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: _____
****

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: _____
****

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