

## **Arnold D. Fong M.D. P.A.**

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### **FINANCIAL POLICY**

**Arnold D. Fong M.D. P.A.** is committed to the provision of quality medical care, and we are pleased to discuss our professional fees with you at any time.

Any questions you may have on our fees, financial policy or what part of a fee you are responsible for can be directed to our personnel.

All new patients may be required to complete a "New Patient Registration" form prior to being seen by the physician. It is important that you complete all information, including insurance information, even if we are not filing for your office visits, as this information may be required in the future.

We will also request to make a copy of your insurance card and any type of picture identification, which will remain a permanent part of your medical records chart.

### **INSURANCE INFORMATION**

If you are covered by Medicare, Tricare, or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company you will be responsible for full payment at the time of your visit.

Self-pay patients are expected to pay for services in full at the time of service.

Should you require admission to hospital, we will file with all insurance plans for our professional fees.

In the event your insurance company has not satisfied the full balance of your account within 90 days, we will notify you so that you may contact your insurance carrier. Ultimately, responsibility for payment for services rendered rests with the patient.

Please advise the office of any changes to your insurance or mailing address.

Payment arrangements can be arranged with the Office Manager prior to services being rendered.

In the event the services of a collection agent is required to collect your account, you would be responsible for any costs incurred for this service.

### **UNACCOMPANIED MINORS**

The parents (or legal guardians) will be responsible for the full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file prior to treatment. However, every effort should be made by parent or guardian to be present during the exam.

Thank you for taking the time to read and understand the financial policy of Arnold D. Fong M.D. P.A.. Please contact us should you have any questions or concerns.

Please sign below to acknowledge your understanding of this policy.

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Responsible Party Signature

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Date

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Patients Name - Print

Arnold D. Fong M.D. P.A.

*Patient Consent for Use and Disclosure  
Of Protected Health Information*

I hereby give my consent for Arnold D. Fong M.D. P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Arnold D. Fong M.D. P.A. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Arnold D. Fong M.D. P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Vicki Fong**  
**1102 A1A N, Suite 106**  
**Ponte Vedra, FL 32082**  
**904-280-8228**

With this consent, Arnold D. Fong M.D. P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "confidential".

With this consent Arnold D. Fong M.D. P.A. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, I have the right to request that Arnold D. Fong M.D. P.A. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Arnold D. Fong M.D. P.A. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Arnold D. Fong M.D. P.A. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient/Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patients Name

\_\_\_\_\_  
Print Parent/Legal Guardian

**Arnold D. Fong M.D. P.A.**

While you are a patient in our office, you will no doubt, at some time, require diagnostic tests. These may include but are not limited to, - **Lab tests, x-rays, CT scans, MRI, Mammography, Ultrasound, and PET scans.**

It is our policy to notify patients of their test results whether they are normal or abnormal.

**If you have had a test and have not heard from this office with in 7 days, we expect you to call us and notify us, so we can track your test results and continue your care.**

Please sign that you have read and understand the statement above.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

MEDICAL RECORDS RELEASE

Patient Name: \_\_\_\_\_

Maiden / Previous/Other Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Section 1.

I, the undersigned hereby authorize the release of information TO:

**Arnold D. Fong M.D. P.A.**  
**1102 A1A N, Suite 106**  
**Ponte Vedra Beach, FL, 32082**  
**(904) 280-8228**  
**Fax: 280-8208**

Transferring Records From: \_\_\_\_\_  
(Office / Provider Name and Address) \_\_\_\_\_  
\_\_\_\_\_

Information to be released:

\_\_\_\_\_ Visit notes including Laboratory and radiology findings from the past **2 years**, hospitalization records, colonoscopy records and findings, immunization records including last influenza and pneumonia vaccines. Mammogram, Pap smears from the last **3 years** and Bone Density for females. PSA for Males.

\_\_\_\_\_ Other (please specify)

The information is to be disclosed for the purpose of \_\_\_\_\_.

I *Specifically Authorize* disclosure of this confidential information to all the persons referred to in Section 1. In order for the above information to be released, you **MUST** sign on both lines below.

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

I understand that I have the right to inspect the disclosed information at any time. This authorization is effective for 12 Months after the date signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. A photocopy or an exact reproduction of this signed Authorization shall have the same force or effect as the original. I understand the information is being disclosed and may be used only for medical, legal and or litigation purposes.

**I understand that this authorization may include records regarding psychiatric, alcohol/drug or sexually transmitted disease/HIV, sexual abuse information.**

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

# Arnold D. Fong M.D. P.A.

**CURRENT MEDICATIONS: (INCLUDE BIRTH CONTROL PILLS, VITAMINS/HERBALS)**

<u>Medicine Name</u>	<u>Dose (e.g. 10mg)</u>	<u>Frequency (e.g. 1 tablet, twice a day)</u>	<u>Who Prescribes?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREFERRED PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_  
PHARMACY PHONE NO: \_\_\_\_\_

**ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS:**

<b>Name of Medication:</b>	<b>Adverse Reaction:</b>
_____	_____
_____	_____
_____	_____

**PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:**

<u>Name:</u>	<u>City/State:</u>	<u>Problem Cared For:</u>	<u>Still Seeing?</u>
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO

**PREVIOUS HOSPITALIZATIONS & SURGERIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

# Arnold D. Fong M.D. P.A.

## NEW PATIENT REGISTRATION

Name \_\_\_\_\_ Social Security#: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Street Address \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different to above) \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ Marital Status: S M W Sep D

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Tel# \_\_\_\_\_ Relationship \_\_\_\_\_

## PATIENT EMPLOYER INFORMATION

Patients Occupation \_\_\_\_\_ Employer Name: \_\_\_\_\_ Tel# \_\_\_\_\_

Employer Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## INSURED PERSON (IF NOT PATIENT)

Name: \_\_\_\_\_ Tel# \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## INSURANCE

Medicare # \_\_\_\_\_ Primary Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Tel# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Tel# \_\_\_\_\_

**Referred By:** Previous Patient of Dr Fong  Another Physician  (Dr \_\_\_\_\_) Family/ Friend.

## 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.**

**I hereby authorize Arnold D Fong MD P.A. to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Arnold D Fong MD P.A. (or to the party that accepts assignment).**

**I certify that the information I reported with regards to my insurance coverage is correct.**

**Either my insurance company or I may revoke this authorization at any time in writing.**

Signature: \_\_\_\_\_ Date \_\_\_\_\_

(Patient/Parent or Legal Guardian)

# Arnold D. Fong M.D. P.A.

## Patient Social & Family History – Review of Systems Form

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Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### **Social History:**

Occupation: \_\_\_\_\_ Marital Status: S M D W Sep Children? \_\_\_\_\_ Ages \_\_\_\_\_

Alcohol: none \_\_\_\_\_ yes \_\_\_\_\_ How Much? \_\_\_\_\_ Per day/Week How Long? \_\_\_\_\_ Yrs

Caffeine: (coffee, tea, colas) \_\_\_\_\_ cups per day.

Exercise: none \_\_\_\_\_ Yes \_\_\_\_\_ How Much? \_\_\_\_\_

Smoking: none \_\_\_\_\_ Yes \_\_\_\_\_ How Much? \_\_\_\_\_ Packs/day How Long? \_\_\_\_\_ Yrs, Year Quit \_\_\_\_\_

Education: Highest Level \_\_\_\_\_ School / University \_\_\_\_\_

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### **Family History (check only those that apply)**

1) Anemia  2) Arthritis  3) Allergy/Asthma  4) Cancer  5) Cholesterol  6) Diabetes  7) Heart Disease

8) High Blood Pressure  9) Kidney Disease  10) Mental Illness  11) Migraine  12) Stroke

13) Other Medical Condition  \_\_\_\_\_

Which relative affected? \_\_\_\_\_

Father: Living \_\_\_\_\_ Deceased \_\_\_\_\_ Age: \_\_\_\_\_ Cause of Death? \_\_\_\_\_

Mother: Living \_\_\_\_\_ Deceased \_\_\_\_\_ Age \_\_\_\_\_ Cause of Death? \_\_\_\_\_



**BlueCross BlueShield  
of Florida**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

## Introduction to the Advance Directive - Living Will

Every competent adult has, in most cases, the freedom to accept or refuse medical treatment. When you are well, you can talk with your physician and family to make your wishes known. However, severe illness or an accident could cause you to be unable to communicate or to make choices. During that time, important decisions about your medical care may have to be made. Without any instructions from you, your family and physicians many not know what treatment you would want.

You can help your family and physicians by telling them, in advance, preferably in writing, what you would want done in certain situations. This planning ahead for future health care decisions is known as an **“ADVANCE DIRECTIVE.”** Your **DIRECTIVE** goes into effect only if your physician and one other physician determine that you suffer from a terminal condition *and* you become incapable of making decisions. You can change it at any time up until that point, by writing or making an oral statement.

There are three types of documents commonly used to express an individual’s **ADVANCE DIRECTIVES**: a Living Will, a Healthcare Surrogate Designation and a Durable Power of Attorney for Healthcare.

A Living Will is a declaration of a person’s desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal condition and is not able to express his or her wishes.

A Healthcare Surrogate Designation is a signed, dated and witnessed document naming another person such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you. The Surrogate’s authority to make decisions is limited to the time when you are incapacitated and must be in accordance with what your wishes would be if you were able to communicate.

The Durable Power of Attorney for Healthcare is a document that, when properly executed, designates a person as the individual’s attorney-in-fact to arrange for and consent to medical, therapeutic and surgical procedures for the individual.

Deciding whether to have an **ADVANCE DIRECTIVE**, and if so, the type and scope of the **DIRECTIVE**, is a complex undertaking. It may be helpful for you to discuss this important decision with your spouse, family, friends, physician, lawyer or spiritual advisor. This is not required, however, and the documents do not need to be notarized.

The attached form for a **DIRECTIVE** describes three situations and allows you to indicate which treatments you would want or would not want if your physician recommended them. If a situation you are particularly concerned about is not included, you can make additional comments in the section provided.

In many cases, in the situations described, it may take days or even weeks for the prognosis (outlook for recovery) to be established. In the interim, until the outlook is known, some of the treatments listed may be appropriate. Only after the prognosis is known with reasonable medical certainty is it appropriate to withdraw or withhold such treatments. The situations described assume that your physician and at least one consultant share the opinion regarding the outlook for your recovery.

After you complete the form, give a copy to your regular physician, your health care surrogate, a trusted family member or friend, and/or your spiritual advisor. If you change your **ADVANCE DIRECTIVE**, make sure they have the latest copy. Carry a copy with you that states the location of the original, or inform all concerned of its location. For more information, visit the State of Florida’s website at [www.myfloridalegal.com](http://www.myfloridalegal.com).

## The Advance Directive - Living Will

If you were in the condition described in the three situations, what would your choice be regarding the possible treatments listed on the left? Mark your choices in the appropriate boxes.

<p><b>DECLARATION</b> made this _____ day of _____, 20____. I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:</p>			
<p><b>Possible Treatments</b> Assume none of the following will improve or cure the condition described in the situations.</p>	<p><b>Situation A</b> If I am in a terminal condition, caused by illness or injury, and have no reasonable hope of recovery or of becoming aware of my surroundings or being able to use my mental abilities, then my wishes regarding the following would be:</p>	<p><b>Situation B</b> If I have a progressive illness, which will continue to worsen and result in my death and which cannot be improved or cured, when the point is reached that I am no longer able to recognize family and friends or speak understandably, my wishes regarding the following would be:</p>	<p><b>Situation C</b> If I have a condition which makes me unable to recognize people or speak understandably, and that condition is permanent and cannot be improved or cured but is NOT terminal, my wishes regarding the following would be:</p>
1. Do you want efforts to be made to resuscitate (chest massage) you if your heart stops beating?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
2. If you are unable to breathe on your own, do you want a mechanical breathing machine (respirator) to be used?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
3. If your kidneys fail, do you want kidney dialysis (cleaning the blood through a machine)?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
4. Do you want any surgery, even if it is life-saving?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
5. Do you want pain medications to keep you comfortable even if they dull consciousness and could shorten your life?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
6. Do you want other medications, such as antibiotics, which may prolong your life?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
7. Do you want food and water given to you through tubes in your veins, nose or stomach?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
Other: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDECIDED
Witness: _____ Witness: _____ Witnesses cannot be spouse, blood relative or surrogate.		Signature: _____ Date: _____	