Luna Beck M.D. and Associates, PA

17820 SE 109th Ave. Suite 107

Summerfield, FL 34491

Ph: 352-307-7940 Fax: 352-307-7941

PATIENT INFORMATION: Date: ________________

(***ALL INFORMATION ON THIS PAGE IS MANDATORY AND MUST BE FILLED OUT***)

YOUR PERSONAL AND HEALTH INFORMATION ARE STRICTLY PRIVATE AND CONFIDENTIAL

1. Name: ____

(Last Name) (First Name) (Middle Initial)

2. SSN# ______________________ **3**. DOB: _______/_______/_______ (mm/dd/yyyy)

4. Age: ______ **5**. Marital Status: S M D W **6**. Race: ______ **7**. Gender: M/F **8**. Religion: _________

9. Address: ____

City: ____________________________________ State: __________________ Zip: _________________

9. Secondary Address: ____

City: ____________________________________ State: __________________ Zip: _________________

10. Home Phone: ( )__________________________ 11. Cell Phone: ( )_____________________

12. Email Address: ____

13. Occupation: ________________________________ 14. Work Phone: ( )____________________

15. Driver's License No. _____________________ 16. Referred by: ______________________________

17. Emergency Contact Name(s): ____

18. Emergency Contact Number(s): ____

19. **PRIMARY INSURANCE:**

Insured Party's Name ____

Insurance Name _________________________ Insurance ID# ______________ Group# __________

20. **SECONDARY INSURANCE:** _______ NONE

Insured Party's Name ____

Insurance Name _________________________ Insurance ID# ______________ Group# __________

21. **ASSIGNMENT AND RELEASE**:

I certify that I, and or my dependents have insurance coverage with _____________ and assign directly to Luna Beck, M.D. PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information in order to obtain payment or insurance benefit information from the above named insurance company (ies). I hereby authorize medical treatment provided by Luna Beck M.D.

Print Patient's Name/Guardian (if minor) ______________________________ Relationship __________

Patient's/Guardian Signature (if minor) _______________________________ Relationship ___________

Patient Record of Disclosure and Consent

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to confidential communications or that a communication of PHI is made by alternate means, such as a correspondence to the individual's office instead of home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone

☐ Work Telephone

☐ OK to leave detailed message

☐ Leave message with call back number only

WRITTEN COMMUNICATION

☐ Ok to mail to home address

☐ Mail to work address

☐ Do not mail any personal info

Please list individuals we can discuss your information with (e.g. treatment, diagnosis, billing, test results, etc.)

Please list their relationship to you and phone number for secure identification.

*** THIS INCLUDES SPOUSES and CHILDREN and GUARDIAN YOU AUTHORIZE ***

Name ______________________________ Relationship _________________ Phone # ____________________

Name ______________________________ Relationship _________________ Phone # ____________________

Name ______________________________ Relationship _________________ Phone # ____________________

Name ______________________________ Relationship _________________ Phone # ____________________

Print Patient's Name: ____

Signature: ____ Date: __________________________

(Parent / Guardian if patient is a minor)

PLEASE CHECK BOX

	FAMILY HISTORY (PLS SPECIFY WHICH FAMILY MEMBER)		**PAST SURGICAL HISTORY**
	ALZHEIMER'S DISEASE		ABDOMINAL
	BIPOLAR DISORDER		AMPUTATION
	BLEEDING DISORDER		ANGIOPLASTY
	CANCER OF THE BREAST		ARTIFICIAL JOINT REPLACEMENT
	CANCER OF THE COLON		BACK SURGERY
	CANCER OF THE LUNGS		BLADDER SUSPENSION
	CANCER OF THE PROSTATE		BLOOD TRANSFUSION
	CANCER OF THE UTERUS		BOWEL SURGERY
	CANCER (OTHER PLS SPECIFY)		BREAST SURGERY
	DVT		CABG (CARDIAC BYPASS)
	DIABETES		CARDIAC CATHERIZATION
	HEART PROBLEMS		CARPAL TUNNEL SYNDROME
	HIGH CHOLESTEROL		HEMORRHOID SURGERY
	PULMONARY EMBOLISM		CYST REMOVAL
	STROKE		KNEE SURGERY ____ LEFT ____ RIGHT
	THYROID DISEASE		LAMINECTOMY
	OTHER		LAPAROSCOPY
			LOBECTOMY
	PREVENTATIVE: PLEASE LIST DATES		POLYP REMOVAL
	PAP SMEAR -		PROSTATE SURGERY
	MAMMOGRAM -		OTHER
	COLONOSCOPY -		
	PSA -		
	BONE DENSITY -		

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and have been provided the opportunity to review it.

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Signature: ____ Date: __________________________

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PAST MEDICAL HISTORY

PLEASE CHECK BOX IF IN PATIENT'S HISTORY

	ALLERGIC RHINITIS (ALLERGIES)		HYPOTHYROIDISM
	ALZHEIMER'S DISEASE		LIVER CONDITIONS
	ANEMIA		LUNG CANCER
	ANGINA		MENOPAUSE
	ANXIETY DISORDER		MIGRAINES
	ARTHRITIS CONDITIONS (Specify)		MYOCARDIAL INFARCTION
	ASTHMA		NEUROPATHY
	BLOOD CLOTTING PROBLEM		OSTEOPOROSIS
	BRAIN TUMOR		OTHER CANCER (Specify)
	CARDIAC ARRHYMTHMIAS		PARKINSON'S DISEASE
	CARDIAC CATHETERIZATION		PERIPHERAL VASCULAR DISEASE
	CARDIAC DISEASE		PNUEMONIA
	CONGESTIVE HEART FAILURE		PULMONARY EMEMA
	CARPAL TUNNEL SYNDROME		PULMONARY EMBOLISM
	CATARACTS		RESTLESS LEG SYNDROME
	COPD		RHEUMATIC HEART DISEASE
	DEMENTIA		SEIZURE DISORDER
	DIABETES		SHINGLES
	DIVERTICULITIS		SHORTNESS OF BREATH
	EMPHYSEMA		SKIN CANCER (Specify)
	FIBROMYALGIA		SLEEP APNEA
	FRACTURE HISTORY (Specify)		STROKE / TIA
	GALLBLADDER HISTORY		SYNCOPE
	GLAUCOMA		THROMBOSIS – DVT
	GOUT		THYROID DISORDER
	HAY FEVER		TRIGEMINAL NEURALGIA
	HEART VALVE CONDITION		ULCER
	HERNIA		OTHERS
	HIGH BLOOD PRESSURE		

____

____

Patient's Name: ____

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PATIENT MEDICATION LIST

Medication Allergies: ____

DATE	MEDICATION USE	DOSAGE	DIRECTIONS

Patient's Name: ____

Local Pharmacy Name: ______________________________________

Pharmacy Tel#: _______________________________________

Local Pharmacy Name: ______________________________________

Pharmacy Tel#: _______________________________________

PLEASE BRING THE FOLLOWING ON YOUR FIRST VISIT

1. Insurance Cards
2. Drivers License
3. Medication Bottles **(First visit and Every Visit to see Dr. Beck)**
4. Bring copies of labs or tests you recently had.
5. Vitamins and Supplements **(First Visit Only)**

Please call to cancel or reschedule your appointment within 24 hours. If you fail to call the following fee will apply.

- New Patient $50.00
- Established Patient $25.00

Patient's Name: ___________________________________ Date: _________________

Patient's Signature: _________________________________

Luna Beck M.D. & Associates, PA

Financial Responsibility and Policy Sheet

Printed Patient's Name: ____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our account manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

INSURANCE: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will

only require you to pay the authorized co-payments / co-insurance at the time of service. This office's policy is to collect this co-payment / co-insurance when you arrive for your appointment.

CO-PAYMENT: The co-payment made at the front desk is for the visit only often considered the time you spent with the Doctor. If you have any procedures performed during your visit to Luna Beck M.D. & Associates, PA., the procedure co-payment, deductible and or co-insurance is not covered in the co-payment made at the front desk. Unless otherwise stated by your insurance company, all other insurances have co-payments and or co-insurance, and yearly deductibles. In other words, the amount you pay during your visit may not be all you owe. Your final responsibility will be determined after your insurance company has received a bill for all services rendered, processed and paid your claim.

Miscellaneous:

- You acknowledge that the insurance card and information provided each visit is the correct and current information. You understand that it is your responsibility to inform Luna Beck M.D. & Associates, PA if a change in your insurance coverage occurs.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Please call your insurance company to verify coverage of these services. The customer service number should be located on your insurance card.
- Statements will be mailed on a monthly basis. The amount due is to be paid in full upon receipt of the statement. Late payment will incur additional charges which include interest (18% per annum or 1.5% per month) and administrative fees.

Private Pay Patients: As a private pay patient you will be asked to make deposit prior to seeing the doctor. It is very important that you ask about the cost of care or services that your physician is recommending prior to the service being performed. At the end of your visit, you may receive a refund or be expected to pay additional charges for the service provided.

Minor Patients: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian custody for payment.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **LUNA BECK M.D. & ASSOCIATES, PA** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Consent for Treatment:

I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures and or treatments prescribed by my physician, his/her assistants or designee as is necessary in his/her judgement.

Authorization to Release Information:

I hereby authorize **LUNA BECK M.D. & ASSOCIATES, PA** to:

1. Release any information necessary to insurance carriers regarding my illness and treatments;
2. Process insurance claims generated in the course of examination or treatment; and
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from **LUNA BECK M.D. & ASSOCIATES, PA** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. In the event of default, I understand that the Luna Beck M.D. & Associates, PA may use an outside Collection Company and or report returned checks to the Attorney General office for the state of Florida.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon receipt of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand that our records contain protected health information about you and as such are highly confidential. When appropriate, this office may use medical records for non-treatment purposes (research, public health, and some operational activities).

__________ Initials acknowledge receipt of this office's **Notice of Privacy Policy**

__________ Initials acknowledge receipt of this office's **Financial Responsibility and Policy**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

____ / ________________ / ___________________

Signature of Patient or Responsible Party if a Minor | Date | Relationship to Patient