LAKE CONWAY PRIMARY CARE
A CITY HEALTH CENTERS CLINIC

LAKE CONWAY MEDICAL CLINIC
5058 S Conway Road
Orlando, FL 32812
Phone: 407-851-2790
Fax: 407-851-2709
www.lakeconwayprimarycare.com

PLEASE CIRCLE ONE

- PRIMARY CARE
- IMMIGRATION
- MED CLEARANCE
- QTC

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Patient's last name:	First:	Middle:	Marital status (circle one):	
			Single / Mar / Div. / Sep / Wid	
Race:	Ethnicity:	Preferred Language:	Birth date:	Sex:
			/ /	☐ M ☐ F
Street address:		Social Security no.:	Home/Cell Phone no.:	
			( )	
City:		State:	Zip code:	
Email:		Preferred Pharmacy Name, Address & Phone number:		

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Subscriber's name (if other than yourself):		Birth date (if other than yourself):
		/ /
Patient's relationship to subscriber: ☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lake Conway Urgent Care, LLCor insurance company to release any information required toprocess my claims.**All payments received must be made payable to Lake Conway Medical CLinic, LLC. No personal or inconvenient checks accepted.**

Patient / Guardian Signature:

Financial Policy

Paymentis due at the time services are rendered, which includes all deductibles, co-insurance and co-payments. Patients who have an insurance carrier in which the practice has a valid contract with will be responsible for all fees.

Depositsare collected from all Self-Pay patients prior to service. Insurance is filed for all primary carriers. Secondary or supplemental insurance is filed as well. A claim form can be provided at the time of service for the patient to file. Patients are responsible for any charges not covered by insurance or other benefits. This practice, Lake Conway Medical Clinic, LLC, DOES NOT ACCEPT PERSONAL CHECKS OR ANY INCONVIENANT CHECKS. This practice, Lake Conway Medical Clinic, LLC DOES ACCEPT MASTER/VISA/AMEX/DISCOVER CREDIT CARDS OR DEBIT/ CHECK CARDS AND PATIENTS ARE RESPONSIBLE for all fees if transaction is not approved or is expired for any reason from your credit card company.

STATEMENTS AND BILLING CORRESPONDANCE are sent to update the patient as to the status of the account and whether your company had fulfilled their obligation to you, the policy owner, to pay claims in a timely manner.

DELINQUENT ACCOUNTS are sent to collections 90 days from the date services were rendered. Patients having financial difficulties are encouraged to discuss them freely with us before the account becomes delinquent.

General Consent

I/we hereby authorize Lake Conway Medical Clinc, LLC, to furnish information and/ or discuss information contained in my medical record, including appointment information, with the following person/persons:

Name: _____ **Relationship:** _____

I/We have provided my general information/insurance information correctly, have read the Financial Policy for Lake Conway Medical Clinic, LLC and also understand and acknowledge the general consent above.

Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment for 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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____