Elizabeth A. Triana, M.D.

3155 Harbor Blvd, Suite 100 Family Practice (941)625-1990
Port Charlotte, FL 33952 Fax (941)625-1991

Patient Information Sheet

Today's Date: ____________

Name: ____ Sex: □ Female □ Male

Social Security Number: _____________________Date of Birth: ____________ Age: ________

Local Home Address: ____

City: _____________________________ Zip Code: _________________

Local Phone Number: _______________________Cell Phone Number: ____________________

Employer's Name: ____

Employer's Address: ____

City: ______________________________ Zip Code: _________________

Phone Number: ____

Marital Status: □ Married □ Divorced □ Single □ Widowed

Spouses Name: ____

Name of person to notify in case of emergency: _______________________________________

Phone: ____

Insurance (Please provide us with your cards for Photo Copying and Review)

Primary Insurance Company: ____

Supplemental Insurance Company: ____

Consents:
I authorize Dr. Triana's office to bill my insurance carrier or carriers on my behalf and assign payments to Dr. Elizabeth Triana. This is to include commercial insurance carriers and or Medicare Part B and supplemental insurance. I authorize the release of my Medical records to my insurance carriers if requested in order to pay my claims with Dr. Triana. I understand that payment of fees incurred are my responsibility and agree to pay the portion allowed, but not covered by my insurance and further understand that a default of payment may result in my account being sent to a collection agency. Any additional costs to collect payment of this debt will be paid by me (patient/guardian).

Patient's or Guardian's Signature: ____

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Patient Consent For Use and Disclosure of Protected Health Information

With my consent, **Elizabeth A. Triana, M.D. – Family Practice** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Triana's **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the **Notice of Privacy Practices** prior to signing this consent.

Elizabeth A. Triana, M.D. –Family Practice 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 Dr. Triana at 3155 Harbor Boulevard, Suite 100, Port Charlotte, FL 33952.

With my consent, Dr. Triana and/or her staff may call my home or other designated location and leave a message on voicemail, an answering machine, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Elizabeth A. Triana, M.D. – Family Practice** may mail to my home or other designated 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 PERSONAL and CONFIDENTIAL.

I have the right to request that **Elizabeth A. Triana, M.D. – Family Practice** restricts how it uses or discloses my PHI to carry out PHO. However, 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 this practice's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations. 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, Dr. Triana may decline to provide treatment to me.

You may release my PHI to : ____

(Family Member)

____ ______/______/______

Signature of Patient or Legal Guardian Date

Print Patients Name: ____