

Greg Cisneros, M.D.
33 Old Kings Rd. North, Suite #2
Palm Coast, FL 32137
386-446-4141

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Social Security #: _____ (REQUIRED FOR BILLING)

Date Of Birth: _____ Male: _____ Female: _____ Race: _____

Marital Status Single: _____ Married _____ Divorced: _____ Separated: _____ Widowed: _____

Employers Name: _____

Employer Address: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Insurance: _____ ID#: _____

Subscribers Name: _____ DOB: _____

Subscriber SS#: _____ (REQUIRED)

Secondary Insurance: _____ ID#: _____

Subscribers Name: _____ DOB: _____

Subscriber SS#: _____ (REQUIRED)

Due to HIPAA Regulations, we are required to have the name of the person we are authorized to discuss your healthcare issues, in the event of a critical matter or emergency.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ DOB: _____

Reason For Visit: _____

Allergies: _____

Family History: (Please Circle the number and on the line write which relative)

1. Diabetes _____ 2. Thyroid: _____ 3. Asthma: _____

4. Cancer: _____ 5. High Cholesterol: _____ 6. Heart Disease: _____

Hosp Admission/Surgeries:

Year: _____ Illness or Operation: _____

Year: _____ Illness or Operation: _____

Vaccines/Dates:

Tetanus: _____ Pneumonia: _____ Shingles: _____ Influenza(flu): _____

Medical History: (Please circle problem and indicate age when started)

Dizzy spells: _____ Leg Pain/walking: _____ Diabetes: _____ Depression: _____

Asthma/Wheezing: _____ Cold/numb feet: _____ Sleep Problems: _____ Memory Loss: _____

Shortness of Breath: _____ Heartburn: _____ Cholesterol: _____ Physical Difficulties: _____

Chest Pain: _____ Thyroid Disease: _____ Headaches: _____ Mental Illness: _____

Irregular Pulse: _____ Seizures: _____ Foot Pain: _____ Skin Lesion: _____

Palpitations: _____ Hypertension: _____ Rashes: _____ Other: _____

Date of last: EKG _____ Colonoscopy _____ PSA _____ Eye Exam _____

Pap Test _____ Mammogram _____ Dexa/Bone Scan _____

Social History:

Do you smoke? Yes _____ No _____ if so, how much per day? _____

Do you drink alcohol? Yes _____ No _____ if so, how much, how often? _____

Do you have a history of drug abuse? Yes _____ No _____ if so, which ones? _____

List of Doctors/Specialists: _____

Greg Cisneros, M.D.

PATIENT _____ DOB _____ SS# _____
The following form is required by the privacy regulations created as a result of the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT OF 1996 (HIPAAA)

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of Dr. Cisneros and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies. If insurance or other benefits are involved: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care, service, or treatment plan.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Dr. Cisneros, the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Dr. Cisneros for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent or legal guardian, do hereby authorize Dr. Cisneros and his employees to use and/or release certain protected health information to any third party payor (such as insurance company or government agency) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Dr. Cisneros and any applicable State or Federal Statutes, concerning diagnosis and treatment when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Dr. Cisneros from all liability that may arise from the release of the information requested.

FOR MEDICARE PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Dr. Cisneros. I understand that I am responsible for my health insurance deductible and coinsurance. Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to: annual testing and physicals. My signature only acknowledges my receipt of this message from Dr. Cisneros as dated below and does not waive any of my rights to request a review.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Cisneros reserves the right to revise the Notice of Privacy Practices at any time, which may be obtained by forwarding a written request to Dr. Cisneros office. With this consent, Dr. Cisneros or his staff may call my home or other alternative locations and leave a message in reference to any items that assist the practice in carrying out their function, such as appointment reminders, insurance items, and lab results, among others.

By signing this form, I am consenting to allow Dr. Cisneros to use and disclose my Protected Health Information, to carry out treatment, payment, and health care operations. I have the right to request that Dr. Cisneros restrict how he uses or discloses my PHI, but the practice is not required to agree to my requested restrictions. If I do not sign this consent, or later revoke it, Dr. Cisneros may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Print Patient's Name

Patient Unable To Sign Due To:

GREG A. CISNEROS, M.D.
Family Medicine
33 Old Kings Road North. STE #2
Palm Coast, FL 32137
Phone: 386-446-4141

Financial Policy:

We require payment **in full due at the time of service**, for Self-pay patients. We do not balance bill. I understand I will not be filing to an insurance carrier. **Visa, MasterCard and Cash accepted.**

If we participate with your insurance company, we will collect all co-payments, deductibles, and/or other co-insurance amounts **at the time of service**. **Visa, MasterCard and Cash accepted.**

I fully understand if I do not pay for services upon check-out, that I **will not** receive any prescriptions written by Dr. Cisneros or the discharge instruction paperwork.

INSURANCE CHANGES You are required to notify us if your insurance changes, or if any information regarding your insurance identification or group number changes up subsequent visits.

RETURNED CHECKS Your account will be assessed a \$30.00 fee for all returned checks. We reserve the right to revoke check privileges at any time.

PAST DUE & LATE FEES

- Your account will be assessed 1.5% interest for balances over 30 days.
- Your account will be assessed a late fee of \$25 per month and/or 1.5% interest for balances due past 60 days.
- You will be responsible for any charges incurred if your account has to be handled by our collection Agency.

I understand that all fees, co-payments, deductibles, and co-insurance amounts are based on estimated charges which may be subject to change after all documentation has been reviewed by our billing manager.

I agree that I will be responsible for any additional charges.

Patient/Guarantor/Legal Guardian Signature

Date

Greg A. Cisneros, M.D.
33 Old Kings Road North, Suite 2
Palm Coast, FL 32137
Phone: 386-446-4141

Medical Appointment Cancellation Policy

Dear Patient,

When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another sick patient. Our policy is as follows:

We request that you give our office a **24-hour notice** in the event that you need to reschedule or cancel your appointment with the physician. (If the office is closed, please leave a message on our answering machine). This allows other sick patients to be scheduled into that appointment time. It also makes it possible to reschedule your appointment more efficiently.

If you miss an appointment without contacting our office, this is considered a missed appointment ("No-Show, No-Call"). A fee of **\$25.00** will be charged to you for a missed appointment. If you accumulate a total of three (3) missed appointments, you may not be rescheduled for future appointments and will be discharged from the practice.

Additionally, if you are more than **15 minutes late** to your scheduled appointment, your appointment will be canceled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Legal Guardian

Date

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Medical Records Release Form

Date: _____

From Doctor or Facility: _____

Address: _____

I hereby authorize and request you to release the following records in your possession to Greg A. Cisneros, M.D. Via Fax 386-264-6764 .

Include Only the Last Year of: _____ **EKG**

_____ **Labs**

_____ **Imaging Reports**

_____ **Any other Special Reports**

Patient Name: _____

Address: _____

DOB: _____

Signature: _____