Carlos A. Labrador, M.D. RoseAnna Javorsky, PA-C
65 65TH STREET SOUTH ST. PETERSBURG, FL 33707
Phone: 727-381-8006 Fax: 727-381-9629
www.drlabrador.com

New Patient Information

Date:_____
***Patient Name:_____**
***Social Security #_____*Date of Birth:_____Sex: M F**
Single, Married, Widowed, Separated, Divorced
***Language:_____ *Race: _____ *Ethnicity:_____**

Primary Home

***Address:_____**
City: _____State:_____ Zip Code:_____Home Phone:_____
Work Phone: _____ **Cell Phone**:_____
Email:_____
Occupation:_____ Employer:_____

EMERGENCY CONTACT

Name:_____ Phone:_____ Relationship:_____
If you have a spouse:
Name:_____ Date of Birth:_____
Social Security #_____ Employer:_____
Work Phone:_____ Cell Phone: _____

INSURANCE INFORMATION

***Primary Insurance**:_____ **Effective Date**:_____
Address:_____
City:_____ State:____ Zip Code:_____Telephone #_____
Name of Insured:_____Relationship to patient:_____
ID #_____Group #_____
Secondary Insurance: _____Effective Date:_____
ID #_____Group #_____

***Do you have high Deductible Plan? If so, you have to pay for your visit at the time of service.**
_____Initial

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STAFF ONLY: Demographics, Driver License or ID, Insurance Card.
_____ Initial
*Required

Worker's Compensation Only

Did your injury occur at work? **Yes No** If yes, Date of injury_____
Is your injury from an auto accident? **Yes No** **If** yes, Date of Accident_____

Adjuster's Name: _____Phone: _____Fax:_____
Address:_____City:_____Zip:_____

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Patient Authorization Form

HIPPA Privacy Notice

I have received and read a copy of Carlos A. Labrador, M.D.,P.A. Notice of Privacy Practices
*By initialing I have read and understand the above*_____

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Carlos A. Labrador, M.D.,P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills.
*By initialing I have read and understand the above*_____

Financial Agreement & Payment Policy

All co- pays/Deductibles or account balances are collected at time of check-in/out.

Patients covered by Insurance

I hereby agree to allow Carlos A. Labrador, M.D.,P.A. services to file any claims to my insurance company or companies for payment of services rendered in this medical practice.
I fully understand that any unpaid balances not covered by my insurance company due to insurance cancellation, deductibles and co pays, or non covered services on your policy, will be deemed due within 30 days from date of service. (Financial arrangements will have to be made with management to carry balances over this period of time.)

Self pay patients

Patients seen without insurance coverage will be required to pay Full Amount on first day of service. This amount will cover only the office visit and will not include any procedures or medications the doctor may need for patient treatment.
Patient accounts with overdue balance or accounts in collections status, will have to be (paid in full) prior to having another appointment. (Unless prior arrangements have been made with Office Manager)
No samples or non-medically necessary prescriptions will be dispensed or written to accounts with overdue or collection balances.
*By initialing I have read and understand the above*_____

Authorization for treatment

I hereby authorize the medical staff of Carlos A. Labrador, M.D.,P.A. to render medical services and treatments as deemed necessary.
*By initialing I have read and understand the above*_____

By signing, I have read, understand and agree to comply with Carlos A. Labrador, M.D.,P.A. policies so noted in the Notice of Privacy Practices.

Signature _____Date _____

Today's Date:_____

Answer all questions below.

Chief Complaint (affected body part)_____

History of Present Illness or Injury **(when and how did it happen):**

***Review of Systems/Past Medical History*:** (please circle all that apply)

High Blood Pressure High Cholesterol Diabetes Cancer Heart Attack Stroke COPD Asthma Renal Disease Liver Disease Bleeding Disorders Rheumatoid Arthritis Pacemaker HIV /AIDS Hepatitis A, B, or C GERD GI Disorders Neurological Disorders Osteoporosis .

Other: _____

Allergies (please circle): **None Penicillin Sulfa Codeine Aspirin Latex**

Other: _____ *Reaction*: _____

Current Medications (name, strength and dose):

1_____ 2 _____

3_____ 4_____

5 _____ 6 _____

7_____ 8_____

***Previous Surgeries & Year*:**

1_____ 2 _____

3_____ 4_____

5 _____ 6 _____

7_____ 8_____

_____

Social History (please circle): **Smoking** Qty_____ Non-Smoker / Quit (year)_____

Drinking Qty_____ **Drugs** Type/Qty_____

Family History

Mother Alive Deceased Unknown Age_____ Condition_____

Father Alive Deceased Unknown Age_____ Condition_____

Siblings Alive Deceased Unknown Age_____ Condition_____

Children Alive Deceased Unknown Age_____ Condition_____

Pharmacy _____

Telephone # _____

Authorization to view RX history from External Source

I authorize Carlos A. Labrador,M.D.,P.A. to view any and all available RX history from an external source. I am aware that Dr. Labrador and Staff uses a secure connection to SureScripts to send and receive most prescription in the office.

By initialing I have read and understand the above_____

I certify that the above information is correct to the best of my knowledge. I will not hold Carlos A. Labrador, M.D., RoseAnna Javorsky, PA-C or any staff members responsible for any errors or omissions that occur secondary to incorrect or incomplete data on this form.

*By initialing I have read and understand the above*_____

Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care.

Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

$10.00:

• Disabled Parking Applications (Forms are provided by DMV)

$25.00/ per form:

• Credit Card deferment forms

• Private Disability Insurance Form

• School, Educational, Disability or Limitation Forms

• If you are unable to make your scheduled appointment, please call the office within 24 hours prior to your appointment time. Otherwise, a fee will be applied.

$35.00/per form

• Family Medical Leave Act (FMLA) forms

• NSF/Return Checks fee**

Writing bad checks is a crime.

Returned checks will have fees added and will be due within 10 days of bank notification.

. By signing I agree to comply with the Form Fee policy of Carlos A. Labrador, M.D.,P.A.

_____ _____

Patient Name (printed) Signature

_____

Date

Consent for the Release of Protected Health Information to Personal Representative.

I, _____ give my written consent for Carlos A. Labrador, M.D.,P.A. to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that Carlos A. Labrador, M.D., P.A. may share my Protected Health Information with:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I do not want my Protected Health Information shared with anyone other than myself at any time. (initial here) _____

Carlos A. Labrador, M.D.,P.A. staff may leave a message:
At Home _____ At Work _____ At Cell_____ On Answering machine _____

Patients' Signature _____ Date: _____

Please provide Insurance Card and Driver License to our Receptionist.

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