Greg A. Cisneros, M.D.
17 N Old Kings Rd. Suite J
Palm Coast, FL 32137

Last Name:_____**First Name:**_____

Mailing Address:_____

City:_____**State:**_____**Zip code:**_____

Home Phone:_____**Cell Phone:**_____

Email Address:_____

Social Security #: (REQUIRED FOR INSURANCE)_____

Date of Birth:_____**Male:**_____**Female:**_____**Race:**_____

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

Employers Name:_____

Employers Address:_____

Occupation:_____

Emergency Contact:_____**Phone:**_____

Relationship:_____

Primary Insurance:_____**ID#:**_____

Subscribers Name:_____**DOB:**_____

Subscribers SS#(REQUIRED FOR INSURANCE)_____

Secondary Insurance:_____**ID#:**_____

Subscribers Name:_____**DOB:**_____

Subscribers SS#(REQUIRED FOR INSURANCE)_____

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 of emergency.

Name:_____**Phone:**_____**Relationship:**_____

Name:_____**Phone:**_____**Relationship:**_____

Name:_____**DOB:**_____

Reason for Visit:_____

Allergies:_____

Family History:
1. Diabetes_____**2.Thyroid**_____**3. Asthma**_____

4.Cancer_____**5.High Cholesterol**_____**6.Heart Disease**_____

Hospital Admissions/Surgeries:

Year:_____**Illness or Operation:**_____

Year:_____**Illness or Operation:**_____

Vaccines/Dates:

Tetanus:_____**Pneumonia:**_____**Shingles:**_____**Influenza:**_____

Personal Medical History: (Circle)

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 Lesions**
Palpitations	**Hypertension**	**Rashes**	**Other:**_____

Date of last EKG_____**Colonoscopy**_____**PSA**_____**Eye Exam**_____

PAP_____**Mammogram**_____**Dexa/Bone Scan**_____

Social History:

Do You Smoke: YES___NO___ if so, how many packs 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_____

NAME:_____ **DOB:**_____

List of Current Medications:

Name of Medications:	**Dose**	**How Often**	**Reason**	**Doctor That prescribes**
Example: Aspirin	81 mg	Once daily	Heart	OTC (over the counter)

Greg A. Cisneros, M.D.

Patient_____**DOB**_____

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 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, 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 Statues, 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 Medical 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, co-pay and co-insurance. 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 Reason Patient unable to sign

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FINANCIAL POLICY:
We Require payment **in full due at the time of the service,** for Self-Pay patients. We do not balance bill. I understand I will not be filing to an insurance carrier. **Visa, MasterCard, Discover and Cash are 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, Discover and Cash are accepted.**

I fully understand if I do not pay for services upon check in/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 before your appointment , if your insurance changes, or if any information regarding your insurance identification or group number changes.

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 a 1.5% interest for balances over 30 days. Your account will be assessed a late fee of $25.00 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 handles by our collection agency.

I understand that all fees, co-payments, deductibles, and c0-insurance amounts are based on estimated charges which mat 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.
17 N Old Kings Rd. Suite J
Palm Coast, FL 32137

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 detailed 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 have missed appointments, you may not be rescheduled for future appointments and may 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 it;s 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**

Greg A. Cisneros, M.D.
17 N Old Kings Rd. Suite J
Palm Coast, FL 32137
P# 386-446-4141
F# 386-264-6764

Medical Records Release Form

Date:_____

From Doctor or Facility:_____

Address:_____

I hereby authorize and request you to release my record 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 SUCH AS EYE EXAMS, COLONOSCOPIES ETC..

Patient Name:_____
Printed name

DOB: _____

Address:_____

_____

_____
Patient and/or legal guardian signature

Authorization for Cell Phone and Text Message Appointment Reminders

NAME:_____DOB:_____

I authorize **Gregory A. Cisneros M.D**. to use my cell phone number to call regarding appointments, treatment, insurance and my account.
_____ (Initial)

I authorize **Gregory A. Cisneros M.D.** to send Appointment Reminders electronically via Text Message to my mobile phone. I understand that this service is offered free of charge, however, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the following patient/mobile phone number:

MOBILE #:

_____

Patient Signature:_____

Date: _____ (OR Patient/Legal Guardian)

Authorization for Email Appointment Reminders

I consent to receiving email communications from **Gregory A. Cisneros M.D.** regarding treatment, insurance, my account and practice updates to the following email address:

EMAIL ADDRESS:

_____

Patient Signature: _____

(OR Patient/Legal Guardian)