Summerfield Office
P: 352-307-9925
F:352-307-8442
Office Hours
Mon – Fri
8 am – 5 pm
Sat 9am – 4pm
Lab Hours
Mon – Fri
8 am - 4:30 pm
Sat 9 am – 2 pm

Mt Dora Office
P: 352-735-3755
F:352-735-3151
Office Hours
Mon – Fri
8 am – 5 pm
Lab Hours
Mon – Fri
8 am - 4:30 pm

Leesburg Office
P: 352-460-4004
F:352-460-4003
Office Hours
Mon –Thurs
8 am – 5 pm
Fri 8 am – 4 pm
Lab Hours
Mon – Thur
8 am - 4:30 pm
Fri 8am – 3:30 pm

Laurel Manor Office
P: 352-633-5282
F:352-633-5284
Office Hours
Mon – Fri
8 am – 5 pm
Lab Hours
Mon – Fri
8 am - 2:30 pm

Lake Sumter Landing Office
P: 352-775-4868
F:352-775-4867
Office Hours
Mon – Fri
8 am – 5 pm
Lab Hours
Mon – Fri
8 am - 2 pm

Billing Department
P:352-314-1944
F:352-314-1942
Mon – Thurs
9 am – 4 pm
Fri 9am – 3 pm

Lakeview Healthcare System

Welcome to Lakeview Healthcare System!

In an effort to decrease your waiting time, we ask that you please complete the enclosed questionnaires.

You can fax in your completed questionnaires to the office your appointment is scheduled in or you can bring in the completed questionnaires to your appointment.

On the day of your appointment, we ask that you bring the following:

- Completed questionnaires
- A list of your current medications and strengths (or the actual bottles of medications work as well)
- Photo ID
- Your insurance card(s)

If you have any questions or need assistance concerning this paperwork, you can call any one of our offices and we will be more than happy to assist.

On behalf of the Lakeview Healthcare System team, welcome and we look forward to seeing you soon!

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Appointments

Patients are seen by appointment and on an emergency basis. When you make appointments, please describe your symptoms to our scheduling staff. If you are unable to keep your appointment, please try and give a minimal 24 hours notice.

Telephone Calls

Our staff will take calls during regular business hours for each office. If you are calling to speak to your doctor and he/she is unavailable, our staff with deliver your message. If you call outside our office hours, your call will be taken by our answering service. When necessary, the on-call doctor will be contacted and respond as soon as possible. Emergency calls will be handled promptly 24 hours a day.

Insurance

We participate in many insurance plans. We will bill your charges directly to these plans.

Prescription

Please allow 72 hours to handle all prescription requests. When you are requesting a refill, please provide us with your pharmacy's phone number or location. Per company policy, if a controlled substance is prescribed, the prescription must be signed for and picked up in one of our office locations.

Hospital Affiliations

Our physicians maintain active privileges at The Villages Regional Hospital, Leesburg Regional Medical Center, Florida Hospital Waterman, and Citrus Memorial Hospital.

Records

Your medical records are confidential. If you wish to have copies of your office records released to another physician, we must have written consent. Please inform our office of any changes to you address, telephone number, or insurance.

Office Fees

We believe our professional fees are within the range of usual and customary charges for this region. Our doctors expect payment at the time of check-in. All copay's, coinsurances, deductibles, and balances are due up front or your appointment will be rescheduled. You will receive a statement for any additional charges deemed patient responsibility by your insurance company.

LAKEVIEW HEALTHCARE SYSTEM

NEW PATIENT FORM

Date:________________________________

S.S#_________-________-_________

Patient name:_______________________________________ Date of Birth____________________

Mailing Address:___________________________ City________________ State______Zip__________
Is this the address you would like to receive all our billing statement/correspondence to? Yes, if no, please list the alternative address here____

Correspondences from our office should be sent in a sealed enveloped marked "CONFIDENTAL"?
_______ YES _______NO

Phone number:____________________ Cell number:________________Other ________________
Please circle the one you wish to receive calls about your appointment, lab, x-ray results or other healthcare information.

Can confidential messages be left on your home answering machine or voice mail? ____ Yes ___ No
____ Other option: Please list____

Sex: M______ F_______ Marital Status: S____, M____, D____, W____, Other______

Occupation:______________________________ Employer:_______________________________

Business address & Phone:____

Whom may we thank for referring you today?____

Emergency contact name:____Phone:________________

Authorization to release information

In an attempt to preserve the confidential nature of the doctor/patient relationship, it is requested that you complete the information listed below regarding appointments and other administrative matters.

Please list all the people whom we may inform about your general medical condition and diagnosis:____

Please list all the persons that we may inform about your condition in an emergency situation only:____

I, the undersigned certify that I or my dependent have insurance with__________________________ and assign directly to Dr. ________________________, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorized the use of the signature on ALL insurance submissions.

_________________________________ ___________________________ _______________
Responsible Party Signature Relationship to patient Date

Patient Consent Form

I consent to the use or disclosure of my protected health information (PHI) by Lakeview Healthcare System for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosing or treatment of me by Lakeview Healthcare System may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lakeview Healthcare System is not required to agree to the restrictions that I may request, and may request I seek another Internal Medicine physician. However, if Lakeview Healthcare System agrees to a restriction that I may request, the restriction is binding on the physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lakeview Healthcare System has taken action in reliance on this consent.

My protected health information (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Lakeview Healthcare System notice of Privacy Practices prior to signing this document. The Lakeview Healthcare System Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations. This notice of Privacy Practices describes my rights and the Lakeview Healthcare System duties with respect to my protected health information.

Lakeview Healthcare System reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________________ ______________________

Signature of Patient or Personal Representative Date

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Lakeview Healthcare System

For reporting purposes we ask that you fill out the following information to the best of your ability.

Email Address: ____

- This will be used to gain access to your Lakeview Internal Medicine, P.A. patient portal. You will also receive appointment reminders and updates once your email is provided.

Race:

- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- Black or African American
- White
- Hispanic
- Other Race
- Other Pacific Islander

Ethnicity:

- Hispanic
- Not Hispanic or Latino

Language:

- English
- Spanish
- Other ____________

Health History (Confidential)

Patient Name: ______________________________ Todays Date: ____________________

Age: ________ Birth Date: ___________ Sex: _____________ Date of last physical examination: _____________

What is the reason for your visit? ____

____

Symptoms: X- all symptoms that you are currently having or have had in the past year

GENERAL	
Chills	
Depression	
Dizziness	
Fainting	
Fever	
Forgetfulness	
Headache	
Loss of Sleep	
Loss of Weight	
Nervousness	
Numbness	
Sweats	

MUSCLE, JOINT, BONE *Pain, weakness, numbness in*			
Arms		Hips	
Back		Legs	
Feet		Neck	
Hands		Shoulder	

GENITO-URINARY	
Blood in urine	
Frequent urination	
Lack of bladder control	
Painful urination	

GASTROINTESTINAL	
Appetite poor	
Bloating	
Bowel changes	
Constipation	
Diarrhea	
Excessive hunger	
Excessive thirst	
Gas	
Hemorrhoids	
Indigestion	
Nausea	
Rectal Bleeding	
Stomach pain	
Vomiting	
Vomiting blood	

CARDIOVASCULAR	
Chest pain	
High blood pressure	
Irregular heart beat	
Low blood pressure	
Poor circulation	
Rapid heart beat	
Swelling of ankles	
Varicose veins	

EYE, EAR, NOSE, THROAT	
Bleeding gums	
Blurred vision	
Crossed eyes	
Difficulty swallowing	
Double vision	
Earache	
Ear discharge	
Hay fever	
Hoarseness	
Loss of hearing	
Nosebleeds	
Persistent cough	
Ringing in ears	
Sinus problems	
Vision-Flashes	
Vision-Halos	

SKIN	
Bruise easily	
Hives	
Itching	
Changes in moles	
Rash	
Scars	
Sore that won't heal	

MEN ONLY	
Breast lump	
Erection difficulties	
Lump in testicles	
Penis discharge	
Sore on penis	
Other	

WOMEN ONLY	
Abnormal pap smear	
Bleeding between menstruation	
Breast lump	
Extreme menstrual pain	
Hot flashes	
Nipple discharge	
Painful intercourse	
Vaginal discharge	
Other	

Date of last menstrual period? ____________

Date of last pap smear? ________

Have you had a mammogram? Yes / No

Are you pregnant? Yes / No

Number of children: ________

Conditions: X- all symptoms that you are currently having or have had in the past year

AIDS		Chemical Dependency		High Cholesterol		Prostate problem	
Alcoholism		Chicken Pox		HIV Positive		Psychiatric care	
Anemia		Diabetes		Kidney Disease		Rheumatic fever	
Anorexia		Emphysema		Liver Disease		Scarlet fever	
Appendicitis		Epilepsy		Measles		Stroke	
Arthritis		Glaucoma		Migraine headaches		Suicide attempt	
Asthma		Goiter		Miscarriage		Thyroid problems	
Bleeding disorders		Gonorrhea		Mononucleosis		Tonsillitis	
Breast lump		Gout		Multiple Sclerosis		Tuberculosis	
Bronchitis		Heart Disease		Mumps		Typhoid fever	
Bulimia		Hepatitis		Pacemaker		Ulcers	
Cancer		Hernia		Pneumonia		Vaginal infections	
Cataracts		Herpes		Polio		Venereal disease	

List Medications you are currently taking:
(use extra sheet of paper if necessary)

____
____
____
____
____
____
____

All known Allergies:

____
____
____
____
____
____

Pharmacy: _____________________________

Phone #: _____________________________

FAMILY HISTORY-FILL IN HEALTH INFORMATION ABOUT YOUR FAMILY

RELATIONSHIP	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	Check (x) if your blood relatives had any of the following disease		
						Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS				PREGNANCY HISTORY		
YEAR	HOSPITAL	REASON FOR HOSPITALIZATION	OUTCOME	BIRTH YR	SEX OF BIRTH	COMPLICATION IF ANY

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES___ NO___ Dates:_____________

Serious Illness/Injuries	Date	Outcome

Health Habits: X all that apply

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational Concerns: X if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
	Your Occupatioin:_______________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of this form:

_______________________________________ _______________________________

Patient or Responsible party signature Date

Name:______________________ Date:______________

Lakeview Healthcare System

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the *most appropriate number* for each situation.

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

Chance of Dozing:	**Situation:**
________________	Sitting and reading
________________	Watching TV
________________	Sitting inactive in a public place (e.g., a theater or a meeting)
________________	As a passenger in a car for an hour without a break
________________	As a driver in a car, while stopped in traffic
________________	Lying down to rest in the afternoon when circumstances permit
________________	Sitting and talking to someone
________________	Sitting quietly after a lunch without alcohol

Total: __________

Lakeview Healthcare System

Patient Responsibility Form

Insurance

1. The patient is responsible for providing Lakeview Healthcare System with the most correct, active and up to date information about their insurance prior to each visit.

2. Lakeview Healthcare System will bill the insurance most recently provided by the patient. If the information given by the patient is inaccurate and the insurance denied the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines so providing correct information at the time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.

3. Patients are responsible for the payment of co-pays at the time of service.

4. Patients are also responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.

5. Lakeview Healthcare System is not responsible for knowing what each individual patient's insurance plan does or does not cover. The patient is responsible for knowing what their plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance.

6. In the event the patient's health plan determines a service to be "not payable, the patient will be responsible for the complete charge and agree to pay the costs of all services provided.

7. Patients have the right to check with their insurance about coverage before receiving any service provided at Lakeview Healthcare System.

8. The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.

9. The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered under the patient's plan. Any balances applied to an out of network rate will be the responsibility of the patient to pay.

10. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.

Lakeview Healthcare System

Address/Demographics Changes

It is important that we have the patient's correct address/phone information on file. The patient is responsible for making Lakeview Healthcare System aware of any address, phone or other demographic changes.

Billing

1. If the patient owes additional money after their visit, they can expect to receive a statement. Statements are sent out once a month.
2. To help keep healthcare costs down, the patient should attempt to pay their bill upon first receipt. Just as we make every effort to accommodate patients when they are in need of medical care, we expect that patients will make every effort to pay their bill promptly. Payment is due at the time services are provided or upon receipt of statement from our billing office.

Medicare Patients

Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients must read the ABN carefully.

Financial Agreement

The patient agrees that in return for the services provided to them by Lakeview Healthcare System, they will pay their account at the time service is rendered or upon insurance claim processing. If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If co-payments, co-insurances and/or deductibles are assigned by the patient's insurance company of health plan, they agree to pay them to Lakeview Healthcare System.

Workers Compensation and Automobile Claims

Lakeview Healthcare System does not accept and/or file workers comp or auto claims.

____
Printed name of Patient

______________________________ ____________
Signature of Patient or Parent/Guardian Date