Florida Primary Care Center

15493 Stoneybrook West Pkwy STE 110 Winter Garden, FL 34787 Phone: 407-299-7791

Last Name:_____First Name:_____Middle Initial:____

Primary Phone Number:_____

Email Address:_____

Date of Birth:_____

SSN:_____

Patient Weight:_____

Gender: Male Female

Address:_____

City, State, Zip Code:_____

In Case Of Emergency:_____Phone:_____

How did you hear about us?_____

Primary Insurance:_____

Policy Number:_____

Group Number:_____

Secondary Insurance:_____

Policy Number:_____

Group Number:_____

Patient Consent for Treatment

Patient Name:_____ Date of Birth_____

_____ I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Florida Primary Care Center, PA and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Florida Primary Care Center, PA.

_____ I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Florida Primary Care Center, PA notice of Privacy Practices.

_____I authorize payment of medical benefits to Florida Primary Care Center, PA physicians or their designee for services rendered.

_____I give Florida Primary Care Center, PA permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice and the Release of Information. ___Yes ____No Initial_____

_____ _____

Patient or Authorized Person Signature Date

Go Bare Form

Under Florida law, doctors are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

_____I have read and understand the above statement.

_____ _____

Patient or Authorized Person Signature Date

Financial Policy and Disclosure

Self-Pay Policy • If you are a self pay patient, you will be required to pay for the office visit before services are rendered. • In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy • If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information. • If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. • If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due. • Deductibles, co-payments, and coinsurance will be collected before services are rendered. • In special cases, we may need your help in contacting your insurance company for the payment of your services.

Overdue and Credit Balances • All over-due patient balances will be sent to collections. • All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.

Divorce or Custody Case Policy • The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI) Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI) This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans

Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address. In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the

My signature verifies that I have been provided a copy of "Notice of Privacy Practices" to review. I understand that if I would like a copy of this Notice, Florida Primary Care Center, PA will provide me with a copy of this documentation.

_____	_____	_____	_____
Patient's Name (please print)	Date of Birth	Signature	Date