ALFRED ALINGU, MD

INTERNAL MEDICINE

Arecho Medical, LLC
10045 Cortez Blvd, Suite 122
Brooksville, FL 34613
Phone 352-596-0405
Fax 352-597-4008

Bayonet Point Medical, LLC
7537 Medical Dr
Hudson, FL 34667
Phone 727-819-1900
Fax 727-869-1993

Name ____________________ Date of Birth ____________________

Social Security Number ____________________ Marital Status ____________________

Address ____________________

City ____________________ State ____________________ Zip Code ____________________

Home Phone ____________________ Cell Phone ____________________

E-mail Address ____________________

Pharmacy Name ____________________ Pharmacy Phone Number ____________________

Emergency Contact ____________________ Phone Number ____________________

Relationship ____________________

Primary Insurance ____________________

Secondary Insurance ____________________

Responsible for Bills Self or

Name ____________________ Relationship ____________________

Address ____________________

Treatment and Payment Agreement

This document authorizes the clinic to examine and treat the patient, review medication history, release any medical information necessary to bill the insurance company, and receive insurance benefit payments. The patient is financially responsible for all charges and deductibles not covered by the insurance company and is subject to all clinic policies. Signature of this document certifies that all above information is current and accurate. A photocopy of this statement serves as the original.

Patient Signature ____________________ Date ____________________

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Authorization to Use or Disclose Health Information

Name ____ Date of Birth________________________

Social Security Number ____________________________ Phone Number ________________________________

I hereby voluntarily authorize Arecho Medical Clinic LLC and Bayonet Point Medical LLC to release ANY and ALL of my protected health information to the following person(s):

Name____ Relationship _____________________________

Name____ Relationship _____________________________

Name____ Relationship _____________________________

Name____ Relationship _____________________________

Patient Signature ____ Date _______________________

Name ____ Date of Birth ____________________________

Please list all medications you are currently taking:

Name of Medication	Dosage	How many times per day?

Please list all vitamins you are currently taking:

____

____

____

Name ______________________________________ Date of Birth ___________________________

Check the box if you have ever had any of the following illnesses:

Illness		Illness		Illness	
Alcohol Overuse		Allergies		Anemia/Low Blood Sugar	
Arthritis		Asthma		Bleeding Tendency	
Cancer		Chicken Pox		Colitis	
Congenital Heart Disease		Depression		Diabetes	
Emphysema		Epilepsy/Seizures		Kidney/Bladder Infections	
Lung Infections		Gallbladder Disease		Goiter	
Gout		Hay Fever		Heart Attack	
Hepatitis		High Blood Pressure		Intestinal Polyps	
Jaundice		Leukemia		Measles	
Migraine		Mumps		Nervous Breakdown	
Radiation Treatment		Rheumatic Fever		Sexually Transmitted Disease	
Sickle Cell Anemia		Stomach Ulcer		Stroke	
Suicide Attempt		Thyroid		Tuberculosis	
Whooping Cough		Other (Please Specify Below)			

Other:____

____

____

Name ____ Date of Birth ____________________________

Personal History and Health Assessment

Race ________________________________ Religion ____

Date of Last Physical Exam _______________________ Physician ________________________________

Check the box if you use any of the following:

Cane		Oxygen		Catheter	
Walker		Wheelchair		Nebulizer	
Glasses		Hearing Aide		Contact Lenses	

If you have received any of the following vaccines, please indicate the year:

Pneumococcal		Rubella	
Tetanus		Influenza	

Do you use alcohol? Yes No
How often? ____

Do you smoke or use tobacco products? Yes No
How much per day? ____

Do you use drugs? Yes No

Family History:

	Living?	Any Illnesses	Age at Death	Cause of Death
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				

Is there a family history of anything not listed above? Please explain: ______________________________

____

Have you ever had surgery or been hospitalized? Please explain: _________________________________

____

Name ____ Date of Birth ____________________________

Personal History and Health Assessment

Have you or a family member ever been diagnosed with a psychiatric or mental illness? Please explain:

____

____

Have you ever taken or been prescribed antidepressants? Yes No

For what reason? ____

Which medications? ____

Dates of use ____

Why did you stop? ____

List any allergies you have (including medication allergies): ____________________________

____

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Authorization for Release of Medical Information

I, the below identified person, hereby voluntarily authorize the release of my protected health information between the following parties:

Records from: ______________________________________ Send to: Alfred Alingu, MD
______________________________________ 10045 Cortez Blvd. Suite 122
______________________________________ Brooksville, FL 34613
______________________________________ Fax 352 - 597 - 4008

I authorize this release of information for the following reason(s):

_____ Consult _____ Relocation _____ Specialist Care
_____ Change of Insurance _____ Other

The following information should be released as a result of this authorization:

_____ ANY and ALL records from all available sources on these dates: ________________________

_____ Complete Chart _____ Laboratory Results _____ Radiology Reports
_____ Demographics _____ Operative Reports _____Therapy Reports
_____ History and Physical _____ Pathology Reports _____ Immunization Record
_____ Medication History _____ Consult Reports _____ Emergency Room
_____ Progress Notes _____ Other: ______________________

I direct that all information in association with this release be held in strict confidence by the recipient and further direct that it is not to be disclosed without my written authorization. However, I understand that the person or entity receiving my information may not be subject to any federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign it. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for 60 days from the date of my signature below, unless I specify an earlier expiration date in this space __________. I understand that I may withdraw this authorization at any time by written notification to the parties involved, unless action has already been taken based on my authorization. If the information above contains information related to treatment for drug or alcohol abuse, psychiatric or mental conditions, or HIV test results, I agree to allow that information to be released as a part of this authorization.

Patient Name ____ Date of Birth ______________ SSN _____________________

Address ____ City __________________________

State ____________________________ Zip Code ___________ Phone Number _____________________________________

Patient Signature ______________________________ Witness _______________________________ Date ______________

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Signature ____ Date ____________________

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Patient Self Determination Act Questionnaire

Don't lose your right to decide! You cannot remove all uncertainty about your future healthcare needs, but by having an advance directive, you can have the peace of mind that comes from making your wished known in advance.

Declaration to Decline Life-Prolonging Procedures - Living Will

_____ I have made a Living Will

_____ I have not made a Living Will

Health Care Surrogate

_____ I have designated a Health Care Surrogate

_____ I have not designated a Health Care Surrogate

Durable Power of Attorney

_____ I have appointed a Durable Power of Attorney for Health Care Decisions

_____ I have not appointed a Durable Power of Attorney for Health Care Decisions

Name ____ Date of Birth ____________________

Patient Signature ____ Date ____________________

Note: If you have a living will or an assigned health care surrogate, we will gladly make a copy of your documents and place it in your chart.

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Patient Portal Consent

The e-MDs Patient Portal is a **secure** internet system that makes it easier for clinics to communicate with patients. The clinic creates patient log-on information for the Portal from its office database. Patients receive their log-on information via e-mail and can access the Portal through their web browser at home. Using the Patient Portal, a patient can accomplish the following tasks:

- Request an appointment
- View test and lab results
- Update health, medication, and contact information
- Request a medication refill
- Create a printed or electronic copy of their chart for other providers

The Patient Portal follows all HIPAA Privacy Laws. Your health information is protected by Federal Law. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers, and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities, and agencies for whom you authorize disclosure, such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals, and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure, such as:

- When required by law
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Organ and tissue donation
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Research, provided that authorization is IRB-approved or privacy board approved

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- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster relief
- Public Health activities (deaths, child abuse, neglect, domestic violence, reactions to medication, product recalls, disease infection exposure, disease injury disability control prevention)

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. **For the purposes of the Patient Portal, your e-mail address will be treated as private medical information. By signing this document, you allow the clinic to use your e-mail address to assign Patient Portal log-on information. You will recieve the logon information to the e-mail address you provide.**

Please print LEGIBLY. It's important that we enter your e-mail correctly in order to protect your information.

Print Name ______________________________

Email Address _________________________

Patient Signature ____________________________________ Date _________________