Mid-Florida Surgical Associates

What you need before your appointment

☐10000 West Colonial Drive, Suite 288, Ocoee, FL 34761	P 407.521.3600	F 407.521.3603
☐1804 Oakley Seaver Drive, Suite A, Clermont, FL 34711	P 352.243.2622	F 352.243.6277

Appointment Date: _____ Time: _____ Doctor: _____

**Please arrive 20 minutes early for your appointment*

Enclosed are our patient forms for your scheduled appointment. Please completely fill out and bring with you.

Please bring the following information with you. Failure to do so will result in your appointment being rescheduled.

- Current Insurance card(s) and valid I.D.
- **If your insurance requires a referral for the visit, please obtain this from your primary care doctor and bring with you to your appointment or have them fax it to our office. If we do not have the referral at the time of your visit, your appointment will be rescheduled.**
- If your insurance is through the Affordable Care Act or Marketplace, proof of premium paid for the current month is required at each visit.
- We will need all medical records pertaining to your visit with the surgeon. These may be faxed prior to your appointment or you may bring them with you. You will need to bring your mammogram, sonogram, MRI, and CT disk(s) and report(s) to your appointment. Failure to have these items will result in your appointment being rescheduled.
- Call the facility where your test was done at least 72 hours prior to pick up so that they may have these items ready for you.
- Payment is due at the time services are rendered. This includes copay, co-insurance, and deductibles.
- Please bring a list of your medications (with the correct spelling) and dosage. If this is not available, the medication bottles will be required.
- Please arrive 20 minutes early for your appointment.
- If you are unable to keep your appointment, we require a 48-hour notice. Failure to do this will result in a cancelation fee of $50.00.

Thank you for your cooperation and we look forward to seeing you soon.

Mid-Florida Surgical Associates

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Jorge L. Florin, M.D., F.A.C.S.
Christopher J. Johnson, D.O., F.A.C.O.S., F.A.C.S.
Jason A. Boardman, M.D., F.A.C.S.
Joseph M. Armotrading II, M.D., F.A.C.S.
Luisangel A. Rondon, M.D., F.A.C.S.

Benjamin V. Chu, PA-C
Amy E. Diehl, PA-C
Courtney C. Beville, PA-C
Michelle D. Heine, PA-C

Patient Information

First _____ MI ____ Last _____

Gender: ___ M ___ F DOB ____/_____/_____ Marital Status _____

Race : ___Black ____White ____Asian ____American Indian *Ethnicity:* ___Hispanic _____Not Hispanic ____Decline

Preferred Language _____ SS# _____/_____/_____

Do you have a living will or medical advance directive? __ yes __ no If yes, must provide a copy.

Address _____ City _____ ST _____ Zip _____

Home# _____ Cell# _____ Work# _____

Email _____ Preferred Contact Method _____

Occupation _____ Employer _____

EMERGENCY CONTACT _____ Relation to Patient _____

HOME# _____ WORK# _____ CELL# _____

Primary Insurance Carrier_____ Copy of Card Provided ____ Y ____ N

Policy Holder's Name_____ DOB_____/_____/_____

Policy Holder's SS# _____/_____/_____ Policy Holder's Relation to Patient _____

Secondary Insurance Carrier _____ Copy of Card Provided ____ Y ____ N

Policy Holder's Name _____ DOB _____/_____/_____

Policy Holder's SS# _____/_____/_____ Policy Holder's Relation to Patient _____

Primary Care Physician _____ Phone _____

I have received the Notice of Privacy Practices, and hereby request and consent to examination and/or medical treatment by Jorge L. Florin, M.D., Christopher J. Johnson, D.O., Jason A. Boardman, M.D., Joseph M. Armotrading II, M.D., Luisangel A. Rondon, M.D., Benjamin V. Chu, P.A.-C, Amy E. Diehl, P.A-C, Courtney C. Beville, PA-C, and Michelle D. Heine, PA-C.

Patient Signature _____ Parent/Power of Attorney Signature _____

Date _____ Parent/Power of Attorney Print _____

Mid-Florida Surgical Associates

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Mid-Florida Surgical Associates to use and/or disclose certain Protected Health Information (PHI) about me to or for the party or parties listed below. This authorization permits Mid-Florida Surgical Associates to use or disclose (in person, via phone or fax) to:

___ you may release to my spouse, name of spouse _____

___ you may release to my employer, name of employer_____

___ you may release to other, name of other person _____

_____

_____

the following health information (specifically describe the information to be released, such as origin of information):

____ medical information ____ financial information ____ anything ____ emergency only

This authorization will remain effective unless notified by you in writing (please initial) _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
I have the right to revoke this authorization. My written revocation must be submitted to Mid-Florida Surgical Associates' Privacy Officer at:

10000 West Colonial Drive
Suite 288
Ocoee, FL 34761

Signature _____ Print _____
Patient or Legal Guardian Patient or Legal Guardian

Relationship to Patient _____ Patient's Name _____
If Self, Disregard If Self, Disregard

Date _____

Updated:

Initial _____ Date _____

Initial _____ Date _____

Initial _____ Date _____

Effective Date 04/14/03

Mid-Florida Surgical Associates

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Mid-Florida Surgical Associates may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and healthcare Operations (TPO). Please refer to Mid-Florida Surgical Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mid-Florida Surgical Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Mid-Florida Surgical Associates
Privacy Officer
10000 West Colonial Drive
Suite 288
Ocoee, FL 34761

With my consent, Mid-Florida Surgical Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Mid-Florida Surgical Associates may email, mail or fax to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Mid-Florida Surgical Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mid-Florida Surgical Associates' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Mid-Florida Surgical Associates may decline to provide treatment to me.

Signature _____ Date _____
Patient or Legal Guardian

Print _____ Patient's Name _____
Patient or Legal Guardian If same, disregard

patconsforuse

Mid-Florida Surgical Associates

Jorge L. Florin, M.D., F.A.C.S.
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Lifetime Insurance Authorization: (Please sign appropriate sections as they apply to your insurance)

Medicare

I request that payment of authorized Medicare and supplement insurance benefits be made on my behalf to Jorge L. Florin, M.D., P.A. DBA as Mid-Florida Surgical Associates for any services furnished to me by Jorge L. Florin, M.D., Christopher J. Johnson, D.O., Joseph M. Armotrading II, M.D., Jason A. Boardman, M.D., Luisangel A. Rondon, M.D., Benjamin V. Chu PA-C, Amy E. Diehl, PA-C, Courtney C. Beville, PA-C, and Michelle D. Heine, PA-C.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits for related services.

Signature _____ Date _____

Medicaid

I authorize the release of any medical information necessary to process this claim and related claims and assign insurance benefits directly to Jorge L. Florin, M.D., P.A., DBA as Mid-Florida Surgical Associates the amount due for medical expenses rendered by Jorge L. Florin, M.D., Christopher J. Johnson, D.O., Joseph M. Armotrading II, M.D., Jason A. Boardman., M.D., Luisangel A. Rondon, M.D., Benjamin V. Chu, PA-C and Amy E. Diehl, PA-C, Courtney C. Beville, PA-C, and Michelle D. Heine, PA-C under the terms of my health insurance company.

Signature _____ Date _____

Commercial Insurance

I authorize the release of any medical information necessary to process this claim and related claims and assign insurance benefits directly to Jorge L. Florin, M.D., P.A., DBA Mid-Florida Surgical Associates the amount due for medical expenses rendered by Jorge L. Florin, M.D., Christopher J. Johnson, D.O., Joseph M. Armotrading II, M.D., Jason A. Boardman, M.D., Luisangel A. Rondon, M.D., Benjamin V. Chu, PA-C, Amy E. Diehl, PA-C, Courtney C. Beville, PA-C, and Michelle D. Heine, PA-C under the terms of my health insurance company. I UNDERSTAND THAT MY DOCTOR BILLS MY CHARGES TO MY INSURANCE COMPANY AS A COURTESY TO ME. I AM RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE, COINSURANCE OR NON-COVERED SERVICE AS STATED IN MY POLICY. THIS WILL BE COLLECTED AT THE TIME THE SERVICE IS RENDERED.

Signature _____ Date _____

Self-Pay or Non-insured Patients: If you do not have insurance or if we are not a provider for your insurance you will be responsible for services as they are rendered.

Signature _____ Date _____

Effective 05/01/09, there will be a fee for re-schedule/cancellation of office or surgery appointments unless a 48 hour notice is given to the office. There will be a $50 fee for cancellation/re-scheduling of an office appointment and a $250 fee for cancellation/re-scheduling of a surgery appointment. Please contact the office for cancellations/re-schedules during regular business hours. Do not call the answering service for this, as the answering service should only be used to reach the physician after hours for **emergencies only**. We appreciate your cooperation with this policy.

Signature _____ Date _____

Mid-Florida Surgical Associates

Patient Name _____ Date of Birth _____
Pharmacy Name _____ Pharmacy Phone_____

I authorize MFSA to download my medication history from my pharmacy portal. __ yes__ no
Have you had the flu vaccine? __ yes __ no Date of Vaccine _____
Have you had the pneumonia vaccine? __ yes __ no Date of Vaccine _____

□ No Known Medication Allergies

Medication Allergies	**Reaction**

Food Allergies/Reaction _____ **□ None**

Environmental Allergies/Reaction (ex.: latex, seasonal, dust, grass, cats, dogs, etc.) **□ None**

_____

List of Current Medications: Prescription, Over-the-counter medications, Supplements

Name of Medication	**Strength**	**How Often Do You Take It?**

***Additional medications can be listed on back of sheet**

Date of Visit	**Patient Signature**
1.	
2.	
3.	
4.	