Infectious Diseases Associates
OF NORTH CENTRAL FLORIDA

Tel: (352) 622-2020
Fax: (352) 622-2025
3306 SW 26th Ave. #104
Ocala, Florida 34471
www.IDocala.com

PATIENT INFORMATION

Please answer all questions to the best of your ability. PLEASE, do not leave any blanks.

LAST NAME_____ **FIRST**_____ **MI**_____

SSN#_____ **DATE OF BIRTH**_____

ADDRESS_____
Street *City* *State* *Zip*

PHONE#_____ **CELL#**_____

EMAIL: _____

MARITAL STATUS: **S M W D Other** **SEX:** **M F**

PRIMARY LANGUAGE_____

RACE _____ **HISPANIC/LATINO** _____ **NON HISPANIC/LATINO**____

SPOUSES NAME_____ **DATE OF BIRTH**_____

PRIMARY PHYSICIAN_____

REFERRING PHYSICIAN_____

EMPLOYER_____ **PHONE#**_____

EMPLOYER ADDRESS_____
Street *City* *State* *Zip*

A PERSON WHO DOES NOT LIVE WITH YOU IN CASE OF AN EMERGENCY

NAME_____ **PHONE#**_____

INSURANCE 1_____ **Policy#** _____

INSURANCE 2_____ **Policy#**_____

DO YOU HAVE A COPAY? YES NO **WHAT IS THE COPAY? $**_____

Infectious Diseases Associates
OF NORTH CENTRAL FLORIDA

Tel: (352) 622-2020
Fax: (352) 622-2025
3306 SW 26th Ave. #104
Ocala, Florida 34471
www.IDocala.com

ASSIGNMENT OF BENEFITS FORM

Name of Insured: _____

I hereby assign all medical benefits to which I am entitled to "Infectious Diseases Associates of North Central Florida, LLC".

This applies for all insurance carriers, including Medicare, private insurance, and any other health/medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changes in insurance coverage.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

(Note: On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.)

SIGNATURE: _____DATE:_____

HIPAA

On April 14, 2003, the state of Florida passes a Patient Privacy Act. The paperwork that we are asking you to fill out is a federal law and must be in all patient charts. If you would like to designate someone to have access to your medical records for any reason, such as appointments, test results, picking up prescriptions, or having any other information on your chart, please let us know and we will have you fill out a form for that.

Notice of Privacy Act Acknowledgement

I acknowledge that the notice of privacy practices has been given or made available to me upon request by 'Infectious Diseases Associates of North Central Florida, LLC'.

SIGNATURE:_____DATE:_____