Central Florida Health
Medical Group

Advanced Directive Determination

Patient Name: _____ **Date of Birth:** _____ **Date form completed:** _____

Information obtained from ☐ Patient ☐ Family _____ ☐ Caregiver _____

Do you have an Advanced Directive? (Living Will, Designation of Health care Surrogate, Power of Attorney for Health Care)		
☐ Yes		**☐ No**
If yes, do you have a copy of your advanced directive with you today? ☐ Yes – Please give to receptionist and she will make a copy for your chart. ☐ No – Please use Section 2 below to describe the intent of your advanced directive.		If no, would you like information on completing an advanced directive? ☐ Yes – Please pick up brochure from receptionist and discuss with your primary care physician ☐ No

If an emergency occurs in the Physician Practice, Emergency Medical Services will be called.

Section 2

FOR USE ONLY FOR THE PATIENT TO DOCUMENT THE INTENT OF EXISTING ADVANCED DIRECTIVE WHEN THE DOCUMENT IS NOT AVAILABLE

I _____ have previously executed an Advanced Directive and this is the intent of that document. If I am both mentally and physically unable to speak for myself and have a terminal condition, end stage condition or am in a persistent vegetative state caused by illness or injury of which to a degree of medical probability, treatment of the condition would be ineffective as determined by two physicians and in accordance with existing law, the following are my wishes:

☐ I want all care provided regardless of my condition.

OR

☐ I want no medical treatments other than those necessary to maintain my comfort and alleviate pain

Explain specific preferences:

_____

_____

_____

_____

_____ _____

Signature of Patient Date

_____

Print Name of Witness

_____ _____

Signature of Witness Date

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Authorization for Release of Medical Information

We can honor a request only if this form is filled out completely

Date of Request: _____

Patient Name: _____

Date of Birth: _____

Please read and initial:
_____ I hereby authorize the CFHA MEDICAL GROUP to obtain my personal health information.

This includes but not limited to: discharge summaries, admission dictation, mental status (psychological evaluations), operative notes, immunizations, outpatient and inpatient summaries related to condition, laboratory reports, radiology, MRI, CAT scan, EEG, EKG and any other record related to condition or the treatment and evaluation of care.

Permission to obtain: (Please initial the following)

Mental Health Records: _____ Sexually Transmitted Diseases: ____ Drug/Alcohol reports: ____

This authorization expires on _____, (or if unspecified, 180 days from the date of signature.)

_____ _____
Signature of patient or patient's representative Date

If patient representative, describe representative's authority or relationship to patient:

_____

RELEASE OF HIV/AIDS INFORMATION (required for each release)

I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment of Acquired Immune Deficiency Syndrome (AIDS) solely to the person or organization described above and solely for the purpose stated above.

_____ _____
(Signature of patient or authorized representative) (Date)

WE WILL PROVIDE YOU A COPY OF THIS SIGNED FORM BY REQUEST

Central Florida Health
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MSP QUESTIONNAIRE

Patient Information:

Last Name: _____ First: _____ Date of Birth: _____

Information provided by: _____ Relationship to patient _____

Employment Status:

- Patient: ❑ Retired Retirement Date: _____ ❑ Employed
- Spouse (if applicable): ❑ Retired Retirement Date: _____ ❑ Employed

Special Benefits:

- Is the patient receiving Black Lung Benefits? ❑ No ❑ Yes
- Are the services to be paid by a government research program? ❑ No ❑ Yes
- Has the Department of Veterans Affairs authorized and agreed to pay for the patient's care at this facility? ❑ No ❑ Yes
- Are services covered by ESRD - End Stage Renal Disease ❑ No ❑ Yes
- Is MCR due to disability? ❑ No ❑ Yes

  Date Disability: _____

Accident Information:

- Is illness / injury due to a work-related accident? ❑ No ❑ Yes
- Is illness / injury due to a nonwork-related accident? ❑ No ❑ Yes

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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PATIENT FINANCIAL POLICY

Thank You for choosing CFHA MEDICAL GROUP for your surgical care needs. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and do not hesitate to ask if you have any questions about the information in this policy.

PAYMENTS ARE DUE AT THE TIME OF SERVICE

We will collect all co-payments at the time of service. Any unpaid deductible, co-insurance or other out of pocket amounts may also be collected before receiving service. For your convenience, we accept cash, checks and most major credit cards, including: Visa, MasterCard, Discover and American Express. We will charge a **$30 returned check fee** to your account in the event of an NSF check. Please note – this fee is not covered by your insurance.

INSURANCE

If you are covered through a Medicare Advantage Plan (Part C) you may have to pay an additional co-pay (the hospital portion and physician portion), coinsurance, co-payment and/or deductible amount. This amount may be higher than the coinsurance owed under traditional Medicare coverage. To find out your responsibility, please contact your Medicare Advantage Plan.

If you have any questions concerning this notice, our Staff will be happy to assist you. If you have question regarding your coinsurance, co-payment or deductible, you may also call the LRMC Billing Department at **(352) 323-5566**.

It is the patient's responsibility to provide us with current insurance information. We will ask for your insurance card(s) at your first visit and will make a copy for our records. If current insurance information is not provided at the time of your service, any balances incurred will become your responsibility. As a courtesy, we will file your insurance claims for you. However, we will not become involved in any disputes between you and your insurance carrier, including, but not limited to: deductibles, co-insurances, non-covered charges and "usual and customary" charges.

We have participating provider agreements in place with many insurance carriers. In the event that we are not participating with your insurance, you may be balance billed for anything not covered by your plan. Please call our billing office if the balance due on your account is more than you are able to pay at one time. We will be happy to discuss a reasonable re-payment plan with you. Unpaid balances greater than 90 days old may be referred to a professional collection agency.

MEDICAL RECORDS FEES AND FORM COMPLETION FEES

We will provide a copy of your medical record to another treating physician at no cost. However, if you would like a copy of your medical record for your personal use, there will be a retrieval and copying fee of **$1.00 per page, up to 25 pages, a $0.25 per page thereafter.** In addition, there is a $25 fee for the completion of paperwork/forms. These forms include, but are not limited to: disability forms, pre-existing condition forms, FMLA forms, etc.

I have read the Patient Financial Policy and I agree to abide by its terms and conditions.

Patient Name (Print): _____

Patient Signature: _____

Today's Date: _____

Central Florida Health
Medical Group

Drs. Luk & Nelson	Drs. Luk & Nelson	Dr. Bundz	Dr. Branch	Dr. Baig	Dr. Bakdash	Dr. Weiser
General Surgery	General Surgery	General Surgery	ENT	General Surgery	Neurology	Neurosurgery
601 E. Dixie Ave.	1400 U.S. Hwy. 441 N	8112 Centralia Ct.	1501 U.S. Hwy. 441 N	601 E. Dixie Ave.	1400 U.S. Hwy. 44	1501 N US Hwy. 441
Suite 801	Suite 526	Suite 101	Suite 1830	Suite 101	Sharon Morse Bldg., Ste. 524	Suite 1832
Leesburg, FL 34748	The Villages, FL 32159	Leesburg, FL 34788	The Villages, FL 32159	Leesburg, FL 34748	The Villages, FL 32159	The Villages FL 32159

Date: _____

Patient Name: _____ Gender: _____

Date of Birth: _____ Social Security #: _____

Race: _____ Ethnicity: _____

Marital Status: (circle one) Married Divorced Widowed Single Partner Legally Separated

Home Telephone: _____ Mobile Telephone: _____

Home Address:

_____
Street City State Zip

Mailing Address:

_____
Street City State Zip

Alternate Address: _____
Street City State Zip

Email Address: _____

Emergency Contact: _____
Relationship Telephone

Nearest Relative: _____
Relationship Telephone

Referring Physician: _____ **Primary Care Physician:** _____

Please list any other Physician's participating in your care: _____

_____

Pharmacy Information: _____

Please read and initial the following agreements:

_____ I understand that a copy of the Notice of Privacy Practices is available to me upon request. By signing this form I acknowledge that I have either received and reviewed a copy of the privacy policy or have declined receiving or reviewing a copy.
_____ I request payment of authorized Medicare and/or other insurance benefits including supplemental and auto insurance benefits to be paid directly to this provider. I authorize the release of any information concerning my healthcare or treatment provided to me to my insurance carriers and their agents to determine benefits payable.
_____ In the event that a copy of my personal health information is needed for reasons other than immediate treatment; I hereby authorize the CFH MEDICAL GROUP to release my personal health information to the following persons acting on my behalf:

Name: _____Relationship: _____

Name: _____Relationship: _____

PATIENT/GUARANTOR SIGNATURE_____DATE: _____

WITNESS SIGNATURE_____DATE: _____