Heldo Gomez Jr., M.D.

Neurological Surgery

Administrative Office:

900 Village Square Crossing, Suite 270 • Palm Beach Gardens, FL 33410 • Phone: 561-627-7855 • Fax: 561-627-5030

Satellite Offices:

941 North Krome Avenue • Homestead, FL 33030

PATIENT INFORMATION

Patient's Name (First, Middle, Last)				
Patient's Address				
City, State, Zip				
Date of Birth	Age	Sex	Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed	Social Security Number
Home Phone	Cell Phone	Work Phone		
Employer				
Employer's Address (Street)				
City, State, Zip				
Occupation (Indicate if Student)				
Nearest Relative / Friend(not in same household)				
Address	Phone			
City, State, Zip				

FILL IN FOR HUSBAND/WIFE

Spouse's Name	
Employer	Employer's Phone
Employer's Address (City, State, Zip)	

FILL IN IF PATIENT IS A MINOR

Mother's Name (First, Middle, Last)	
Employer	Employer's Phone
Employer's Address (City, State, Zip)	
Mother's Name (First, Middle, Last)	
Employer	Employer's Phone
Employer's Address (City, State, Zip)	

LIFETIME AUTHORIZATION
Medicare Certification For Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

I request that this authorization also apply to all other insurances.

Signed ___________________________________ Date ________________

By ____

Title or relationship ____
If signed by other beneficiary, state the reason the patient was unable to sign:

FINANCIAL POLICY

- **BASIC POLICY: The patient is responsible for medical bills in our office.** Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims.
- **IF YOU DO NOT HAVE INSURANCE:** Our policy requires payment in full today, unless other arrangements are made. If you cannot pay in full now, we request partial payment today as you arrange for credit on your account with a payment plan agreement with our Credit and Collections Manager.
- **IF YOU HAVE INSURANCE:** Fill out the patient's section of our form. If you are covered by Medicaid, Medicare, or other insurance, please present your identification card to the receptionist at the time of your appointment.
- **WORKMAN'S COMPENSATION:** In the event it is determined by the Worker's Compensation Board that the illness or injury is not a result of a compensable Worker's Compensation Case, **I hereby agree to pay the usual and customary fees for the services rendered.**
- **REJECTED CLAIMS:** If your insurance company rejects your claim, or if they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full after your insurance payment, call 561-627-7855.
- **FORMS OF PAYMENT:** We accept payments in cash, check, credit card or money order. Checks must be made payable to the individual doctor whose name is on your statement.
- **RETURNED CHECKS:** A $10.00 handling charge is applied to all returned checks.
- **DELINQUENT ACCOUNTS:** Delinquent accounts over 90 days are turned over to our Collection Manager, unless other arrangements are made. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the doctor to decide appropriate legal action including placing a lien on a third party case. We reserve the right to add late charges for delinquent accounts requiring collections action and to add attorney fees, court costs, and/or collections agency fees.
- **MONTHLY STATEMENTS:** Once your insurance has paid you are responsible for the unpaid balance. You will receive an itemized monthly statement of any patient balance until your bill is paid in full. Interest of 1.5% (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of $0.50 per month.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I hereby further give a lien to Healthcare Provider for all funds owing to me from my case by way of insurance payments, judgment, verdict or other source, which may be paid to my attorney or myself.

In addition to the foregoing, in order to secure my obligation to pay the amount of my Charges to Healthcare Provider, and in consideration for Healthcare Provider's agreements set forth herein, I hereby grant to Healthcare Provider, in accordance with the Uniform Commercial Code as in effect in the applicable jurisdiction, a security interest in and lien upon: (i) the Proceeds; and (ii) all proceeds thereof, in each case whether now owned or hereafter existing, acquired or arising, and wherever located. I authorize Healthcare Provider to file one or more UCC financing statements (and continuations thereof) naming me as debtor and evidencing Healthcare Provider's security interest in such collateral.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Heldo Gomez, M.D. PA.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I have read and agree to the Financial Policy of this office.

______________________________ ______________________________

Signature (Parent if Minor) **Date**

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Medical Release of Records for Patient's Chart History

Please fill out the names of your treating physicians, insurance company and spouse below so Dr. Gomez and or his office may communicate with them regarding your care and forward medical records to them.

I give authorization for release of all records, x-rays, etc. by phone, mail, fax or in person to:

Referring Doctors office: ______________________________

Address: ______________________________

Primary Care Physician/Family Physician: ______________________________

Address: ______________________________

Neurologist: ______________________________

Address: ______________________________

Pain Management Doctor: ______________________________

Address: ______________________________

Chiropractor: ______________________________

Address: ______________________________

Attorney: ______________________________

Address: ______________________________

Insurance Company: ______________________________

Address: ______________________________

Spouse: ______________________ Date of Birth: ______________

______________________ Date: ______________
Patient's Signature

____
Patient's Printed Name

Note: This authorization includes your work status, balance of account, who your legal representative is, or insurance claim information. Please include everyone that you intend to release information to on this form.

This document represents Heldo Gomez, Jr., M.D. policy complying with the HIPPA Privacy Rule

Patient information used for the purpose of treating healthcare problems, tracking improvement, and trending medical therapies. Patient information is described as health history, physical examinations, test results, diagnosis, pharmacy prescriptions, and laboratory results, obtained with the intention of providing treatment to the patient. Patient information also includes patient demographics (address, phone number, medical insurance, social security number, etc.).

We will disclose this information to referring physicians (whom the patient has a doctor/patient relationship), and to healthcare providers that our office wishes to refer for additional medical diagnosis or treatment (includes are pharmacies for prescriptions). Patient's verbal approval will be obtained prior to the release of the information to the healthcare providers. Medical insurance representatives will have access to patient information as per the patient's contractual arrangement with their medical insurance policies. We will release patient information to insurance representatives necessary to obtain authorizations for medical procedures and office visits. All other requests for patient information will be released only with the patient's written approval.

We will use patient information for the purpose of billing. All necessary information to satisfy the insurance provider's request to support medical payments will be shared with the medical insurance company.

We will release patient information to any additional entity at the request of the patient after providing a written release of information. Heldo Gomez, Jr., M.D. are the custodian for their patient's information and will hold the records until such time as one of the following occur:

1. Heldo Gomez, Jr., M.D. no longer exists as a treating entity. In which case the files will be placed in storage after notice is given in a local paper.
2. Patients request files be transferred to another physician and a written release is obtained.
3. Patient information becomes inactive as defined by Florida Statutes.

In the event that questions or disputes occur concerning patient information the Medical Director will resolve all disputes. The office manager, office personnel, or the Medical Director can answer questions concerning this policy.

I authorize the office to contact me at my home, cell, or work phone numbers provided to them; and also to mail correspondence to my home address.

If this is not acceptable to you please specify how we may contact you:

____

____

I have reviewed this document and I understand its context.

______________________________   _______________
Patient Signature   Date

Chief Complaint – Reason For Today's Visit

What hurts?

[] Neck   [] Mid-Back   [] Shoulder []R / []L   [] Hip []R / []L
[] Back   [] Headaches   [] Knee []R / []L   [] Ankle []R / []L

When did your pain begin? ___________________

How did your pain begin?

[] Unknown

[] Auto Accident   Date: ___________________

[] Slip & Fall Accident   Date: ___________________

[] Work Related Injury   Date: ___________________

[] After Surgery   Date: ___________________

Who was the doctor that preformed your previous surgery? ____________________________

What was the name of the surgery? ____

Does the pain radiate or travel into your arms or legs? [] Yes   [] No
If so, which are or leg?

[] Right Arm   [] Right Leg
[] Left Arm   [] Left Leg

Please explain: ____

____

Do you have numbness or tingling into your arms, hands, legs or feet? [] Yes   [] No

[] Right Arm   [] Right Hand   [] Right Leg   [] Right Foot
[] Left Arm   [] Left Hand   [] Left Leg   [] Left Foot

Please explain: ____

____

Do you have weakness in your arms, hands or feet? [] Yes   [] No

[] Right Arm   [] Right Hand   [] Right Leg   [] Right Foot
[] Left Arm   [] Left Hand   [] Left Leg   [] Left Foot

Please explain: ____

____

What makes your pain better?

[] Laying Down   [] Wear Lumbar Brace   [] Rest   [] Massage   [] Lean to the Left
[] Standing   [] Leaning Backwards   [] Traction   [] Sitting   [] Lean to the Right
[] Heat   [] Leaning Forward   [] Ice   [] Therapy   [] Moving around
[] Sports   [] Running   [] Throwing   [] Reaching   [] Overhead Movements
[] Lifting   [] Stooping   [] Bending   [] Twisting   [] Squatting
[] Knee Brace   [] Elbow Brace

What makes your pain worse?

[] Laying Down   [] Wear Lumbar Brace   [] Rest   [] Massage   [] Lean to the Left
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[] Sports   [] Running   [] Throwing   [] Reaching   [] Overhead Movements
[] Lifting   [] Stooping   [] Bending   [] Twisting   [] Squatting
[] Knee Brace   [] Elbow Brace

Please list your medical / illness history:

A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________

Please list your surgical history:

A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________

Please list all medications **Dosage** **Frequency**

A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________

List all Allergies to Medications:

____

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