Santiago Martinez, M.D., P.A.

DIPLOMATE OF THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY
733 S. Goldenrod Road, Suite A Orlando, FL 32822
Orlando: 407-672-0060 Clermont: 352-242-3791

PATIENT INFORMATION PLEASE PRINT CLEARLY TODAY'S DATE:

LAST NAME FIRST NAME MI AGE BIRTH DATE SOCIAL SECURITY #

STREET ADDRESS HOME PHONE WORK PHONE

CITY STATE ZIP SEX: M □ F □ MARITAL STATUS: S□ M □ D □ SEP □ DRIVER'S LICENSE #

EMPLOYER'S NAME ADDRESS OCCUPATION

SPOUSE □ GUARDIAN □ RESPONSIBLE PARTY □

LAST NAME FIRST NAME MI AGE BIRTH DATE SOCIAL SECURITY #

STREET ADDRESS HOME PHONE WORK PHONE

CITY STATE ZIP SEX: M □ F □ MARITAL STATUS: S□ M □ D □ SEP □ DRIVER'S LICENSE #

EMPLOYER'S NAME ADDRESS OCCUPATION

EMERGENCY INFORMATION

NAME-NOT LIVING WITH YOU RELATIONSHIP WORK PHONE HOME PHONE

ADDRESS CITY STATE ZIP

PHYSICIAN WHO REFERRED YOU HERE: _____ **PHONE:** _____

PRIMARY INSURANCE INFORMATION PLEASE GIVE ALL INSURANCE CARDS & DRIVER'S LICENSE TO RECEPTIONIST FOR COPYING

COMPANY NAME _____ ADDRESS _____ PHONE # _____

NAME OF INSURED_____ DATE OF BIRTH _____ RELATIONSHIP:_____

POLICY/ID NUMBER _____ GROUP NUMBER _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE INFORMATION

COMPANY NAME _____ ADDRESS _____ PHONE # _____

NAME OF INSURED_____ DATE OF BIRTH _____ RELATIONSHIP:_____

POLICY/ID NUMBER _____ GROUP NUMBER _____ EFFECTIVE DATE: _____

I, the undersigned, certify that I (or my dependents) have insurance coverage and assign directly to Dr. Santiago Martinez all insurance benefits, if any, otherwise payable to me for services rendered. Some services may not be cover by my insurance according to their guidelines; therefore, I acknowledge and accept liability for payment of these services.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically relates facility, pharmacy, insurance company or government agency to disclose or furnish to Dr. Santiago Martinez, or his representatives, any and all information with respect to any illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments, or benefits and copies of all applicable records that may be requested. A photostatic copy of this authorization is to be considered as valid as the original.

Patient or Authorized Signature: _____ Date: _____

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ORLANDO: (407) 672-0060 ▪ CLERMONT: (352) 242-3791

Financial Policy and Insurance Billing Information

We are dedicated to providing you with the best possible care and service. Your understanding of our financial policies is an essential element of your care and treatment. Our policy is that unless other arrangements have been made in advance, full payment is due at the time of service. This enables us to avoid the cost of sending monthly statements, thus allowing us to keep our fees down. For your convenience we accept Debits cards, VISA and Mastercard.

PLEASE READ THROUGHLY AND SIGN THE BOTTOM OF THIS FORM

1. Insurance Plans: We have made arrangements to accept a wide variety of medical plans. We will be filing claims according to our contract with each company. We will bill those plans with which we have an agreement and will collect any required co-payment, coinsurance and deductible at the time of service. In the event your health plan determines a service to be "not covered", you may be responsible for the complete charge. In the event that we bill you, your payment will be due upon the receipt of that statement. For your information, we recommend that you contact your insurance carrier to determine benefits for your care in our office.

2. Medicare: Medicare does not always cover all procedures and testing that we perform in our office. If we need to perform a test that Medicare may not cover, a staff member will have you sign an Advanced Beneficiary Notice explaining this prior to the testing. If Medicare does not cover the test, you will be responsible for the charge. Our billing staff may appeal for coverage of the service upon request. Please feel free to contact our billing office for assistance.

   Spirometry testing may not be covered. Medicare does not cover food allergy testing.

3. Collections: Delinquent accounts may be turned over to our collections agency. If this occurs, the account must be paid in full prior to another appointment being scheduled. Dismissal from the practice may also occur.

4. No Shows: Please be courteous and contact us within 24 hours to reschedule or cancel your appointment. There are many patients that may need to be scheduled. We reserve the right to charge you for missing your appointment.

5. Minor Patients: Minor patients (under the age of 18) must be accompanied by a legal guardian in order to receive care. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

   I have read and understand the above financial policy of Santiago Martinez, M.D. I also agree to the terms presented.

Signature of Patient/Guardian Date _____

ACKNOWLEDGMENT
of
RECEIPT OF NOTICE REGARDING PRIVACY
of
PERSONAL HEALTH INFORMATION

I, _____(please print patient's name), acknowledge that I have access to a copy of Santiago Martinez, M.D., P.A.'s

Notice Regarding Privacy of Personal Health Information.

Date: _____

Signature of Patient: _____

Signature of Patient's Legal Guardian (if applicable):_____

Relationship to Patient:_____