Lake Health Care Center, Inc. 910 Mt.Homer Rd Eustis, Fl 32726

Phone (352) 357-8615 Fax (352) 357-5873

Last Name:_____ First Name:_____ M.I.____
Mailing Address:_____ City, State:_____Zip Code:_____
Out of State Mailing Address_____
SSN #:_____ ☐ Male ☐Female DOB:_____ Age: _____
Primary Phone # : _____ Secondary Phone # :_____
Primary Insurance: _____Secondary Insurance: _____
Email Address: _____ Marital Status : _____
Spouses Name: _____ Children ☐ Yes ☐No # of : _____
Employer:_____ Occupation:_____ Work #: _____

In an Emergency Contact:_____ Phone #: _____

The present illness/complaint/health problem that brought you in the office today is: _____
_____
How and when did the main complaint or health problem start?_____
_____(If auto accident, list date: _____)

What treatment have you had for this complaint or health problem?

☐ Medication	☐ X-Rays	☐ Physical Therapy	☐ Injections
☐ Blood Tests	☐ Urine Test	☐ Stool Test	☐ Pap Smear
☐ MRI	☐ CT	☐ NCV/EMG	☐ Hospitalization

Past History: Please list the following:
Doctors: _____
Hospitalizations: _____
Prior surgeries: _____
Current medications: _____
All illnesses: _____
Which pharmacy do you use? _____ Phone # :_____
Have you had any bad reactions to any medications or treatment in the past? ☐ Yes ☐ No
Please list any Allergies: _____

Family History: (Please list any major illness, disease or cause of death of any family members.)
Mother: _____ Father: _____
Brother (s): _____ Sister (s): _____

Social History:
Have you ever been treated for an on the job injury? ☐ Yes ☐ No. Year of Injury:_____
Do you: ☐ Smoke ☐ Chew Tobacco ☐ Drugs ☐ Drink Coffee ☐ Drink Tea
☐ Drink Alcohol ☐ Exercise

Signature: _____ **Date:** _____

Review of Health Systems (Please check all that apply)

Diabetes: ☐ Type I ☐ Type II ☐ Other: _____

Eyes: ☐ Glasses ☐ Cataracts ☐ Vision Problems ☐ Glaucoma

ENT: ☐ Hearing Disorder ☐ Tinnitus ☐ Vertigo ☐ Ear Infection ☐ Nosebleeds ☐ Swallowing Disorders ☐ Neck Masses

Pulmonary: ☐ Shortness of Breath ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Tuberculosis ☐ Emphysema ☐ Difficulty Sleeping

Cardiovascular: ☐ Chest Pain ☐ Palpitation ☐ Murmur ☐ Blood Pressure ☐ Cramps at Night ☐ Radiation of Pain Down Legs ☐ Leg Cramps While Walking ☐ Varicose Veins ☐ Easy Bruising ☐ Blood Clots in Legs ☐ Swelling of Feet or Ankles ☐ Superficial Phlebitis ☐ Bleeding Problems ☐ Blood Transfusion

GI: ☐ Ulcer ☐ Gallbladder ☐ Bowel Irregularity ☐ Hepatitis ☐ Rectal Bleeding ☐ Hiatal Hernia ☐ Reflux ☐ Liver Problems

GU: ☐ Incontinence ☐ Infection ☐ Venereal Disease ☐ Kidney Disease ☐ Sexual/Menstrual

Skin: ☐Scars ☐ Rashes ☐ Infections ☐ Skin Cancer ☐ Skin Changes

Musculoskeletal: ☐ Arthritis ☐ Osteoporosis ☐ Fractures ☐ Significant Joint Pain

Neurological: ☐ Dizziness ☐ Fainting ☐ Headaches ☐ Nerve Disorder ☐ Epilepsy ☐Seizures ☐ Numbness in Feet ☐ Stroke

Psychiatric: ☐ Depression ☐ Anxiety ☐ Mental Illness ☐ Chemical Dependence

Hematologic / Immune: MC Anemia ☐ Bleeding Disorder ☐ Allergies / Hay Fever ☐ Positive HIV

Other: ☐ Cancer (Type): _____ ☐ Currently Pregnant

The above information is complete and accurate to the best of my knowledge. I hereby give permission for Lake Health Care Center to examine and perform necessary diagnostic testing and treatment related to my condition. I hereby authorize and clinically indicate photographs or x-rays or area(s) of complaint.

_____ _____

Signature of Patient / Parent / Guardian **Date**

Lake Health Care Center, INC.
Phone (352) 357-8615 Fax (352) 357-5873
Tax ID # 59-3081973

Direct Payment Authorization with Assignment of Benefits & Policy Rights

The undersigned _____, by way of original or copy hereof, hereby assigns the benefits of insurance with _____ ("Insurer") to make payments directly to Lake Health Care Center, Inc. (LHCC) for services rendered to the patient by LHCC, which were necessitated by illness or medical conditions requiring treatment. The undersigned authorizes and directs Insurer to make any and all benefits payment for services rendered by LHCC only, and to forward the same to LHCC's place of business, being 910 Mt. Homer Road Eustis, FL 32726. The undersigned has read the information herein and it is true to the best of his or her knowledge and belief.

This assignment includes, but is not limited to, all rights to collect benefits directly from Insurer for services that the undersigned has received and all rights to proceed against Insurer in any action, including legal suit, if for any reason Insurer fails to make payments of benefits due to the undersigned or his or her assignee.

As part of this assignment of rights and benefits, which becomes binding upon Insurer upon receipt of said assignment, I hereby instruct Insurer that, in the event of dispute of medical benefits for any reason, including medical reasonableness and / or necessity, that the amount of benefits claimed by LHCC is to he held in abeyance and not disbursed until the resolution of any legal proceedings brought by LHCC.

The undersigned agrees to pay, in a current manner, any applicable deductible, co-payment or professional service charges over and above this insurance payment that is not covered by the Insurer.

The undersigned has assured his or her physician at LHCC that Insurer is the ONLY third party or payer he or she is authorizing to review his or her claims for payment. DO NOT send the undersigned's insurance assignment or bills to other networks, brokers, reprising groups or enter him or her into a "silence PPO" chain or blind / non-directed PPO. The undersigned's physician has accepted me for treatment on this basis only.

Signature: _____ Date: _____

Name of Insurance Company: _____Claim #: _____
Address: _____ Fax #: _____
Policy #: _____ Group #: _____ Deductible $: _____Copay: $_____
Termination Date: _____ Effective Date: _____ Coinsurance: _____
Name of Adjuster: _____ Phone: _____ Ext: _____

The undersigned hereby accepts assignment of the insurance benefits for the services rendered to the above named patient and to be paid directly to LHCC under the above named insurance coverage in accordance with Florida Statutes. The undersigned understands that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement containing false, incomplete or misleading information is guilty of a felony of the third degree. The undersigned has read the information herein and it is true to the best of his or her knowledge and belief.

By: _____ Date: _____
Print Name: _____

Please confirm the above patient's coverage by faxing to LHCC ASAP. *If receiving this by fax, Lake Health Care Center certifies that an original of this document is on file with the patient's signature.

Consent for Treatment

I am giving general consent to be seen by a physician(s) at Lake Health Care Center. The physician I am seeing will explain the diagnosis, prognosis, nature, purpose and description of the proposed treatment and procedures; he or she will explain the risks and benefits of the proposed treatment or procedure, including the likelihood of success, as well as any alternatives; he or she will provide these explanations regardless of the cost of the treatment options or the extent of which they are covered by health insurance; he or she will also discuss the risks and benefits of NOT receiving or undergoing treatment or procedure.

Signature: _____ Date: _____

Patient Self Determination Act

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida statutes, please answer the following questions.

Declaration to Decline Life-prolonging Procedures (Living Will)

- ☐ I have made such declarations.
- ☐ I have NOT made such declarations

Health Care Surrogate

- ☐ I have designated a health care surrogate.
- ☐ I have NOT designated a health care surrogate.

Durable Power of Attorney

- ☐ I have appointed a durable power of attorney (POA) for health care decisions.
- ☐ I have NOT appointed a durable power of attorney (POA) for health care decisions.

Signature: _____ Date: _____

Consent to Use & Disclose Information for Treatment, Payment or Health Care Operations

The Patient hereby consents to the use and disclosure of his or her protected health information ("PHI","medical records") by Lake Health Care Center (LHCC) in order to carry out treatment, payment, or health care operations. The Patient should review the LHCC'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.

LHCC reserves the right to change the terms of its Notice of Privacy Practices at any time. If LHCC does change the terms of its Notice of Privacy Practices, the Patient may obtain a copy of the revised Notice.

The Patient retains the right to request that LHCC further restrict how his or her PHI is used and disclosed to carry out treatment, payment, or health care operations. LHCC is not required to agree to such requested restrictions; however, if LHCC does agree to the Patient's requested restriction(s), such restrictions are then binding on the practice.

The Patient acknowledges and agrees that LHCC may disclose his or her PHI to the following individuals who are either his or her family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

The Patient agrees that LHCC **MAY NOT** 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
_____ If the Patient is under the age of eighteen, Pregnancy Information

Backside —>

The Patient agrees and consents to LHCC releasing information to him or her in the following alternative manners (please initial the appropriate spaces below):

_____ Via Regular Mail with the envelopes being marked personal and confidential addressed to the Patient.
_____ Via Telephone, if the Patient contacts LHCC and provides the appropriate information (including his or her name, social security number and unique personal identifier).
_____ Appointment reminders and messages to contact the office due to test results.

At all times, the Patient retains the right to revoke this consent. Such revocation must be submitted to LHCC in writing. The revocation shall be effective except to the extent that the practice has already taken action through prior consent.

LHCC may refuse to treat the Patient if he or she (or an authorized representative) does not sign this consent form. If the Patient (or authorized representative) signs this consent and then revokes it, LHCC has the right to refuse to provide further treatment to him or her 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 received a copy of this consent, and I am the Patient or am authorized to act on behalf of the Patient to sign this sealed document verifying consent to the above stated terms.

_____ _____

Signature of Patient (or Authorized Representative) **Date**