



ENROLLMENT FORM

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT INFORMATION

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

ADDRESS _____ DATE OF BIRTH ____/____/____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

(Your E-mail is required to create you access to your patient portal)

SSN _____ HOME / CELL PHONE _____

ETHNICITY DID NOT SPECIFY HISPANIC/LATINO MARRIED
 NOT HISPANIC/LATINO DIVORCED WIDOWED

RACE DID NOT SPECIFY ASIAN WHITE MARRIED
 BLACK/AFRICAN AMERICAN DIVORCED WIDOWED
 AMERICAN INDIAN/ALASKA NATIVE
 NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

PREFERRED LANGUAGE _____ OCCUPATION _____

PREFERRED METHOD OF COMUNICATION _____ EMPLOYER _____

PREFERRED PHARMACY & LOCATION _____ NEXT OF KIN _____
RELATIONSHIP _____

CONTACT NUMBER _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY?

YES NO

IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____

CONTACT NUMBER _____

FIRST NAME _____ MIDDLE _____

EMAIL _____

LAST NAME _____

EMPLOYER _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ EFFECTIVE DATE _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ EFFECTIVE DATE _____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

PRINTED NAME _____



PATIENT RESPONSIBILITIES & AUTHORIZATIONS

**PLEASE READ AND INITIAL EACH LINE.
IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST FOR ASSISTANCE.**

____ I understand that my co-payment is due at each visit. Cash, check, Mastercard, and Discover cards are acceptable methods of payment.

____ I understand that I will be charged \$25 for any/all missed appointments without 24 hour notice of cancellation prior to the appointment.

____ I understand that I could be discharged from the practice for failing to provide notice of cancellation for three or more appointments.

____ I understand that I may be responsible for charges related to the completion of certain forms and letters. The cost for such forms or letters is \$25

____ I understand that I will be charged \$25 for any returned check.

____ I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account.

____ I understand that I am financially responsible for the charges not covered by my insurance, such as: deductibles, coinsurance.

____ I authorize the release of any medical or other information necessary to process the insurance claim(s).

____ I understand that I am responsible for any collection and/or attorney fees should my account be turned over to a collection agency.

____ I authorize payment directly to the billing office of this physician/clinic for the medical and/or surgical benefits, if any, otherwise payable to me for services.

____ I authorize payment of insurance benefits to the physician or supplier for all services rendered.

I UNDERSTAND AND ACCEPT THE ABOVE RESPONSIBILITIES AND AUTHORIZATIONS.
SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____
PRINTED NAME _____

CONSENT TO PHOTOGRAPH

Dr. Erich Arias, M.D. and/or his associates are authorized to take medical photographs before, during, and/or after a procedure or treatment for the professional purpose of documentation.

YES, I give my consent to be photographed. **NO**, I do not consent to being photographed.
SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____
PRINTED NAME _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this document is available upon request.

I have received a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

PRINTED NAME _____

Please list the names of anyone who the office staff may release information to on your behalf. If they are not on this list, no information will be released regarding your care or condition.

NAME		
RELATIONSHIP TO YOU		
CONTACT INFORMATION		
COMMENTS		

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

- Individual refused to accept Notice Individual was unable to sign An emergency situation prevented us from obtaining acknowledgment
- Individual refused to sign Acknowledgment Other:

HEALTH HISTORY & INFORMATION

(You can enroll and enter your medical information online at www.hl-clinic.com)

CHIEF COMPLAINT (WHY YOU ARE HERE TO SEE THE PHYSICIAN):						
YES	NO	MEDICAL HISTORY	YES	NO	MEDICAL HISTORY	OTHER, PLEASE SPECIFY:
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE (STD)	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HEREDITARY DEFECTS	
<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	RENAL DISEASE	
<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATOLOGICAL DISEASE	
<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	INFECTIOUS DISEASE	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL DISORDER	
FAMILY MEDICAL HISTORY						
MEDICATION ALLERGIES & REACTIONS			IMMUNIZATIONS		SOCIAL HABITS	
					ALCOHOL	TOBACCO
					<input type="checkbox"/> NEVER <input type="checkbox"/> RARELY <input type="checkbox"/> MODERATE <input type="checkbox"/> DAILY	<input type="checkbox"/> NEVER <input type="checkbox"/> CURRENTLY <input type="checkbox"/> QUIT DATE: _____
					RECREATIONAL DRUGS	
					SEX	
					<input type="checkbox"/> SEXUALLY ACTIVE <input type="checkbox"/> PREGNANT OR TRYING <input type="checkbox"/> INTERCOURSE DISCOMFORT <input type="checkbox"/> USE CONTRACEPTIVE(S)	ANY CONCERN REGARDING YOUR SEX LIFE? Y or N
PREVENTATIVE SCREENINGS (Check all that apply & Please indicate date of last exam)			<input type="checkbox"/> ENDOSCOPY <input type="checkbox"/> COLONOSCOPY <input type="checkbox"/> DEXA SCAN <input type="checkbox"/> MAMMOGRAM <input type="checkbox"/> PAP SMEAR <input type="checkbox"/> LUNG CANCER SCREEN		<input type="checkbox"/> OTHER, PLEASE SPECIFY:	
PAST SURGICAL HISTORY						
DATE	REASON				HOSPITAL/DOCTOR	
PREVIOUS PRIMARY CARE PHYSICIAN (PCP)						
NAME & PHONE NUMBER:						
PLEASE LIST ALL MEDICATIONS INCLUDING ANYTHING OVER THE COUNTER- (Please ask receptionist for additional paper if necessary)						
PHARMACY NAME, ADDRESS & PHONE NUMBER:						
NAME	DOSE		FREQUENCY TAKEN		PRESCRIBED BY	
CARE TEAM - PLEASE LIST ANY OTHER DOCTORS YOU SEE, THEIR SPECIALTY, AND WHAT YOU ARE BEING TREATED FOR						
NAME	SPECIALTY		CONDITION(S) BEING TREATED			



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT'S NAME _____	DATE OF BIRTH ____ / ____ / ____
ADDRESS _____	PHONE NUMBER _____
CITY _____ STATE ____ ZIP _____	SSN _____
DATE OF REQUEST _____	

<input type="checkbox"/> I AUTHORIZE HEALTHY LIVING CLINIC, LLC TO RELEASE INFORMATION TO: <hr/> NAME OF PROVIDER OR FACILITY <hr/> ADDRESS <hr/> CITY, STATE, ZIP <hr/> PHONE NUMBER <hr/> FAX NUMBER	O R	<input type="checkbox"/> I AUTHORIZE HEALTHY LIVING CLINIC, LLC TO OBTAIN INFORMATION FROM: <hr/> NAME OF PROVIDER OR FACILITY <hr/> ADDRESS <hr/> CITY, STATE, ZIP <hr/> PHONE NUMBER <hr/> FAX NUMBER
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PURPOSE FOR THIS REQUEST _____

TYPE OF RECORDS REQUESTED:

- ENTIRE RECORD
- TREATMENT SUMMARY (INCLUDES HISTORY/PHYSICAL, LABS, X RAYS, OPERATIVE REPORTS, PATHOLOGY)
- LASTS MEDICAL VISITS INCLUDING LAST NOTES, X RAYS OR LABORATORY TESTS

SPECIFIC INFORMATION

- PROCEDURE REPORT
- HISTORY & PHYSICAL
- PHYSICAL THERAPY
- LAB RESULTS
- XRAY REPORTS
- OTHER _____

AUTHORIZATION VALID FOR:

ALL AUTHORIZATIONS ARE VALID FOR ONE YEAR UNLESS SPECIFICALLY REQUESTED DIFFERENTLY BY THE PATIENT OR BY THE FACILITY THAT WE ARE REQUESTING RECORDS.

This authorization is valid only until _____.

I UNDERSTAND THAT:

I may cancel this authorization at any time by submitting a **written** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

PRINTED NAME _____