Janet A. Betchkal, M.D. P.A.

NEW PATIENT FORMS

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Date: _____

Dear _____

We would like to take a brief opportunity to welcome you to our office. We would like to make your first visit as easy as possible, so we have enclosed some information and forms for you to complete and bring with you to your visit.

Please have these forms completed and signed BEFORE you come to the office. This will ensure that we are prompt and stay on schedule with your appointment time. If you are using your computer, you can complete these forms electronically by simply entering in the information into the fields provided, and then printing to bring with you. You can also save the file to your computer for future use, and upload to our Patient Portal if you have access.

Please be sure to arrive 15 minutes prior to your appointment time. Allow time to find a parking space in the garage as it can get busy at times.

Please bring your insurance cards, photo identification, and a list of all your present medications you are taking (include dosage and instructions). If you have any records from your referring doctor, bring those as well. The first visit takes about 3- 3 ½ hours, so please be prepared to stay.

NOTE: If your insurance is an HMO or a Medicaid HMO, a referral is required, and YOU must acquire one from your primary care physician. This must be done BEFORE you arrive for your visit.

Your appointment with Dr. Betchkal is:

_____ at _____.

Our office is located on the first floor of the Dillon Building at St. Vincent's Hospital. We are SUITE 134 across from Subway.

**In consideration for those with allergies and/or breathing problems, please refrain from wearing perfume or cologne to our office.

Thank you

Directions to Janet A. Betchkal, M.D. P.A.

From I-95 North of Jacksonville

Take I-95 South to the Stockton Street exit (351A). Turn right onto Forrest Street. Turn left on to Stockton Street and follow until it intersects with Riverside Avenue. Turn Right on Riverside Avenue. At the next traffic light, turn left onto Shircliff Way. Take the first right into the parking garage for the Dillon Professional Building and park. Take the elevator to the first floor. Our office is the second suite on the right just past the cafeteria across from Subway- Suite 134.

From I-95 South of Jacksonville

Take I-95 North to I-10 West. Take the Stockton Street exit. Turn left onto Stockton Street and follow until it intersects with Riverside Avenue. Turn right on Riverside Avenue. At the next traffic light, turn left on to Shircliff Way. Take the first right into the parking garage for the Dillon Professional Building and park. Take the elevator to the first floor. Our office is the second suite on the right just past the cafeteria across from Subway- Suite 134.

From I-10 West of Jacksonville

Follow I-10 East. Take the Stockton Street exit. Turn left on to Stockton Street and follow until it intersects with Riverside Avenue. Turn right on Riverside Avenue. At the next traffic light, turn left on to Shircliff Way. Take the first right into the parking garage for the Dillon Professional Building and park. Take the elevator to the first floor. Our office is the second suite on the right just past the cafeteria across from Subway- Suite 134.

PATIENT INFORMATION

First Name: _____ Last Name _____ Middle Initial ____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell Phone #: _____ Other #: _____

SSN#: _____ Date of Birth: _____ Sex:_____

Email Address _____

Occupation _____

Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widowed

Referring Doctor _____ Phone:#:_____

Primary Care _____ Phone:#:_____

Emergency Contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

HIPAA Contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Janet A. Betchkal, M.D. P.A.

Practice Limited to Glaucoma & Related Eye Diseases -
wwwJanetBetchkalMD.com

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ _____ Nickname: _____

Pharmacy Name & Location: _____

Pharmacy Phone #: _____ Pharmacy Fax If Known: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White
☐ African American ☐ Native Hawaiian or Pacific Islander
☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Decline to answer

Preferred Lang: ☐ English ☐ Spanish ☐ Other (please specify): _____

Have you had your Influenza vaccine this year/season? ☐ Yes ☐ No

Have you ever had a Pneumonia vaccine? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever been exposed to or infected with Hepatitis A, B, C, HIV, or Tuberculosis?
☐ Yes ☐ No

Are you ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No
If YES, please list the name of medication, reaction, and severity below.

Medication	Reaction	Severity
_____	_____	☐ mild ☐ moderate ☐ severe ☐ unknown
_____	_____	☐ mild ☐ moderate ☐ severe ☐ unknown
_____	_____	☐ mild ☐ moderate ☐ severe ☐ unknown
_____	_____	☐ mild ☐ moderate ☐ severe ☐ unknown
_____	_____	☐ mild ☐ moderate ☐ severe ☐ unknown

Medication List

Name	Frequency	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Surgeries/Operations/Dates: (Please List):

1. _____
2. _____
3. _____
4. _____
5. _____

Past Ocular History: (CIRCLE ALL THAT APPLY)

Overall Healthy: ☐ Yes ☐ No Cataracts: ☐ Yes ☐ No Hyperopia (Far Sighted): ☐ Yes ☐ No

Glaucoma: ☐ Yes ☐ No Dry Eyes: ☐ Yes ☐ No Myopia (Near Sighted): ☐ Yes ☐ No

Astigmatism: ☐ Yes ☐ No Iritis: ☐ Yes ☐ No Keratoconus: ☐ Yes ☐ No

Optic Neuritis: ☐ Yes ☐ No Macular Degeneration: ☐ Yes ☐ No

Retinal Detachment: ☐ Yes ☐ No

Injury or Trauma: ☐ Yes ☐ No If yes, please describe:

_____

Ocular Surgeries: CHECK ALL THAT APPY)

☐ No prior ocular surgery ☐ Trabeculectomy (Glaucoma Surgery) ☐ RK

☐ Foreign Body Removal ☐ Punctal Plugs ☐ LASIK ☐ Cataract Surgery

☐ Strabismus/Muscle Surgery ☐ PRK ☐ Retinal Laser Surgery

☐ Vitrectomy ☐ Corneal Transplant

Other _____

Systemic Illnesses: (CHECK ALL THAT APPLY)

☐ No history of illnesses ☐ Congestive Heart Failure ☐ Hepatitis ☐ Lung Disease

☐ Diabetes ☐ High Blood Pressure ☐ COPD ☐ Anemia

☐ High Cholesterol ☐ Arrhythmia ☐ Arthritis ☐ Migraine/Headaches

☐ Eczema ☐ HIV ☐ Polymyalgia ☐ Fibromyalgia

☐ Thyroid Disease ☐ Asthma ☐ Hearing Loss ☐ Kidney Failure

☐ Psychiatric Disorder ☐ Kidney Stones ☐ Skin Cancer ☐ Stroke

☐ Heart Attack ☐ Liver Disease ☐ Cancer ☐ Sleep Apnea/Snoring

☐ Cold Hands/Feet ☐ Multiple Sclerosis ☐ Alzheimer's/Dementia

☐ Rheumatoid Arthritis Other: _____

Ocular Significant Illnesses: (CHECK ALL THAT APPLY)

☐ Overall Healthy ☐ Herpes Simplex ☐ Hypothyroidism ☐ Sjogrens

☐ Graves' Disease ☐ Hypertension ☐ Hyperthyroidism ☐ Lupus

☐ Multiple Sclerosis ☐ Rheumatoid Arthritis ☐ Diabetes ☐ HIV/AIDS

Other: _____

Infections: (CHECK ALL THAT APPLY)

☐ Overall Healthy ☐ Herpes Simplex ☐ HIV/AIDS ☐ Syphillis

☐ Chicken Pox ☐ Shingles ☐ Meningitis ☐ Toxoplasmosis

☐ Hepatitis A/B/C ☐ MRSA

Review of Systems: (CHECK ALL THAT APPY FOR EACH CATEGORY)

General

☐ Overall healthy, ☐ Weight Loss or gain, ☐ Fatigue/Tiredness, ☐ Weakness,
☐ Trouble Sleeping

Integumentary (Skin, Hair, Nails)

☐ No symptoms, ☐ Rashes, ☐ Itching, ☐ Dryness, ☐ Color changes, ☐ Hair or Nail Changes,
☐ Suspicious Growth

Ear/Nose/Mouth/Throat

☐ No Symptoms, ☐ decreased hearing, ☐ Ringing in ears, ☐ Earache, ☐ Vertigo,
☐ Stuffiness, ☐ Discharge, Itching, ☐ Hay Fever, ☐ Nosebleeds, ☐ Sinus ☐ Pain/pressure,
☐ Bleeding of Teeth or gums, ☐ Dry Mouth, ☐ Sore Throat, ☐ Hoarseness

Respiratory

☐ No Symptoms, Cough, ☐ coughing up blood, ☐ Shortness of breath, ☐ Wheezing,
☐ Painful/Difficulty Breathing

Cardiovascular

☐ No Symptoms, ☐ Chest pain and discomfort, ☐ Tightness in chest, ☐ Palpitations,
☐ Shortness of breath with activity, ☐ Difficulty breathing lying down, ☐ Swelling (edema),
☐ Calf pain with walking, ☐ Leg cramping

Gastrointestinal

☐ No Symptoms, ☐ Difficulty swallowing, ☐ Heartburn/Acid Reflux, ☐ change in appetite,
☐ Nausea, ☐ Change in bowel habits, ☐ Rectal bleeding, ☐ Constipation, ☐ Diarrhea,
☐ Hiatal hernia

Genitourinary

☐ No Symptoms, ☐ change in frequency or urgency in urination, ☐ Burning or pain, ☐ Blood in urine, ☐ Incontinence, ☐ Pain with intercourse, ☐ Hot flashes, ☐ Vaginal discharge, ☐ itching or rash

Musculoskeletal

☐ No Symptoms, ☐ Muscle or joint pain, ☐ Stiffness, ☐ Back Pain, ☐ Redness of joints, ☐ Swelling of joints

Neurological

☐ No Symptoms, Dizziness, ☐ Fainting, ☐ Seizures, ☐ Weakness, ☐ Numbness, ☐ Tingling, ☐ Tremor, ☐ Decreased memory, ☐ Disorientation

Endocrine

☐ No Symptoms, ☐ Heat or cold intolerance, ☐ Sweating, ☐ Frequent urination, ☐ Excessive Thirst, ☐ Change in appetite, ☐ Yellow eyes or skin

Hematologic/Lymphatic

☐ No Symptoms, ☐ Ease of Bruising, ☐ Ease of Bleeding, ☐ Anemia

Psychiatric

☐ No Symptoms, ☐ Anxiety, ☐ Depression, ☐ Memory Loss, ☐ Stress, ☐ Hallucinations

Allergies/Immunological

☐ No Symptoms, ☐ Environmental allergies, ☐ Reduced Immunity

Social History: (CHECK ALL THAT APPLY)

Smoking: ☐ Current smoker, ☐ Social smoker, ☐ Former smoker, ☐ Never smoked

Alcohol use: ☐ Yes ☐No If yes, how much and how often? _____

Recreational Drug Use: ☐ Yes ☐ No If yes, what and how often ? _____

Family History: (CHECK ALL THAT APPLY)

Glaucoma: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Macular Degeneration: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Cataracts: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Blindness: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Diabetes: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

High blood pressure: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Heart Disease: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Cancer: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Sickle Cell Anemia: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Sickle Cell Trait: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Stroke: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

High Cholesterol: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Kidney Disease: ☐ No family history, ☐ Mother, ☐ Father, ☐ Sister, ☐ Brother,
☐ Grandmother (maternal/paternal), ☐ Grandfather (maternal/paternal)

Appointment Cancellation Policy

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call Dr. Betchkal's office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at (904)384-3500 between the hours of 7:00am – 4:00pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows/Rescheduled

A cancellation is considered late when the appointment is cancelled or rescheduled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $25.00 missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee.

Signature: _____

Date: _____

FINANCIAL PRACTICES DISCLOSURE

Welcome to Janet A. Betchkal M.D., P.A.. Our practice participates in many medical insurance plans. If we are participating providers for your plan, we will file the claim on your behalf. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, most major credit cards, and Care Credit. Please be sure to provide us with your most current insurance card(s) at each visit and advise us of any changes. Many insurance plans are no longer using the social security number as the patient ID, and have changed to using the Employee ID as the subscriber number. If you are not the primary cardholder please make sure you give us the correct subscriber (employee) ID number at the time of your visit. All of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Copayments/Coinsurance/Deductibles: If your plan requires that you pay a copayment, deductible or coinsurance, you are required to pay at the time services are rendered. Self-Pay Patients: Patients with no insurance are expected to pay at the time of service for all care rendered. Authorizations/Referrals: Many insurance plans require a referral/authorization for office visits and/or procedures. You will need to obtain this referral/authorization from your primary care or referring physician prior to being seen in our office. If you are having surgery, we will assist in getting pre-certification or prior approval for your procedure. Non-Covered Services: On occasion, we may render a service that is not covered by your insurance plan. We make every effort to inform you of this in advance. Any non-covered services will become due and payable by you upon notice from your insurance carrier. Out-of-Network Services: We make every effort to verify your plan benefits prior to your appointment. In the event that you obtain services by a physician who is not a participating provider with your plan, the amount will become due from you. Please always make sure that the doctors you are treating with participate with your plan. Affordable Care Plans/Healthcare Exchange: If you have an Affordable Care Plan, you are responsible for paying your healthcare insurance premiums in a timely manner. Failure to pay your insurance premiums will result in your benefits being terminated. If your insurance is cancelled for failure to pay your premium, you will be held liable for the amount of the bill for the services rendered by our physicians. This amount will be due in full upon notice. I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of my personal information, whether medical or otherwise, to release to any third-party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits. I request that payment of authorized health care benefits be paid, and I assign the benefits payable for physician services to the physician or organization furnishing the services. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges. By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

Patient/Legal Guardian Signature: _____

Printed Name: _____

Date Signed: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer in writing at the address below.

Janet A. Betchkal, M.D. P.A.

Practice Limited to Glaucoma & Related Eye Diseases -
wwwJanetBetchkalMD.com

HIPAA AUTHORIZATION AND CONSENT

HIPAA Notice of Privacy Practices Acknowledgment

I have had access to or received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry outtreatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorization to Obtain and / or Release Medical and Pharmacy Records

I hereby authorize all physicians, health care entities, and pharmacies participating in my health care to obtain, release, use, and disclosure myentire medical record by mail, phone, fax, and electronic transmission in order to carry out my treatment, payment, and healthcare operations.

Lifetime Signature on File (Applies to Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to Janet A. Betchkal, M.D. P.A., or professional associate for any services furnished to me by the practice. I authorize the release of any and all medical or other informationnecessary for processing claims to the Center for Medicare and Medicaid Services (CMS).

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company any and all information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, inpatient or outpatient surgery, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen withoutan authorization I will be considered a self- pay patient and will be required to pay in full for all services performed.

Authorization to Release Information to a Personal Representative or Third Party

Please complete the section below If you would like anyone else to have access to your information. I understand that authorization for release of information to the below can only be revoked upon written notice.

(*Check the type of information you authorize use to share.*)

Name	Relationship	Phone #	Power of Attorney	HIPAA Billing	HIPAA Medical
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐

I acknowledge that all sections of this form have been read in full and explained as necessary.

Full Legal Name of Patient or Responsible Party _____

Signature Required: _____ **Date:** _____