CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

NAME: _____
LAST FIRST MIDDLE

HOME ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ DATE OF BIRTH: _____ AGE: _____

CELL#: _____ SSN: _____ SEX: MALE / FEMALE

EMERGENCY CONTACT AND PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

SPOUSE'S NAME: _____ WORK PHONE: _____

INSURANCE INFORMATION:

AUTO OR HEALTH INSURANCE (CIRCLE ONE)

PRIMARY INSURED PARTY: _____ RELATIONSHIP: _____

INSURANCE COMPANY: _____ INSURANCE PHONE: _____

ADDRESS: _____

POLICY #: _____ CLAIM #: _____

SECONDARY INSURED PARTY: _____ RELATIONSHIP: _____

INSURANCE COMPANY: _____ INSURANCE PHONE: _____

ADDRESS: _____

POLICY #: _____ CLAIM #: _____

MEDICAL INFORMATION:

REASON FOR TODAY'S VISIT? _____

WHAT ARE YOUR SYMPTOMS? _____

WAS THIS ACCIDENT: ( ) AUTOMOBILE ( )JOB INJURY ( ) OTHER

DATE OF ACCIDENT OR INJURY: _____

CONFIDENTIAL PATIENT INFORMATION

PAST MEDICAL HISTORY: HAVE YOU EVER BEEN TREATED FOR:

	NO	YES		NO	YES
ANEMIA			HIGH BLOOD PRESSURE		
ULCER			CANCER		
ASTHMA			EPILEPSY		
STROKE			DIABETES		
BLEEDING DISORDER			HEART ATTACK		
HIV/AIDS			EMPHYSEMA		
LIVER PROBLEMS			KIDNEY PROBLEMS		
HEART DISEASE / ANGINA			ALCOHOL OR DRUG ABUSE		

ARE YOU CLAUSTROPHOBIC? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO IF YES HOW MANY PACKS PER DAY? _____

CURRENT MEDICATIONS:

NAME OF MEDICATION(S)	TAKEN FOR

ALLERGIES:

_____

_____

SURGERIES:

_____

_____

FAMILY HISTORY: PLEASE LIST ANY SERIOUS ILLNESS THAT HAVE OCCURRED IN YOUR FAMILY:

CANCER	☐ YES ☐ NO	LOCATION OF CANCER: _____	RELATION: _____
HEART DISEASE	☐ YES ☐ NO	RELATION: _____	
HIGH BLOOD PRESSURE	☐ YES ☐ NO	RELATION: _____	
STROKE	☐ YES ☐ NO	RELATION: _____	
DIABETES	☐ YES ☐ NO	RELATION: _____	
INTERCRANIAL ANEURYSM	☐ YES ☐ NO	RELATION: _____	
BRAIN TUMOR	☐ YES ☐ NO	RELATION: _____	
OTHER SERIOUS ILLNESSES	☐ YES ☐ NO	RELATION: _____	

PLEASE SPECIFY : _____

CONFIDENTIAL PATIENT INFORMATION

REVIEW OF SYSTEMS: DO YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

GLAUCOMA	☐ YES	☐ NO	
WEARING HEARING AIDS	☐ YES	☐ NO	DATE OF LAST EXAM: _____
HEARING LOSS	☐ YES	☐ NO	
RINGING IN THE EARS	☐ YES	☐ NO	☐ LEFT ☐ RIGHT ☐ BOTH
BALANCE DISTURBANCE (e.g. VERTIGO, SPINNING)	☐ YES	☐ NO	
CHEST PAIN OR ANGINA	☐ YES	☐ NO	
HIGH BLOOD PRESSURE	☐ YES	☐ NO	
HEART MURMUR	☐ YES	☐ NO	
HIGH CHOLESTEROL	☐ YES	☐ NO	
ASTHMA	☐ YES	☐ NO	
BRONCHITIS	☐ YES	☐ NO	
EMPHYSEMA	☐ YES	☐ NO	
NAUSEA	☐ YES	☐ NO	
LIVER DISEASE	☐ YES	☐ NO	
ABDOMINAL PAIN	☐ YES	☐ NO	
BROKEN BONES	☐ YES	☐ NO	LIST: _____
BACK PAIN	☐ YES	☐ NO	
JOINT PAIN OR SWELLING	☐ YES	☐ NO	
ARM OR LEG PAIN / WEAKNESS	☐ YES	☐ NO	
ARTHRITIS	☐ YES	☐ NO	WHERE: _____
SKIN DISEASE	☐ YES	☐ NO	WHERE: _____
DOUBLE OR BLURRED VISION	☐ YES	☐ NO	
SEIZURES	☐ YES	☐ NO	
FAINTING SPELLS OR "BLACKING OUT"	☐ YES	☐ NO	
ANXIETY	☐ YES	☐ NO	
DEPRESSION	☐ YES	☐ NO	
DIABETES	☐ YES	☐ NO	
ANEMIA	☐ YES	☐ NO	
BRUSING EASILY	☐ YES	☐ NO	
T.B.	☐ YES	☐ NO	

CANCER INFORMATION

LUNG CANCER	☐ YES	☐ NO	DATE OF LAST CHEST X-RAY: _____
COLON CANCER	☐ YES	☐ NO	
PROSTATE CANCER (MALES)	☐ YES	☐ NO	
ENDOMETRIOSIS (FEMALES)	☐ YES	☐ NO	
UTERINE OR CERVICAL CANCER (FEMALES)	☐ YES	☐ NO	
BREAST CANCER	☐ YES	☐ NO	
SKIN CANCER	☐ YES	☐ NO	

ANY OTHER ACTIVE (MILIGNANT) CANCER _____

CONFIDENTIAL PATIENT INFORMATION

ATTORNEY INFORMATION:

ATTORNEY NAME: _____

ADDRESS: _____

STREET CITY STATE ZIP

PHONE #: _____ FAX #: _____

I UNDERSTAND THAT THIS OFFICE WILL PREPARE MY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT DR. CRIS E. LANGHEIER TO ENDORSE MY NAME TO ANY CHECK WRITTEN IN BOTH OUR NAMES, WHERE AS SUCH A CHECK IS PAYMENT FOR SERVICES REGARDING MY INJURY. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE: _____ DATE: _____

OR

GUARDIAN'S SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. Thank You.

TO:

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

YOUR NAME	**PHONE NO.** (Include Area Code) **HOME**	**BUSINESS**

YOUR ADDRESS (No,Street,City or Town,State & Zip Code) **Permanent Address if Different**	**How Long Have You Lived In Florida?**	**Date of Birth**	**Social Security #**

Date and Time of Accident A.M. P.M.	**Place of Accident (Street,City or Town & State)**

Brief Description of Accident and Vehicles Involved:(If Additional Space is Needed, Use Reverse Side)

Describe Motor Vehicle You Own:

Describe Motor Vehicle Owned By Any Member of Your Family:

As a Result of This Accident Were You Injured? YES ☐ NO ☐ If Your Answer is Yes, Complete The Rest of This Form
If No, Sign Here and Return This Form To Us.

Signature _____ DATE _____

Describe Your Injury:(If Additional Space is Needed, Use Reverse Side)

Were You Treated By A Doctor YES ☐ NO ☐	**Doctor's Name and Address**

If You Were Treated In A Hospital Were You AN IN-PATIENT? ____ OUT-PATIENT? ____	**Hospital's Name and Address**

Amount of Medical Bills To Date $	**Will You Have More Medical Expense** YES ☐ NO ☐	**At The Time of Your Accident Were You In The Course of Your Employment?** YES ☐ NO ☐

Did You Lose Wages or Salary As A Resu Of Your Injury? YES ☐ NO ☐	**If YES, Amount Lost To Date** $	What Is Your Average Weekly Wage or Salary? $

If You Lost Wages: **Date Disability From Work Began: / /** **Date You Returned To Work: / /**

Have you received or are you eligible for payments under any Workmen's Compensation or unemployment law? YES ☐ NO ☐ If YES, Amount $ Per Week Per Month

List Names and Addresses of Your Present Employer(s) and Give Your Occupation and Dates of Employment for Each.

Employer and Address	*Your Occupation*	*From*	*To*
Employer and Address	*Your Occupation*	*From*	*To*

As A Result of Your Injury, Have You Had Any Other Expenses YES ☐ **NO** ☐ If "YES", Explain On Reverse Side

SIGNATURE: _____ DATE: _____

IMPORTANT:
1. To Be Eligible For Benefits, Complete and Sign This Application
2. Sign Attached Authorization(s)
3. Return Promptly With Any Medical Bills You Have Received To Date

Langheier Healthcare

P.O. Box 1287
Tarpon Springs, Fl. 34688

Authorization for Release of Protected Health Information

Patient Name_____ Date of Birth_____

Information Requested From: _____

_____

Recipient of Information: _____ Self Other _____

Address:_____

_____

Phone #:_____

Fax#:_____

Information To Be Disclosed:

( ) All Patient intake data/patient history.
( ) All Doctor's and Nurse's notes, memos, phone messages, or other such documents.
( ) Office notes and records of office visits.
( ) All reports containing opinions, diagnosis, recommendations, or evaluations of the patient's medical condition, prognosis, disabilities, future medical needs, limitations, or ability to work.
( ) Records from other Health Care Providers.
( ) Diagnostic and lab test results, as well as, reports interpreting such tests or data.
( ) All Correspondance
( ) X- ray, CT Scan, Myelogram, bone scan, and/ or MRI reports or results.
( ) Any psychological testing reports and results.
( ) Information related to HIV tests and results.
( ) Financial Statement

Purpose of Disclosure

( ) Continuing care with another physician or hospital
( ) Personal Copy
( ) Other: _____

Authorization

I Understand that:

1. This authorization will remain in effect for 1 year.
2. I may revoke this authorization at any time in writing, but if I do , it will not affect any actions takenk prior to receiving the revocation.
3. I may refuse to sign this authorization and that is strictly voluntary.
4. My treatment, payment, enrollment, or eligibility for benefits may not be conditiones on signing thisk authorization.
5. If the requestor or receiver is not a health plan or health care provider, the release of information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I may see and obtain a copy of the information described on this form, for any reasonable copy fee, If I ask for it.
7. I will receive a copy of this form.I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I also acknowledge I have reas the above and authorize the disclosure of the protected health information as stated.

Patient/ Guardian
Signature _____ Date_____

Relationship to Patient

Patient/ Guardian
Printed Name_____ _____

Witness Signature_____ Date_____

NOTICE: PATIENT PRIVACY
October 15, 2002

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Tiffany Cole, Administrator of Langheier Healthcare at 727 943-7354.

I have received a copy of this notice for my personal file:

_____ _____
Patient signature Date

AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

RE:

To Whom It May Concern:

I hereby authorize and DIRECT you, my attorney, to PAY DIRECTLY TO **DR. CRIS E. LANGHEIER, P.O. Box 1287 Tarpon Springs, FL. 34688** such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due to this office, and to withhold such sums from any disability, medical payments benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said office.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay any additional charges equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering service at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Authorization.

I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks/forms for payment of my doctor's bill.

Patient's Signature:_____ **Date:**_____

Witness's Signature:_____ **Date:**_____

THE UNDERSIGNED, BEING ATTORNEY OF RECORD FOR THE ABOVE PATIENT DOES HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE AUTHORIZATION, AND DOES AGREE TO HONOR THE SAME TO PROTECT ADEQUATELY SAID PROVIDER NAMED ABOVE.

Attorney's Signature:_____**Date:**_____

ATTORNEY: PLEASE DATE, SIGN AND RETURN ONE COPY TO PROVIDERS OFFICE.

ASSIGNMENT OF BENEFITS/ POLICY RIGHTS

This Assignment of Benefits Concerns the following:

PATIENT: _____

PROVIDER: DR CRIS E. LANGHEIER

PROVIDER ADDRESS: _____

_____

DATE OF INCIDENT/ACCIDENT: _____

INSURANCE COMPANY NAME: _____

POLICY OWNERS'S NAME: _____

POLICY OR CLAIM NUMBER: _____

PATIENT: I, the undersigned patient, understand and agree that the above-referred Provider requires payment at the time services are rendered, in consideration of provider not requiring payment at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/ or other insurance which may be available to pay Provider on my behalf to the said Provider. This assignment is for services and/ or supplies rendered for treatment of personal injuries sustained in the automobile accident or incident on the above-referenced date to myself, the undersigned patient, who is covered by Personal Injury Protection (PIP) coverage or other insurance coverage under the above-named Policy Owner's name, in accordance with Florida Statutes 627.736(5). The undersigned is responsible for any applicable deductible or co-payment not covered by the P.I.P or other insurance coverage. PIP or other insurance policy rights, which I am assigning hereby, are to be covered through a policy of insurance with the company commonly known as the above-referred insurance company, policy or claim number. In the event an error has been made in naming the appropriate insurance company, policy, or claim number, I agree to execute any further or additional documents to remedy such error. It is my intent to assign benefits and/or policy rights from any applicable PIP, medical payments, and/or other insurance for which benefits may be paid to said Provider on my behalf as a result of injuries sustained by me in the above-referred incident/accident.

This assignment is intended to transfer all of the patient's right to collect benefits from said insurance company, including. But not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This Assignment further include the right to collect payments for the reasonable costs connected with the copying and mailing records to the insurer's request and in accordance with Florida Statues 627.736 (6). This assignment also includes any right to recover attorney's fees and costs for such action brought by the Provider as Patient's assignee. I agree that the said provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different that the attorney handling my personal injury/ bodily injury claim or case. In the event of litigation or arbitration, I agree to cooperate with the said Provider and in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, trial of case, or any other proceeding that may be reasonably required, and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this Assignment by taking a position inconsistent with the said Provider's pursuit of payment.

This Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon my execution. I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/ or necessity, that the amount of benefits claimed by the said Provider is to be set aside and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read the information herein and it is true to the best of my knowledge and belief.

_____	_____	_____
Patient/ Guardian Signature	Print Patient/ Guardian's Name	Date

Provider: The undersigned, on behalf of the above-referred Provider, hereby accepts assignment of the insurance rights and benefits for the services rendered to above-referenced patient, and to be paid directly to the above-referred Provider under the above-referred patient's Personal Injury Protection (P.I.P) or other insurance coverage with above-referred insurance carrier and in accordance with Florida Statue 627.736 et Seq.

By: _____ Date: _____

Authorized Agent/ Representative

Dr. Cris E. Langheier

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize Langheier Healthcare to use and disclose my health and medical information for the purposes of Treatment, Payment and Health Care Operations.*

***Treatment** (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

***Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Langheier Healthcare "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so <u>in writing</u>, except to the extent that Langheier Healthcare has already used or disclosed the information in reliance on this Consent.

_____
Signature of Patient

_____
Signature of Person Authorized by Law

_____
Date