LEBOWITZ MEDICAL GROUP, P.A.

DATE:________________

NAME________________________________ MI_________D.O.B.______________AGE_______________________

Local Address______________________________________City_________________State________Zip__________

Home Phone______________________Cell Phone______________________Work Phone______________________

Other Address_____________________________________City_________________State________Zip___________

Occupation______________________________________Employer____

Spouse's Name_________________________________Referred By____

Social Security Number_______________________Allergies____

In case of Emergency, notify_______________________________________Phone____________________________

Current medications and dosage____

____

Previous hospitalizations and surgeries (dates)____

____

Personal Medical History

1. High Blood Pressure	Yes ( )	No ( )	5. Cancer	Yes ( )	No ( )
2. Heart Disease	Yes ( )	No ( )	6. Diabetes	Yes ( )	No ( )
3. Lung Disease	Yes ( )	No ( )	7. Arthritis	Yes ( )	No ( )
4. Leg Pains	Yes ( )	No ( )	8. Seizures	Yes ( )	No ( )

Other – Please explain____

____

Family Medical History (Please state known family illnesses)

Father____________________________________ Alive ( ) Deceased ( ) ____________________________________

Mother___________________________________ Alive ( ) Deceased ( ) ____________________________________

Brother___________________________________ Alive ( ) Deceased ( ) ____________________________________

Sister_____________________________________Alive ( ) Deceased ( ) ____________________________________

Children_________________________________ Alive ( ) Deceased ( ) ____________________________________

Tobacco Yes ( ) No ( ) Amount ________________ Alcohol Yes ( ) No ( ) Amount______________________

Reason for seeing the Doctor____

Email Address ____

OFFICE POLICY

Patient Name (please print)________________________________ **Date**___________________________________

I, the undersigned, hereby authorize Lebowitz Medical Group, PA, to release to any insurance carrier represented as contractually responsible for payment as whole or part of the patient's health care bill, such diagnostic and therapeutic information and records as may be necessary to determine benefits entitlement and to process payment of claims, for health care provided to the patient. I also grant authorization to release said medical records to any peer review organization and referring physicians for continuity of medical care.

I hereby authorize any insurance carrier represented as contractually responsible for payment as whole or in part of the patient's health care bill, to pay directly to this office all medical benefits for services provided by Lebowitz Medical Group, PA.

The office staff at Lebowitz Medical Group, PA has provided me with all necessary billing information. I understand that I am financially responsible to Lebowitz Medical Group, PA, for any charges incurred. I understand that this office grants me a 30-day "grace period" on anticipated insurance payments, and that any charges not paid by an insurance company within the 30-day period, immediately become by responsibility. I also agree to be liable for any attorney fees required to enforce said billing policy.

Signature____ **Date**______________________________________

PATIENT SELF DETERMINING ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

1. Decision to Decline Life-Prolonging Procedure (Living Will) –
( ) Yes, I have made a declaration.
( ) No, I have not made such a declaration.

2. Health Care Surrogate --
( ) Yes, I have designated a Health Care Surrogate.
( ) No, I have not designated a Health Care Surrogate.

3. Patient Power of Attorney --
( ) Yes, I have appointed a Durable Power of Attorney for Health Care Decisions.
( ) No, I have not appointed a Durable Power of Attorney for Health Care Decisions.

____

Signature of Patient or Representative/Date

Yearly Reconfirmation

I acknowledge that this information remains accurate.

Signature of Patient or Representative/Date	Signature of Patient or Representative/Date
Signature of Patient or Representative/Date	Signature of Patient or Representative/Date
Signature of Patient or Representative/Date	Signature of Patient or Representative/Date

I have been provided with information regarding the Patient Self Determination Act but decline to answer the above questions.

Signature of Patient or Representative/Date____

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Lebowitz Medical Group. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office.

I acknowledge receipt of the *Notice of Privacy Practices* of Lebowitz Medical Group.

_______________________________________ ____________________________________

Signature Date

Office Personnel Signature _________________________________ Date____________________________

Patient Name ____

Patient's D.O.B.____