Roberto Garcia, M.D., P.A.

Diplomate of the American Board of Allergy, Asthma and Immunology

Who may we thank for referring you today? _____

Where did you find our contact info? ☐ Google ☐ Friend /Relative ☐ Insurance Co. website ☐ ZocDoc ☐ Health Grades ☐ Yellow pages ☐ Other _____

Patient Identification: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

LAST NAME _____ **FIRST** _____ **M.I.** _____

AGE _____ D.O.B. _____ Social Security # _____ - _____ - _____

Address _____ City/State_____ ZIP _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Patient Occupation _____ Employer's Name _____

Employer Address_____ City/State_____ ZIP_____

Primary Care Physician_____ Phone (____) _____

PCP Address_____ City/State/Zip _____

Pharmacy _____ Phone: (____) _____

FINANCIAL RESPONSIBILITY (If alternative from patient)

LAST NAME_____ **FIRST**_____ **M.I.**_____

Social Security #_____D.O.B_____ Relationship to patient_____

Address_____ City/State_____ ZIP_____

Home Phone (___) _____ Work Phone (___) _____ Employer_____

Employer Address_____ City/State_____ ZIP_____

YOU ARE RESPONSIBLE FOR PAST BALANCES AND COPAYMENTS. UNLESS THESE BALANCES ARE PAID, WILL NEED TO RESCHEDULE YOUR APPOINTMENTS. WE DO NOT FILE SECONDARY INSURANCES.

[ ] I consent to release my images/photos and clinical data related to the allergy diagnosis for research purpose.

[ ] I do not want my photos, images or clinical data released for research purpose.

I consent to the treatment necessary for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I understand and allow confirmation of appointments to be called to my home and if necessary a message left on my answering machine. I acknowledge full financial responsibility for services rendered by Dr. Roberto Garcia MD. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Dr. Roberto Garcia MD, PA should they elect to receive such payment. I have read and fully understand the above consent for treatment, financial responsibility, release of medical records, and insurance authorization.

This office participates in a program that allows us to obtain prescribed medication information and refill history from participating pharmacies and insurance companies. In order for us to obtain your medication history, you must give your consent. Please select one of the following consent types.

- ◯ All medication history.
- ◯ Only those medications prescribed by my provider.
- ◯ All medication history. (Consent given by patient's parent or guardian.)
- ◯ Only those medications prescribed by my provider. (Consent given by patient's parent or
- ◯ No medication history may be obtained from outside sources.

SIGNATURE_____ DATE: _____

FORM COMPLETED BY: _____

CLINIC: _____Sheldon ____ S.Tampa ____ Lutz

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OFFICE BILLING POLICY

1. Self pay patients, full payment by the patient is required at the time service is rendered.
2. On all HMO, PPO, PPC, BC/BS of Florida, Medicare and Medicaid policies, the patient is responsible for his/her co-payment at the time of service. There will be no exceptions.
3. During the early phase of the diagnosis of allergic or chronic respiratory problems it is necessary to perform diagnostic procedures that provide useful information about the condition that affects the patients. In the follow-up process it may be necessary to perform these procedures again from time to time depending on the severity of the condition. These include pulmonary function tests and skin testing.
4. If the patient needs immunotherapy, the office will bill the insurance company and the patient is responsible for the amount the insurance company does not pay, (or the patient portion that is set by insurance company).
5. Should your insurance company not pay for pre-existing conditions, or termination of policy you will be responsible for payment in full.
6. **PATIENTS WITHOUT A REFERRAL WILL NOT BE SEEN BY THE DOCTOR**.
7. WE DO NOT BILL ANY SECONDARY INSURANCE, therefore the 20% is expected at the time of the visit and you are expected to file your own secondary insurance.

If it is necessary for the bill to be turned over to a Collection Agency for litigation, all costs, including attorney and court fees will be paid by patient.

******* I understand that I will be responsible for the payment of any services that my insurance company will not cover. *****

I understand that I may be charged 1.5% interest rate per month on any unpaid balance.

I authorize and request payment to be made to Dr. Roberto Garcia, MD, PA by my insurance company.

Patient Signature_____ Date_____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and the request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social security Act and 31 USC 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also applies.

SIGNATURE_____ Date_____

10940 Sheldon Rd Tampa, FL 33626 • PHONE (813) 926-4058 • FAX (813) 926-9872
508 S. Habana Ave Ste 210 Tampa, FL 33609 • PHONE (813) 873-9010 • FAX (813) 926-9872
21756 State Rd 54 Ste 102 Lutz, FL 33549 • PHONE (813) 948-0081 • FAX (813) 926-9872

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PATIENT RECORD OF DISCLOSURES

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

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

Please check your preferred phone number:

☐ Home telephone_____

☐ Work phone _____

☐ Cell phone _____

___Leave call-back number only

___Leave message with detailed information

___Leave a message with call-back number

☐ Written communication via USPS

___Via mail to my home address

___May mail to work/office

☐ Other_____

☐ May contact family member, spouse, partner, friend (name and phone number) _____

_____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for HI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosure made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided on this sheet, if completed properly will constitute an adequate record.

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GUIDELINES FOR COMPLIANCE OF TREATMENT IN THE OFFICE

During your course of treatment, Dr. Roberto Garcia will make certain recommendations for your asthma and/or allergic disease.

These guidelines will include medical guidance, treatment, prescriptions, environmental recommendations, keeping the practice informed of changes or cancellations of medications, and keeping appointments.

Environmental recommendations can include encasing mattresses and pillows and keeping humidity levels lower than 50% in your household

Medication requests will not be refilled if you have not had an office appointment within 3 months.

Noncompliance to medication and no shows for appointments can result in a dismissal letter from the practice.

I accept medical guidelines and treatment.

Patient :

_____	_____	_____
Signed	Print	Date

Parent/Guardian

_____	_____
Signed	Print

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Cancellation/No Show Policy For Doctor Appointments and Skin Test Appointments

Thank you for selecting me as your medical care provider. You are a valued patient at our clinic. As you are aware, I am dedicated to treatment of the whole patient and not just illness. When we schedule appointments, we set time and professional resources to meet your individual needs. When a patient fails to show up for an appointment, or cancel with less than 24 hours notice, our valuable resources are idle and a patient care opportunity is lost.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances. In this event we ask that you call our office to avoid **A Missed Appointment Fee of $20.00**. This allows my office staff to schedule another patient who is in need of medical care. Again, I am committed to provide you with best care possible and to answer any questions you may have regarding your health and well-being.

Skin Test Appointment: Due to the extended amount of time needed for skin test appointments, last minute cancellations or no show appointments without 72hrs notice prevents us from scheduling another patient for that slot. **No Show** OR **Same Day Cancellation** fee will be **$50.00**.Unfortunately until the fee is satisfied you will not be able to reschedule your skin test appointment.

THANK YOU,

Roberto Garcia, MD

_____ _____
(Patient / Legal Guardian signature) Date

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