

**LOUISE I. BUHRMANN, MD, PA
JAIRO R. NUNEZ, MD, PA
PRAVEEN C. PATHAK, MD**

1485 S. Semoran Blvd., Building 6, Suite 1454, Winter Park, FL 32792
Phone (407) 671-2258 / Fax (407) 671-2675

PATIENT INFORMATION

Date _____ New Patient _____ or Update of Information _____

How did you hear of our office? _____

Patient Name (first, middle, last) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Alternate Phone _____

Marital Status _____ Gender _____ Date of Birth _____ Age _____

Social Security # _____ Employer _____

School (If currently a student) _____

Emergency Contact _____ Relationship to patient _____

Home Phone _____ Work Phone _____

If patient is under the age of 18 please complete parent/guardian information below:

Mother's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Mother's Home Phone _____ Mother's Work Phone _____

Father's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Father's Home Phone _____ Father's Work Phone _____

Who does patient live with? Mother _____ Father _____ Both _____ Other _____

If Guardian is someone other than listed above: Name _____

Address _____ Phone _____

PRIMARY INSURANCE POLICY

Name of Insurance Company_____

Name of Managed Care Company_____

Address to Mail Claims_____

Phone Number for Benefit/Precert Information_____/_____

Name of Insured's Employer_____

Name of Policy Holder_____SS#_____

Date of Birth of Policy Holder_____Group Name/Number_____

SECONDARY INSURANCE POLICY

Name of Insurance Company_____

Name of Managed Care Company_____

Address to Mail Claims_____

Phone Number for Benefit/Precert Information_____/_____

Name of Insured's Employer_____

Name of Policy Holder_____SS#_____

Date of Birth of Policy Holder_____Group Name/Number_____

I authorize information to be sent to my insurance company for purposes of payment. I also agree to pay for services rendered. If it becomes necessary to turn my account over to a collection agency, I understand that I will be responsible for all reasonable fees incurred to collect the account. This includes attorney fees and court costs.

Signature of Patient_____Print_____

Signature of Insured_____Print_____

Please have your insurance card(s) ready to be photocopied.

**LOUISE I. BUHRMANN, MD, PA
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PRAVEEN C. PATHAK, MD**

1485 S. SEMORAN BLVD., SUITE 1454 - WINTER PARK, FLORIDA 32792

Patient Name: _____ **Date:** _____

Please give us complete information on past or current physicians, therapists or facilities that we may need to request medical records from.

1. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

2. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

3. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

4. Physician: _____

Address: _____

City/St./Zip: _____

Telephone: _____

LOUISE I. BUHRMANN, MD, PA
JAIRO R. NUNEZ, MD, PA
PRAVEEN C. PATHAK, MD

PSYCHIATRY/PSYCHOTHERAPY

1485 S. Semoran Blvd. • Building 6, Suite 1454 • Winter Park, FL 32792 • Phone (407) 671-2258 • Fax (407) 671-2675

GENERAL HEALTH QUESTIONNAIRE

Please complete the following so that we may better serve you:

Any serious medical problems? _____

Do you have a family doctor or an internist? _____ Who? _____

May I communicate with your doctor about you? _____ Any hospitalizations? _____

Date _____ Reason _____

Date _____ Reason _____

Any allergies? _____

What medications are you on now? Include over-the-counter medicines and herbal remedies. _____

Recreational drugs? _____ Do you drink alcohol? _____

Do you use nicotine/smoke cigarettes? _____ Do you use caffeine? _____

Do you have a history of: **(PLEASE MARK YES OR NO FOR EACH ONE)**

	YES	NO		YES	NO
Heart disease	_____	_____	Muscle and joint problems	_____	_____
High blood pressure	_____	_____	Eyesight problems	_____	_____
Respiratory / lung problems	_____	_____	Hearing problems	_____	_____
Stomachaches	_____	_____	Loss of consciousness	_____	_____
Indigestion	_____	_____	Severe headaches	_____	_____
Irritable bowel syndrome	_____	_____	Seizures	_____	_____
Dieting frequently	_____	_____	Being knocked unconscious	_____	_____
Diarrhea	_____	_____	Weight concerns	_____	_____
Constipation	_____	_____	Urinary problems	_____	_____
Menstrual problems:	_____	_____	Thyroid problems	_____	_____
			Diabetes	_____	_____

Print Name _____ Signature _____

Date: _____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____

City/State/ZipCode: _____

Date of Birth: _____ **SS# (last 4 digits)** _____

I hereby authorize (please check your doctor's name below):

____ **Louise I. Buhrmann, MD, PA**

____ **Jairo R. Nunez, MD, PA**

____ **Praveen C. Pathak, MD**

to () **release my medical information to** and/or () **obtain my medical information from** the following doctor, hospital, attorney or other entity:

Name of Doctor/Hospital/Attorney/Other Entity: _____

Approximate Dates of Service/Hospitalization: _____

Address: _____

City/State/Zip: _____

Phone/Fax Number: _____

This release is for the purpose of (please check):

____ **Continuing Medical Care**

____ **Legal Representation**

____ **Other:** _____

I understand that this information may include information of a psychological, psychiatric, AIDS, HIV, alcohol or drug related nature. I recognize that the information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of such information. This authorization will expire one year from the signature date and may be revoked in writing by the patient at any time, except to the extent that action has already been taken in good faith. Information released may be subject to re-disclosure by the recipient. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

Patient/Guardian Signature

Date

Relationship to Patient

Witness Signature

Date

Provider's Authorization to Release

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SIGNATURE ON FILE / FINANCIAL AGREEMENT

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my Insurance Companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me to obtain payment from my insurance companies.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

I am responsible for any insurance deductibles and co-payments.

If I am not using insurance I understand that I am responsible for payment in full at the time of my appointment.

I understand that I may be charged for appointments canceled with less than 24 hours notice.

Name (Please print) _____

Signature _____ Date _____

Louise I. Buhrmann, MD, PA

Jairo R. Nunez, MD, PA

Praveen C. Pathak, MD

Psychiatry

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("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 have received, read and understand 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 Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or 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: _____

Date: _____

OFFICE USE ONLY

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

Date:	Initials:	Reason:
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. (If you have any questions about this notice, please contact the Office Manager in this office at 407-671-2258, 1485 S. Semoran Blvd., Suite 1454, Winter Park, Florida 32792.)

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone who provide "call coverage" when Louise I. Buhrmann, M.D. is not available.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive in this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed Consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. It is important that your primary care doctor knows what medications you are on to avoid medication interactions. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy and obtaining lab results. We do not require authorization to call or fax in prescriptions.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but will not apply to any uses and disclosures that occurred before that time. If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. We do get written authorizations also.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena signed by a judge.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena signed by a judge, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so and we would follow that with a written authorization. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it are in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any Consent we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Office Manager in this office in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review. You have the right to have your psychiatric records sent to another mental health provider or physician. If you want to personally review your records you may do this in the presence of Dr. Buhrmann.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, ask for, complete and submit a Medical Record Amendment/Correction Form to the Office Manager in this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and healthcare operations. To obtain this list, you must submit your request in writing to the Office Manager in this office. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the healthcare information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about any treatment you have had.

We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may submit a written note and send it to the Office Manager in this office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may submit a written note to the Office Manager in this office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically you are still entitled to a paper copy. To obtain such a copy, contact the Office Manager in this office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Teresa, Office Manager at 407-671-2258, 1485 S. Semoran Blvd., Suite 1454, Winter Park, Florida 32792. You will not be penalized for filing a complaint.