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 ____________________

FORM: FMC00001.112008

FLORIDA MEDICAL CLINIC, P.A.

Your Life, Our Specialty

Consent for Purposes of Treatment, Financial Responsibility and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. Notice of Privacy Practices prior to signing this document. The Florida Medical Clinic, P.A. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The Notice of Privacy Practices for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This Notice of Privacy Practices also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Medical Clinic, P.A.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

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, I understand that I may be billed an administrative fee.

_______ 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.

_______ Initials

Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPAA) and FMC's policies on use and disclosure of my protected health information.

____
Name of Patient

____
Name of Guardian or Personal Representative

____
Signature of Patient

____
Signature of Guardian or Personal Representative

____
Date

Florida Medical Clinic, P.A.

NEW PATIENT

Name: ______________________________ **Date of Birth:** ______________ **Date:** ______________

My problem is:

1.) ______________________________
2.) ______________________________
3.) ______________________________

It has lasted: ______________________________

Please circle:

Today it is: better; worse; stable; resolved; recurred

What part of the body is most affected? ______________________________

What makes it worse? ______________________________

It has been treated with? ______________________________

Previous episodes? Yes or No **Do you smoke?** Yes or No

Any other past history of skin problems? ______________________________

Personal history of previous skin cancer? Yes or No

I am allergic to ______________________________

I am being treated for: Diabetes, High blood pressure, Heart problems, a heart murmur, internal cancer, breathing problems, arthritis.

I am taking a blood thinner: Yes or No

I have had a: (hip, knee, heart valve) **replaced.**

Present Medications: ______________________________

____

____

Any family members with similar problems? Yes or No

Family history of skin cancer? Yes or No

Bad scars? Yes or No

Present job: ______________________________. **Married, Single, Divorced, Widowed.**

Review of Systems: Itching, Burning, Bleeding, Bruising, Nausea, Vomiting, Dizziness, Dryness, Muscle or Joint pains, Hives, Fever, Blurred Vision, Headaches, Pain in Swallowing.

Reviewed by: ______________________________

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

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

I authorize FLORIDA MEDICAL CLINIC to share protected health information with the following persons:

Last Name	First Name	Relationship	Phone #
1.			
2.			
3.			

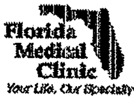
This includes (please check all areas that apply)

- ☐ 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 ____________

FMC Personnel ______________________________ Date ____________



38135 Market Square
Zephyrhills, FL 33542

AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB	Account #	
COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS NOT THE PATIENT		
Name of Representative		
Relationship to Patient (parent, health proxy, etc.)	Phone #	
Email Address		
I AUTHORIZE FLORIDA MEDICAL CLINIC, PA TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:		
METHOD	**CONTACT INFORMATION**	
☐ TEXT		
☐ EMAIL		
☐ VIDEO CONFERENCE		
☐ I do not authorize Florida Medical Clinic, PA to communicate with me via electronic means		

This Authorization to Communicate PHI via electronic means expires

☐Upon written revocation ☐Automatically one year from the date of signing
☐Another date/event:

I understand by selecting the method of communication above and signing below, I authorize Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.
My signature on this Authorization indicates that I am giving permission for Florida Medical Clinic to communicate with me via the method checked above.
I understand Florida Medical Clinic may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers at Florida Medical Clinic.
I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic cannot sell or distribute my communication method or information with any third-party without my prior consent.
I understand that, by federal law, the Florida Medical Clinic may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic's Notice of Privacy Practices.
I hereby release Florida Medical Clinic and its employees from any and all liability that may arise from the release of information as I have directed.
I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
I understand that I may refuse to sign this Authorization, and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Signature	Date
Print Name:	Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative

Name: ______________________________ **DOB:** ________________________

What Pharmacy do you prefer?

Name: ______________________________

Address: ______________________________

____

Phone #: ______________________________

What medications are you currently taking:

_________________ mg:_____ Dose:______ _________________ mg:_____ Dose:______

_________________ mg:_____ Dose:______ _________________ mg:_____ Dose:______

_________________ mg:_____ Dose:______ _________________ mg:_____ Dose:______

_________________ mg:_____ Dose:______ _________________ mg:_____ Dose:______

_________________ mg:_____ Dose:______ _________________ mg:_____ Dose:______

_________________ mg:_____ Dose:______ _________________ mg:_____ Dose:______

Do you have any Allergies? **How does it affect you?**

______________________________ ______________________________

______________________________ ______________________________

Do you Smoke? Please circle one: **YES** **NO**

Have you ever Smoked? Please circle one: **YES** **NO**

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

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

I authorize FLORIDA MEDICAL CLINIC to verbally share protected health information with the following persons:

Last Name	First Name	Relationship	Phone #
1.			
2.			
3.			

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 ____________

FMC Personnel ______________________________ Date ____________