

**Gowani Medical Associates, MD, PA**

7224 Stone Rock Circle, Orlando Florida 32819

**REF PHYSICIAN:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Spouse/Guardian Name: \_\_\_\_\_ Who has Custody (If Child) \_\_\_\_\_

Home phone : (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_ Are you Disabled? \_\_\_\_\_ Date: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT \_\_\_\_\_

Nearest Relative not Living with you \_\_\_\_\_ : Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How were you referred to our office? (Referral Source) \_\_\_\_\_

**Responsible Party (if someone other than patient)**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number : \_\_\_\_\_

Home phone : (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Responsible party is also the Policy Holder for Patient  Primary Insurance Holder  Secondary Insurance Holder

**Insurance Information (please provide insurance card)**

Name of PRIMARY Insurance : \_\_\_\_\_ SECONDARY INS \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_\_

Relationship of patient:  Self  Spouse  Child  Other Policy Holder SSN #: \_\_\_\_\_

**FINANCIAL POLICY**

I request that payment of authorized Medicare and commercial benefits be made on my behalf for all services furnished to me by physicians of Gowani Medical Associates. I also authorize GMA PLLC to release to HCFA and its agencies any information needed to determine my benefits. ALL professional fees are due at the time of service. Prior authorization and approval are responsibility of the patient. For any Balance over 30 days a monthly financial fee of \$15/month and no greater than \$30/month will be charged to your account. If payment is not received from your insurance company in a timely manner you will be billed for the full amount of the services performed. For any accounts turned over to a collections agency, you will be responsible for their fees and charges in ADDITION to the outstanding balance including financial charges. For any returned check or credit card transaction a fee of \$35.00 will be applied to your account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Gowani Medical Associates, MDPA**  
Nasima Gowani, MD ; Sherali Gowani, MD, FACC ; Yasmeen Gowani, MD, FCCP  
**7224 Stone Rock Cir. Orlando Florida, 32819**  
**Phone: 407-345-4999 Fax (407) 352-6450**

**PATIENT CONTACT INFORMATION-We will use all numbers to confirm your appointments and contact you.**

I. Please list the family members or other persons, whom we may inform about your medical condition and your diagnosis and contact in case of emergency

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

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II. I understand that there will a **\$50.00** charge for all appointments that **I cancel within 48 business hours or if I no show for the appointment. For Nuclear stress test the Charge will be \$ 500. The Sleep Study no show/cancellation charge will be \$200 and a 7 day notice. I WILL CALL 407-345-4999 EXT 101 to change my appointment. If my account is charged and remains unpaid, it may be sent to a collections agency for debt collection and could impact my credit score.**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**PEDIATRIC PATIENTS:** Please list the family members or other persons, if any, who are authorized to accompany your child/minor for their appointment, Please bear in mind that you are authorizing us to release information about their medical condition and diagnosis:

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

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**Electronic Communications to Patients AND Acknowledgement of HIPPA Policy**

Gowani Medical Associates, MD PLC (GMA) utilizes an Electronic Health Records system (EHR) to fully support an electronic patient care experience through implementation of a common electronic health record platform. GMA is pleased to offer our EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

**Use of Electronic Communication from GMA to the Patient**

**Please check the appropriate box below:**

**Yes**, I want GMA to communicate my information with me through a secure system that is designed to keep your information safe. You will be notified via email of appointments and when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information. Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review:

**E-mail address:** \_\_\_\_\_

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

**No**, I do not want GMA to use electronic communication as a way to communicate my information to me.

**GMA E-mail Guidelines:** At this time, GMA can send e-mails to patients. All e-mail you receive from GMA is sent under the name and domain of gowanimedical.com. The patient is responsible to notify GMA promptly of any changes to his/her e-mail address.

**Confidentiality and Privacy** If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information. GMA will not share your e-mail address with anyone unauthorized to view your medical record.

**Acknowledgement of HIPPA Policy:** **I hereby agree that I have been provided with the HIPPA policy and that I have read, reviewed and understand the HIPPA policy**

**Consent and Agreement**

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from GMA. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

Patient Name \_\_\_\_\_ Guardian Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

Date: \_\_\_\_\_

**Please initial next to all authorized types of communication:**

\_\_\_\_\_ I authorize the forwarding of any medical information needed for the care and management of my health.

\_\_\_\_\_ I authorize the forwarding of medical information including HIV and MENTAL HEALTH/PSYCHIATRIC records needed for the care and management of my health.

\_\_\_\_\_ I authorize to release all of my medical information including MENTAL HEALTH/PSYCHIATRIC records needed for the care and management of my health.

\_\_\_\_\_ I authorize the forwarding of any medical information needed for insurance to process my claims. I would also like to assign benefits to the doctors of Gowani Medical Associates MDPA.

\_\_\_\_\_ I authorize to release my name, birth date and any other personal information needed to phone in a prescription to a pharmacy or order tests at any outside facility including a another medical institution, a doctor's office, hospital, etc.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Release To: \_\_\_\_\_ Address: \_\_\_\_\_

Release From: \_\_\_\_\_ Address: \_\_\_\_\_

I understand that this consent can be **revoked** at any time in writing except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

This Consent will be valid for 5 years but you will be required to sign consent every year to keep your files up to date.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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I \_\_\_\_\_ Hereby give permission to Gowani Medical Associates and staff to grant permission to view my prescription history from and by external sources.

\_\_\_\_\_

Signature / Date