Florida Medical Clinic
*Your Life, Our Specialty*

## PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____

LOCAL ADDRESS _____ DATE OF BIRTH ____/____/____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SOCIAL SECURITY _____ CELL PHONE ( ) _____

ETHNICITY: ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO ☐ REFUSED HOME PHONE ( ) _____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ WHITE WORK PHONE ( ) _____

☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

☐ OTHER ☐ OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

PREFERRED LANGUAGE _____ PHONE ( ) _____

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED EMPLOYER _____

☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT ADDRESS _____

## PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

## EMERGENCY CONTACT

NAME _____ HOME PHONE ( ) _____

RELATIONSHIP _____ WORK PHONE ( ) _____

## IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE ( ) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

## IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

**NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.**

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT ____/____/____ Place of accident _____ How did accident happen? _____

CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____

## IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME _____ EMPLOYER PHONE( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

## INSURANCE INFORMATION

***PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST***

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

## SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SIGNATURE _____ DATE _____

**Financial Responsibility**

This is an agreement between Florida Medical Clinic, P.A., a Florida Corporation, as a creditor, and the Patient/Debtor named on this form.

In this agreement the words “I”, “you,” “your,” and “yours” mean the Patient/Debtor. The word “account” means any account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Florida Medical Clinic, P.A. (FMC) and/or its affiliated entities.

Insurance: Insurance is a contract between you and your insurance company. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fact, insurers will routinely stall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of FMC. We will NOT under any circumstance falsify or change a diagnosis or symptom in order to convince an insurer to ‘pay’ for care that is not covered, nor do we delete or change the content in the record that may prevent, or cause, it to be considered covered.

_____ Initials HMO Plans: Any co-payments required by an insurance company must be paid at the time of service. Should FMC render services and I am unable to pay my co-payment at the time of service.

_____ Initials PPO Plans: FMC has agreed to accept the discounted rate from your plan, and we will **estimate** balances to the best of ability. However, since these are **estimates** only, I understand that any remaining balances due to deductibles, co-insurance, and non-covered claims are my responsibility to pay FMC. Your appointment may be rescheduled if your estimated amount due is not paid at check in.

_____ Initials Missed Appointment Fee: I understand that *Appointment Reminders are a courtesy.* Failure to show up for, or cancelation of an appointment with less than 24 hour notice (48 hour notice for FMC Ambulatory Surgery Center procedures), may result in a no show fee assessed to my account. The no show fee varies by FMC practice location and is subject to change. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be discharged from the FMC practice location.

_____ Initials After Hours Services: Please be advised additional fees may be subject for services rendered after hours, which includes evenings (after 5pm), weekends, and holidays.

_____ Initials Administrative Charges: I understand that additional administrative charges may apply for items such as the completion of medical forms, telephone consultations, and physician letters.
*(This is not an exhaustive list)*

**Guarantee of Payment:**

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay FMC all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge or upon presentation of the first bill by FMC. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. I understand and agree that if FMC is required to bring a claim or file an action to enforce this agreement, FMC shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed FMC for its services. Based on permissible purpose under the Fair Credit Reporting Act, FMC reserves the right to run a credit report for the sole purpose of determining my ability to meet incurred expenses directly related to my treatment.


***Payments received will be posted to the oldest outstanding balance on your account.***

Returned Checks: A Returned check will result in a service fee based on the face value of the check and may require all future payments to be made by cash or credit card. A collection agency may be used in the recovery of debt attributed to returned checks, in addition to the payment of the check plus any court cost, reasonable attorney fees and any bank fees incurred by the payee in taking action as pursuant to *Florida Statute 68.065*.

Divorce, Dependent and Child Custody Cases: Regarding divorce, the presenting guardian accompanying the person (minor or disabled adult) who receives care at FMC is responsible for payment of copays, co-insurance and/or deductibles at the time of service.

**Assignment of Benefits:**

I hereby assign, grant and transfer to FMC, now and in the future, all of my rights and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payer for those costs I incur in receiving services from FMC. The included insurance policies and insurer would include, but are not limited to, health, auto, UM and PIP; and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to FMC was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to FMC the amount due me in any potential or pending claim for medical benefits under the respective policies, expressly including all PIP policies. I agree that should the amount received by FMC be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services rendered by FMC are not covered by said insurance policy, I am responsible to FMC for payment of the entire bill.

Patient/Guarantor *(Print):* _____

Patient/Guarantor *(Signature):* _____ Date: _____

**Florida Medical Clinic, P.A.**
**Authorization to Share Protected Health Information**

| Patient Name: | Second Form of Identification (DOB/Account#) |
|---|---|
| | |

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____

Florida Medical Clinic

Date: _____

# PATIENT QUESTIONNAIRE

Name:_____ Age:_____ Date of Birth:_____

Referred By: _____ Primary Care Physician:_____

Other Physicians involved in your care: _____

Please describe the reason for your visit: _____

**MEDICATIONS:** What medications are you currently taking? Include over-the-counter. If **none**, please initial here: _____

| Prescription name and strength | Directions |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**PREFERRED PHARMACY:** _____ Phone or Location: _____

**DRUG ALLERGIES:** Do you have any known allergies to medications, latex, or surgical tape? Please list the *allergy* and the *reaction*.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

**PERSONAL HISTORY**:

**Surgery**:

☐ **Gall Bladder** ☐ **Appendectomy** ☐ **Hiatal Hernia** ☐ **Inguinal Hernia** ☐ **Colon Resection** ☐ **Hysterectomy** ☐ **Gastric Bypass**

Other surgeries not listed/ dates_____

_____

Please describe any previous problems with Anesthesia_____

**Medical Problems:**

☐ Diabetes Mellitus ☐ Hypertension ☐ Hyperlipidemia ☐ Migraine Headaches

Other _____

**SYSTEMS REVIEW (please check those that apply to you):**

**Digestive System**

☐ Difficulty in swallowing ☐ Change in appetite ☐ Heartburn/esophageal reflux

☐ Nausea/vomiting ☐ Abdominal pain ☐ Bloating/belching/gaseousness

**Digestive System (continued)**

□ Hemorrhoids □ Constipation □ Indigestion
□ Diarrhea/ loose stools □ Black stools □ Gastrointestinal bleeding
□ Rectal bleeding □ Change in bowel habits □ Irritable Bowel Syndrome
□ Crohn's Disease/Ulcerative Colitis □ Gallstones/gallbladder disease □ Hepatitis/liver disease

**Ear, Nose, Throat**

□ Sinus pain □ Nose bleeds □ Hoarseness
□ Hearing loss □ Ear pain/ringing

**Cardiology**

□ Chest pain or pressure □ Palpitations □ Pacemaker/Defibrillator
□ History of heart attack □ Mitral Valve Prolapse or Murmur □ Artificial Heart Valve
□ Hypertension/high blood pressure

**Pulmonary/ Respiratory**

□ Shortness of Breath □ Loss of breath on exertion □ Asthma/wheezing/coughing

**Genitourinary**

Are you pregnant? _____ Date of last period? _____

□ Recent/frequent Urinary Tract Inf. □ Blood in urine □ Burning with urination
□ Urine incontinence □ History of kidney stones □ Genital bleeding/discharge

**Musculoskeletal**

□ Joint pain/ arthritis □ Back pain □ Problems with walking

**Lymphatic/Hematology**

□ Enlarged nodes/ swollen glands □ Anemia □ Bleeding problems

**Allergy/Immunology**

□ HIV/AIDS □ Blood transfusions

**Dermatological/ Skin**

□ Dermatitis or rash □ Itching □ Psoriasis

**Endocrine**

□ Diabetes □ Thyroid problem □ Hormonal problem
□ Enlarged nodes/ swollen glands □ Anemia □ Bleeding problems

**Neurological**

□ Headaches □ Seizure disorder □ Stroke
□ Tingling or numbness □ Dizziness

**Psychiatric**

□ Anxiety □ Depression □ Insomnia
□ Memory loss □ Past evaluation and treatment

**OTHER? _____**

**Obstetric History (Females)**: Number of pregnancies? _____ Deliveries? _____ Number of children? _____

**FAMILY HISTORY:**

Mother: Living age _____ or Age at death _____ Cause of death _____

Father: Living age _____ or Age at death _____ Cause of death _____

Please mark the applicable items for each family member(s):

| | Crohns Disease | Colon Cancer | Colon Polyps | Liver Disease | Ulcerative Colitis |
|---|---|---|---|---|---|
| **Mother** | □ | □ | □ | □ | □ |
| **Father** | □ | □ | □ | □ | □ |
| **Sister(s)** | □ | □ | □ | □ | □ |
| **Brother(s)** | □ | □ | □ | □ | □ |

**SOCIAL HISTORY:**

**Occupation?** _____

**Marital Status**

□ Single □ Married □ Divorced □ Separated □ Widowed

Do you currently smoke tobacco? Yes □ No □
How many per day? _____
How many years total? _____

If no, have you quit smoking? Yes □ No □
How many years total? _____

Do you drink alcoholic beverages? Yes □ No □
How many per day? _____
How many years total? _____

If no, have you quit drinking alcohol? Yes □ No □
How many years total? _____

Do you drink caffeinated beverages? Yes □ No □
How many do you have each day? _____

Do you currently use illegal drugs? Yes □ No □
Drugs:: _____

If yes, please list the drugs:
_____

**Cancellation/Missed Appointment Policy for Office Appointments**

Due to the increased number of missed and/or cancelled office appointments, the office has found it necessary to charge a $25.00 fee if 24 business hours notice is not given. This will be due prior to rescheduling your appointment.

**Cancellation/Missed Appointment Policy for Procedures**

Due to the increased number of missed and/or cancelled procedure appointments, the office found it necessary to charge a $50.00 fee if 48 business hours notice is not given. This will be due prior to rescheduling your procedure.

It is of utmost importance that you cancel and/or reschedule with the procedure scheduler.

**Acknowledge of Receipt**

I acknowledge that I've read and understand Florida Medical Clinic GI's cancellation and/or missed procedure policy.

**Patient Signature:** _____ **Date:** _____