WEST ORANGE FAMILY MEDICAL CARE

1002 S. DILLARD STREET, SUITE 102
WINTER GARDEN, FL 34787
PHONE 407-877-3577 FAX 407-877-8495

MICHAEL MERCADO, MD
FRANCISCO GONZALEZ, PA

PATIENT REGISTRATION FORM

Today's Date	**Who was your previous doctor?:**
Who Referred You To Practice?:	

Identifying Information

First, Middle, and Last Name	Date of Birth
Marital Status	Male_____ Female_____
Single__ Married__ Partnered__ Divorce__ Widowed__	
Occupation or Type of Job Performed	Social Security Number
Employment Status	
Working___ Unemployed___ Disabled___ Retired___	

Contact

Email Address	Mobile Phone
Can We Send Mobile Text Notifications?	Can We Send Voice Notifications?
Yes_____ No_____	Yes_____ No_____
Home Phone	Work Phone and Extension
Preferred Method of Communication:	Mobile Phone____ Home____ Work_____

Address

Physical Address Line 1: (no P.O. Box)	
Physical Address Line 2:	
City:	
State and Zip Code:	

Demographics

Ethnicity or Family's Country of Origen:	
Preferred Language:	English___ Spanish___ Other_____
Race (s): Asian___ Black___	Hispanic___ White___ Other_____

Next of Kin

Next of Kin, First and Last Name	Relationship to Patient
Next of Kin Address	Next of Kin Phone Number
Name of Alternate Emergency Contact	Emergency Phone Number
What is your mother's first and last name: (This is a phone in security question)	

Payment Information

Preferred Payment Preference:	Self Pay_____ Medical Insurance_____
Who Is Financial Responsible For Patient's Medical Bills?	Self_____ Name Other_____

Insurance Information

Name of **PRIMARY** Insurance Carrier	Patient Identification Number
Name and Relationship of Insured	Insured's Social Security Number
Employer Providing Insurance Coverage	Group Number

Name of **SECONDARY** Insurance Carrier	Patient Identification Number
Name and Relationship of Insured	Insured's Social Security Number
Employer Providing Insurance Coverage	Group Number

Name of **PRESCRIPTION** Coverage Plan	
Local Pharmacy Name and Address	Local Pharmacy Phone Number
Mail Order "90 Day" Pharmacy Name	Mail Order Pharmacy Address and Phone

The above information is true to the best of my knowledge. I am consenting to medical evaluation, medical testing, treatment, wellness recommendations, and possible referral to specialists as deemed medically necessary by any and all of the board certified primary care providers employed at West Orange Family Medical Care, PA.

Signed
Patient/Guardian_____Date_____

Patient Care Policies at West Orange Family Medical Care, Update for 2014

1. Dr. Michael G Mercado is the Directing Physician at WOFMC and although he may not directly take care of you, he is at all times available as a medical consultant for any highly-trained and experienced Nurse Practitioner or Physician's Assistant entrusted to autonomously provide medical care to patients at WOFMC.

2. The entire staff at WOFMC works together as a team and is committed to providing our patients with a comfortable environment to receive compassionate, competent, and individualized medical care. If there is a situation that does not meet your expectation, we will do our best to correct, however we do ask for your calm and respectful treatment of each staff member at all times.

3. Medical care is provided by appointment only. Every request you may have related to your medical care requires "face-to-face" time with a provider who can then document your encounter and your plan of care to be implemented. This includes prescription renewals, home care and DME provision. Home care agencies take care of skilled and intermittent medical needs. Home care does not provide care to homebound sick or elderly patients who are chronic but stable.

4. If you become sick and need an urgent or same day visit, please be assured that we will make every effort for you to be seen by a provider. You will receive treatment for that illness only. We do our best to keep your wait time as short as possible, but in our effort to be thorough and attentive with every patient, and as some of our patients are severely ill and require more critical medical care; we apologize if you are not seen by your provider at your appointment time.

5. We request that you bring ALL your medications with you to every visit so we have an accurate accounting of your treatments. We request that you have your medications refilled at the time of your visit. When you or your pharmacy contacts our office for refills outside of an office visit, we still have to consult your chart to see if your refill is appropriate. Prescribing for patients who are in the office takes priority and your refill request could take up to one week to complete.

6. If you require a prescription of a controlled medication, for pain, muscle spasm, cough, insomnia, anxiety, ADD/ADHD in the course of your medical treatment, it will be prescribed by Dr. Mercado only. Documented testing results, report of symptoms and physical findings must support the use of a controlled substance, and only when all others methods of treatment have failed. Urine testing will be done at random visits at your cost and surveillance reports of your controlled substance use as tracked by the pharmacies and the State of Florida will be reviewed. Do not call the office at anytime for refill of controlled meds, as you will need an office visit. Lost or stolen meds or scripts will not be replaced.

7 You may find that your insurance company will not pay for certain medical procedures, medical equipment, specialty medications, brand name drugs, or even some generic medications or that deductibles or co-pays do not fit your budget. WOFMC providers will choose medications or treatments that are on formulary with your insurance carrier. If you consider a medication or treatment to be life-saving, exclusive of all other options, you will be referred to a specialist. Pre-authorizations or any other letters of appeal are generally NOT done in this office.

8. WOFMC is in the process of converting from a paper medical record keeping system to Practice Fusion, a cloud-based electronic medical record keeping system. The staff considers patient confidentiality to be a very serious matter and therefore we have many layers of electronic security that help keep your medical history private. In the event that the entire Practice Fusion data base becomes hacked, our office will inform you as soon as is humanly possible and put you in touch with the administrative offices of Practice Fusion.

9. For the convenience of our patients, WOFMC offers a line of natural patented nutritional supplements and skin care products developed and distributed by Mannatech, Inc. Mannatech's products contain stabilized aloe vera in addition to other high quality ingredients. While our providers, in the course of interpreting your labs results, may recommend certain vitamins or minerals, our patients are under NO obligation to purchase those supplements from our office. Any interested patient will be referred to Lillian Mercado, our Wellness Coach. Most importantly, the offering of Mannatech nutritional supplements in our office is NEVER intended to treat conditions or cure illness. We care only to potentially provide you with the availability of high quality nutritional products that you would seek out for yourself in a retail marketplace.

Signed as Received_____ Date_____

PATIENT MAY KEEP A COPY OF THIS FORM

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

WEST ORANGE FAMILY MEDICAL CARE, PA
1002 S. DILLARD STREET, SUITE 102, WINTER GARDEN, FL 34787
(407) 877-3577

Our Financial Policy

Thank you for choosing our office as your health care provider. We are committed to your treatment being successful. Please understand that the payment of your bill is considered a part of your treatment, to provide you with staff and facility in which to serve you. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

All patients must complete our patient registration form, disclosure of insurance or other form of payment and health history questionnaire, before seeing any of the providers at West Orange Family Medical Care.

- Full payment of office visit, insurance deductibles, or co-pays are due at the time of service.
- We accept cash, checks, Visa, MasterCard and American Express.
- We offer an extended payment plan with prior credit approval by the Office Manager, after the first visit.
- The providers are not aware of payment arrangements, except to the extent that they are sensitive to provide treatments that are covered by your insurance or affordable to you otherwise.

REGARDING INSURANCE
We will bill your insurance after your deductible has been met. If payment is not made by your insurance company, the patient becomes fully responsible for payment. If you insurance company has not paid your account service within 45 days of billing, the balance will be automatically transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance, you will be informed in advance of service rendered, as much as we are aware.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER
All co-pays and deductible are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the paragraphs above.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and our charges are considered "usual and customary" for our geographical area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS
The adult accompanying a minor, the parent(s) or the signed guardian (s) is/are responsible for full payment. We will not provide medical service for an unaccompanied minor under the age of 16. For unaccompanied minors, over the age of 16, medical service for non-emergency treatment is affected with prior approval of parent or guardian, however, treatment will be denied unless charges have been pre-authorized by the parent and payment of medical treatment is paid at the time of service.

Thank you for your cooperation with adhering to the details of our Financial Policy.

I (printed name) _____have read, understood, and agree to the Financial Policies, as stated above.

PATIENT (OR GUARDIAN) SIGNATURE_____ **DATE**_____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE (Please checkmark your answer)

DECLARATION TO DECLINE LIFE-PROLONGING PROCEDURES (LIVING WILL)

_____I HAVE made such a declaration and will provide the office with a copy.
_____I have NOT made such a declaration.

HEALTH CARE SURROGATE

_____I HAVE a designated a health care surrogate and will provide the office with documentation.
_____I have NOT designated a health care surrogate.

DURABLE POWER OF ATTORNEY

_____I HAVE appointed a durable power of attorney for health care decisions and will provide documentation.
_____I have NOT appointed a durable power of attorney for health care decisions.

PATIENT SIGNATURE_____ **DATE**_____

PLEASE BE AWARE OF WEST ORANGE FAMILY MEDICAL CARE'S UPDATE NARCOTIC MEDICATION POLICY.

EFFECTIVE IMMEDIATELY WE WILL NO LONGER PRESCRIBE ANY NARCOTIC MEDICATION WITHOUT PREVIOUS MEDICAL RECORDS.

IN ORDER TO BE ABLE TO PRESCRIBE ANY NARCOTIC MEDICATIONS ALL PATIENTS ARE REQUIRED TO HAVE PREVIOUS MEDICAL RECORDS ON FILE.

PATIENT NAME (PRINT): _____

PATIENT NAME (SIGN): _____

WITNESS NAME (PRINT): _____

WITNESS NAME (SIGN): _____

DATE: _____

Revised June 1, 2016

West Orange Family Medical Care 407-877-3577

Dr. Michael Mercado, Medical Director

Francisco Gonzalez, PA

Today's Date:

ADULT AND GERIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Although it is most helpful to give our practitioners a complete health history, providing your history is at your discretion.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous Primary Care Provider:	**Date of last physical exam:**
List Specialist Doctors:	

PERSONAL HEALTH HISTORY

Have you had? check ☐ Measles ☐ Chickenpox ☐ Shingles ☐ MRSA ☐ Rheumatic Fever ☐ Polio ☐ +TB skin test ☐ Lyme ☐ HIV

Have you had any immunizations and if so, approximately when? check	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Shingles
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed such as:

__Allergies	__Cancer	__Depression	__Gastritis	__Herniated Discs	__Murmur	__Seizures
__Asthma	__COPD	__Diabetes	__Heart Failure	__Irritable Bowel	__Migraines	__Spinal Disease
__Anemia	__Cardiac	__Esophagitis	__Hypertension	__Infections	__Obesity	_____
__Arthritis	__Circulation	__Emphysema	__High Cholesterol	__Joint Disease	__Pneumonia	_____
__Apnea	__Colitis	__Fainting	__High Triglycerides	__Kidney Disease	__Pain	_____
__Anxiety	__Diverticulitis	__Falls	__Hiatal Hernia	__Liver Disease	__Psoariasis	_____

Surgeries (Childhood, Cosmetic, Head and Neck, Heart, Lung, Abdominal, Pelvic, Joints, Spinal, Vascular, Sensory)

Year	Have you had any surgery like, but not limited to the ones mentioned below?	Doctor/Hospital
	(Cosmetic/Plastic, Tonsillectomy, Gallbladder, Hysterectomy, Vasectomy, Cardiac, etc.)	

List when you've had These Procedures, Diagnostic Tests, Health Screenings and or any Hospitalizations in the Last 5 Years:

Year				Doctor/Hospital
	Cardiac Stress Test_____	Cardiac Catheterization_____	Cardiac Ultrasound_____	
	Biopsy Procedure_____	Colonoscopy_____	Endoscopy_____	
	Ultrasounds_____	Chest-xray_____	CT Scans_____	
	MRI_____	Blood drawn_____	Lipid Panel_____	

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed oral drugs, inhalers, nebulizer treatments, topical or eye drops, and over-the-counter drugs, including vitamins		
Name the Drug	Strength	Frequency Taken
Do you use **oxygen** supplement?_____	Do you use **CPAP** equipment?_____	Do you use any **Mobility** assistance?_____

What Are Your Allergies and Reactions to Medications or Food or Supplements. If none, write "No Known Allergies"	
Name the Drug	Reaction You Had (Hives, Throat Closing, Eyes Swollen, Nausea, Vomiting, Stomach Pain....)

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Have you ever been on diet pills or any medically prescribed diet program?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	How many meals you eat in an average day?_____ How many snacks do you have in an average day?_____					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola/Sodas		
	How many combined cups/cans containing caffeine do you have per day_____?					
Alcohol	Do you drink alcohol, like wine, beer, and other liquors?				☐ Yes	☐ No
	If yes, what alcohol beverages do you drink?					
	How many alcohol drinks per week do you have_____?					
	Are you concerned about the amount of alcohol you drink?				☐ Yes	☐ No
	Have you considered stopping drinking because it hurts you or others?				☐ Yes	☐ No
	Have you ever experienced blackouts, not remembering after drinking alcohol?				☐ Yes	☐ No
	Are you prone to "binge" drinking, excessive drinking only once in a while?				☐ Yes	☐ No
	Do you drive after drinking or been arrested for DUI?				☐ Yes	☐ No
Tobacco	Do you use tobacco to smoke or chew?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs like pot, cocaine, or other?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Education	Highest level of education? grade school ☐ high school ☐ some college ☐ BS/BA ☐ Masters/PhD ☐		
Occupation	Is/Was there anything unhealthy or risky about your job? If so, what?		
	What is/was your profession or what types of jobs have you done?		
	Are you? employed ☐ part- time ☐ full-time ☐ unemployed ☐ disabled ☐ retired ☐		
Sexual Activity	Do you want to discuss a problem that you are having with sexual activity?	☐ Yes	☐ No
	Do you want to discuss being tested for different sexually transmitted infections?	☐ Yes	☐ No
	If you are male, do you or have you had sex with same sex partners?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem as well as Hepatitis. Risk factors for these illnesses include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you at work or at home?	☐ Yes	☐ No
Do you feel depressed, like feeling hopeless or helpless sometimes?	☐ Yes	☐ No
Do you have panic attacks when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently or feel like you don't want to be around other people?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping, either falling asleep or staying asleep?	☐ Yes	☐ No
Have you ever been to a counselor or psychiatrist?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:_____ Date of last menstruation:_____ Or approximate age of menopause:_____		
Date of last gyn exam and pap smear:_____ Date of last Mammogram:_____ Date of any Biopsy:_____		
Date of any Bone Density Study:_____ Are you diagnosed with Osteopenia or Osteoporosis?_____		
Do you have heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____? Number of live births _____? Number of adult children still living_____?		
Are you pregnant, trying to get pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, endometrial ablation, colposcopy, cervix cryosurgery or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination a lot or even a little?	☐ Yes	☐ No
Any hot flashes, flushing or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night? If yes, how many times per night are you getting up to urinate? _____	☐ Yes	☐ No
Date of last PSA blood test_____? Date of last prostate and rectal exam?_____?		
Has the force of your urination decreased or do you have trouble starting the stream of urine?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Do you feel have any unusual discharge or have sores on the skin?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood or see pink in your urine?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Are you taking or do you want to be taking any medication for ED?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

West Orange Family Medical Care, PA

Diplomate, American Board of Family Medicine
Michael G. Mercado, M.D., FAAFP, CMD

_____ Print Patient full name

_____/_____/_____ Birth date

_____ Street address

_____-_____-_____ Social Security Number

_____ City/State/Zip

(_____)_____-_____ Home phone number

I, _____, do hereby authorize WEST ORANGE FAMILY MEDICAL CARE, P.A. to receive:
patient name

_____ Discharge Summary
_____ History & Physical
_____ Progress Notes
_____ Operative Notes
_____ Pathology Reports
_____ Laboratory Reports
_____ Radiology Reports
_____ ECG/EEG/Cardiac Cath
_____ Emergency Reports
_____ Entire Chart
_____ Other _____

ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO COMPLY WITH YOUR REQUEST (please check one)

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RECEIVE INFORMATION FROM: _____
Name of Company/Agency/facility/Person

Phone #: _____ _____
Street Address

Fax #: _____ _____
City/State/Zip

PURPOSE OF DISCLOSURE:

____ Referral to specialist ____ Insurance ____ Workers Comp ____ Change of Doctor/Provider
____ Legal Investigation ____ Disability determination ____ Self ____ Continuing care
Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home, work or cell)
(_____) _____-_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished many not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate — Date

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West Orange Family Medical Care, PA

Diplomate, American Board of Family Medicine

Michael G. Mercado, M.D., FAAFP, CMD

FORMS EFFECTIVE 6-1-17

At times a patient may be required by insurance providers, employers, etc. to have form(s) completed. Form completion is not considered part of your "normal" medical care provide by our office, but a separate service that requires payment for completion. Please note that we do not complete all forms given to our office, we reserve the right to decline completing such form(s). You will not be charged for any form(s) that have not been completed. It is possible that completed form(s) may not satisfy the recipient (insurance or employers, etc.) and as such may require additions form(s), should this occur the patient is responsible for additional fees as stated below.

Please be aware that it may take up to 2 weeks for your form(s) to be completed. To ensure accuracy and to avoid possible delays, the patient is responsible for completing all fields that pertain but not limited to; Employee information, medical facts, performance impediment, amount of leave needed, etc. It is also necessary that the patient attach a summary of his/her condition explaining why the form(s) are being required. In addition, if there are any fields left blank for any reason, you must include an explanation as to why you feel you cannot input an answer. Without this information you may hinder your form(s) readiness fro pick up.

PAYMENT IS DUE AFTER FORM(S) HAVE BEEN COMPLETED. YOU WILL NOT RECEIVE, HAVE FAXED OR MAILED ANY FORM(S) UNTIL PAYMENT HAS BEEN MADE. PLEASE REFER TO THE TABLE BELOW FOR FEE SCHEDULE.

Disability Form(s) (short and long term)	45.00
FMLA form(s)	25.00
Letter explaining diagnosis, travel letter(s)	25.00
Form(s) for court of any kind	25.00
Jury duty excuse, work or school excuse, Handicap form(s) for DMV	0.00

Michael Mercado MD

Michael Mercado, M.D.

Patient Name _____ Date _____

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