Florida Infectious Disease Specialist, Inc.

102 Park Place Blvd. Building D Suite 2 & 3, Kissimmee, FL 34741
Tel: (407) 944-4900 Fax: (407) 483-0688

Patient Information:

Apellido:	Nombre:	Inicial:
Fecha de Nacimiento:	Female Male	S.S#:
Email:	Estado Civil: Single / Married / Divorced / Widowed	
Dirección:		
Ciudad:	Estado:	Area postal:
Tel:	Mobil:	
Farmacia:	Tel.:	Area postal:
Medico primario:		Tel:
Ocupación:	Empleador::	
Dirección:		Tel::

En caso de Emergencia:

Nombre:	Relación:
Tel:	Mobil:

Consentimiento para el Tratamiento:

Yo, _____,Por la presente, doy mi consentimiento a FLIDS para que me brinde tratamiento médico como mi médico. Autorizo y dirijo el pago de mis beneficios médicos a FLIDS en mi nombre por cualquier servicio que me sea proporcionado por los proveedores. Asimismo, autorizo a FLIDS a divulgar a mi aseguradora, agencias gubernamentales o cualquier otra entidad financieramente responsable de mi atención médica, toda la información, incluyendo el diagnóstico y los registros de cualquier tratamiento o examen realizado, que sea necesaria para justificar el pago de dichos servicios médicos, así como la información requerida para la precertificación, autorización o derivación a otro proveedor médico.También afirmo solemnemente que la información proporcionada por mí es correcta y está actualizada según mi mejor conocimiento. Notificaré de inmediato a FLIDS sobre cualquier cambio en esta información

_____ _____ _____

Firma del Paciente or Tutor Legal **Nombre del Paciente** **Fecha**

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Problemas Médicos Actuales: Por favor, marque con un círculo todos los que apliquen en este momento.:

Falta de aire	S / N	Dolor Abdominal	S / N	Dolor de cabeza	S / N
Dolor de pecho	S / N	Nausea	S / N	Tos	S / N
Diarrea / Estreñimiento	S / N	Dolor en articulaciones	S / N	Problemas al orinar	S / N
Tobillos hinchados	S / N	Palpitaciones	S / N	Debil	S / N
Sibilancias	S / N	Dolor de oído	S / N	Otro:	
Perdida de peso	S / N	Mareos	S / N		
Cambio en su apetito	S / N	Vision Borrosa	S / N		

Historial Médico Pasado:

Problemas del corazón	S / N	Enfermedad de riñón	S / N	Convulsiones	S / N
Alta presion	S / N	Enfermedad Venérea	S / N	Anemia	S / N
Enfermedades de la piel	S / N	HIV	S / N	Hemorroides	S / N
Desorden en la sangre	S / N	Infección de pecho	S / N	Asma	S / N
Defecto auditivo	S / N	Diabetes	S / N	Otro:	
Gota	S / N	Ictericia	S / N		
Enfermedad tiroidea	S / N	Cancer	S / N		

Cirugías:

Nombre	Fecha
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Ultimo Fisico? _____ Fuma? S / N Cuanto? _____ Usa drogas ilicitas? S / N
Consume Alcohol? S / N Cuanto? _____ Tiene Testamento? S / N

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Vacunas:	**Fecha:**		**Fecha:**
Influenza (gripe)		Virus sincitial respiratorio (VSR)	
Covid-19 (Co V-2)		Sarampión, paperas y rubéola (SPR)	
Herpes zóster (Culebrilla)		Hepatitis A	
Neumocócica (Neumonía)		Hepatitis B	
Virus del papiloma humano (VPH)		Hepatitis A/B	
Tétanos, difteria y tos ferina (Tdap)		Varicela	
Meningocócica (Meningitis)		Viruela del mono (Mpox)	
Polio		Fiebre Amarilla	

Historial Familiar: Marque todos los que apliquen	**Madre**	**Padre**	**Hermanos**
Cancer			
Diabetes			
Epilepsia			
Problemas del corazón			
Alta presion			
Enfermedad de riñón			
Enfermedad tiroidea			

Lista de Medicamentos:

Medication Name	**Dose (mg/ gm/ # of pills)**	**Frequency**

Alergias a Medicamentos: _____

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Políticas de la Oficina:

No show fee

Se cobrará una tarifa de **$50.00** a su cuenta por no asistir a su cita. Este cargo es responsabilidad del paciente y no será facturado a ninguna compañía de seguros. Debe ponerse en contacto con la oficina para cancelar o reprogramar al menos 24 horas antes de su cita programada.

Formularios/Cartas

Hay una tarifa de **$35.00 o más** por la finalización de formularios/cartas. (Tenga en cuenta que FLIDS no llenar ciertos formularios ni redacta ciertos tipos de cartas, por favor llame a la oficina y verifique con la recepcionista primero). Hay un plazo de 7 días para completar todos los documentos externos que requieran la firma de un médico. Si se necesita acelerar el trámite, habrá un cargo adicional de **$10.00** además de la tarifa estándar por dichos documentos. La tarifa debe pagarse cuando los formularios/cartas sean entregados a la práctica para su finalización y debe ser pagada antes de ser enviados por fax o recogidos por el paciente o un miembro autorizado de la familia.

Responsabilidad financiera del individuo:

- Entiendo que soy responsable financieramente por mi deducible del seguro de salud, coseguro o servicios no cubiertos.
- Los copagos deben pagarse en el momento del servicio.
- Si mi plan requiere una referencia, debo obtenerla antes de mi visita.
- En caso de que mi plan de salud determine que un servicio no es pagable, seré responsable por el cargo completo y aceptó pagar el costo de todos los servicios proporcionados.
- Si no tengo seguro, acepto pagar por los servicios médicos prestados en el momento del servicio.

Solicitud de pago de Medicare:

Solicito el pago de los beneficios autorizados de Medicare a ser realizados a mi nombre o a mi favor por cualquier servicio proporcionado por o en FLIDS. Autorizo a cualquier titular de información médica o de otro tipo sobre mí para que libere a Medicare y sus agentes cualquier información necesaria para determinar estos beneficios para los servicios relacionados.

Firma:_____ **Fecha**: _____

Autorización para Buzón de Voz

La siguiente información nos ayudará a comunicarnos con usted sobre su atención mientras protegemos su confidencialidad. Cuando devolvemos las llamadas y el contestador automático responde, no dejamos un mensaje si el nombre del número telefónico no está en el mensaje grabado para identificar la residencia. Tampoco se dejará información con una persona no autorizada que pueda contestar el teléfono. Tenga en cuenta que, según nuestro aviso de prácticas de privacidad, los recordatorios de citas se harán a través de nuestro sistema automatizado de FLIDS. ¿Podemos hablar con alguna otra persona que no sea usted respecto a la información médica, de seguros o financiera? S / N Si la respuesta es sí, por favor, indique el nombre y número de teléfono a continuación:

Nombre: _____ Tel: _____ Relación: _____

Nombre: _____ Tel: _____ Relación: _____

Aviso de Privacidad:

He recibido una copia del aviso de privacidad de Florida Infectious Disease Specialist, Inc.

Firma:_____ **Fecha**: _____

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Authorization for the Release of Medical Records:

Last Name:	Name:	Initial:
DOB:	S.S#:	
Address:		
City:	State:	Zipcode:
Ph:		

I Authorize Florida Infectious Disease Specialists, Inc. Release / Obtain my medical Records to/from:

Name:	
Address:	
Ph:	Fax:

Specific Documents to be release:

_____ All Records
_____Operative Records
_____Psychiatric
_____X-rays reports
_____History & Physical
_____Vaccination records
_____Drug / Alcohol
_____Discharge summary
_____AIDS / HIV
_____Other:

Purpose of information:

_____ Continue Medical Care _____Insurance _____Personal

This request is authorized to include any federal and/or state protection under Florida Statutes 394.459(9) Psychiatric information, 397.053/396.112, Drug and Alcohol Abuse information, 381.600 HIV and AIDS related condition and/or 397.50(3) records of minor client.

NOTE TO REQUESTING PARTY: Florida state has established guidelines and cost rates for the opening of records. Your signature on this form indicates your knowledge of this statement.

I hereby release Florida Infectious Disease, Inc. and employees agents, Officers and affiliates, from any and all liability, responsibility, claims, damages which may result from the release of information authorized by the consent of release of information.

Signature:_____ **Date**: _____

Florida Infectious Disease Specialists, INC.
Off: 102 Park Place Blvd. Bldg. D Suite 3
Kissimmee, FL 34741
Phone: (407).944.4900
Fax: 407.483.0688

NOTICE OF PRIVACY PRACTICES
Effective Date: 4/1/2010

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
NOTICE OF PRIVACY POLICY
Effective April 14, 2010.

The following is the ("privacy policy") of Florida Infectious Disease Specialist, INC.
("covered entity") as described in the health insurance Portability and accountability act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered entities by law to maintain the privacy of your personal health information and to provide you with the notice of Covered entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this privacy notice.

YOUR PERSONAL HEALTH INFORMATION.
We collect your personal health information through treatment, payment and related healthcare operation, the application and enrollment process and/or healthcare providers or health plans or through other means as applicable. Your personal information is protected by law and it broadly includes any information, oral, written or recorded that is created or received by certain healthcare entities, including healthcare providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information and to provide you with the notice of Covered entity's legal duties and private policies with respect to your personal health information. We are required by law to abide by the terms of this privacy Notice.

USES OF DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION:
Generally we do not use or disclose your personal health information without your permission. Further, once your permission. The Following are the circumstances under which we are permitted by law to use or disclose personal health information.

Without your Consent:
Without your Consent we may use or disclose your personal health information in order to provide you with services and the treatment that you require or request, or to collect payment for these services and to conduct other health related care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.
Examples of treatment activities include:

The provision, coordination or management of health care and related services by health care providers.
Consultation between health care providers to another.

Examples of payment activities include:

Billing and collection activities and related data processing.
Actions by health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provisions of benefits under its health plan or insurance agreement, determination of eligibility or coverage, adjudication or subrogation of health benefit claim.
Medical necessity and appropriateness of care reviews, utilization review activities.
Disclosure to consumer reporting agencies of information relating to collecting of premiums or reimbursement.

Examples of healthcare operations Include: **Florida Infectious Disease Specialist, INC**

Development of guidelines.
Contacting patients with information about treatment alternatives or communications in connection with case management of care coordination.
Reviewing the qualification of training health care professionals.
Underwriting and premium rating.
Medical review. Legal services and auditing functions and general administrative activities such as customer services and data analysis.

As Required By Law:
We may use or disclose your personal health information to the extent that, law and the use or disclosure requires such use or disclosure requires that use or disclosure complies with and is limited to the relevant requirements of such law.

Examples of instances in which we are required to disclose your personal health information include:
Public Health activities including preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food and dietary supplements or product defects or problems to the food and drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work related injury or illness in order to comply with Federal or state law.

Disclosure regarding victims of abuse, neglect, or domestic violence including, reporting to social services or protective service agencies.
Health oversight activities including, audits civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative or criminal proceedings or actions or other activities necessary for appropriate government benefit programs.
Judicial and administrative proceedings in response to an order of a court or an administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.
Law enforcement purpose of identifying or locating a suspect, fugitive, material witness or missing person, or reporting crimes in emergencies, or reporting death.
Disclosure about decedents for purposes of cadaver donation of organs, eyes, or tissues.
For research purposes under certain conditions.
To avert a serious threat to health or safety.
Military and veterans activities,
National security and intelligence activities, protective services of the president and others,
Medical suitability determination by entities that are components of the Department of State.
Correctional institutions and other law enforcement custodial situations.
Covered entities that are government programs providing public benefits and for workers compensation.

All other situations, with your specific authorization:
Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with terms of your authorization. You may revoke your authorization to use or disclose your personal health information at any time except to the extent that we have taken action in reliance on such authorization, or, if you provide the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice:
We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you. We may contact you to raise funds for the covered entity. If we are a group health plan or health insurance or HMO with respect to a group health plan, we may disclose your personal health information to be a sponsor of the plan.

Your Rights with request to Your Personal Health Information:
Under HIPAA, you have certain with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.
Right to Request Restrictions in Use or Disclosure:
You have the right to request restrictions on certain uses and disclosures of your personal health information. You may request restrictions on the following uses or disclosures:

To carry out treatment, payment or healthcare operations.

Disclosure to family, relatives or close personal friends, personal health information directly relevant to your care or payment related to your health care, or your location, general condition or death.

Instances in which you are not present or you permission cannot practicably be obtained due to your incapacity or an emergency circumstance,

Permitting another person to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information.

Disclosure to a public or a private entity authorized b y law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal health information in violation of such restrictions, except in certain emergency situations. We will not accept a request to restrict uses or disclosure that are otherwise required by law.

Right to Receive Confidential Communication:

You have the Right to receive Confidential Communication of your personal health information. We may require written requests. We may condition the provision of confidential communication on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis.

We must permit you to request and must accommodate reasonable requests by you to receive communication of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communication of personal health information from us by alternative means or at alternative locations; if you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect And Copy Your Personal Health Information:

Your designated record set is a group of records we maintain that includes records about you, or enrollment, payment claims adjudication and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information contained in your record set, except for:

Psychotherapy notes.

Information compiled in reasonable anticipation of or for use in, a civil, criminal or administrative action or proceeding.

Health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form of format requested by you, if it is readily producible in such form or format or if not in a readable hard copy form or such other form of format. We may provide you with a summary of personal health information requested in lieu of providing access to the personal health information or may provide an explanation of personal information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost based fee for copying, postage; if you request a mailing and the cost of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will attempt to accommodate and request for any personal health information in a reasonable manner and to the extent possible, giving you access to other personal health information after excluding the information as to which we have grounds to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights and a description of how you may file a complaint with
us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Personal Health Information:

You have the right to request that we amend your personal health information or a record about your contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) We determine that the information or record that is the subject of request was not created by us, (b) The information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit a written denial stating the basis of denial your right to submit a written statement disagreeing with the denial and a description of how you may file a complaint with us or the secretary of US Department of Health and Human Services (DHHS). This Denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosure of your personal health information that is the subject of the amendment. Copies of all requests, denials and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of your prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied or could foresee ably rely, on such information to your detriment. All requests for amendments shall be sent to:

Florida Infectious Disease Specialist, INC
102 Park Place Blvd. Bldg. D Suite 2 & 3
Kissimmee, FL 34741

Right to Receive an Accounting of Disclosure of Your Personal Health Information:

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosure of your personal health information that we have made within the six year period immediately preceding the date on which the accounting is requested. You may request an accounting of all disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosures, the name and if known, the address of the entity or person who received the information; a brief description of the information disclosed and a brief statement of purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information.

We are not required to provide accounting disclosures for the following purpose: (a) Treatment, payment and health care operations; (b) Disclosures pursuant to your authorization, (c) Disclosures to you, (d) For a facility directory or to persons in your care, (e) for national security and intelligence purpose (f) to correctional institutions and (g) with respect to disclosure to occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health services or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge but will impose a reasonable cost based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All realest for an accounting shall be sent to:

Florida Infectious Disease Specialist, INC.
102 Park Place Blvd. Bldg. D Suite 2 & 3
Kissimmee, FL 34741

You may file a complaint with us and with secretary of DHHS if you believe that your privacy rights have been violated, You may submit your complain in writing, by mail or electronically to our privacy officer, A complaint must name the entity that is the subject of the complaint and describe the acts provisions' believed to be in violation of the applicable requirements of HIPAA or this priv. A complaint must be received by us or filed with the secretary of DHHS within 180 days of when you knew or should have known that the act or omission complaint occurred. You will not be retaliated against for filing any complaint.

Acknowledgement of receipt of Privacy Notice:

I have received a copy of the Privacy notice from
Dr. Sajid Chaudhary, M.D / Dr. Shoaib Siddiqui, M.D / Dr. Mehmood Nawab
Dr. Nida Hameed, M.D / Dr. Madiha Syed, M.D