ADVANCED MEDICAL, PA
Palomino Park III
3347 SR 7, Suite 206
Wellington, FL 33449

NEW PATIENT INFORMATION

PERSONAL INFORMATION

Name:

_____

Address:

_____

City:_____ State:_____ Zip Code: _____

Email:

_____

Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date: ____/____/____ Sex: Female ___ Male____

Race:_____

Social Security:_____

Employer_____

Occupation:_____ Fulltime ___ Part time ____ Retired ____ Student ____

Married ____ Widowed ____ Divorced ____ Legally Separated ____ Single ____

SPOUSES INFORMATION

Spouse name:

_____

Work Phone : _____ Cell Phone: _____

Emergency contact person:

_____

Phone: _____ Work Phone: _____ Cell Phone:_____

INSURANCE INFORMATION

Insurance Carrier: _____Policy Holder's name:

_____

Address:
_____

Birth date ____/____/____ Social Security:
_____

Secondary Insurance Carrier _____Policy Holder's Name:
_____

Address:
_____

Birth date: ____/____/____ Social Security:
_____

***PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD (s) AND A COPY OF YOUR DRIVER'S LICENSE**

HEALTH HISTORY

What is your main complaint or concerns that you need to be seen by the physician:
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

(Medical diagnosis that family members have (i.e. High blood pressure, Cancer, etc)

Father:
_____

Mother:
_____

Grandfather Maternal:
_____

Grandmother Maternal:
_____

Grandfather Paternal:
_____

Grandmother
Paternal:_____

Siblings:

_____

Children:

_____

CURRENT MEDICATIONS

Please include: Dose, Frequency, when the prescription was prescribed and the prescribing physician.

(Please be sure to include vitamins, herbal supplements and all over the counter medications)

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please list any Medication allergies

_____

_____

_____

SURGERIES

Please list previous surgeries and Diagnosis (reason surgery was performed)

- _____
- _____
- _____
- _____
- _____

SOCIAL HISTORY

_____Alcohol Use _____Regular Exercise _____

_____Illegal Drug Use _____Chemical Contacts

Pets in home

_____

Religious preference:

_____

Tobacco Use: ____ Yes ____ No Type: ____Cigarettes ____Snuff ____Pipe ____Cigar

How many years used: _____How many packs a day:_____

Have you quit: _____Yes _____ No Years since quitting: _____

OTHER TREATING PHYSICIANS AND DIAGNOSIS (reason for treatment)

1._____

_

2.

_____

3._____

_

4._____

_

POWER OF ATTORNEY

Do you have a medical power of attorney or living will? _____Yes _____ No

(If so, please provide us with a copy for our records)

SIX MONTH MEDICAL HISTORY

____ Abdominal pain ____ Acne problems ____ Addictions drugs/alcohol

____Allergies (please specify) _____ ____Anemia

____Angry feelings ____Anxious feelings

____Arthritis ____Back Pain ____Balance problems

____Black stools ____Blood clotting problems ____Blood in urine

____Bloody cough ____Blurred vision ____Breast changes

____Burning urination ____Calf pain ____Cancer

____Changes in skin lesion ____Change in voice ____Chest pain

____Chills ____ Cold intolerance ____Constipation

____Depression ____Diabetes ____Diarrhea

____Difficulty hearing ____Difficulty swallowing ____Double vision

____Eczema ____Elevated blood pressure ____Emotional/physical abuse

____Episodes of passing out ____Excess hair growth ____Extreme thirst

____Fatigue ____Feeling of hopelessness ____Feet swelling

____Fever ____Forgetfulness ___Gout attack

____Hair loss ____Heart attack ____Headache

____Heavy menstral bleeding ____Height loss ____Hemorrhoids

____Herpes/STD's ____ Hypertension ____Impotence

____Irregular heart rate ____Joint Pain ____Joint redness

____Loss of appetite ____Nausea ____ Numbness

____Pacemaker ____Painful urination ____Panic attacks

____Rash ____Recent night sweats ____Seizures

____Shortness of breath ____Sickle cell ____Sinus congestion

____Snoring ____Sore throat ____Suicide thoughts/attempts

____Thyroid disease ____Unexplained weight change ____Urinates >5 times a day

____Varicose veins ____Vomiting ____Wheezing

Please list any other medical history not listed above:

_____

_____

ADVANCED MEDICAL, PA

OFFICE POLICY

We would like to take this opportunity to welcome you to the office. Please take the time to read through some of our Office Policies:

- New Patients – New patients are expected to complete several patient information forms. Also, please present a copy of your driver's license and insurance card at time of check in.
- Co-payments – Co-payments are expected at time of service
- Referrals – As part of the HMO process, your primary physician must determine if a referral is indicated. Without first obtaining a referral from our office, your visit to a specialist will not be covered and you will be responsible for any bill from the specialist. This includes all services outside the specialist's office (i.e. X-rays, lab, etc.) Please be also advised, only physicians in the participating provider directory will be covered. Please allow seven to ten working days for obtaining a routine referral before making an appointment with a specialist. Please make sure you have the referral authorization in hand when attending your specialist's appointment. STAT referrals will be done within 24 to 48 hours.

Signature:
_____

ADVANCED DIRECTIVES

A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.
Have you prepared a living will? _____Yes _____No
The foregoing recommendations are for healthy individuals without symptoms of illness. Special conditions may change the frequency and the type of tests you desire.
Please sign below to acknowledge that you have read and understand this information.

Signature : _____Print Name:_____Date:_____

ADVANCED MEDICAL, PA

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please check below how you wish our office to contact you:

_____ Home telephone: _____

_____Leave a message with information

_____Leave a message with call back number only

_____ Work telephone: _____

_____ Leave a message with information

_____Leave a message with call back number only

_____ Written communication

_____Mail to my home address

_____Mail to work/office address

_____Fax to this number: _____

_____ Email Communication

_____ Email information to the following email address

_____

_____ List two individuals authorized for communication

- _____
- _____

_____ _____

Patient Signature Birth Date

_____ _____

Print Name Date

ADVANCED MEDICAL, PA

Dear Patients:

It is not the policy of our practice to give results over the phone. When you are scheduled for any diagnostic testing, blood work, surgery, and biopsy or have any in office procedures, you must have a follow up appointment for results and continuation of care. It is your responsibility to make and keep all scheduled appointments for follow up care. If you cannot make an appointment, it is your responsibility to reschedule that appointment. Thank you for your attention to this matter.

_____ _____

Patient Signature **Date**

ADVANCED MEDICAL, PA

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Ishan Gunawardene M.D. to use and disclose protected health information (PHI) about my medical treatment to carry out further treatment, payment and healthcare operations (TPO).

Our Privacy of Practice provides a more complete description of such uses and disclosures.

You have the right to review the Notice of Privacy Practices prior to signing this consent.

Ishan Gunawardene, MD reserves the right to revise its Notice of Privacy Practice at any time.

With this consent, Ishan Gunawardene, MD may call my residence or other alternative location and leave a message on voicemail or in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance billing and any calls pertaining to my clinical care, including laboratory results etc.

With this consent, Ishan Gunawardene, MD may mail to my residence or other alternative locations any items that assist in the practice of carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Ishan Gunawardene, MD restrict how his practice uses or discloses my PHI to carry out TPO.

With this consent, Ishan Gunawardene MD may email to my email address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Ishan Gunawardene, MD restrict how his practice uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if the practice does, the practice is bound by this agreement. By signing this form, I am consenting to Ishan Gunawardene, MD the use and disclosure for 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, Ishan Gunawardene MD may decline to provide treatment.

_____

Signature

_____ _____

Print Name Date

ADVANCED MEDICAL, PA

OFFICE FINANCIAL POLICY

We will be happy to accept your insurance as soon as our office verifies your coverage. As a courtesy, we will submit your claims for each service provided by our office. If your benefits have not been verified at the time of your appointment, you will be responsible for payment at the time services are rendered.

Office Policies regarding insurance assignment:

- If your deductible has not been met at the time of your verification, you are responsible for the amount of your visit.
- You are responsible for the percentage not covered by your insurance company for each office visit.
- Our office does not guarantee that your insurance will cover all services. Verification is not a guarantee of payment by your insurance company. Please be advised if your insurance claim is denied, you are responsible for the full amount.
- Our office will NOT enter a dispute with your insurance company over a claim. This is your responsibility and obligation.
- Any claims unpaid by your insurance company over 60 days will become your responsibility.
- Insurance changes and updates must be given to our office 24 hours prior to you appointment. This will assist us in insuring that you do have coverage and your insurance company will cover your appointment.

_____ _____

Signature Date

ADVANCED MEDICAL, PA

POLICY ON CONTROLLED SUBSTANCE:

We strictly adhere to Federal and State Narcotic Regulations.

Controlled Substances will not be prescribed for first time visits, unless accompanied by supporting medical records, or it is deemed necessary after a thorough exam by our physician.

Please note the fees paid are for the physician's professional service only. This has no bearing on what medicines will be prescribed.

_____ _____

Signature Date

ADVANCED MEDICAL, PA

AUTHORIZATION FOR RELEASE OF PHI, PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

- I authorize the use or disclosure of the above named individual's health information as described below.
- The following individual or organization is authorized to make the disclosure:

Name/Facility
_____

Address:
_____

Phone: _____ Fax: _____

- Disclose the following information for treatment dates _____to _____

  Entire Medical Records _____ or Other _____

- The purpose of this disclosure is continuing Medical Care _____ Legal Matter _____ Insurance _____ Personal _____ Other _____
- I understand that the information in my health records may include information relating to Sexually transmitted diseases, Acquired immunodeficiency syndrome (AIDS), Human immunodeficiency virus (HIV), Behavioral or mental health services, Diagnosis of or Treatment for alcohol and/or drug abuse, and Genetic testing.
- This information may be disclosed to and used by the following individual or organization:

  ADVANCED MEDICAL, PA TEL # 561-434-1935

  ISHAN GUNAWARDENE, MD FAX # 561-434-3169

  3347 SR 7, SUITE 206

  WELLINGTON, FL 33449

  For the purpose of: _____

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for continuation , or quality of Advance Medical, PA or Dr. Ishan Gunawardene's treatment; except however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this document.

By signing below, I hereby authorize Advanced Medical, PA/Ishan Gunawardene, MD to obtain, use and disclose my health information for the term of this Authorization and for the specific purposes listed.

I understand that once Advanced Medical, PA/Ishan Gunawardene, MD discloses my health information to the recipient, Advanced Medical, PA/Ishan Gunawardene, MD cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health information.

_____ _____

Signature of Patient/Legal Representative Date

ADVANCE MEDICAL, PA

AUTHORIZATION OF TREATMENT

FINANCIAL AGREEMENT INFORMATION

Name:_____Phone:_____

(LAST) (FIRST)

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment, administration of anesthetics and performance of diagnostic and /or surgical procedures. I understand that I am under the care and supervision of Ishan Gunawardene, MD and it is the responsibility of the staff to carry out instructions of such physician.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Ishan Gunawardene, MD accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by the assignment or for any and all charges, which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other source may be applied to any other accounts owed to said physician (s) by the insured or his/her family.

RELEASE OF INFORMATION

The physician (s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician (s) or to the patient (s) charges including but limited to insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND THE MEDICAID PATIENT IDENTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediary carriers, any information

needed for this or a related Medicare or Medicaid claim. I request payment for authorized benefits are made on my behalf. I assign the benefits payable for physician (s) services. I understand that I am the responsible for my health insurance deductibles and co-insurance.

_____ _____

Print Patient's Name Date

_____ _____

Witness Patient Signature or
Representative

If signed by representative please explain relation to
patient:_____

ADVANCED MEDICAL, PA

STATEMENT OF PATIENT PRIVACY RIGHTS

New Federal legislation mandates that certain information about how Advanced Medical, PA uses your confidential medical record be provided to you and that we maintain a record of any entity with whom we share your information.

At Advanced Medical, PA we have always regarded all medical and personal information as completely confidential. As a result many of the new federal mandates have not changed the way we handle information other than to tell you how we protect your information.

We will record and provide to you upon request, information about any release of your information other than the use of your information for the purpose of providing you with care in our office, sharing pertinent information with other practitioners involved in your care (specialists etc.) and you insurance company for the purposes of verifying your treatment for claims to be paid.

The patient information forms that you have signed authorize the use of your information for these purposes. We do not provide information to anyone else unless you send a separate release or if we receive a court order signed by a judge or the clerk of the court. If you would like a family member to be able to inquire about your care (i.e. confirming your appointment or checking to see if you are in our office) we will not reveal this information unless you have signed a specific release identifying the person who you authorize to receive this information.

Please be advised. Our staff will take the appropriate measures to identify the person the information will be released to. Please be patient with this process, as it ensures your privacy.

I have read my rights regarding the Patient Privacy Policy and have been provided a copy.

Signature

Date