CLARISSA ABRANTES, MD **NIRALI PATEL, PA-C**
749 CR 466 Lady Lake FL 32159 P. (352) 350-5130 F. (352) 350-1684
www.mypulsemds.com

Demographic Information

Last Name: _____ **First Name:** _____ **Mid Int:** __

Date of Birth: _____/_____/_____ **SS#:** _____-____-_____ **Gender:** M F

Marital Status: __Single __Married __Widowed **Preferred Language:** English; Spanish; ____

Race: ___American Indian/Alaskan ___Asian ___African American ___Caucasian

___Hawaiian ___ Other: _____ ___Decline

Ethnicity: ___Hispanic/ Latino ___Not Hispanic/ Latino ___ Decline

Florida State Address: _____ **City:** _____ **Zip:** _____

Phone: Home: (___)_____-_____ **Cell:** (___)_____-_____ **Work:** (___)_____-____

Email: _____@_____.com

2nd Address: _____**City:** _____ **Sate:**_____ **Zip:** ___

Pharmacy Name: _____ **Phone:**(_____)_____-____

Emergency Contact Name:_____ **Phone:** (_____)_____-____

I authorize Pulse MD to release to any insurance company/Medicare or its carriers any information needed to process and pay my claims. I permit a copy of this to be used for that purpose and to request payment of medical insurance and medical benefits to be made directly to Pulse MD. I understand that it is mandatory to inform the healthcare provider of any other party who may be responsible for paying any deductible amount, co- pay, or any percentage fees not paid by the insurance company of third party within a reasonable time which is not to exceed 60 days. I also authorize payment of my insurance/ Medicare benefits to be paid directly Pulse MD for my treatment. I also understand that it is my responsibility to pay any unpaid amounts not paid by the insurance company/Medicare.

Insurance regulations suggest that we inform you in advance of we believe a service may not be covered or fully reimbursed by your insurance. In the doctor's professional judgment certain services are needed in order to give high quality healthcare and to help provide a diagnosis, but some services may not be reimbursed by them. These services may include but are not limited to an EKG, labs, biopsy, etc. Aegis Medical Group will only perform these services when required and the results will help us to provide you with quality health care.

Patient Agreement: I certify that I have read and fully understand the above information. I understand that I will be responsible for payment of any medically necessary services should they be denied by my insurance. I understand that I have the right to accept and refuse medical treatment.

_____ _____ _____/ _____/ 20____
Signature Printed Name Date

Pulse MD

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Advance Directive/ Living Will/ Power of Attorney/ 5 Wishes/ DNR

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply: We would like a copy for our records.

___ I have executed an Advanced Directive ___ I have NOT executed an Advance Directive

Check the one(s) you have and can provide copies of to our office:

□Living Will □Durable Medical Power of Attorney □5 Wishes □Do Not Resuscitate (DNR)

_____ _____ _____/ _____/ 20____

Signature Printed Name Date

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Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Pulse MD to use and disclose protected health information about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Pulse MD describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pulse MD 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 Pulse MD.

With this consent, Pulse MD may call my place of residence or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Pulse MD may mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pulse MD restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow Pulse MD to use and disclose 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, or later revoke it, Pulse MD may decline to provide treatment to me.

TPO Definition: Treatment, Payment, Operation

_____ _____ _____/ _____/ 20____

Signature Printed Name Date

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HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

I authorize Pulse MD to use and disclose my protected health information as described below:

1. Extent of Information to be released
   a. I authorize the release of my COMPLETE health record (including records relating to my mental health as well as treatment of alcohol and/ or drug abuse **initials: _____**
   b. I authorize the release of my COMPLETE health record with the **EXCEPTION** of the following information: (please initial next to the records to exclude)
      1. _____ Mental Health records
      2. _____ Alcohol/ drug abuse treatment
      3. _____ Other: (please specify):_____
2. This medical information may be used by the entity I authorize to receive this information for medical treatment, consultation, billing/ claims, payments, or other purposes as I may direct.
3. This authorization shall be in force and effective until
   a. _____ (list date)
   b. Twelve months from date this form is signed **initials:_____**
4. I understand that I have the right to revoke this authorization at any time. I further understand that in order to revoke I must submit in writing. I understand that the revocation is not effective to the extent that any person/ entity has already acted in reliance on my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, and/ or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws.
7. I authorize the release of information to include diagnosis, records, exams rendered to me, and claims data to the following individuals:
   a. Spouse: Name: _____
   b. Child(ren): Name(s)_____
      _____
   c. Other (please indicate relationship) _____

8. Messages regarding my healthcare may:
   a._____ (initial) be left on any one of my messaging systems using the numbers I have provided
   b._____ (initial) NOT be left on any messaging system. I would like a message to return the provider's call instead.

_____ _____ _____/ _____/ 20____

Signature Printed Name Date

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Prescription Pick- up Authorization

Last Name: _____ First Name: _____

Date of Birth: _____/ _____/ _____

I hereby authorize the individual (s) listed below to pick up my prescribed prescription(s) from any of the Pulse MD locations. Pulse MD's staff reserves the right to request proof of identity to pick up any prescriptions. My representative must be able to provide a valid photo identification. I further understand that any individual who is not listed will NOT be able to pick up my prescriptions. I am able to change this authorization at any time but understand that the changes MUST be submitted in writing to Pulse MD.

Name of authorized person (please print legibly)	**Relationship to patient named above**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____ _____/ _____/ 20____

Signature Printed Name Date

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Consent to Release Confidential Information

Last Name: _____ First Name: _____

Last 4 of SS#: _____ Date of Birth: _____/ _____/ _____

I hereby authorize that a copy of my medical records be released to the following:

Records to be released to: Records to be released from:

Pulse MD _____

Phone: _____
Fax: _____

Please initial next to option of your choice:

_____ This release is to cover **ALL** records contained in my medical chart to include psych, drug, & any alcohol treatments.

_____ This release is to cover ALL records contained in my medical chart EXCEPT:

_____ Any psychiatric records/ treatment

_____ Any drug related records/ treatment

_____ Any alcohol related records/ treatment

I understand that the purpose of the record release is for continuity of my medical care. The information contained in my medical records (s) may include diagnosis, evaluation and/ or treatment of any mental or emotional condition (s). This may also include alcohol and/ or drug related addictions. Information regarding HIV infection with any probable causative agent of AIDS are also considered a part of my medical record. The expiration of this release is one year from the date of signature. I may revoke this authorization at any time by notifying and providing Pulse MD in writing. The written revocation will be effective on the date of notification except to any actions already taken. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal privacy regulations. By authorizing the use or disclosure if information, there will be no conditions placed on my health care of payment of my health care. I have the right to receive a copy of this form after I have signed it. In compliance with Florida State Law, I may be required to pay a fee for any retrieval and photocopying of records and/ or supervising inspections of medical records.

_____ _____ _____/ _____/ 20____

Signature Printed Name Date

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Patient Responsibility Form

1. The patient is responsible for providing Pulse MD with the most correct, active and up to date information about their insurance prior to each visit.
2. Pulse MD will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines by providing correct information at tine time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.
3. Patients are responsible for the payment of co-pays at the time of service.
4. Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
5. Pulse MD is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance
6. In the event a patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.
7. Patients have the right to check with their insurance about coverage before receiving any service provided at Pulse MD.
8. The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether our physicians participate.
9. The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.
10. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.
11. Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.
12. The patient agrees that in return for the services provided to them by Pulse MD, they will pay their account at the time service is rendered or upon insurance claim processing- If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If copayments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to Aegis Medical Group.

Worker's Compensation and Automobile Claims

Pulse MD does **not** accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding Pulse MD's policies regarding patient responsibilities.

_____ _____ _____/ _____/ 20____

Signature Printed Name Date