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We are pleased to welcome you to our practice and look forward to meeting you at your scheduled appointment. Our goal is to provide our patients with compassionate, high quality care. Please review our policies below, developed over 25 years in private practice, and **complete the enclosed new patient paperwork to bring with you to your appointment.**

Appointment Access

Access to the practice is by appointment. We strive to have same-day appointments available. We encourage you to schedule your follow-up appointment at check-out.

Referrals

If you have a medical condition that needs an authorization/referral you will be required to schedule an office visit at our facility prior to obtaining the authorization/referral. Additionally, if it has been more than 3 months since your last visit you may be required to come in for an appointment before an authorization/referral can be issued. Please notify us at least 5 business days prior to your specialist appointment.

Copays, Deductibles, and Coinsurance

Your copay, deductible, or coinsurance is due at the time services are rendered.

Insurance cards and Identification

Please bring your insurance card and photo identification to your appointments, as they must be presented at each office visit.

Prescription Medications

For your safety and well-being, new prescriptions and prescription refills require office visits for evaluation by a provider. Requests for new prescriptions and prescription refills will not be taken over the phone during or after office hours. Please talk to your provider at your appointment to make sure you have enough medication to last until your next visit.

We understand that unexpected events arise, and so a small refill of a chronic medication may be granted during or after office hours, as determined by the on-call provider. You must then schedule an appointment with a provider to evaluate your treatment plan and obtain a full prescription refill. The intent of this policy is to ensure you are receiving safe, high quality care.

Lab and Diagnostic Test Results

At present, lab and diagnostic test results are reviewed at an appointment with your provider. As the functionality of our electronic health record advances, you will be able to view some of these results in your patient portal. For interpretation of any results in your portal, and for a plan of care, you will need to schedule an appointment with your provider.



Cardiology New Patient Forms

*Please do not mail or fax this form.
Bring it with you to your appointment.*

Referring Physician: _____

Reason for today's visit: _____

Patient Name: _____

Address: _____
Street City State ZIP Code

E-mail Address: _____

Home Phone: (____) _____ **Emergency Phone:** (____) _____

Date of Birth: _____ **Sex:** M / F **Marital Status:** _____

Social Security #: _____ **Student:** Y / N **If yes:** Full- or Part-Time

Are you Hispanic or Latino? Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street City State ZIP Code

Phone: (____) _____ **Extension:** _____

Emergency Contact: _____

Primary Phone: (____) _____ **Alternate Phone:** (____) _____

Address: _____
Street City State ZIP Code

Primary Insurance Company: _____

Claims Address: _____
Street or PO Box City State ZIP Code

Name of Insured: _____ **ID # of Insured:** _____

Group # of Insured: _____ **Relationship to Insured:** _____

Date of Birth of Insured: _____ **Social Security # of Insured:** _____

Secondary Insurance Company: _____

Claims Address: _____
Street or PO Box City State ZIP Code

Name of Insured: _____ **ID # of Insured:** _____

Group # of Insured: _____ **Relationship to Insured:** _____

Date of Birth of Insured: _____ **Social Security # of Insured:** _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature:** _____

I hereby authorize LoCicero Medical Group to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to Karon R. LoCicero, M.D. or to the party who accepts assignment.

I certify the information I have provided with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

Date: _____ **Signature:** _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Date: _____ **Signature:** _____

REGISTRATION FOR THE PATIENT PORTAL

LoCicero Medical Group provides a Website and internet-based services offering a secure, private channel for healthcare consultation communications with your physician, personal medical information storage, online healthcare information, and related products, services and content.

You may register for the secure Patient Portal at **lociceromedicalgroup.com/my-lmg/patient-portal**

We are excited to offer our patients this service and believe that this means of communication will enhance your relationship with our practice.

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

- () I HAVE MADE SUCH A DECLARATION.
- () I HAVE **NOT** MADE SUCH A DECLARATION.

Health Care Surrogate

- () I HAVE DESIGNATED A HEALTH CARE SURROGATE.
- () I HAVE **NOT** DESIGNATED A HEALTH CARE SURROGATE.

Durable Power of Attorney

- () I HAVE APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.
- () I HAVE **NOT** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

Signature of Patient or Representative	Date
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I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Representative	Date
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YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date

PATIENT NAME: _____

DATE: _____

PERSONAL HISTORY

ILLNESS: Do you have or have you ever had:

Please encircle all answers-no or yes

Measles.....no yes
German Measles.....no yes
Mumps.....no yes
Chicken Pox.....no yes
Whooping Cough.....no yes
Scarlet fever or Scarleting.....no yes
Diphtheria.....no yes
Smallpox.....no yes
Pneumonia.....no yes
Influenza.....no yes
Pleurisy.....no yes
Rheumatic Fever or
Heart Disease.....no yes
Arthritis or Rheumatism.....no yes
Any Bone or Joint Disease.....no yes
Neuritis or Neuralgia.....no yes
Bursitis, Sciatica or
Lumbago.....no yes
Polio or Meningitis.....no yes
Gonorrhea or Syphilis.....no yes
Anemia.....no yes
Jaundice.....no yes
Epilepsy.....no yes
Migraine Headaches.....no yes
Tuberculosis.....no yes
Diabetes.....no yes
Cancer.....no yes
High or Low
Blood Pressure.....no yes
Ulcer.....no yes
Hepatitis.....no yes
Nervous breakdown.....no yes
Food, chemical or
Drug poisoning.....no yes
Hay fever or Asthma.....no yes
Hives or Eczema.....no yes
Frequent infections or boils.....no yes
Frequent colds or sore throat.....no yes

ALLERGIES: Are you allergic to:

Penicillin or Sulfa.....no yes
Asprin, Codine or
Morphine.....no yes
Mycins or other Antibiotics.....no yes
Tetanus Antitoxins or
Serums.....no yes
Other: _____

INJURIES: Have you had any:

Broken or cracked bones.....no yes
Concussion or head injury.....no yes

WEIGHT: Now: _____
One year ago: _____
Maximum: _____ When: _____

TRANSFUSIONS: Have you

Ever had:

Blood or Plasma

Transfusion.....no yes

Date: _____

SURGERY: Have you had:

Appendectomy.....no yes

Any other operation.....no yes

Have you ever been advised to have any surgical operation which has not been done.....no yes

Give details: _____

Have you been treated or hospitalized for any other illness not previously mentioned.....no yes

Give details: _____

X-RAYS: Have you ever had

X-rays of:

Chest.....no yes

Stomach or colon.....no yes

Gall Bladder.....no yes

Extremities.....no yes

Back.....no yes

Mammograms(F).....no yes

EKG: Have you ever had an

Electrocardiogram?.....no yes

Date: _____

IMMUNIZATIONS: Have you had:

Tetanus Shots.....no yes

Date Last

Tetanus: _____

SYSTEMS REVIEW:

EYES

Eye Strain.....no yes

Seeing Double.....no yes

Seeing Halo about Lights.....no yes

EARS:

Hearing loss.....no yes

Infections.....no yes

Ringing in ears.....no yes

Earache or discharge.....no yes

THROAT AND MOUTH:

Frequent sore throats.....no yes

Hoarseness.....no yes

Bleeding gums.....no yes

NECK:

Goiter.....no yes

Lump or Swelling.....no yes

Pain or Stiffness.....no yes

BREAST:

Lump.....no yes

Discharge.....no yes

Pain.....no yes

HEART AND LUNGS:

Chronic cough.....no yes

Coughing up blood.....no yes

Shortness of breath.....no yes

Night sweats.....no yes

Chest pain or pressure.....no yes

Palpitations or fluttering.....no yes

Swollen ankles.....no yes

INTESTINAL:

Loss of appetite.....no yes

Trouble swallowing.....no yes

Nausea or vomiting.....no yes

Vomiting blood.....no yes

Pain in abdomen.....no yes

Gall bladder trouble.....no yes

Belching or bloating.....no yes

Change in bowel habits.....no yes

Constipation.....no yes

Diarrhea.....no yes

Blood in stool or

Hemorrhoids.....no yes

Black (tarry) stools.....no yes

KIDNEY, BLADDER AND GENITALS:

Albumin or sugar in

Urine.....no yes

Blood or puss in urine.....no yes

Kidney or bladder

Infection.....no yes

Getting up nights to urinate

(_____ times).....no yes

Trouble starting urine

Stream.....no yes

Discharge.....no yes

