

ABID RASOOL, M.D.
M. A. AWAN, M.D.

4501 S. SEMORAN BLVD. • ORLANDO, FL 32822 • TELEPHONE: 380-1428

PATIENT INFORMATION PLEASE PRINT						TODAY'S DATE			
LAST NAME		FIRST NAME		M.I.	HOME PHONE		WORK PHONE		
STREET ADDRESS					D.O.B.		SOCIAL SECURITY #		
CITY	STATE	ZIP	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> DIV <input type="checkbox"/> SEP		DRIVER'S LICENSE #			
EMPLOYER NAME			ADDRESS			OCCUPATION			
HOW DID YOU LEARN ABOUT PREMCARE?				<input type="checkbox"/> YELLOW PAGES (Southern Bell)		<input type="checkbox"/> FRIEND		<input type="checkbox"/> SIGN (Outdoor)	
				<input type="checkbox"/> DONNELLY DIRECTORY		<input type="checkbox"/> M.D.		<input type="checkbox"/> OTHER	

SPOUSE / RESPONSIBLE PARTY							
LAST NAME		FIRST NAME		M.I.	HOME PHONE		WORK PHONE
STREET ADDRESS					D.O.B.		SOCIAL SECURITY #
CITY	STATE	ZIP	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DRIVER'S LICENSE #			
EMPLOYER NAME			ADDRESS			PHONE #	
RELATIONSHIP TO PATIENT							
PAYMENT TODAY WILL BE MADE BY <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> INSURANCE							

INSURANCE INFORMATION											
PRIMARY INSURANCE				SECONDARY INSURANCE							
INSURANCE COMPANY		PHONE		INSURANCE COMPANY		PHONE					
ADDRESS				ADDRESS							
CITY/STATE/ZIP				CITY/STATE/ZIP							
I.D. NUMBER				I.D. NUMBER							
GROUP NAME OR NUMBER				GROUP NAME OR NUMBER							
INSURED'S LAST NAME		FIRST NAME		INSURED'S LAST NAME		FIRST NAME					
ADDRESS				ADDRESS							
CITY/STATE/ZIP				CITY/STATE/ZIP							
RELATIONSHIP TO GUARANTOR		<input type="checkbox"/> SELF <input type="checkbox"/> HUSBAND <input type="checkbox"/> PARENT <input type="checkbox"/> WIFE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		EMPLOYER INS. PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO		RELATIONSHIP TO GUARANTOR		<input type="checkbox"/> SELF <input type="checkbox"/> HUSBAND <input type="checkbox"/> PARENT <input type="checkbox"/> WIFE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		EMPLOYER INS. PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO	

IT IS YOUR RESPONSIBILITY TO PAY THE DEDUCTIBLE AND CO-INSURANCE

ARE YOU A MEDICARE PATIENT: YES NO IS THIS AN ACCIDENT? AUTO WORKERS COMPENSATION LIABILITY OTHER

WE DO NOT ACCEPT HUMANA GOLD PLUS PLANS PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST TO BE COPIED

EMERGENCY INFORMATION				
NAME - NOT LIVING WITH YOU		RELATIONSHIP	HOME PHONE	WORK PHONE
STREET ADDRESS		CITY/STATE/ZIP		

CONSENT TO TREATMENT	
I hereby give consent to PREMCARE to provide whatever treatment they may deem necessary to the patient above.	
_____ PATIENT / RESPONSIBLE PARTY SIGNATURE	_____ DATE

PAYMENT AGREEMENT & INFORMATION RELEASE	
I understand that I am responsible for charges incurred for service and that payment is due at time of service. It is my responsibility to bill my insurance company for these fees. I understand I am responsible for charges not covered by the insurance policy, and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, interest, collection costs, and attorney's fees. I authorize PREMCARE and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me, needed to determine these benefits or the benefits payable for related services.	
_____ PATIENT / RESPONSIBLE PARTY SIGNATURE	_____ DATE

PREMCARE FAMILY MEDICAL CENTER, INC.
4501 S. Semoran Boulevard
Orlando, FL 32822
(407) 380-1428

A WRITTEN POLICY

Dear Patient:

We are pleased you have chosen PREMCARE Family Medical Center for your medical needs. As the physician provides the medical care you need, we, the members of his staff, will be available to help you understand our office procedures. The following information concerning the financial policy of the practice is important.

Payment is collected at the time service is rendered. We do not bill. Our office visit for a new patient starts between \$75.00 - \$115.00. The charge is determined by the amount of time the doctor spends with the patient and the complexity of the problem and decision making. Follow-up visits are determined in the same manner.

INSURANCE

We will file your claim with your insurance company only after you have met your deductible for the calendar year. If your deductible has not been met, you will be given all the necessary paperwork to file the claim yourself. NO insurance will be filed in the evening hours or on the weekend since we cannot verify coverage. Once we have verified that your deductible has been satisfied, your percentage of co-payment will need to be paid at the time service is rendered. We will file your insurance claim only once. If payment is not received within 30 days, the amount will be due from the patient within 10 days of being notified.

MEDICARE PATIENTS

We will file your Medicare and secondary insurance at the time of your visit. You will be responsible for any services or supplies that are not covered by Medicare. You will receive a statement for these charges, your 20% co-pay and your deductible, if not met for the current year.

MEDICAID PATIENTS

We are not providers for the Genesis or Century Medicaid programs. If you are a Medicaid patient, you must present your Medicaid card at each visit. Without your card, we cannot perform services for you under the Medicaid program. If you are 21 years of age or older, you will be asked to pay \$2.00 at the time of your visit as required by Medicaid.

If you are covered under a PPO contract, your co-payment will be due at the time of service and cannot be billed.

To assist you in meeting our financial policies, we accept VISA, MasterCard and Discover. Thank you for your support of this policy.

Sincerely,

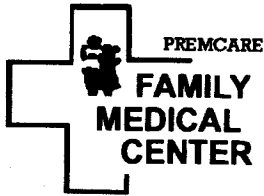
PREMCARE Family Medical
Center Staff

Date

**I HAVE READ AND UNDERSTAND THE ABOVE
POLICY.**

Print Name

Signature



ABID RASOOL, M.D.
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ADVANCED DIRECTIVE

(FOR COMPLIANCE WITH THE SELF DETERMINATION ACT)

HAVE YOU EXECUTED AN ADVANCED DIRECTIVE? YES _____ NO _____

(This is a document that protects you and your family in case of illness.)

IF YES, IS THIS DIRECTIVE IN THE FORM OF:

_____ LIVING WILL (This document states that you do not wish life support when death is inevitable and would protect you as the patient to express your personal wishes.)

_____ DURABLE POWER OF ATTORNEY (This document protects you in the event of illness when you are unable to make decisions for yourself. This document allows the person of your choice to handle your personal affairs and will enable them to sign your name on any legal document.)

_____ HEALTH CARE SURROGATE (This is a person you choose to represent you and make medical decisions for you. This person would be able to make decisions if you were unable to do so.)

IF YOU HAVE EXECUTED AN ADVANCED DIRECTIVE, HAVE YOU PROVIDED THIS OFFICE WITH A COPY FOR YOUR MEDICAL RECORDS?

_____ YES

_____ NO

Signature of Patient _____

Premcare Family Medical Center

PATIENT CONSENT FORM

CONSENT TO USE AND DISCLOSURE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we request your consent to the following possible scenarios. It is our office policy to require your reading and signing this consent form prior to treatment or medical services in our office. If you have any questions, please ask a staff member for clarification.

EVENTS OF DISCLOSURE: please initial and date your consent to authorize us to relay any information about you to receive benefits, payment or other information to benefit you, your healthcare/medical services or account with our office.

_____ (1) In the event my insurance company requests a copy of my medical records for clarification to receive payment on my account, I authorize Premcare Family Medical Center to relay such information as deemed necessary.

_____ (2) In the event Dr. Awan or Dr. Rasool needs to refer me to another physician for further treatment or consultation, I authorize either one of them to relay information as deemed necessary.

_____ (3) In the event a hospital needs any part of my records faxed to their facility for clarification or history of treatment, I authorize the relaying of any such information as deemed necessary.

_____ (4) In the event my pharmacy calls or faxes a request for information to fill a prescription for me, I authorize this office to relay any such information as deemed necessary.

_____ (5) In the event another physician requests copies of my medical records for the purpose of treatment, I authorize Premcare Family Medical Center to relay any such information as deemed necessary.

_____ (6) In the event that Dr. Awan or Dr. Rasool needs to discuss my medical status/treatment and/or history with a physician involved in my care, I authorize either of them to relay any such information via telephone, fax or mail as deemed necessary.

_____ (7) In the event a Lab or Diagnostic Center requires a faxed order for a test to be performed, I authorize the faxing of such order deemed as necessary.

_____ (8) In the event that a family member needs to be involved in my care or treatment at Premcare Family Medical Center, I authorize the communication of any information deemed necessary (to the following family member only: _____).

I understand that I have the right to revoke this consent in writing, at any time, and that any revocation will become effective on the date it has been received by this office and will apply to the specific uses and disclosures as addressed above.

Patient Name _____ Date ____ / ____ / ____

Patient Signature (or parent, if a minor) _____

Acknowledgement of Privacy Notice

I, _____, hereby acknowledge
that a copy of the Notice of Privacy Practices is available
upon request to me by PREMCARE Family Medical Center.

Signed: _____ Date: _____