BARBARA L. SCHWARTZ, M.D., P.A.

PRACTICE LIMITED TO INTERNAL MEDICINE

483 N. SEMORAN BLVD. • #200 • WINTER PARK, FL 32792 • PHONE (407) 644-3866 • FAX (407) 644-2820

Name _____ Age _____ Date _____

Address _____ City, State & Zip _____

Phone _____ Sex _____ Date of Birth _____ Marital Status _____

Social Security # _____ Occupation _____

Employer _____ Address _____

Employer Phone# _____ Cell # _____

Spouse or Next of Kin _____ Phone # _____

Address _____

Referred by _____

Allergies to Medications _____

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of medical information necessary to process my insurance claim.

Signed _____ Date _____

I authorize payment of medical benefits to Dr. Barbara Schwartz for services rendered.

Signed _____ Date _____

I authorize the release of my health information to my spouse and/or next of kin

_____

The office staff may leave messages on my answering machine or voice mail YES____ NO____

I understand I can change the authorization information anytime in writing.

Signed _____ Date _____

OFFICE FINANCIAL POLICY

The last few years and the years to come are very busy with regard to health care reform. The insurance companies have initiated new changes that will affect the way we handle your account. These are some billing guidelines that our office follows that allow us to survive health care reform.

PLEASE READ THOROUGHLY AND SIGN THIS FORM

1. It is your responsibility to inform us of any changes regarding your Insurance or contact information. If you fail to do so, you will be responsible for any charges incurred.

2. We will collect your co-pay or any other uncovered expense at the time of service Please be prepared to pay before or after the doctor sees you.

3. Please be thorough with your insurance information if you expect us to file for you. You will be responsible for any unpaid balances due to lack of information.

4. It is at our discretion that we will charge your account with a re-billing fee if we must refile balances over 45 days old. This fee will be payable by you.

5. As a courtesy, we will file your insurance. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should.

6. Your insurance will send you an explanation of benefits (EOB) that explains what they have paid and a copy to our office. This is a record that you must keep on file. If you do not agree with the payment, please contact your insurance company.

7. If your insurance denies payment on your account, you will be asked to pay by check, cash, or credit card. If you do not pay in a timely fashion, your account will be subject to placement with a collection company.

8. TO ALL MEDICARE PATIENTS: We will continue to participate as a Medicare provider. We will bill Medicare as well as your secondary insurance, but if payment is not received from your secondary within 45 days, you will be notified and must pay our office the balance due. You must then contact your secondary insurance to refund you.

9. Patients requiring referrals due to your insurance plan must allow our office five (5) days to a quire this, please provide us with a fax # and any other information needed You must be seen at least once a year by our office to receive referrals.

10. SELF-PAY PATIENTS: This includes people with no insurance and patients who have an indemnity plan and wish to file their own insurance. Payments for medical service are expected on the day the service is rendered. If you are unable to pay for services in

full, you must contact our office to make a payment agreement before coming to see the doctor. If you have no agreement with our office, payment in full will be expected.

11. If your insurance is out of state (except for PPO insurance) or out of country coverage, you must pay for your visit at the time of service. Ninety-five percent of out of state insurance companies and a hundred percent of out of country companies pay the patient and will not pay us directly (even if they tell you that they will).

12. NO SHOW POLICY: In ordered to provide excellent patient care we reserve a scheduled appointment time especially for you. If you confirm your appointment and do not show or fail to give our office 24 hours notice of cancellation, your slot has been booked and cannot be overbooked for another patient. You will be charged a $30.00 no show fee.

13. RECORDS: There is a charge for records the fee is guided by the state, fees are .25cents per page up to 25 pages then a $1.00 a page after that no more that $35.00 plus postage if required.

14. FORMS: There is a fee payable in advance for all forms needing to be filled out by the doctor or forms requiring only a signature. This fee can range between $15.00 and $25.00.

AS A FINAL NOTE:

1. Our practice is not the cause of insurance delays or denials. We file to the Insurance companies on a timely basis.
2. Remember, you and /or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.
3. If you have any questions regarding this financial policy, please ask or call BEFORE you are seen

PATIENT
SIGNATURE:_____DATE_____
(Patient/legal Guardian/other Authorized Representative)

Name _____ Date _____

Address _____

_____

Home Phone # _____

Employer _____

Employer Phone # _____

FAMILY HISTORY - Has any blood relative had any of the following:
Circle 'yes' or 'no' - If so, what relationship: _____

Anemia	yes	no	_____
Bleeding tendency	yes	no	_____
Leukemia	yes	no	_____
Repeated infections	yes	no	_____
Crippling arthritis	yes	no	_____
Heart Disease	yes	no	_____
Chronic lung disease	yes	no	_____
Tuberculosis	yes	no	_____
High Blood Pressure	yes	no	_____
Kidney disease	yes	no	_____
Asthma	yes	no	_____
Severe allergies	yes	no	_____
Mental illness	yes	no	_____
Convulsions or fits	yes	no	_____
Migraine headaches	yes	no	_____
Diabetes	yes	no	_____
Gout	yes	no	_____
Obesity	yes	no	_____
Thyroid trouble	yes	no	_____
Peptic ulcer	yes	no	_____
Chronic diarrhea	yes	no	_____
Cancer	yes	no	_____

PAST HISTORY

Have you ever had:			Year
Measles	yes	no	
Mumps	yes	no	
Whooping cough	yes	no	
Polio	yes	no	
Scarlet fever	yes	no	
Diphtheria	yes	no	
Meningitis	yes	no	
Infectious mono	yes	no	
Valley fever	yes	no	
Tuberculosis	yes	no	
Exposure to TB	yes	no	
Malaria	yes	no	
Bronchitis	yes	no	
Pneumonia	yes	no	
Pleurisy	yes	no	
Hepatitis (yellow jaundice)	yes	no	
Bladder infect.	yes	no	
Rheumatic fever	yes	no	
Kidney disease	yes	no	
Hives	yes	no	
Hay fever/sinusitis	yes	no	
Asthma	yes	no	
Emphysema	yes	no	
Arthritis	yes	no	
Back trouble	yes	no	
High blood press.	yes	no	
Heart disease	yes	no	
Anemia	yes	no	
Bleeding tendency	yes	no	
Nose bleeds	yes	no	
Ulcer	yes	no	
Cancer	yes	no	
Hemorrhoids	yes	no	
Blood transfusion	yes	no	

Operations:			**Year**
Tonsils	yes	no	
Appendix	yes	no	
Gall bladder	yes	no	
Stomach	yes	no	
Breast	yes	no	
Uterus &/or ovary	yes	no	
Prostate	yes	no	
Hernia	yes	no	
Thyroid	yes	no	
Varicose veins	yes	no	
Hemorrhoids	yes	no	
Heart	yes	no	
Other	yes	no	
Injuries:			
Head	yes	no	
Chest	yes	no	
Abdomen	yes	no	
Broken bones	yes	no	
Back	yes	no	
Other	yes	no	
Allergies *(are you allergic to):*			
Tetanus antitoxin	yes	no	
Penicillin	yes	no	
Sulfa	yes	no	
Other drugs	yes	no	
List _____			
Foods	yes	no	
Cosmetics	yes	no	
Other	yes	no	
Immunizations:			**Year**
Smallpox	yes	no	
Tetanus	yes	no	
Polio shots	yes	no	
Polio oral	yes	no	
Other	yes	no	

Do you have a Living Will?

Yes_____ No_____

History of Substance Abuse?

Yes_____ No_____

	Present Age, or Age at Death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Brothers or Sisters		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Children		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PERSONAL HISTORY

Birthplace _____ Date _____

Nationality _____ Religion _____

Marital status _____ Health of spouse _____

Occupations _____

Exposure to toxic substances _____

Residence past 5 years _____

Education through _____ grade Habits: Sleep _____ hrs/per night

Recreation _____

Exercise _____

Average per day:

Alcohol (type) _____

Tobacco (type) _____

Tea, coffee _____

Medicines taken regularly _____

_____

_____

_____

_____

_____

Hospitalization and/or other Illnesses: _____

_____

_____

_____

Have you ever had the following:

General

Tire easily, weakness	yes no
Marked weight change	yes no
Night sweats	yes no
Persistent fever	yes no
Sensitivity to heat	yes no
Sensitivity to cold	yes no

Skin

Eruptions (rash)	yes no
Change in color	yes no
Change in hair	yes no
Change in nails	yes no

Eyes

Trouble seeing	yes no
Eye pain	yes no
Inflamed eyes	yes no
Double vision	yes no
Worn glasses	yes no

Ears

Loss of hearing	yes no
Ringing in ears	yes no
Discharge	yes no

Nose

Loss of smell	yes no
Frequent colds	yes no
Obstruction	yes no
Excess discharge	yes no
Nosebleeds	yes no

Mouth

Sore gums	yes no
Soreness of tongue	yes no
Dental problems	yes no

Throat

Postnasal drainage	yes no
Soreness	yes no
Hoarseness	yes no

Breasts

Lumps	yes no
Discharge	yes no

Cardio-Respiratory System

Cough, persisting	yes no
Sputum (phlegm)	yes no
Bloody sputum	yes no
Wheezing	yes no
Chest pain or discomfort	yes no
Pain on breathing	yes no
Shortness of breath	yes no
Difficulty breathing while lying down	yes no
Swelling of ankles	yes no
Bluish fingers or lips	yes no
High blood pressure	yes no
Palpitations	yes no
Vein trouble	yes no

Digestive System Indicate average food selection each meal:

Breakfast _____

Lunch _____

Dinner _____

Change in appetite	yes no
Difficulty swallowing	yes no
Heartburn	yes no
Abdominal distress	yes no
Belching or excess gas	yes no
Abdominal enlargement	yes no
Nausea	yes no
Vomiting	yes no
Vomiting of blood	yes no
Rectal bleeding	yes no
Tarry stools	yes no
Jaundice	yes no
Constipation	yes no
Diarrhea	yes no
Hemorrhoids	yes no
Need for laxatives	yes no

Genitourinary System

Increase in frequency of urination (day)	yes no
Increase in frequency of urination (night)	yes no
Feel need to urinate without much urine	yes no
Unable to hold urine	yes no
Pain or burning	yes no
Blood in urine	yes no
Lack of sex drive	yes no

Endocrine

Thyroid trouble	yes no
Adrenal trouble	yes no
Cortisone treatment	yes no
Diabetes	yes no

Locomotor

Muscle cramps	yes no
Muscle weakness	yes no
Pain in joints	yes no
Swollen joints	yes no
Stiffness	yes no
Deformity of joints	yes no

Nervous System

Headaches	yes no
Dizziness	yes no
Fainting	yes no
Convulsions or fits	yes no
Nervousness	yes no
Sleeplessness	yes no
Depression	yes no
Change in sensation	yes no
Memory loss	yes no
Poor coordination	yes no
Weakness or paralysis of muscles	yes no

GYN-OB

Started menstruating at age _____ Date of last PAP test _____

Interval between periods _____ days Duration _____ days

Flow: light normal heavy Date of last period _____

Pain with periods yes no duration _____

Number of pregnancies _____ Number of miscarriages _____

Number of births _____

Wt. of babies at birth _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ , HEREBY AUTHORIZE:

DR._____

( ) TO RELEASE ANY AND ALL MEDICAL INFORMATION IN MY RECORDS, INCLUDING INFORMATION REGARDING ANY SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC TREATMENT, DRUG AND/OR AIDS INFORMATION. ***PATIENT MAY DELETE ANY OF THE PREVIOUS CATEGORIES BY MARKING THROUGH IT.***

( ) I WISH ONLY SPECIFIC INFORMATION AND/OR REPORTS TO BE RELEASED AS FOLLOWS:

_____
_____
_____

( ) I WISH TO RELEASE ONLY RECORDS NEEDED FOR OFFICE VISIT OF DOCTOR I HAVE BEEN ADVISED TO SEE.

_____

PLEASE RELEASE REQUESTED INFORMATION TO:

DR._____

_____

_____

_____

NAME (PRINT) _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

PATIENT SIGNATURE _____