James McCauley, M.D.
Efrain Rosario-Carlo, M.D.
Cami Cowart, ARNP
Crystal Baumann, ARNP
15260 NW 147th Drive, Alachua, Florida 32615
Phone: 386-418-1222 Fax: 386-418-0622

Today's Date: _____

Patient Name: _____ DOB _____ Sex _____ Soc Sec: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Marital Status: Married ____ Single ____ Other ____ Ethnicity: _____ Race: ____ Language: _____

Employer: _____ Occupation: _____ Phone: _____

Spouse Name: _____ Phone: _____

Responsible Party if Minor: _____ DOB: _____ Phone: _____

Local Pharmacy: _____ Phone: _____

Mail Order Pharmacy: _____Phone: _____

Consent to Treat

Recognizing the need for medical care, I do hereby consent to the services as ordered by my care Provider including routine examinations, laboratory procedures, medical or surgical treatment, x-ray examination, or other medical services rendered under the general and specific instructions of McCauley & Associates Medical Group.
I hereby give my consent and authorize McCauley & Associates to treat existing conditions and any conditions which may arise during my association with my care provider.
I understand that the care provider will explain and condition(s) to me, and any treatment procedures or alternative methods of treating my condition(s). The care provider will discuss with me foreseeable risks of any stated treatment and I understand that there may be undesirable results. I authorize the care provider and his or her employee(s) to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not previously known.
I have carefully read an understand this consent to treatment form.

_____ _____

Signature of Patient/Legal Guardian Date

Insurance Assignment Authorization and Authorization to Release Information

I. RELEASE OF INFORMATION – I, the below named patient do hereby authorize any physician examining and/or treating me to release to any third party payor any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under the Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor. It is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for insurance or third-party payor within a reasonable period not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date: _____ Patient Signature: _____

Subscriber (If different from patient): _____

ORIGINAL SIGNATURE ON FILE AT PHYSICIANS OFFICE MEDIGAP (SECONDARY INSURANCE) SIGNATURE

_____	_____	_____
Name of Beneficiary	Health Insurance Company	Medigap Policy Number

I request payment of authorized MEDIGAP benefits made on my behalf to James McCauley, MD or Efrain Rosario-Carlo, MD for any services furnished by (physician/supplier). I authorize any holder of medical information about me to James W. McCauley, MD or Efrain Rosario-Carlo, MD any information needed to determine benefits or the benefits payable for related services.

Patient Acknowledgement of Receipt of the Notice of Privacy Practices (HIPPA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

-Obtain payment from third party payers.

-Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing this document, I acknowledge that you have provided me with a copy of your Notice of Privacy Practices. This notice of privacy practices contains a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Authorization to release information:

I, _____ authorize the following person(s) to receive any and all medical information about me.

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

_____ _____

Signature of Patient/Guardian Date

Advanced Directive Notification

Advanced Directives are properly executed documents allowing you to give directions about future medical and psychiatric care or to designate another person to make medical and psychiatric decisions for you if you lose the ability to make decisions for yourself.

_____ I have an Advanced Directive/Living Will/Medical Power of Attorney/Do Not Resuscitate Order (Circle all that apply)

_____ I do not have an Advanced Directive

_____ I wish to initiate an Advanced Directive

_____ _____

Signature of Patient/Legal Representative Date

Medications/Over the Counter Medications/Vitamins/Supplements

Medication Name	Dosage	Frequency

Allergies

Please list all drug/medication allergies you may have or are aware of:

Allergy	Reaction/What Happened

Hospitalizations/Surgery

Date	**Operation/Illness**	**Name of Hospital**	**City, State**

Falls

Have you had any falls within the last 6 months? _____

Do you feel weak, dizzy or unsteady on your feet? _____

Do you use a walker, cane or wheelchair? If so, which one? _____

Illnesses

Condition	Date	Condition	Date	Condition	Date	Condition	Date	Condition	Date
Anemia		Chest Pain		Epilepsy		High Blood Pressure		STD	
Arthritis		Colitis		Gallstones		HIV		Thyroid Disease	
Asthma		Depression		Gout		Kidney Stones		Yellow Jaundice	
Anxiety		Diabetes		Heart Trouble		Liver Disease			
Bipolar		Diverticulosis		Heart Murmur		Mental Illness			
Blood Transfusion		Drug Addiction		Hepatitis		Plebitis/Blood Clots			
Cancer		Emphysema		Hemorrhoids		Rheumatic Fever			

Family History

Relationship	**Age, if living**	**Age at death**	**Cause of death**	**Please check if your blood relatives have had any of the following and relation to you**
Father				Allergies
Mother				Arthritis
Brothers				Asthma
				Cancer(type)
				Diabetes
				High Blood Pressure
Sisters				Kidney Stones
				Stroke
				Tuberculosis
				Heart Disease (Heart Failure/InFarct/Other)
Spouse				High Cholesterol
Children:				Mental Illness
Son				Other
Daughter				

Social History

Smoker _____ If so, how much? _____ How long? _____

Non-Smoker _____

Alcohol _____ If so, how often? _____ How long? _____

Drink Caffeine: yes or no

Exercise: yes or no

Children: _____ If so, how many? _____

Immunizations

Vaccination	Date
Prevnar 13	
Pneumococcal Pneumonia	
Zostavax	
Tetanus	
Flu Shot/Influenza	
TB Test	
Stool Blood Test (Hemoccult)	
Shingrix, 2 doses	
Other	

Test

Procedure	Date	Where Performed	Doctor who performed test
Mammogram			
Colonoscopy			
Pap Smear			
Bone Density			
Diabetic Eye Exam			
Other Imaging (CT, MRI)			
Echocardiogram			
EKG			
Stress Test			
Flexible Sigmoidoscopy			
Barium Enema/Colon x-ray			
Other			

Practice Guidelines & Patient Financial Policies

Emergencies: Our Providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you will call 911 and seek the nearest emergency room.

Prescription Refills and Prior Authorizations: It is our policy that you must be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled at patient visits or by pharmacy request. This includes mail order pharmacies. Phone call refills may take up to 72 hours to be completed. We cannot take weekend, walk in, or after hours' refill request. Patients must bring a copy of their pharmacy formulary for mediation coverage. Patients are responsible for providing what medication their insurance plan will cover. This helps decrease the amount of prior authorizations for the nursing staff and numerous prescriptions by the Doctors for meds not covered by plans.

Telephone encounters and sick patients: Our practitioners do not treat new patients or new illnesses over the telephone. The physician may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the telephone.

Information: You agree to provide your correct name, current and correct address, cellular or other phone number, insurance information, social security number, driver's license, or photo identification (no copies accepted) at the time of registration, or as requested by the practice at any time.

Financial Responsibility: By initialing and signing below, you accept financial responsibility for all charges rendered by you. If a minor or under guardianship, the parent or guardian accompanying the minor assumes this liability.

Payment Methods: We accept cash, check, and credit cards. See receptionist regarding credit cards and insurance companies in which the practice participates.

Appointments: We require a 24-hour notice of cancellation as a courtesy to other patients seeking services. A $25.00 fee will be charged for missed appointments. A pattern of missed appointments may result in a discharge from the practice.

Medical Records: The medical chart is the property of the practice. However, copies of your medical information are available upon request. The practice charges a fee of $1.00 per page for the first 25 pages and $0.25 for every page after that. Medical records requested by another physician's office are submitted for no charge with a signed release form.

Insurance copayments, deductibles and coinsurance: Insurance companies do not pay all fees and may exclude certain services form coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or noncovered services are to be paid in a timely manner. You accept responsibility for all expenses even if your insurance company is billed as a courtesy.

Statement Policy: Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of the statement may be delayed until your insurance responds to a claim for services. Such a delay may take months. Patients are still responsible for all service fees.

Collection and bank fees: Accounts more than 90 days old are subject to be transferred to an outside collection agency. Banks charge for checks that do not clear or cannot be cashed. A $25.00 returned check fee will be charged for returned checks.

Patient Discharge: The practice may discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. Due to quality of care concerns, the practice may discharge you for failure to comply with treatment plans outlined by your physician.

Insurance Claims: Our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event the insurer send payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all the terms of this policy and by my signature below, I attest that I fully understand each item and agree to the above.

Signature: _____ Printed Name: _____

Date: _____

Sign up for our patient portal!

You can now send messages to your nurse, request appointments, refills and view your medical records on line. Please provide us with your email and we will give you a sign on.

Email _____

James McCauley, M.D.

Efrain Rosario-Carlo, M.D.

Cami Cowart, APRN

Crystal Baumann, APRN

15260 NW 147th Drive, Alachua, Florida 32615

Phone: 386-418-1222 Fax: 386-418-0622

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Mailing Address: _____

Phone#: _____ Other Phone #: _____

Clinic/Other Physician Info to be released from:

Clinic Name _____ Physician Name _____

Address _____

Phone _____ Fax _____

Medical Records Date of Service Requested: _____

Please fax requested documents to (386)418-0622 or mail them to the above listed address if the content is too much to transmit vis facsimile.

_____ Clinic/Office Notes
_____ Mental Health/ Occupational/Workers' comp
_____ Labs/X-ray/Mammogram Reports
_____ All the Above (including records relating to HIV, Alcohol/drug treatment, communicable disease and/or those marked confidential)

_____ Hospital Reports
_____ Immunizations
_____ Other _____

Reason for release:

_____ Legal
_____ Consult/Second Opinion
_____ Insurance claim report
_____ Out of town move
_____ Selected new Physician
_____ Referred by Dr. _____

Authorization: I authorize the above provider to release the information marked above to the recipient, McCauley & Associates.

_____
Signature of Patient/Guardian

_____
Relationship to Patient

_____
Date of Patient signature

_____
Reason Patient unable to sign