Advanced Family Care

978 International Parkway Lake Mary, FL 32746
Phone: 407.391.3131 Fax:407.833.9165

2836 Enterprise Road Suite 4 DeBary, FL 32713
Phone: 386.951.4538 Fax: 386.259.3689

www.advancedfamilycare.net

Last Name: ________________________________ **First Name:** _______________________________ **MI:** _______

Date of Birth: ________________________ **Marital Status:** ______________________________________**Sex: F / M**

Phone #: ____ **SSN#**_________-_______-__________

Address: _________________________________ **City/State** ___________________________ **Zip code:** _________

Emergency Contact Name & Phone #: ____

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

____

____

Email: ____

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

Friend/Family   Facebook/Social Media   Lake Mary Life   School Planner   Google/Website   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. I further acknowledge that any insurance benefits, when received by and paid to DR. MAGUED IBRAHIM will be credited to my account in accordance with the above said statement.

Patient Signature: ____ **Date:** ____________________________

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Patient Name: ____

By Signing this paper, I 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, Deductible, Co-Insurance) is due at the time that the services are rendered.

Any Balance that is 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.

Patient Signature: ____

Time has been specifically reserved for your appointment.
Please call at least 24 hours ahead of time. We understand emergencies arise and there are scheduling conflicts, we just ask that if you must cancel an appointment or reschedule it to please try to give us 24-hour notice.
There will be a $50.00 charge if you fail to show up for an appointment or cancel within 24 hours.

Patient Signature: ____

By signing this paper, I agree to have Advanced Family Care Digitally reproduce my photo into my Electronic Medical Health Record for identification purposes only.

I understand that this is for my personal protection so that others may not impersonate me.

Patient Signature: ____

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CONSENT TO DICLOSE PERSONAL INFORMATION

I ____, give Dr. Ibrahim & his 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: _________________________________

4) Name: ____ Relation: ________________________

   Contact Information: _________________________________

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

Patient Signature: ____ Date: _______________

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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:

ADVANCED FAMILY CARE
978 International Pkwy
Lake Mary FL,32746
Phone (407)391-3131 Fax (407)833-9165

FROM:

Office/Physician Name:____

Phone #:____

Fax #:____

Patient Information Needed for:

- ☐ CONTINUATION OF CARE
- ☐ Social Security/Disability
- ☐ Insurance
- ☐ Personal Use
- ☐ Other: ________________

Information to be released:

- ☐ ALL MEDICAL RECORDS ON FILE
- ☐ Consultation Report
- ☐ Operative Reports
- ☐ Lab/Path Reports
- ☐ X-Ray Reports/Images

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 six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: ____ Date: ______________________

Notice of Privacy Practice

Your Rights

Following is a statement of your rights with the respect to your protected health information

- **You have the right to inspect and copy your protected health information.** Under Federal law, however, you may not copy the following records: Psychotherapy notes, information complied in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information.** This means that you may ask us to not use or disclose any part of your protected health information for the purpose of treatment, payment or health operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care for notification as described in this Notice of Privacy Practice. Your request must state the specific restrictions requested and to whom you want the restriction to apply to. Your Physician is not required to agree to such restriction that you may request. If the Physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another health care professional.
- **You have the right to request confidential communication from us by alternative means or at an alternative location.** You have the right to obtain a copy of the privacy notice from us upon request even if you have agreed to accept the notice alternatively i.e. electronically.
- **You may have the right to have your physician amend your protected health information.** If we deny your request for the amendment, you have the right to file a statement of disagreement with us as we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any on your protected health information.
- **We reserve the right to change the terms of this notice and will inform you by mail of any changes.** You then have the right to object or withdraw as provided in this notice.
- **Complaints may be made to us or to the Security of Health and Human Services if you believe that your privacy rights have been violated by us.** You may file a complaint with us by notifying our HIPAA compliance coordinator of your complaint. We will not retaliate against you for filing a complaint.
- This notice was published and became effective by law on/or before April 14, 2003.

We are required by law to maintain the privacy of and to provide individuals with this notice or legal duties and privacy practice with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Coordinator in person or by phone on our main Phone number 407.391.3131.

By signing below, you acknowledge that you have received notice of our privacy practice and acknowledge that you understand the above information.

Patient Signature: ____

Date: ______________________________ Witness: ______________________________

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Patient Name:____ DOB:____________________

ALLERGIES

Please list all that apply

Name of Allergy	Reaction
Medication:	
Food:	

☐ NO KNOWN DRUG OR FOOD ALLERGIES

MEDICATIONS

Medication Name	Dose	Frequency

☐ NO DAILY MEDICATIONS OR SUPPLEMENTS

Patient Name:____ DOB:____________________

FAMILY MEDICAL HISTORY

Please check all that apply

		Who (mom/dad/grandparents)			Who (mom/dad/grandparents)
	Asthma			Heart Disease	
	Arthritis			Hypertension	
	Cancer			Stroke	
	Diabetes			Mental Illness	

ARE YOU A SMOKER? YES / NO

IF YES, HOW MUCH DID OR DO YOU SMOKE PER DAY? _________________________________

PERSONAL MEDICAL HISTORY

Please check all that apply

	Asthma		Anemia
	Angina/Chest Pain		Arthritis
	Cancer		Chronic Bronchitis
	Cirrhosis of Liver		Clotting Disorder
	Diabetes		Emphysema
	Epilepsy		Gallstones
	Heart Attack		Hepatitis
	High Blood Pressure		High Cholesterol
	HIV/AIDS		Kidney Disease
	Kidney Stones		Migraines
	Thrombocytopenia		Tuberculosis
	Ulcers (Gastric)		Venous Thrombosis (blood clot)

HOSPITALIZATION/SURGICAL HISTORY

Please list all that apply

Date/Year	Hospitalization/Operation