NEW PATIENT WELCOME PACKET

- We would like to take this opportunity to Welcome and Thank you for becoming a patient with our practice. Every effort will be made to provide you with excellent healthcare services. Our goal is to make you feel as welcome and as comfortable as possible during each visit to our office. We take your health very seriously and would like to give you some helpful information to provide you with best possible care.

- Office hours: 8:30am – 5:30pm Monday – Thursday and 8:30 am– 12:30pm on Friday. Please arrive 10 minutes before your appointment time to fill in the necessary paperwork.

- Whenever you need to schedule an appointment, please feel free to call our office. Every effort will be made to make you an appointment at our earliest convenience and same day appointments for urgent healthcare needs.

- Please call 3-4 days prior to needing prescription refills to ensure you receive your medications in a timely manner. Please be advised that it may take up to 72 hours to process refills.

- If for some reason you are unable to keep your scheduled appointment, we request that you give us at least 24- hour notice so that we may make this appointment to someone else in need.

- We strive to always treat every person with respect. We ask that you please always treat our office staff respectfully or actions will possibly be taken including asking you to leave the premises and/or seek a new physician.

- We welcome and appreciate your opinions and feedback. Please feel free to contact our office with any concerns or issues you may have.

Last Name: _____ First Name: _____

MI: _____ Date of Birth: _____ Marital Status:_____

Sex: F / M Phone #: _____

SSN#_____-_____-_____ Address: _____

City/State _____Zip code: _____

Emergency Contact Name, Phone & Relationship:

_____

Pharmacy Name & Address/Phone Number (Field REQUIRED for all prescriptions!):

_____

_____

Email:

_____

How did you hear about us (Please circle all that apply)

Friend/Family/social media/Google/Other: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID#_____GROUP#_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of information relating to all claims for benefits, submitted on behalf of myself and/or dependent. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered. I understand I am financially responsible for all charges incurred.

Patient Signature: _____Date: _____

Patient name: _____ DOB: _____

FINANCIAL RESPONSIBILITY AGREEMENT

I authorize Apollo Primary Care, LLC to release any medical information necessary to process all claims for reimbursement on my behalf. I authorize payment to be made directly to the above provider and / or named physicians of affiliates for services rendered. I also understand that I am fully responsible for all Fees and expenses incurred if my health insurance carrier does not pay my bill. I agree to pay any charges that are not covered immediately. Full payment (including any balances, Co-payment, deductibles, Co-insurance) is due at the time that the services are rendered.

Any balances that are over 90 days past due will be turned over to our collections department and reported to the proper credit reporting agencies unless previous arrangements have been made. I also understand and agree that it is my responsibility to know if the provider I am seeing is a contracted and in-network provider with my insurance company or plan.

NO SHOW APPOINTMENTS

Time has been specifically reserved for your appointment. Please give us at least 24-hour notice if you must cancel or reschedule for some reason if you are not able to make it.

CONSENT FOR PHOTO

I agree to have Apollo Primary Care, LLC digitally reproduce my photo into my Electronic Medical Records for identification purposes only. I understand this is for my personal protection so that others may not impersonate me.

CONSENT TO TREAT

I, the undersigned voluntarily give consent to Apollo Primary care, LLC to provide and perform such medical/diagnostic/minor surgical treatment(s) and /or services as deemed advisable and necessary for the diagnosis and/ or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

HIPAA DISCLOSURE

I acknowledged that I have received and read a copy of Apollo Primary Care's HIPAA notice of privacy policy.

EXTERNAL RX

I consent to retrieve external medication history from other providers as necessary electronically

TELEVISIT / COMMUNICATION

I consent to perform audio/video communication to provide medical care if needed.

I consent to receive text messages from Apollo Primary Care for appointment reminders, test results, and other healthcare-related communication.

Patient's signature: _____ Date: _____

CONSENT TO DISCLOSE PERSONAL INFORMATION

I _____, give Dr. Kumar & her office staff permission to disclose health and my personal information TO:

1. Name: _____

   Relation: _____

   Contact Information: _____

2. Name: _____

   Relation: _____

   Contact Information: _____

3. Name: _____

   Relation: _____

   Contact Information: _____

OR

Please check the box below if you do not wish to disclose.

☐ I do not wish to disclose any of my personal health information to anyone.

**This authorization may be revoked or changed by the undersigned patient at any time. Such revocation must be in writing and addressed to Dr. Kumar and her office staff.

Patient Signature: _____Date: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Last Name: _____ **First Name**: _____

MI: _____ **Date of Birth**: _____ **Phone #:** _____

Address: _____

City/State _____ **Zip code**: _____

I, the undersigned, authorize the release of information specified below from the medical record(s) of the above name patient. All specified records are authorized to be sent

TO:

Apollo Primary Care, LLC
721 Ciara Creek Cv, Longwood, FL 32750
Phone: 407-887-7565 Fax: 407-987-3694

FROM:

Office/Physician Name:_____

Phone #:_____

Fax #:_____

Information to be released: □ ALL MEDICAL RECORDS ON FILE □ Consultation Report □ Operative Reports □ Lab/Path Reports □ X-Ray Reports/Images

Purpose of release: □ CONTINUITY OF CARE □ Insurance □ Other

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. The authorization will expire one (1) year from the date of my signature unless I revoke the authorization prior to that time.

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

Patient Name:_____ DOB:_____

Previous physician name: _____

Previous physician address/ contact number: _____

PATIENT MEDICAL HISTORY

*PERSONAL MEDICAL HISTORY ***Please check all that apply****

☐ Asthma	☐Anemia	☐ Hepatitis
☐ Angina/Chest Pain	☐ Arthritis	☐ High Blood Pressure
☐ Cancer	☐ Chronic Bronchitis	☐ High Cholesterol
☐ Cirrhosis of Liver	☐ Bleeding/Clotting Disorder	☐ Blood Clot
☐ Colitis	☐ Depression/Anxiety	☐ Heart failure (CHF)
☐ Diabetes	☐ Emphysema	☐ Heart arrhythmia/ A.fib
☐ Epilepsy/ seizures	☐ Gallstones	☐ Thyroid disease
☐ Amputation	☐ Sleep apnea	☐ Stomach ulcers Gastric)
☐ Heart Attack	☐ Bipolar disorder	☐ Schizophrenia
☐ Kidney Disease	☐ Kidney Stones	☐ Gout
☐ HIV/AIDS	☐ Tuberculosis (TB)	☐ Migraines

HOSPITALIZATION/SURGICAL HISTORY

*****Please list all that apply*****

Date/Year	***Hospitalization***

Date/Year	***Surgery***

Patient Name:_____ DOB:_____

ALLERGIES

Please list all that apply

Medication	***Allergic Reaction***

☐ NO KNOWN DRUG OR FOOD ALLERGIES

MEDICATIONS

Medication Name	***Dose***	***Frequency***

☐ NO DAILY MEDICATIONS OR SUPPLEMENTS

PLEASE BRING ALL MEDICATIONS AND ANY SUPPLEMENTS THAT YOU TAKE REGULARLY TO YOUR APPOINTMENT!!

Patient Name:_____ DOB:_____

FAMILY MEDICAL HISTORY

Please check all that apply

Condition	***Who (mom/dad or maternal/paternal grandparents)***	***Condition***	***Who (mom/dad or maternal/paternal grandparents)***
Asthma		*Stroke*	
Heart Disease		*Diabetes*	
Arthritis		*Mental Illness*	
Hypertension		*Bleeding Disorder*	
Cancer (Specify)		*Lung Disease*	
Cirrhosis			

PERSONAL HISTORY

****Please check all that apply****

1. *Have you ever smoked cigarettes/Cigars?* *Yes/ No* *(If No, move to #5)*
2. *If yes, do you currently smoke?* *Yes/ No* *(If No, move to #4)*
3. *If yes, how many packs per day?* _____ *PPD*
4. *Number of years you smoked* _____
5. *Do you drink alcohol?* *Yes/ No*
6. *If yes, how many drinks do you drink?* _____ *per day OR* _____ *per week*
7. *Have you ever used any of the following drugs? Yes/ No*
8. *If Yes, Please check all that apply*

   ___ *Marijuana* ___ *LSD* ___ *Cocaine* ____ *Speed* ___ *IV drug use* ___

   Other: Specify _____ *Do you currently use any of these drugs?* _____
9. *Exercise: Daily*____, *Times per week* _____, *Type of Exercise*_____

   Does not exercise routinely _____
10. *Living Situation: Lives with / Spouse/ Parents/ Significant other/ Alone* _____