ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

Is your condition a result of a work injury? **YES** **NO** Auto accident? **YES** **NO** Date of Injury? _____

PATIENT PERSONAL INFORMATION

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed **Sex:** ○ Female ○ Male
Name:_____ **Email:**_____
Date Of Birth: ___/___/____ **Home Phone:** (____)____-____ **Work Phone:** (____)____-____
Street Address: _____(**Apt #**____) **City:** _____
State: _____ **Zip Code:** _____ **Social Security #:** ____-____-_____
Drivers License #:_____ **State:** _____
Spouse Name:_____ **Spouse #:**(____)____-_____
Occupation:_____ **Full Time** ○ **Part Time** ○
Employer Name:_____

GUARDIAN/RESPONSIBLE PARTY INFORMATION

Responsible Party:_____ **Date Of Birth:**___/___/____
Relationship To Patient: ○ **Self** ○ **Other:**_____ **Phone #:**(____)____-_____
Street Address:_____ **City:**_____ **State:**_____
Zip Code: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance Name:_____
Member ID #:_____ **Group #:**_____
Relationship to Insured: ○Self ○Spouse ○Other:_____ **Date of Birth:**___/____/____
Secondary Insurance Name:_____
Member ID #:_____ **Group #:**_____
Relationship to Insured: ○Self ○Spouse ○Other:_____ **Date of Birth:**___/___/____

EMERGENCY CONTACT

Name:_____ **Relationship:**_____
Date Of Birth:___/___/____ **Phone Number:**(____)____-_____
Street Address:_____
City:_____ **State:**_____ **Zip Code:**_____

PHARMACY

Name of Pharmacy: _____ **Phone Number:**_____
Address:_____ **City:**_____ **State:**_____
Zip Code:_____

Signature:_____ Date:_____

ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

MEDICATION LIST

Please list any current medications, including any non-prescriptions such as aspirin, vitamins, glucosamine, laxatives, etc.

Name of Drug & Dose:

1._____ **2.**_____
3._____ **4.**_____
5._____ **6.**_____
7._____ **8.**_____
9._____ **10.**_____
11._____ **12.**_____
13._____ **14.**_____
15._____ **16.**_____
17._____ **18.**_____
19._____ **20.**_____

MEDICAL HISTORY

○ Low BP ○ High BP	○Fainting or Blackouts	○ Tuberculosis	○ Heart Burn/Acid Reflux
○ Migraines or Headaches	○Vertigo	○ Allergies	○ Thrombosis/ Circulatory Problems
○ Heart Problems	○ Kidney Disease	○ Joint Pain/Discomfort	○ COPD
○ Asthma/Chest Conditions	○ Stroke	○ Varicose Veins	○ Fluid Retention
○ Respiratory Illness	○ Sciatica/Back Pain	○ HIV/AIDS Positive	○ Diabetes
○ Epilepsy	○ Skin Condition	○ Organ Problems	○ Reproductive Problems
○ Fatigue	○ Anxiety or Depression	○ Stress	○ Pregnant Weeks:_____
○ Constipation or Diarrhea	○ Bruising	○ Cancer	○ Type Of Cancer _____

If you have any other conditions you are aware of, please list:

_____

_____

Signature:_____ Date:_____

ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

HIPAA RELEASE FORM

Name:_____ **DOB:**___/___/_____

○ I authorize the release of information including diagnosis, records, examinations, rendered to me and claims information. This information may be released to:

1. Spouse: _____
2. Children: _____
3. Other: _____

○ Information is not to be released to anymore.

This Release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call me at:

○ **Home:**_____ ○ **Work:**_____ ○ **Cell:**_____

If unable to reach me:
○ Leave a detailed message
○ Leave a message asking to return your call
○ **Other:** _____

Best day(s) to reach me is _____
Time(s): _____

Signed:_____ **Date:**___/___/_____

Witness:_____ **Date:**___/___/_____

Signature:_____ Date:_____

ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

IF YOU HAVE MEDICARE:

Our office accepts assignments on all Medicare claims, not including Medicare HMO companies. Medicare pays 80% of all allowable amounts after your deductible has been met. You are responsible for the deduction and 20% coinsurance. If you have a supplemental insurance, we will file a claim on your behalf. If your supplemental insurance fails to pay, we will request the payment from you.

IF YOU HAVE COMMERCIAL/INDIVIDUAL INSURANCE:

If our physicians are participating in your insurance company's network, our office will bill your insurance company for you and request payment will be sent directly to us. If we are NOT participating in the network, we will request payment from you in full from your prior to your visit. We can submit a claim on your behalf if you request before you leave the office. As the patient, you are required by your insurance policy to pay for any coinsurance, deductible, or other non-covered services at the time it is rendered. We will make reasonable attempts to collect payment from your insurance company, but payment in full is required within 60 days of the date of service.

FINAL AGREEMENT:

- I understand I am authorizing Ahmed Aidoo, MD, MPH to send claims on my behalf to my insurance company for payment of services rendered to me.
- I am authorizing the staff of Ahmen Aidoo, MD, MPH to act on my behalf to discuss with my insurance company the reasons for any claim denials, and to request any information or records needed to have my claims processed in a timely manner.
- I understand that I am fully responsible for any balance on my account for services rendered to me by Ahmed Aidoo, MD, MPH and staff.
- I understand that payment is expected at the time of service unless prior arrangements are made.
- I understand that should my account be turned over to an outside collection agency at any time, I will be given 30 days to select another physician for my future medical care. I will also be responsible for all fees incurred to collect the debt owed on my account.

CONSENT FOR TREATMENT:

The undersigned consents to the provision of examinations, treatments, medical and laboratory procedures, drugs and supplies to the patient, as ordered or requested by the patient's physician(s) and acknowledges that no guarantee has been made as to the results of such treatments, procedures, or examinations.

_____ _____/_____/_____

Patient/Guardian Signature **Date**

_____

Patient/Guardian Printed Name

Signature:_____ Date:_____

ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

AGREEMENT TO RECEIVE CCM SERVICES

As of Jan. 1st, 2015, Medicare covers chronic care management (CCM) services provided by physician practices per calendar month. I understand that my primary physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24 hours a day, 7 days a week, including telephone access and other non face-to-face means of communication. (ex. email)
- The ability to get successive routine appointments with my designated primary care physician or member of my care team.
- Care management of my chronic conditions, including timely scheduling of all recommended preventative care services, medication reconciliation, and oversight of my medication management.
- Creation of a comprehensive care plan for all my health issues that is specific to me and congruent with my choices and values.
- Management of my care as I move between and among health care providers and settings. Including the following: Referrals to other health care providers, follow ups after any hospital or emergency room discharge, or any other facility. (e.g skilled nursing facility)
- Coordination with home and community based providers of clinical services.

I understand that as a part of these services, I will receive a copy of my comprehensive plan of care. I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke these services. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that **Ahmed Aidoo, MD, MPH,** is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them. My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services. The designation is effective as of the date below and will remain effective until revoked by me.

Patient name (printed):_____
Patient Signature:_____ **Date:**___/_____/_____

Signature:_____ Date:_____

ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213
affsm.com

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

Advance Written Notice of Non-Coverage Care Management and Therapies including:

Weight loss, IV Vitamin infusion, IV Fluid for Wellness, and Cosmetic Skin Care.

I understand that any healthcare provider that works for **All Florida Family & Sports Medicine**, is providing extra services for Weight loss, IV Vitamin infusion, IV Fluid for wellness, and skin care for cosmetics. These cosmetic services will not be billed to your private insurance, medicaid, or medicare insurance. The physicians and other providers that work for **All Florida Family & Sports Medicine** will NOT file a claim to your private insurance, medicaid, or medicare for any services for cosmetic treatment or therapies. Medicaid, Medicare, or private insurance will NOT reimburse **All Florida Family & Sports Medicine** for these services. I understand that **All Florida Family & Sports Medicine** will be accepting me as a private-pay patient for these Cosmetic Services, and I will be responsible for paying any service I receive through **All Florida Family & Sports Medicine** at the time of service. By signing this agreement, you agree with the above contract.

Name (Printed): _____

Signature: _____

Date: ___/____/_____

Witness Signature: _____

Signature:_____ Date:_____

ALL FLORIDA FAMILY & SPORTS MEDICINE

3501 13th Street
Saint Cloud, Fl 34769
results@affsm.com

Phone: 407-891-6463
Fax: 407-891-0213
affsm.com

320 West Oak Street
Kissimmee, Fl 34741
info@affsm.com

Advanced Beneficiary Notice of Non-Coverage (ABN)

Note: If Medicare doesn't pay for *D* "*All Florida and Family Sports Medicine*", listed below, you may have to pay. Your insurance doesn't pay for everything, even some care that your healthcare provider has good reason to think you need. We expect Medicare to not pay for the **D List below.**

D.	E. **Estimated Cost**
Weight Loss	Initial Visit: $75.00 Follow up Visit: $55.00
Vitamin Injections	1mL: $30.00 2mL: $40.00
IV Vitamin Fusion	$100.00
IV Fluid for Wellness	$100.00
Skin Care	$50.00-$60.00

WHAT YOU NEED TO KNOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after reading this form.
- Choose an option below about whether to receive the D. List above.
  Note: If you choose option 1 or 2, we may help to use any other insurance that you may have, but Medicare cannot require us to do this.

F. **OPTIONS:** *Check only one box... We cannot choose one for you.*

- ☐ Option 1: I want the D.__ listed above. You may asked to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand if Medicare doesn't pay, I am responsible for payment. I can appeal to Medicare by following the directions on MSN. If Medicare does, you will refund any payment I made to you, less copays or deductibles.
- ☐ Option 2: I want the D.__ listed above, but do NOT bill Medicare. You may ask to be paid now as I am responsible for payment. I Can not appeal if Medicare is billed.
- ☐ Option 3: I don't want D.__ listed above. I understand with this choice I am NOT responsible for payment, and cannot appeal to see if Medicare can pay.

G: Additional Information:

This notice gives our opinion, not an official Medicare decision. If any questions call medicare billing at 1-800-633-4227. Signing below means you understand this notice, and will receive a copy.

Signature:_____ Date:_____

Signature:____ Date:__________________________