ALLIANCE MEDICAL ASSOCIATES, INC.

Date: ______________________

ALLERGIC TO: ______________________

Pharmacy Name / Phone#: ______________________

____

Account #: ______________________

1. Were you injured on the Job?
2. Were you injured in an auto accident?
3. What date did you first consult us for this condition?

PATIENT

Name, Last: ______________________ First: ______________________ Middle Initial: __________

Previous Full Name and/or Maiden Name: ______________________

Your Address: ______________________ P.O. Box/R.R. Route: ______________________

City: ______________________ State: ______________________ Zip: __________

Phone: (_____) ______________________ S.S. #: _____ - _____ - ________ Birth Date: _____ / _____ / _____ Age: ______

Marital Status: ______________________

Email: ______________________

YOUR EMPLOYER:

Name: ______________________ Department: ______________________

Address: ______________________ Occupation: ______________________

City: ______________________ State: __________ Zip: __________ Phone: (_____) ______________________ Ext: ______

Name of Supervisor: ______________________

HUSBAND/WIFE's Name: ______________________ DOB: ______________________

S.S. #: _____ - _____ - ________

EMERGENCY:

Name: ______________________ Relationship: ______________________ Phone: (_____) ______________________

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to Alliance Medical Associates, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

____
(signature of patient)

____
(signature of parent)

Date: ______________________

MEDICAL HISTORY

Name ______________________ SS # ______________________ Date ______________

Address ____ Occupation ______________

Phone (home) ______________ (work) ______________ Date of birth ______________

Chief complaint ____

DRUG ALLERGIES

CURRENT MEDS

FAMILY HISTORY

	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/convulsions						
Bleeding disorder						
Kidney disorder						
Thyroid disease						
Mental illness						
Osteoporosis						

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? _____ Yes _____ No Planning pregnancy? _____ Yes _____ No

MEDICAL HISTORY

Headache	Lactose intolerance	Depression
Shortness of breath	Gallbladder disease	Gout
Heart palpitations	Prostate disease	Scarlet fever
Heart murmur	Bowel irregularity	Chronic rashes
Chest pain	Incontinence	Rheumatic fever
Dizziness/fainting	Sexual/menstrual dysfunction	Mumps
Peripheral vascular disease	Venereal disease	Measles
Allergies/hay fever	Frequent infections	Rubella
Asthma	Hepatitis	Polio
Bronchitis	Anemia	Diptheria
Pneumonia	Arthritis	Tetanus
Ulcer	Osteoporosis	
GI disorder	Nervousness	

HABITS

Smoke:	Coffee:	Sleep:
Packs daily ______	Cups daily ______	Difficulty falling asleep ______
How long? ______	other caffeine ______	Continuity disturbances ______
Interested in stopping? ______	Alcohol Type/amount ______	Snoring ______
Contact with blood or body fluid at work	Diet Salt intake ______	Early morning awakening ______
______	Fat intake ______	Daytime drowsiness ______

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Alliance Medical Associates, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Alliance Medical Associates Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy practices prior to signing this consent.

Alliance Medical Associates, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Alliance Medical Associates, Inc.'s Privacy Officer at 1800 S.E. 17th Street, Building 800, Ocala, FL 34471.

With my consent, Alliance Medical Associates, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent Alliance Medical Associates, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Alliance Medical Associates, Inc. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Alliance Medical Associates, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Alliance Medical Associates, Inc. may decline to provide treatment to me.

I have received, read and acknowledged the Privacy Policy of Alliance Medical Associates, Inc.

____

Signature of Patient of Legal Guardian

____ ____________________

Patient's Name ***Date***

____

Print Name of Patient or Legal Guardian

M.W. Kang, M.D. **Anwar A. Khan, M.D.** **Jessie D. Te, M.D.**

Alliance Medical Associates, Inc.

1800 S.E. 17th Street - Building 800 Ocala, FL 34471 (352) 622-7268

10969 S.E. 175th Place Road – Suite 200 Summerfield, FL 34491 (352) 307-2112

FLORIDA

DECLARATION

Declaration made this ______________________ day of ______________________ (month,year).
I, ____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time I should have a terminal condition and if my physician has determined that there can be no recovery from such condition and that my death is imminent, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

Other directions:

If the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Designation Clause*

I authorize ____,

residing at ____,

to make treatment decisions on my behalf should I be:

(1) diagnosed as suffering from a terminal condition and
(2) comatose, incompetent or otherwise mentally or physically incapable of communication.

I have discussed my desires concerning terminal care with this person, and I trust his/her judgment on my behalf. I understand that if I have not filled in any name in this clause, my declaration will nevertheless be given effect should the appropriate circumstances arise.

Signed ______________________________

The declarant is known to me and I believe him or her to be of sound mind.

Witness ______________________________ Witness ______________________________

* *Designation of proxy is an optional provision in Florida's Life-Prolonging Procedure Act, Fla. Stat. 765.05(2), which does not specify its form. Wording of the clause is suggested by the Society for the Right to Die. If you choose not to use the Designation Clause, it is advisable to draw a line through it.*

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Notice of Privacy Practices.

and

I authorize information to be discussed with/released to another individual: YES / N0

____________________________ __________________________

Individuals Name Relationship

____________________________ __________________________

Individuals Name Relationship

and

I consent to information being left on my answering machine: YES / NO

________________________ _________________________ _____________

Name (Please Print) Signature Date

Date acknowledgement received____

Or

Reason acknowledgement was not obtained

____

____

____

________________________ _________________________ ____________

Employee/Rep Name Signature Date

EFFECTIVE IMMEDIATELY, ANY PAST DUE BALANCE MORE THAN 30 DAYS OLD; WILL BE FORWARDED TO A COLLECTION AGENCY THAT PROCESSES THROUGH THE CREDIT BUREAU.

YOU WILL BE RESPONSIBLE FOR THE FEES INCURRED WHICH MAY BE 30-60% ADDED TO YOUR BALANCE DUE.

WE APPRECIATE YOUR PAYMENT DUE AT THE TIME OF YOUR VISIT WITH THE PHYSICIAN.

THANK YOU FOR YOUR COOPERATION.

MANAGEMENT.

____

PATIENT NAME/SIGNATURE

____

WITNESS

____

DATE

ALLIANCE MEDICAL ASSOCIATES, INC
1800 SE 17th Street, Suite 800
Phone: (352) 622-7268
Fax: (352) 622-6045

ATTENTION!

EFFECTIVE IMMEDIATELY
ALL PATIENTS THAT NO-SHOW
WITHOUT A 48 HOUR CANCELATION
NOTICE WILL BE ISSUED A $50 FEE
PER NO-SHOW.
YOU MAY BE DISCHARGED AS A
PATIENT FOR NO-SHOWS AND/OR
CANCELATIONS TO YOUR
APPOINTMENTS.

THANK YOU, MANAGEMENT.

Signature: ______________________________ Date: _______________

ALLIANCE MEDICAL ASSOCIATES, INC.
1800 SE 17TH Street Suite 800
Ocala, FL 34471

Insurance Information

Do you have Medicare Insurance? ________ Yes ________ No

If "Yes", what is your Medicare number? ____________________

If "No", what is the name of your insurance carrier? ____________________

Insurance address: ____________________

Group #____________________ ID# ____________________

Subscriber's Name: ____________________ DOB: __________ SS#_____-_____-_____

Does your insurance require pre-admission certification: ________ Yes ________ No

If "Yes", please provide us with the telephone number: (_____)____________________

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in correct billing procedures, please answer the following questions:

1.) Is your illness due to:
   A. A work-related condition? ________ Yes ________ No
   B. An automobile accident? ________ Yes ________ No
   C. The fault of another party? ________ Yes ________ No
2.) Are you eligible for coverage under the Veteran's Administration? _____ Yes _____ No
3.) Are you a student? ________ Yes ________ No
   If "Yes," are you a Full-Time Student? ________ Yes ________ No
4.) Are you employed? ________ Yes ________ No
   If "Yes," Employer's Name: ____________________
   Employer's Address: ____________________
   If "No," please provide date of retirement, if applicable: ____________________
5.) Is your spouse employed? ________ Yes ________ No
   If "Yes," Employer's Name: ____________________
   Spouse Employer Address: ____________________
   If "No," please provide date of retirement, if applicable: ____________________

PLEASE READ CAREFULLY In Consideration for services rendered by ALLIANCE MEDICAL ASSOCIATES, INC., I hereby agree to release the information requested, as needed, by my insurance company and assign insurance benefits to ALLIANCE MEDICAL ASSOCIATES, INC. I further agree to be solely responsible for any balances my insurance carrier does not pay.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT.

SIGNATURE: ____________________ DATE: ____________________

RELATIONSHIP TO PATIENT: ____________________

I request that payment of authorized Medigap benefits be made on my behalf to ALLIANCE MEDICAL ASSOCIATES, INC. for any services rendered by ALLIANCE MEDICAL ASSOCIATES, INC.

SIGNATURE: ____________________ DATE: ____________________

CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____

(Patients name)

____

(BIRTH DATE) (MEDICAL RECORD NO.)

I HEREBY AUTHORIZE ______________________________

____

____

(USE STAMP)

TO RELEASE INFORMATION IN MY MEDICAL REDCORDS, INCLUDING (UNLESS NOTED):

- Information about communicable diseases and infections, as defined by statute and Florida Department of Public Health rules (which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV" acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC").
- Alcohol and drug abuse treatment information protected under the regulations in 42 code of federal regulations, part 2.
- Mental health treatment records, psychological services and social services information communications made by me to a social worker or psychologist.

I AUTHORIZE SUCH DISCLOSURE TO THE INDIVIDUALS OR ORGANIZATIONS LISTED BELOW IN ACCORDANCE WITH THE CONDITIONS LISTED ABOVE.

1. Person(s) or organization(s) to whom disclosure is to be made:

   Alliance Medical Associates — M. Kang, MD
   1800 SE 17th Street Building 800 — A. Khan, MD
   Ocala, FL 34471 — J. Te, MD
   Phone: (352)-622-7268 Fax: (352)-622-6045

2. Specific type of information not to be disclosed:
   ____
   ____
3. Are ALL RECORDS to be disclosed? YES _____ NO ______
4. Reason For needing such disclosure:______________________________

This authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance, on the authorization. If not previously revoked, this authorization will terminate six(6) months from the date of this signature

Signature of Patient: ______________________________ Date: ______________

(OR PARENT/GUARDIAN)

Signature of Witness: ______________________________ Date: ______________