LENITA HANSON, M.D., P.A. dba Ultracare Endocrine and Diabetes Consultants
389 Commercial Ct, Ste A, Venice, FL 34292
Tel: 941-484-1200 Fax: 941-484-1244

PATIENT INFORMATION FORM

NAME: ______________________________________HOME PHONE:_______________

HOME ADDRESS: ____

CITY: __________________ZIP:__________ MARITAL STATUS: __M __S __D __W

DATE OF BIRTH: ___________ SOCIAL SEC# _______-_______-______ GENDER: __M __F

RACE: __CAUCASIAN __AFRICAN AMERICAN __ASIAN __HISPANIC __OTHER ________________

OCCUPATION: ________________________EMPLOYER: ____________________________

WORK PHONE:____________ CELL PHONE: ___________ EMAIL: _____________________

NAME OF PERSON (S) WHOM YOU AUTHORIZE US TO DISCUSS YOUR PROTECTED HEALTH INFORMATION:
NAME: ______________________________________HOME PHONE:_______________
HOME ADDRESS: ____
CITY: ____ZIP:______________________
RELATIONSHIP TO YOU: ____
NAME: __________________HOME PHONE: ____________RELATIONSHIP___________
HOME ADDRESS: ____
CITY: ____ZIP:______________________
RELATIONSHIP TO YOU: ____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING: __ ADVANCE DIRECTIVE __LIVING WILL __ SURROGATE

WHO WILL BE RESPONSIBLE FOR YOUR BILL? ____SELF ___INSURANCE __OTHER________________
HOW WILL YOU BE PAYING YOUR CO-PAY/ DEDUCTIBLE/PORTION OF YOUR BILL?
__CASH __CHECK (THERE IS A $25:00 SERVICE CHARGE FOR RETURNED CHECKS) ___CREDIT CARD
ARE YOU THE INSURANCE SUBSCRIBER? IF NOT PLEASE GIVE NAME OF SUBSCRIBER: ___________________
DATE OF BIRTH OF SUBSCRIBER: ____________ SOC SEC # OF SUBSCRIBER:____________________

I HEREBY AUTHORIZE AND DIRECT PAYMENT TO LENITA HANSON, M.D., P.A. FOR ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE. I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON

both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Lenita Hanson, M.D., P.A. of any changes in my status or the above information.

Signature : ____Date: ___________________________

Signature of parent(if minor)____________________________***Date:*** ___________________________

I have also read and have received a copy of the practice HIPAA Notice of Privacy Practices and I hereby consent to the use of my Protected Health Information as outlined in the Notice of Privacy Practices.

Signature : ____Date: ___________________________

Signature of parent(if minor)____________________________***Date:*** ___________________________

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LIFETIME MEDICARE B SIGNATURE AUTHORIZATION

If you are covered by Medicare, Please complete

For services beginning________________, I authorize any holder of medical or other information about me to release to the social security administration and Health Care Financing Administration or its intermediaries or carriers, or to other billing agents of Lenita Hanson, M.D., P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

Patient signature: ____

Health Insurance claim? Medicare number: _____________________________________

If someone other than patient is signing; By: ____________________________________

Reason patient is unable to sign: ____

MEDIGAP INSURANCE

I request that payment of authorized Medigap benefits be made on my behalf to Lenita Hanson, M.D., P.A. for services furnished to me by Lenita Hanson, M.D., P.A.
I authorize any holder of medical information about me to release to Lenita Hanson, M.D., P.A. any information needed to determine these benefits or the benefits for related services.
I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to "cross - over" automatically.

Patient
Signature:____

Insurance Policy
name:____

Insurance Policy
Number:____