Welcome To Our Office! **University Family Medicine Center, PA**
10055 University Blvd., Orlando, FL 32817

Name Last _____ **First**_____ **MI**_____

Home (_____)_____ **Work** (_____) _____ **Cell** (_____)_____

E-mail address_____ **@** _____

At which numbers/ e-mail can we contact you? Home Cell Work E-mail Other_____

Mailing Address_____ **City**_____ **State**_____ **Zip**_____

SSN_____-_____-_____ **Place of Birth**_____ **Date of Birth**_____ **Age** _____ **Male/ Female**

Occupation/ Employer _____**Employer Address** _____

Marital Status _____ **Spouse's Name** _____ **Spouse's Occupation** _____

Spouse's Employer _____ **Work Phone** (_____) _____

Insurance Information- Please provide insurance card and driver's license

Policy Holder's Name_____ **Relationship to Patient**_____

Insured's SS # _____ **Insured's Date of Birth**_____

Nearest Living Relative (not in household)

Name _____ **Relationship** _____**Home Phone** _____

Address _____ **Cell phone** _____

How did you learn of UFMC, PA? _____

Advanced Directive: All adults in health care settings have the right in the state of Florida to an "advanced directive". This is a written or oral statement made and witnessed in advanced of a serious illness or injury, stating how medical decisions will be made. An advanced directive enables you to state your choice, or may name some one to make your choice for you, if you should become unable to make decisions about your medical treatment. An advanced directive can enable you to make decisions.
I have received information on advanced directive:

Signature: _____ **Date:** _____

I authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company and I authorize my insurance company to pay UNIVERSITY FAMILY MEDICINE CENTER, PA any medical benefits due me for their services. I understand that I am responsible to pay deductibles, co pay and any other charge not paid by my insurance company. **Our policy is that payment is expected in full at time services are rendered,** unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company for the initial filing. You are responsible for repeat filing of insurance or filing to secondary insurance. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT. Therefore, verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary.
We welcome you to our practice and look forward to offering you and your family a high quality of health care.

To the best of my knowledge the above information is correct. I understand and agree to comply with University Family medicine Center's financial policy.

Signature: _____ **Date:**_____