PLEASE CIRCLE DESIRED PROVIDER

DR. JORGE A. AGUILAR

ALEXIS AULISIO, APRN

WELCOME TO OUR OFFICE
JORGE A. AGUILAR, MD, P.A. AND ASSOCIATES
905 BEACH BLVD
JACKSONVILLE BEACH, FL 32250

As your health care providers, we are committed to providing you, the patient, with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our practice policy and procedures that effect all providers and patients.

OFFICE HOURS:

Our standard office hours for scheduled appointments are from 8:00 AM to 4:00 PM Monday through Thursday. Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment.
There is a $25 missed appointment charge if not cancelled within 24 hours of the scheduled appointment.
You may call our answering service and leave a message that will be forwarded to our office the morning of the next business day.

PRESCRIPTIONS AND REFILLS:

You are responsible for your medication and their refills. Please call the pharmacy for all refill requests or notify our office of any written prescription three days in advance of your refill needs **(No less than 24 hours' notice)**. The pharmacy will notify our office of your request. **This process is much faster as we will have all the information that the pharmacy needs to do your fill**. In order to comply with the Drug Enforcement Agency there will be **NO** prescriptions called in after hours or on weekends by any on-call Provider.

I have read and understand what is expected of me, the patient.

Signature_____ **Date**_____

JORGE A. AGUILAR, MD, P.A., AND ASSOCIATES
(PLEASE PRINT)

Patient Info

Last Name:	Mobile Phone:
First Name: M.I.	Home Phone:
Address:	Work Phone:
City/State/Zip:	Date of Birth:
Sex: Male/Female (Circle One)	Social Security # **(MANDATORY)**
Employer/School	Driver's License #
Occupation:	Marital Status: M S D W (Circle One) Email Address:

Emergency contact

Name:	
Phone Number:	Relationship:

Policyholder Info: (Self/Parent/Spouse)

Last Name:	Mobile Phone:
First Name: M.I.	Work Phone:
Address:	Social Security #
City/State/Zip:	Date of Birth:
Employer:	Marital Status: M S D W (Circle One)

Local Friend/Relative (Not living with you)

Name:	Relationship:
Address:	Phone #:

Who Referred You

Name:

Insurance Info: Primary Secondary

Name:	Name:
ID #:	ID #:
Group #:	Group #:
Phone #:	Phone #:
Address:	Address:
In network: Yes / No (Circle One)	In network: Yes / No (Circle One)
Date Info Updated:	Date Info Updated:
Point of Contact:	Point of Contact:

JORGE A. AGUILAR, MD, P.A.
AND ASSOCIATES

The following questionnaire will enable our office to provide you with better healthcare. Please take a few minutes to answer each of the following questions and then return it on the day of your appointment.
All information will be strictly confidential.

Name: _____ Date: _____

Address: _____ Email: _____

Mobile: _____ Date of Birth: _____ Age: _____ Place of Birth: _____

Ethnicity: _____ Religion: _____ Education (Highest Level Attended): _____

Occupation: _____ How Long: _____

Father: Alive ☐ Deceased ☐ Present health or cause of death: _____

Mother: Alive ☐ Deceased ☐ Present health or cause of death: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

	# Alive	Health	# Deceased	Cause of Death
Brothers:				
Sisters:				
Children:				

Describe briefly the reason for your visit today and the duration of the problem:

_____

_____

How were you referred to this office? _____

At Present:

I can do my usual work ☐ Yes ☐ No I can work, but with limit ☐ Yes ☐ No

I am unable to perform my normal work ☐ Yes ☐ No

Drug History

List all medications that you take, including over-the-counter drugs. PLEASE BRING ALL MEDICATION TO YOUR FIRST APPOINTMENT:

DRUG	**STRENGTH**	**HOW OFTEN**

Have you ever had drug dependency? _____

List all medication you have had a bad reaction or allergy to. What type of reaction? _____

_____

_____

Have you ever had any of these immunizations?

	Yes	No		Yes	No
Tetanus	☐	☐	TB Skin Test	☐	☐
Rubella	☐	☐	Flu Vaccine	☐	☐
Pneumonia/Prevnar	☐	☐	Hepatitis A or B	☐	☐

Date of last physical exam: _____

List all previous hospitalizations and surgical procedures: _____

_____

_____

_____

_____

_____

_____

Please indicate which of the below you have used:

	Yes	No	What amount	Duration	If quit, when?
Tobacco	☐	☐			
Alcohol	☐	☐			
Caffeine	☐	☐			

Have you worked around the following?

	Yes	No		Yes	No
Fumes	☐	☐	Asbestos	☐	☐
Toxic Substances	☐	☐	Noise	☐	☐
Dust	☐	☐	Radiation	☐	☐

Have you traveled to a foreign country within the last year? If so, Where? _____ When? _____

Please indicate if you have ever had the following exams and date of last exam:

	Yes	No	When		Yes	No	When
Eye Exam	☐	☐	_____	Abdominal Ultrasound	☐	☐	_____
Colonoscopy	☐	☐	_____	Aortic Ultrasound	☐	☐	_____
Chest X-ray	☐	☐	_____	Abdominal CT/MR	☐	☐	_____
Upper/Lower Endoscopy	☐	☐	_____	Breast X-ray (Mammo)	☐	☐	_____
Cardiac Stress Test	☐	☐	_____	HIV/HEP C	☐	☐	_____
Lower ext. Ultrasound	☐	☐	_____	Angiogram, Biopsy	☐	☐	_____
Carotid Ultrasound	☐	☐	_____	Other Diagnostic Eval	☐	☐	_____

Please indicate if any immediate family members have had any of these conditions:

	Yes	No	Relationship		Yes	No	Relationship
Alcoholism	☐	☐	_____	Migraines	☐	☐	_____
Arthritis	☐	☐	_____	Kidney Stones	☐	☐	_____
Asthma	☐	☐	_____	Gallbladder Stones	☐	☐	_____
Chronic Bronchitis	☐	☐	_____	Anemia	☐	☐	_____
Emphysema	☐	☐	_____	Mental Illness	☐	☐	_____
Cystic Fibrosis	☐	☐	_____	Thyroid Disorder	☐	☐	_____
Cancer	☐	☐	_____	Tuberculosis	☐	☐	_____
Cirrhosis/Liver Disease	☐	☐	_____	Colon/Rectal Polyps	☐	☐	_____
Diabetes	☐	☐	_____	Prostate Enlargement	☐	☐	_____
Epilepsy	☐	☐	_____	Peripheral Vascular Disease	☐	☐	_____
Heart Disease	☐	☐	_____	Lupus/Rheumatoid Arthritis	☐	☐	_____
High Blood Pressure	☐	☐	_____	Glaucoma/Other Eye Disorder	☐	☐	_____
Kidney Disease	☐	☐	_____	Stroke/TIA's	☐	☐	_____

For Women Only

Are you Pregnant _____
Number of Pregnancies _____
Number of live births _____
Number of Miscarriages _____
Number of Abortions _____
Type of Birth Control used _____

Vaginal Discharge with itching or burning _____
Abnormal Vaginal Bleeding _____
Bleeding after Menopause _____
How often do you exam your breasts _____
Do you have any lumps in your breast _____
The date of your last pap smear _____

Please indicate if **YOU** have had any of the following conditions:

	Yes	No		Yes	No
High Cholesterol/Triglycerides	☐	☐	Heart pauses	☐	☐
Diabetes	☐	☐	Congestive heart failure	☐	☐
Overweight	☐	☐	Pericarditis	☐	☐
Fever/Chills	☐	☐	Palpitations	☐	☐
Loss of Appetite	☐	☐	Heart murmurs	☐	☐
Unexplained weight loss	☐	☐	Swelling of feet, hands, or legs	☐	☐
Anemia	☐	☐	Pain in legs while walking	☐	☐
Cancer	☐	☐	Tingling/numbness of legs	☐	☐
Tumor	☐	☐	Varicose veins/Phlebitis	☐	☐
Easy bleeding or bruising	☐	☐	Difficulty breathing	☐	☐
Allergies (Hay Fever, Asthma, Hives)	☐	☐	Nocturnal shortness of breath	☐	☐
Skin problems, changes in moles	☐	☐	Lung disease	☐	☐
Ear, nose, or throat problems	☐	☐	High blood pressure	☐	☐
Thyroid disorder or nodules	☐	☐	Prolonged hoarseness	☐	☐
Glaucoma	☐	☐	Burning or urinary retention	☐	☐
Heart Disease/Ischemic or Valvular	☐	☐	Difficulty swallowing	☐	☐
Angina/Chest pain	☐	☐	Abdominal pain	☐	☐
Tuberculosis	☐	☐	Stomach/duodenal ulcer	☐	☐

	Yes	No		Yes	No
Blood in Urine	☐	☐	Fried/spicy food intolerance	☐	☐
STI	☐	☐	Nausea/vomiting	☐	☐
Arthritis	☐	☐	Sputum production	☐	☐
Pain/Swelling of the joints	☐	☐	Hiatal hernia	☐	☐
Back trouble/pain	☐	☐	Liver disease	☐	☐
Gout	☐	☐	Change in bowel habits	☐	☐
Frequent/severe headache	☐	☐	Colon or bowel disorder	☐	☐
Epilepsy/seizures	☐	☐	Constipation/diarrhea	☐	☐
Dizziness/blackouts	☐	☐	Bloody/tarry stool	☐	☐
Stroke/transient weakness of extremities	☐	☐	Frequent bladder/kidney infection	☐	☐
Slurred speech/loss of vision	☐	☐	Kidney gallstones	☐	☐
Mental Disorders	☐	☐	Urinary problems	☐	☐
Difficulty sleeping	☐	☐	Nervous/anxious	☐	☐
Previous blood transfusion	☐	☐	Loss of sexual interest/impotence	☐	☐
Other conditions	☐	☐			

If you answered yes to any of the above, briefly explain: _____

Name of other healthcare providers:	Reasons you are seeing them:

Dr. Jorge Aguilar and Alexis Aulisio APRN's commitment is to provide you with comprehensive health treatment and thanks you for your helpful answers to achieve that goal.

LIVING WILL

Declaration made this _____ day of _____ 20____

I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do thereby declare:

That at any time I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition:

1. 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 and,
2. I ☐ do ☐ do not desire that nutrition and hydration (food and water) be administered to me artificially through an invasive procedure.

It is my intention that declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that it has been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate the following in the following order as my surrogate to carry out the provisions of this declaration:

1. _____
2. _____

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

Signature _____ Date _____

Witnesses:

Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:

****

I, _____ decline this form Date: _____

****

HIPPA Notice of Privacy Practices

JORGE A. AGUILAR, MD P.A.
905 BEACH BOULEVARD
JACKSONVILLE BEACH, FL 32250
904-241-8300

Patient Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996- (HIPAA) Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments.

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of **Dr. Aguilar and Associates**. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment**. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **Payment**. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **Health Care Operations**. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services**. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research**. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst **Dr. Aguilar and Associates** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates**. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Organ and Tissue Donation**. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation**. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks**. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence**. We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities**. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes**. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
- **Law Enforcement**. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security**. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**
- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify with, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Payment for Your Care**. Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider does not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
- **Disaster Relief**. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities**. We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy**. You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal need-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Summary or Explanation**. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records**. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
- **Receive Notice of a Breach**. You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments**. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must

tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Accounting of Disclosures**. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Request Restrictions**. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Request Confidential Communications**. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing, and you must specify how or where we are to contact you.
- **Paper Copy of This Notice**. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by asking any front desk personal.
- **Changes to This Notice**
  We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future.
- **Complaints**
  If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer, at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. You will not be penalized for filing a complaint. Notice Effective 9/23/2013

I acknowledge that I read and/or received a copy of the Patient Notice of Privacy Practices effective September 23, 2013.

Print Name:_____ Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's name: _____ SSN: _____
Date of birth: _____ Phone No. _____

I AUTHORIZE: **Jorge A. Aguilar, MD, PA & Associates**
905 Beach Blvd.
Jacksonville Beach, FL 32250
P: 904-241-8300 F: 904-241-0831

PLEASE CHECK ONE OF THE FOLLOWING AND INCLUDE NAME, ADDRESS AND PHONE NUMBER

☐ To obtain from: _____
_____
_____

☐ To release to: _____
_____
_____

INFORMATION TO BE RELEASED: 12 months of records will be copied unless otherwise indicated.
(Please circle Yes or No for each category listed)

Y	N	Medical History	Y	N	Operative Reports	Y	N	Consultations
Y	N	Treatment/Test	Y	N	Lab Results	Y	N	Imaging Results
Y	N	Pathology Report	Y	N	Hospital Records	Y	N	HIV/AIDS Record
Y	N	Social History	Y	N	Medication List	Y	N	Sexual Assault Record
Y	N	Mental Health Record	Y	N	Child Abuse Record	Y	N	Medical Examiner's Report
Y	N	Venereal Disease	Y	N	Substance Abuse Record	Y	N	Minor's Report

Y N Other (Specify) _____

This information is needed for the following purpose(s): _____

I understand that these records are of privileged and confidential status. I waive that status for the purpose contained within this authorization. l agree to hold Jorge A. Aguilar MD, P.A. & Associates harmless form any and all cost, liability and damages of any nature whatsoever, including attorney fees: resulting directly or indirectly from Jorge A. Aguilar, MD, P.A. & Associates release of these records pursuant to this consent. This authorization will automatically expire ninety (90) days following date of signature without my express revocation.

I acknowledge that I have read and understand this authorization and its content.

Signature of Patient **Date** **Relationship to patient if signed by guardian**

Witness **Date** **Reason patient is unable to sign**

Prohibition of redisclosure. This information is being disclosed to you from records whose confidentiality is protected by state laws, specifically Florida Statutes 395.3025,455.667 and 394.59 State laws prohibit you from any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A general authorization is not sufficient for this purpose.

Sent by: _____ FAX PICK UP MAIL DATE COMPLETED: _____

DO NOT FAX MORE THAN 14 PAGES AT A TIME

Jorge A. Aguilar, MD, P.A and Associates

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AN AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

Please read and sign the following:

1. **I authorize this office to release or receive any information necessary to expedite insurance claims.**
2. **I hereby authorize this office to bill my insurance company directly for their services.**
3. **I authorize payment directly to my Physician of any insurance benefits otherwise payable to me.**
4. **In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my Physician for which these fees are payable.**

I understand that I am directly and fully financially responsible to my Physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my doctor's bill directly.

I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

There will be a $25.00 Office Charge + Bank Charges, which must be paid.

I have read and understand what is expected of me, the patient, in relation to any care, my insurance carriers and my financial responsibilities.

Signature _____ **Date** _____

PLEASE PRESENT BOTH YOUR INSURANCE CARD AND YOUR DRIVERS LICENSE SO THAT WE MAY MAKE A COPY FORYOUR RECORDS.

INSTRUCTIONS

We prefer you to drop off forms directly to our office in order to expedite your appointment. Other options are faxing, emailing, or mailing the forms to us.

If faxing forms, please fax to 904-241-0831

Email to 905eaglebuilding@gmail.com

or

Mail to: Jorge A. Aguilar, MD, P.A. and Associates

905 Beach Blvd, Ste. A

Jacksonville Beach, FL 32250

Please call if you have any questions.

904-241-8300 ext. 201