Pulse MD

Welcome to Pule MD! As a New Patient, you ask that you provide us the following information in order to better serve your ongoing care. If, at any time, this information changes, we request that you notify us immediately to prevent any interruption in your care.

Please Print:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Preferred Language: _____

Email Address: _____

Marital Status: Single_____ Married_____Widowed_____Divorced_____Never Married ____

Race: _____American Indian/Alaskan _____Asian _____African American _____Caucasian

_____Hawaiian _____Other (please specify): _____ _____Decline to Answer

Ethnicity: _____Hispanic/Latino _____Non-Hispanic/Latino _____Decline to Answer

Male_____ Female_____ Transgender_____ Non-Binary_____ Prefer not to answer_____

Florida Address: _____City/ST/Zip_____

Preferred Phone: (_____) _____ - _____ Is this a mobile phone: YES NO

Secondary Phone: (_____) _____ - _____ Is this a mobile phone: YES NO

Secondary Address: _____City/ST/Zip_____

Emergency Contact: In the event we are unable to reach you, who should we contact (do not list someone in the same household unless they have a different contact number)?

Name: _____ Phone: (_____) _____ - _____

Relationship to you: _____

Please Note: Health Information will NOT be released to this person unless they are named on your privacy form.

Pharmacy Information:

Preferred Local Pharmacy: _____

Street Address: _____ Phone: (_____) _____ - _____

Mail Order Pharmacy: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Insurance Information:

Primary Insurance _____ Member/Subscriber #: _____

Group # _____ Phone: (_____) _____ - _____

Is this policy in your name? YES NO If not, name of insured: _____

Secondary Insurance _____ Member/Subscriber #: _____

Group # _____ Phone: (_____) _____ - _____

Is this policy in your name? YES NO If not, name of insured: _____

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 of fees not paid by the insurance company of any 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 to Pule MD for my treatment. I also understand that it is my responsibility to pay any unpaid amounts not paid by the insurance coverage/Medicare.

Insurance regulations suggest that we inform you in advance if we believe a service may not be covered or fully reimbursed by your insurance. In the doctors' 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 insurance. These services may include but are not limited to an EKG, labs, biopsy, etc. Pulse MD will only perform these services when required and the results will help us to provide you with quality health care.

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.

Patient printed name: _____

Patient Signature: _____ Date: _____

Pulse MD

Clarissa Abrantes, MD Dianna Bridges, APRN Youssef Aouni, APRN
749 CR 466 * Lady Lake, FL 32159 * Phone: (352) 350-5130 * Fax: (352) 350-1684
www.mypulsemds.com

Pulse MD Financial Policy

1. As a courtesy, we will file your primary and secondary insurance. It is your responsibility to make sure that your insurance company has your most recent address and contact information, and that we have the most recent insurance information for you.
2. We are required to make a copy of your insurance cards for verification purposes, so please be sure to bring your cards and a government-issued photo ID to each visit.
3. It is your responsibility to pay your deductible, co-payment and non-covered service fees at the time of service. For your convenience, we accept cash, checks, and Visa, Mastercard and American Express credit cards. There is a $25 charge on all returned checks.
4. Should you miss your appointment or cancel less than 24 hours prior to a scheduled appointment, there will be a service charge of $25 charge.
5. Questions regarding the amount your insurance paid to our office must be directed to your insurance company as they are the ones who have the specifics on coverage. If payment is not received within 30 days of the filing date with your insurance, you will be responsible for paying those charges, and will need to seek reimbursement directly with your insurance company.
6. Should your care require outside testing, you will be responsible for payment to those providers, and providing your insurance information to them for payment.
7. Should you require completion of forms for any reason (FMLA, Workers' Compensation, etc.) there is a $25 charge. In addition, please allow for 72 business hours for form completion. Payment due prior to release of forms.
8. I understand that if I have now or in the future any form of Power of Attorney with regard to my medical care, I will need to provide a copy of the document to Pulse MD before they can allow the individual named within to act in my place.

I have read and understand the financial policy and agree to abide by the terms as directed.

Patient (or Legal Guardian) Name: _____

Patient (or Legal Guardian) Signature: _____

Date: _____ Pulse MD Signature: _____

Pulse MD

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency,) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

III. MEDICARE/MEDICAID – As patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or co-payment at the time of service, and any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____

Date: _____

The Patient and Practice Relationship and Code of Conduct

Our goal is to provide all patients with high quality health care in a manner that clearly recognizes an individual's needs and rights. We also recognize that in order to accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. As a result, the following patient rights and responsibilities are shared.

AS A PATIENT YOU SHOULD EXPECT:

- To receive considerate care that is respectful of your personal beliefs and cultural and spiritual values.
- To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment.
- To appropriate assessment and management of your symptoms, including pain.
- To know the contents of your medical records through interpretation by the provider.
- To know who it is that is interviewing and examining you.
- To have explained to you ways that you can prevent your medical problem from recurring.
- To refuse to be examined or treated by health practitioners and to be informed of the consequence of such decisions.
- To be assured of the confidential treatment of disclosures and records and to have the opportunity to approve or refuse the release of such information except when release of specific information is required by law or is necessary to safeguard you or the community.
- To participate in the consideration of ethical issues that arise in the provision of your care.

AS A PATIENT YOU HAVE THE RESPONSIBILITY:

- To provide Pulse MDs with information about your current symptoms, including pain.
- To provide Pulse MDs with information about past illnesses, hospitalizations and medications.
- To ask questions if you do not understand the directions or treatment being given by a provider.
- To keep appointments or telephone the office at least 24 hours ahead if you need to cancel.
- To be respectful of others and others' property while in our facility.
- To keep an up-to-date list of all medications, and to contact the office if there are any changes. To monitor prescription refill status and to initiate the refill process with a minimum of one week of medication remaining
- To treat all staff members with common courtesy whether in office or through other means of communication.

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____

Date: _____

Pulse MD

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. 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.
4. Patients have the right to check with their insurance about coverage before receiving any service provided at Pulse MD.
5. 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.
6. 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.
7. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.
8. 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.
9. 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.

Pulse MD

Prescription Refill Policy

We understand how important it is to always have an adequate supply of your prescription medications available to you. The best way to prevent running out of your medications is to keep a log of your medications and request refills at your regular appointments. We will make every attempt to provide you with your medications well in advance of your need, and as such, provide you with numerous ways you can request a refill before you run out.

- **Patient Portal Requests**: the fastest and most efficient method of requesting a refill, accessing your account via the Healow app only requires 24 hours for processing refill requests.
- **Pharmacy Requests**: when your prescription needs to be refilled but you have none left, your pharmacy will reach out to us for a refill authorization. Please allow for at least 72 hours to process a pharmacy request for refill.
- **Patient Refill Line**: you can call our convenient patient refill line by dialing our office and selecting the appropriate prompt for prescription refills. Please note that all requests made through the patient refill line will require at least 72 hours for processing.
- **In-Person Requests**: you can come to the office for a refill request, but all such requests must be entered manually, and will need at least 72 hours for processing.

If you are completely out of a medication, you can reach out to your pharmacy for an emergency extension of the prescription (generally 3 days' medicine). Please note that in some cases, refill requests cannot be honored without an office visit. In most cases, requests for refills on controlled substances will require an office visit. Please do not use several methods to request a refill on the same medication.

I have read and understand the prescription refill policy.

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____

Date: _____

Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). At Pulse MD, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice: You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information: Each time you visit Pulse MD, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves numerous purposes:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving public health
- A source of data for our planning and marketing
- A tool with which we can assess and work to improve care and outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights: Although your health record is the physical property of Pulse MD, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524
- Request to Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: Pulse MD is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Pulse MD reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of How Pulse MD May Use or Disclose Your Health Information:

For Treatment--Pulse MD may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in

your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them during your treatment and note how you respond to those actions.

For Payment—Pulse MD may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used during treatment.

For Health Care Operations--For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide.

For Appointments—Pulse MD may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

For Business Associates--Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

For Directory--Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

For Notification, or Communication with Family Members--Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

For Research--We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

For Funeral Directors--We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

For Organ Procurement Organizations--Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

*For Food and Drug Administration (FD*A)--We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

For Workers Compensation--We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

For Public Health--Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

When Required by Law—Pulse MD may use and disclose information about you as required by law. For example, Pulse MD may disclose information for the following purposes: For Judicial and Administrative Proceedings Pursuant to Legal Authority; To report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For Health and Safety--Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

For Government Functions--Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Officer at Pulse MD, 749 CR 466, Lady Lake, FL 32159 * 352-350-5130 * 352-.350-1684. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

The address for the OCR is listed below: Office for Civil Rights - U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201 866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Pulse MD is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for: Pulse MD

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____

Date: _____

Pulse MD

Patient Name: _____

Date Completed: _____

Providers Involved in My Care

Please provide the following information for any providers involved in your healthcare either currently, or within the last five years.

Type:	Doctor	Phone	City and State
Cardiologist			
Dermatologist			
ENT			
Gastroenterologist			
OB/GYN			
Nephrologist			
Oncologist			
Opthalmologist			
Orthopedist			
Phych (counselor)			
Pulmonologist			
Rheumatologist			
Urologist			

Most Recent Primary Care Physician: _____

Phone Number: _____

Patient Name: _____

Date Completed: _____

Family Medical Health History

Please complete the following information for your blood (genetic) relatives only.

Relative Type	Living or Deceased	Current Age or age at death	Cause of Death	Any Known Health Conditions:
Father				
Mother				
Brother(s)				
Sister(s)				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Children				

◯ I was adopted

Legal Documentation

An Advanced 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, and provide a copy of each document to our office. We can scan the original and return it to you for your convenience while you wait.

I understand that I have the right to accept and or refuse medical treatment, and to exercise my right in the implentation of an Advanced Directive. I have the following Advanced Directive(s), and agree to provide a copy to Pulse MD:

- ◯ Living Will
- ◯ Durable/Medical Power of Attorney
- ◯ 5 Wishes
- ◯ Do Not Rescusitate (DNR)
- ◯ I do not have an Advanced Directive

Patient Printed Name: _____ Patient Signature: _____

Date: _____

Pulse MD

Patient Name: _____

Date Completed: _____

Current Medications

Please provide the following information for any medication you currently take on a regular basis. Be sure to include any vitamins, supplements, nutritional program items or other over-the-counter medications you take.

Medication	Strength	Times/Day	Special Instructions ("take with food", etc.)

Pulse MD

Patient Name: _____

Date Completed: _____

Prevention and Maintenance of your Health

Please provide the details for the vaccines and procedures requested below.

Type	Date	Type	Date	Type	Date
Flu Shot		Mammogram		Heart Cath	
Pneumonia Shot		Pap Smear		Echocardiogram	
Shingles Shot		Last Menses		Stress Test	
Hepatitis B		Hysterectomy?		Chest X-Ray	
Covid #1		Bone Density		PSA Test	
Covid #2		Colonoscopy		Dermo Exam	
Covid Booster #1		Polyps? Y N		Hearing Test	
Covid Booster #2		Endoscopy		Eye Exam	
Tetnus		Barrett's? Y N			

Please describe: _____

Pulse MD

Patient Name: _____

Date Completed: _____

Prior Medical History

Surgical History - Please include any major surgeries you've ever had.

Procedure	Date

Hospitalizations within the last year not included above:

Reason	Date

Have you ever had a blood transfusion? Y N If yes, how many? _____

Reason? _____

Fractures

Type/Bone	Date

Pulse MD

Patient Name: _____

Date Completed: _____

Chronic Medical Conditions

Please select any chronic conditions for which you have been diagnosed and been treated in the past. Please provide details whenever possible.

Condition	Date	Condition	Date	Condition	Date
Cardiovascular		**Gastrointestinal**		**Neurology**	
CAD CHF		GERD/Acid Reflux		Seizures	
Heart Attack		Cirrhosis		Stroke	
Pacemaker		Hepatitis		Epilepsy	
Defibrillator		Gastritis		TIA	
A Fib		Diverticulosis		Dementia	
Heart Arrythmia		Hemorrhoids		Alzheimer's Disease	
Hypertension		IBS		Neuropathy	
High Cholesterol		Urinary Incontinence		Migraines	
DVT/PE		Bowel Incontinence		Parkinson's Disease	
Peripheral Vascular Disease		**Pulmonary**		**Orthopedic**	
Valvular Disease		COPD		Gout	
Other		Asthma		Osteoarthritis	
Endocrine		Bronchitis		Osteoporosis	
Diabetes		Sleep Apnea		Scoliosis	
Hyperthyroidism		Chronic Cough		Sciatica	
Hypothyroidism		**Psych**		**Other**	
Autoimmune		Anxiety			
Rheumatoid Arthritis		Depression			
Psoriasis		PTSD			
Lupus		Other			

Patient Name:_____

Date Completed: _____

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

I authorize Pulse MD to use and disclose my protected health information (PHI) 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):
        i. _____ Mental Health records
        ii. _____ Alcohol/drug abuse treatment
        iii. _____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 effect until
    a. _____ Date, **OR**
    b. Twelve months from the date of this form: _____ **INITIALS**
4. I understand that I have the right to revoke this authorization at any time, and it must be done 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 or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest the claim.
5. I understand 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 not 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 (please print):
    a. _____ Relationship _____
    b. _____ Relationship _____
    c. _____ Relationship _____

8. Messages regarding my healthcare **MAY** _____ (initials) **MAY NOT** _____ (initials) be left on any on of the messaging systems using the numbers I have provided.

Patient Signature: _____ Date Signed: _____

Clarissa Abrantes, MD
Dianna Bridges, APRN * Youssef Aouni, APRN

749 CR 466, Lady Lake FL 32159
Phone: (352) 352-5130 * Fax: (352) 350-1684

Consent for Release of Confidential Information

Last Name _____ First Name _____
Date of Birth: _____ / _____ / _____ Last 4 Digits of SS#: _____

I hereby authorize a copy of my medical records be released to Pulse MD:

From: _____ (physician name)
_____ (practice name)
Phone: (_____) _____-_____ Fax: (_____) _____-_____
City/State: _____

From: _____ (physician name)
_____ (practice name)
Phone: (_____) _____-_____ Fax: (_____) _____-_____
City/State: _____

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**

OR

I authorize the release of my COMPLETE health record **with the EXCEPTION of** the following information (please initial next to the records to exclude):

i. _____ Mental Health records
ii. _____ Alcohol/drug abuse treatment
iii. _____ Other: (please specify): _____

I understand that the purpose of the records release is for continuity of my medical care. The information contained in my medical records may include diagnoses, evaluations and or treatments of any mental or emotional conditions. This may also include alcohol and or drug related addictions. Information regarding HIV infection with any probably causative agent of AIDS are also considered a part of my medical record. This expiration of this release is one year from the date of signature. I may revoke this authorization in writing at any time, and it will be effective immediately except for any action already in progress. Any information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by regulations. By authorizing the use of disclosure of information, there will be no conditions placed on my healthcare. 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 retrieval and or photocopying of records and or supervising inspections of medical records.

_____ _____
Patient Signature Date Signed