ ____/_____
Number of:
Pregnancies - _____ Live Births - _____ Miscarriages - _____ Abortions - _____

Men ONLY:
Date of last prostate exam: ____/____/_____

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PREVIOUS PROVIDERS/ SPECIALISTS

(Note: If you need referrals in the future, you need to identify your doctors here)

1) Physician / Specialist Name:_____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) ____ -_____ Fax: (____) ____ -_____

2) Physician / Specialist Name:_____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) ____ -_____ Fax: (____) ____ -_____

3) Physician / Specialist Name:_____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) ____ -_____ Fax: (____) ____ -_____

4) Physician / Specialist Name:_____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) ____ -_____ Fax: (____) ____ -_____

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E- PRESCRIBING / MEDICATION HISTORY CONSENT FORM

E- Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include

- ➔ Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the drug benefit plan
- ➔ Medication History Transaction- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- ➔ Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient prescription has been picked up, not picked up, or partially filled.

By signing this consent you are agreeing that West Orlando Internal Medicine can request and use your prescription medication history from other healthcare providers and/ or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to West Orlando Internal Medicine to enroll me in the E-Prescribing Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Please Print) _____ Date of Birth: ___/___/___

Signature (Patient or Guardian)_____ Today's Date: ___/____/____

Relationship to Patient_____

West Orlando Internal Medicine
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FINANCIAL POLICY

In order for us to be able to continue to deliver high quality of care, it is necessary to provide a financial policy. **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.**

1. Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct information so that we may submit to your insurance.
2. We will collect your deductible, co-payment, or for non-covered services along with any balance due after insurance on your account at the time of your visit. We accept cash, checks, Visa, Mastercard, and Discover.
3. If we do not participate with your insurance, we will file your claim as a courtesy and ask that you follow up to make sure payment is made to us in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance. Balances are expected to be paid in full within 30 days. If payment on your account is not received in the alloted time, your account may be referred to a collection agency and reported to the credit bureau. We will assess a 1% monthly interest charge on unpaid balances over 60 days old.
   COLLECTION AGENCIES- In the event your account becomes delinquent and is turned over to a collection agency and/or attorney you will be financially responsible for all associated collection fees and legal fees that West Orlando Internal Medicine, LLC incurs through the process utilized to collect the delinquent balance. Please be advised if your account is turned over to a collection agency you can be discharged from the practice.
   RETURNED CHECKS- Check returned to West Orlando Internal Medicine by the bank will be assessed a returned check fee, in addition to the original amount of the check. You have ten days (10) to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time, the check will be sent to the State Attorney's office for further collection.

4. **MEDICARE PATIENTS-** We are participating providers with Medicare and we will submit to Medicare for all your covered services. If you have supplemental insurance, we will also submit that for you. If payment is not received within 30 days of being submitted, we will ask you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at each time of service. Each yea you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
5. **MEDICAID PATIENTS-** We are not participating providers with straight Medicaid. We ask that you pay for your services at the time of each visit. We are participating with Wellcare-Medicaid
6. **HMO-PPO PATIENTS-** If we participate with your plan, we will submit your services to the insurance for you. Your co-payment will be collected at the time of service- no exceptions- If your plan requires you to choose a primary care physician, it is your responsibility to make sure you contact your insurance carrier and assign Dr. Osama Ansari as your PCP. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from our office prior to seeing the specialist. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out of network benefits, file your services, and we expect payment of your portion of the services at the time they are rendered.
7. **SELF-PAY PATIENTS-** Patients without insurance coverage will be expected to pay at the time of services, If you are unable to pay in full, you must contact our credit manager prior to seeing the doctor to make a payment arrangement.
8. **NO SHOWS / MISSED APPOINTMENTS/ LAST MINUTE CANCELLATION OR RESCHEDULE-** Providers and staff of West Orlando Internal Medicine, LLC rely on the pre-scheduled appointments and plan their day to day activities. Last minute reschedules or cancellations and no-shows disrupt the daily activities and also curtall the ability to schedule another patient in your pre-scheduled slot. If you have to cancel or reschedule your appointment, please provide us with at least 48 hour notice. Therefore any appointments cancelled without proper notice or any missed appointment will result in a fee of $25.00.

Remember, whether you have insurance or not, you are ultimately financially responsible for payment of your services. If you have any questions regarding our financial policy please contact our office manager at 407.338.3939.

I have read and acknowledge the financial policy at West Orlando Internal Medicine.

Signature:_____ Date:_____/_____/_____

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HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have read the West Orlando Internal Medicine, LLC HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION- I, the below named patient, do hereby authorize any physicians examining and/or treating me to release any third payer (such as an insurance company or governmental agencies, ie Blue Cross Blue Shield of Florida) any medical, psychiatric condition, alcohol or drug related condition and any records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT- I, the below named subscriber, hereby authorize payment directly to any physician examining or treating ,e or any group and /or individual surgical and/ or medical benefits herein specified and otherwise payable to me for the services as described but not to exceed the reasonable and customary charge for theses services.

MEDICARE/MEDICAID- Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for my payment under Title XVIII XIX of the Social Security Act is correct. I authorize any holder of medical or other information about meto release to Social Security Administration Division of Family Services or its intermediaries or carries and information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. The assignment will remain in effect until revoked by me in writing.

CONSENT FOR TREATMENT- I, the below named patient hereby give my consent for treatment to all physicians associated with West Orlando Internal Medicine, LLC

C**ONSENT TO DISCUSS MEDICALCONDITION OR RELEASE RECORDS**- I, the below names patient, do hereby authorize West Orlando Medicine, LLC to discuss my medical conditions with, or release my medical records to the below named person (s):

NAME:_____ RELATIONSHIP:_____ PHONE:_____

NAME:_____ RELATIONSHIP:_____ PHONE:_____

I authorize West Orlando Internal Medicine to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone /Answering Machine
- ❑ Yes
- ❑ No

Work Telephone / Work Voicemail
- ❑ Yes
- ❑ No

Cell Phone/ Voicemail
- ❑ Yes
- ❑ No

Signature:_____ Date: _____/ _____/_____

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MEDICAL RECORDS RELEASE FORM

HIPAA COMPLIANT **AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION**

Records to be released from:_____
(Doctor or Facility Name)

Fax Number: (____) ____-_____ Phone Number:(____) ____-_____

Patient Name: _____ (Please Print)

DOB: ____/____/_____ Social Security Number: * - ** - _____ (last four ONLY)**

I authorize and request the disclosure of all protected information for purpose of review and evaluation from the above-named doctor or healthcare provider to:

Requesting Provider: *Dr. Osama Ansari, MD*
Requested Information (if more than 25 pages please mail) **Dates - From: _____ to _____**

- ❏ All Records
- ❏ Office/ Consult Visit Notes - Last 2 only
- ❏ Lab Reports Only
- ❏ Radiology Reports Only
- ❏ Cardiology Reports Only
- ❏ Hospital Records- (To include) H&P, Discharge Summary, Labs, All Consult Notes, Any CT Scans- X Rays- MRI's- Medication Reconciliation.
- ❏ Alcohol/ Drug Abuse Information/ HIV Testing/ ARC and/or AIDS diagnosis
- ❏ Other

  _____
  _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I understand the following

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____
Signature of Patient or Legal Authorized Representative Date

_____ _____
Name of Legally Authorized Representative for Patient Relationship to Patient