CITY HEALTHCARE
1920 Don Wickham Drive, Suite 140, Clermont, FL 34711
Ph: 352-227-3341 Fax: 352-227-3342

"NEW PATIENT" FIRST CONTACT QUESTIONNAIRE

*Date:*_____

Patient Name: _____ *DOB:* _____

*Address:*_____

*Ph#:*_____ *Cell #:*_____ *SS#:*_____

Insurance: _____ *ID #:*_____ *Eff. Date:* _____

Previous Insurance, PCP and reason for changing PCP's: _____

_____

*Who referred you to our office:*_____

Chronic Medical Conditions: _____

_____

Recent illnesses / recent hospitalizations: Y / N

Hospital Name: _____ *City:* _____

Reason for Hospital visit: _____

Currently seeing any specialist / for what condition *next appointment*

Medical equipment *own – rent* *vendor*

C I T Y H E A L T H C A R E
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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES

THE PATIENT HEREBY CONSENTS TO THE USE OR DISCLOSURE OF HIS/HER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("PROTECTED HEALTH INFORMATION") AND PATIENT MEDICAL RECORD INFORMATION BY AASMA RIAZ, M.D. IN ORDER TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PATIENT SHOULD REVIEW THE PRACTICE'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF THE POTENTIAL USES AND DISCLOSURES OF SUCH INFORMATION, AND THE PATIENT HAS THE RIGHT TO REVIEW SUCH NOTICE PRIOR TO SIGNING THIS CONSENT FORM.

THE PRACTICE RESERVES FOR ITSELF THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. IF THE PRACTICE DOES CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES, PATIENT MAY OBTAIN A COPY OF THE REVISED NOTICE IN THE OFFICE OR BY SENDING A WRITTEN REQUEST TO CITY HEALTHCARE, 1920 DON WICKHAM DR., CLERMONT, FL 34711.

PATIENT RETAINS THE RIGHT TO REQUEST THAT THE PRACTICE FURTHER RESTRICT HOW HIS/HER PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PRACTICE IS NOT REQUIRED TO AGREE TO SUCH REQUESTED RESTRICTIONS; HOWEVER, IF THE PRACTICE DOES AGREE TO PATIENT'S REQUESTED RESTRICTION(S), SUCH RESTRICTIONS ARE THEN BINDING ON THE PRACTICE.

PATIENT ACKNOWLEDGES AND AGREES THAT THE PRACTICE MAY DISCLOSE PATIENT'S PROTECTED HEALTH INFORMATION AND PATIENT MEDICAL RECORD INFORMATION TO THE FOLLOWING INDIVIDUALS WHO ARE EITHER THE PATIENT'S FAMILY MEMBERS, LEGAL REPRESENTATIVES, GUARDIANS, HEALTH CARE SURROGATES, OR HAVE POWER OF ATTORNEY ON BEHALF OF THE PATIENT:

WITH THIS CONSENT, AASMA RIAZ, M.D. MAY DISCUSS MY MEDICAL INFORMATION WITH:

NAME:_____ RELATIONSHIP:_____PHONE #:_____

NAME:_____ RELATIONS HIP:_____PHONE #:_____

NAME:_____ RELATIONSHIP:_____PHONE #:_____

THE PATIENT AGREES THAT THE PRACTICE MAY DISCLOSE THE FOLLOWING TYPES OF INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORDS (PLEASE INITIAL THE APPROPRIATE CATEGORIES LISTED BELOW):

_____ HIV/AIDS INFORMATION

_____ MENTAL HEALTH INFORMATION

_____ SUBSTANCE ABUSE INFORMATION

_____ SEXUALLY TRANSMITTED DISEASE INFORMATION

PATIENT AGREES AND CONSENTS TO THE PRACTICE RELEASING INFORMATION TO PATIENT IN THE FOLLOWING ALTERNATIVE MANNERS (PLEASE INITIAL THE APPROPRIATE SPACES BELOW):

_____ VIA E-MAIL TO THE PATIENT'S DESIGNATED E-MAIL ADDRESS WHICH IS: .

_____ VIA REGULAR MAIL WITH ANY ENVELOPES BEING MARKED PERSONAL AND CONFIDENTIAL AND ADDRESSED TO PATIENT.

_____ VIA TELEPHONE, IF PATIENT CONTACTS THE PRACTICE AND PROVIDES THE APPROPRIATE INFORMATION (INCLUDING THE PATIENT'S NAME, SOCIAL SECURITY NUMBER AND UNIQUE PERSONAL IDENTIFIER).

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

AT ALL TIMES, PATIENT RETAINS 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 IN RELIANCE ON THE CONSENT.

THE PRACTICE MAY REFUSE TO TREAT PATIENT IF HE/SHE (OR AN AUTHORIZED REPRESENTATIVE) DOES NOT SIGN THIS CONSENT FORM. IF PATIENT (OR AUTHORIZED REPRESENTATIVE) SIGNS THIS CONSENT AND THEN REVOKES IT, THE PRACTICE HAS THE RIGHT TO REFUSE TO PROVIDE FURTHER TREATMENT TO PATIENT 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, IF REQUESTED, RECEIVED A PAPER COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____
SIGNATURE OF __PATIENT__AUTHORIZED REPRESENTATIVE* DATE

_____ _____
PRINTED NAME *IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT

*PLEASE EXPLAIN REPRESENTATIVE'S RELATIONSHIP TO PATIENT AND INCLUDE A DESCRIPTION OF REPRESENTATIVE'S

AUTHORITY TO ACT ON BEHALF OF THE PATIENT: _____

_____

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AUTHORIZATION TO RELEASE/REQUEST MEDICAL INFORMATION

PATIENT NAME: _____

ADDRESS: _____

PHONE #: _____

DATE OF BIRTH: _____

RELEASED FROM:

NAME:_____

ADDRESS:_____

_____

PHONE:_____

FAX:_____

RELEASED TO:

NAME:___Dr. Aasma Riaz_____

ADDRESS:_1920 Don Wickham Dr. # 140_____

_____Clermont, FL 34711_____

PHONE:__352-227-3341_____

FAX:_____352-227-3342_____

INFORMATION REQUESTED: (PLEASE CHECK)

____ COMPLETE HEALTH RECORD
____ VISIT SUMMARY
____ HISTORY & PHYSICAL
____ CONSULTATION REPORTS
____ DIAGNOSTIC IMAGING
____ LABORATORY TESTS (PLEASE SPECIFY)_____
____ OTHER (PLEASE SPECIFY)_____

____ MEDICATIONS LIST
____ PROGRESS NOTES
____ PROCEDURE REPORTS
____ EKG

IF APPLICABLE, I ALSO GIVE PERMISSION FOR THE FOLOWING TO BE DISCLOSED (PLEASE INITIAL):

____ AIDS/HIV TREATMENT

____ BEHAVIORAL HEALTH SERVICES / PSYCHIATRIC CARE

____ TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE

____ SEXUALLY TRANSMITTED DISEASES (STD)

____ GENETIC COUNSELING / TESTING

WHY DO YOU NEED THESE RECORDS?_____

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE PROVIDER(S) OF CARE. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO REVIEW OR CONTEST A CLAIM. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: _____. **IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT, OR CONDITION, THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS. IF THIS AUTHORIZATION PERTAINS TO ONESELF AS THE PATIENT, THE EXPIRATION DATE CAN BE DOCUMENTED AS UNLIMITED. IF DOCUMENTED AS SUCH, IT IS THE RESPONSIBILITY OF THE INDIVIDUAL TO NOTIFY THE PRACTICE OF ANY LIFE CHANGES, I.E. GUARDIANSHIP, SO THAT APPROPRIATE DOCUMENTATION IS GIVEN FOR THE CHANGE.**

- I UNDERSTAND THAT ANY DISCLOSURE OF HEALTHCARE INFORMATION CARRIES WITH IT THE POTENTIAL FOR UNAUTHORIZED AND FUTURE REDISCLOSURES, AS ALLOWED BY HIPAA AND OTHER FEDERAL PRIVACY RULES. IF I HAVE QUESTIONS ABOUT DISCLOSURES OF MY HEALTH INFORMATION, I CAN CONTACT MY PROVIDER OF CARE.
- THIS FACILITY, ITS EMPLOYEES, OFFICERS, AND PHYSICIANS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.
- FEES FOR COPIES OF MEDICAL RECORDS IN PAPER OR ELECTRONIC ONTO DISK TO BE CHARGED IN ACCORDANCE WITH THE STATE OF FLORIDA FEE SCHEDULE AND THE ACTUAL COST OF POSTAGE.

_____ _____
SIGNATURE OF __PATIENT __PERSONAL REPRESENTATIVE PRINTED NAME

_____ _____ _____
IF PERSONAL REPRESENTATIVE-RELATIONSHIP TO PATIENT DATE