Florida Medical Clinic
Your Life. Our Specialty.
Family Medicine Division

Nyree Bryant DO
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11/12/17

Dear New Patient,

Welcome to Florida Medical Clinic! We are happy that you have made our office your choice for your medical care needs. In order for us to provide you with excellent service and quality care, we ask that you take a few moments to read over some important information. If you are a new patient that has been assigned to our office, our physicians recommend that you make an appointment with our office as soon as possible but no later than 7 days for a new patient visit. Please contact the office during regular business hours at (813) 899-2015 to schedule an appointment. We are located at 13311 N. 56th Street, Tampa, FL 33617. Please do not hesitate to contact our office for directions. We provide equal access to all patients accepted into this practice.

We are pleased to announce a new initiative in the office called **Patient-Centered Medical Home (PCMH)** -- a new way of managing your health care. PCMH is a model of care designed to improve the coordination of your health care with an emphasis on your all-around well-being.

This means that the Physician and your care team will:

- Care for you based on your own needs, health profile, and history.
- Explain the choice you have for care and help you decide which on is best for you.
- Guide you through the health care system so that we work as a team if you ever need more care from a specialist.
- Help you try to improve your health by talking with you about wellness, prevention, and follow-up care.

We offer the following ways to contact us to get the care you need:

1. Contact the office directly during regular business hours at (813) 899-2015
   Our office is open Monday – Friday 8:00 AM – 12:00 PM and 1:00 - 5:00 PM, and 7:00 AM- 5 PM on Wednesdays
   During Business Hours: Urgent messages left before 4 PM will be answered within 2 hours. Routine or non urgent messages will be answered by the end of the business day.
2. Via Internet- using the patient portal with secure messaging.
3. **AFTER HOURS CARE**: To speak to our physicians or require after hours care, please call (813) 8992015 and an operator will contact the physician to coordinate your care. Our physicians are available to you **ANYTIME** during the day or evening hours if you have an urgent need. Please call 911 in the event of an emergency.

PRESCRIPTION REFILLS: We ask that medication refill requests be done 48 hours in advance. Our office offers several ways to request medication refills:

1. We prefer you contact your retail or mail order pharmacy directly, they will send us a refill request.
2. Contact the office directly during regular business hours at (813) 899-2015
3. Contact the office through our patient portal utilizing secure messaging.

HOSPITALS: Florida Hospitals Tampa and Wesley Chapel are the Hospitals in our area. Florida Medical Clinic has a team of hospital medicine physicians that will coordinate your care while you are the hospital. Upon arrival to any hospital, please inform the hospital staff who your primary care physician is and that you are a patient of Florida Medical Clinic.

REFERRALS: Your insurance plan may require referrals for most services provided outside the Primary Care Physician's office. Our physicians utilize the services of a preferred network of specialist and facilities. It is very important to make sure you have a referral for any service not provided by your Primary Care Physician.

These services include, but are not limited to:

- Office visits to a specialist
- Any diagnostic studies such as MRI, X-ray, etc.
- Therapy services
- Home health care services and items such as walkers and wheelchairs

If you are not sure if the service you need requires a referral, please contact our office or your insurance carrier for verification.

OUT OF AREA CARE:
When traveling outside the service area it is very important to contact your Primary Care Provider prior to receiving medical care, unless the care is emergent or urgent. Here are some helpful hints while outside the service area:

- Prior to leaving town, make an appointment with your Primary Care Provider for a routine checkup, refill medications, and to answer any questions you may have about your medical care while out of town.
- Contact your primary Care Provider prior to receiving medical care. Our physicians can be reached after hours and on the weekends by calling the office number and leaving a message with the answering service to have a provider return your call.
- When emergencies happen and hospitalization is necessary the hospital takes care of contacting the insurance company for authorization. If possible, while in the hospital, if you or a family member could contact the office to let your physicians know right away, you have been admitted this will help facilitate coordination of care. If this is not possible, once you are released from the hospital it's your responsibility to contact your Primary Care Physician for any further authorizations. Any care not provided as inpatient admission to the hospital will require a referral in order to be covered.
- When labs need to be drawn out of state, it is very important to use a lab that is contracted with your insurance plan. If you are unable to locate a lab in your area please contact your insurance plan.

NO-SHOW POLICY:
No-Show definition: Any scheduled office appointment in which a patient fails to maintain.
Patient is considered a No-Show when:

- The patient is more than 15 minutes late for his/her appointment.
- Patient does not contact the office to cancel the appointment prior to the appointment time.

Patient-centered care won't work without your help. We want you to be an active part of your own healthcare.

Here are some ways you can do that.

- Learn about your health condition and what you can do to stay as healthy as possible.
- Follow the care plan that you and your medical team create together.
- Bring any questions you have to each visit. Also, bring all medication bottles including vitamins and any over the counter medications with you on each visit.
- Ask us to explain if you don't understand something
- Tell us if you get care from other health professions, so we can work with them for the best care possible.
- Talk with us about your experience getting care from us, so we can keep making it better.

Again, we would like to welcome you to our practice and look forward to providing you with excellent care and service.

Sincerely,

Your Healthcare Team

FAMILY HISTORY FORM

Patient Name: _____ Date: _____

Please only check if your family member **HAS or HAD** the listed chronic condition:

Condition:	Mother	Father	Brother	Sister	Other
Hardening of Arteries	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐
Color Blind	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐
Eczema: Skin Condition	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Central Loss of Vision	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

Please Specify Other: _____

PATIENT HISTORY FORM

Patient Name: _____ **Patient DOB**: _____ **Today's Date:** _____

What are you being seen for today? _____

Please Print your current medications and dosage (include prescribed and over counter, vitamins and supplements):

_____

_____

_____

_____

Are you currently being treated for any of the following? (Please circle all that apply)

☐Diabetes	Thyroid Disease	High Blood Pressure	High Cholesterol	Heart Disease
Asthma	Cancer	Osteoporosis	Kidney Disease	Epilepsy
Stroke	Arthritis	Anemia	Bleeds Easily	Tuberculosis
Headaches	Hepatitis	HIV	Hayfever/Allergies	Depression/Anxiety

Other: _____

Are you currently seeing any other physicians? No Yes If yes, please list: _____

_____

Allergies – (Please list your allergies below and include the type of reaction):
Medications&Reaction: _____
Food:_____ Latex/Other: _____

Surgeries/Accidents/Hospitalizations:(please list and include dates)_____

_____

_____

Family History	**Age**	**Alive/Deceased**	**Medical Issues/Diseases**	**If deceased, cause of death**
Father				
Mother				
Grandparents/Maternal				
Grandparents/Paternal				
Siblings – Brothers # ___				
Siblings – Sisters# ____				
Spouse				
Children # of _____				
Children				
Other:				

Social History

Employer & Occupation: _____
Occupational Exposures []Fumes []Dust []Solvents []airborne particles []noise

Marital Status: []Single []Married []Separated []Divorced [] Widowed
Alcohol: []Never []Rarely []Moderate []Daily Drinks/week/day _____ Type? _____
Tobacco: []Never [] Rarely []Frequently… Packs/day _____ []Previously but quit when? _____
Caffeine: []Never []Rarely []Frequently… Amt/daily _____ Type: _____
Use of drugs: []Never []Rarely []Previously, but quit, when? _____ Type? _____

Social History (con't)

Patient Name: _____ **Patient DOB:** _____

Do you exercise? []No []Yes If Yes, How often and what type: _____
Are you sexually active? []No []Yes
Do you travel outside USA? []No []Yes If Yes, where: _____
Smoke Detector in your home? []No []Yes Religion (optional): _____
Do you have a Living Will []No []Yes Do you have an Advanced Directive []No []Yes
Do you have any pets? []No []Yes If Yes, please list type and # _____

Review of Systems

Please indicate any personal & current symptoms below

Constitutional Systems			**Comments**
Recent Weight Change	No	Yes	
Fever	No	Yes	
Chills	No	Yes	
Sleep Disorder	No	Yes	
Other: _____			

Gastrointestinal			**Comments**
Abdominal Pain	No	Yes	
Nausea/vomiting	No	Yes	
Indigestion/Heartburn	No	Yes	
Other: _____			

Eyes		
Eye disease/cataracts	No	Yes
Wear glasses/contacts	No	Yes
Blurred/double vision	No	Yes
Glaucoma	No	Yes
Other: _____		

Respiratory		
Wheezing	No	Yes
Frequent Cough	No	Yes
Shortness of Breath	No	Yes
Other: _____		

Ear/Nose/Throat/Mouth		
Hearing changes	No	Yes
Sore throat	No	Yes
Chronic sinus problems	No	Yes
Nose bleeds	No	Yes
Other: _____		

Neurological		
Tremors	No	Yes
Dizzy spells	No	Yes
numbness/tingling	No	Yes
Frequent/headaches	No	Yes
Seizures	No	Yes
Other: _____		

Cardiovascular		
Chest Pain	No	Yes
Irregular heartbeat	No	Yes
Swelling in ankles	No	Yes
Murmur	No	Yes
Other: _____		

Integumentary (skin)		
Rash	No	Yes
Lumps/bumps	No	Yes
Moles/skin tags	No	Yes
Other: _____		

Endocrine		
Excessive thirst	No	Yes
Too hot/cold	No	Yes
Tired/sluggish	No	Yes
Other: _____		

Musculoskeletal		
Bone pain	No	Yes
Muscle pain	No	Yes
Joint pain	No	Yes
Other: _____		

Hematologic/Lymphatic		
Swollen glands	No	Yes
Blood clotting problem	No	Yes
Bruising	No	Yes
Other: _____		

Genitourinary		
Change in urine stream	No	Yes
Nocturia (getting up at night)	No	Yes
Urinary frequency >8x/day	No	Yes
Other: _____		

Allergic/Immunologic		
Hay Fever	No	Yes
Drug Allergies	No	Yes
Food	No	Yes
Animal	No	Yes
Other: _____		

Psychological		
Are you generally happy?	No	Yes
Do you feel depressed?	No	Yes
Do you feel anxious?	No	Yes
Do you feel safe at home	No	Yes
Other concerns: _____		

Sexual History		
Change in sex drive	No	Yes
Sexual performance satisfactory	No	Yes
Sexual Trauma	No	Yes
Other concerns: _____		

Last Exam or Lab tests	Please enter date (mo/yr)	
Dental: _____	Eye: _____	
Pelvic: _____	Pap Smear: _____	
Prostate: _____	PSA: _____	
Mammogram: _____	Colonoscopy: _____	
Cholesterol: _____	Stool Tested: _____	

Are you here today to review any of the above issues? No Yes If yes please list them: _____

_____

***Any non-urgent issues marked above that are not address today should be addressed in a follow up visit or physical. Your physician will instruct you if a follow up is necessary.**

For Office Use Only:
Dr/PA/NP sig: _____ Date: _____

FLORIDA MEDICAL CLINIC
Family Practice Temple Terrace

Patient Responsibility for Follow Up

A note to our valued patients,

We view your healthcare as a shared responsibility. We will always endeavor to provide you with the best health care possible. This may mean we need to order diagnostic tests and/or refer you to other health care providers. As such, we ask you to partner with us and accept the following responsibilities.

Patient Name: _____

(Initial) _____ When any tests or consultations are ordered for you, we rely on you to accept responsibility to schedule any needed appointments in a timely manner. *Feel free to ask us to help you with the scheduling process.* If you haven't heard from someone about the results within two weeks of the test being done, please contact us to be sure the information is available and that you know what the results are and what needs to be done next. If it is unclear to you what the next step is after a consultation or test, we will rely on you to ask about it or any other questions you may have. *Sometimes, no news is not good news, just "no news".*

(Initial) _____ If follow up is ordered, such as repeat or additional testing, medication or other treatment changes, visits, etc, we will rely on you to accept full responsibility for following up on this, including any consequences of not following up. Reminders will not be given. If you have any questions about the necessity of, or reason for, the test, consultation or other follow up, we will rely on you to ask those questions.

I understand the above and agree to this.

Signature _____ Date _____

Witnessed _____ Date _____

George R. Davis, DO • Nyree D. Bryant, DO
www.floridamedicalclinic.com
13311 North 56th Street • Tampa, Florida 33617 • (813)899 2015 • (813)355 5904

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 _____

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.

Florida Medical Clinic
Your Life. Our Specialty.

_____ 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 'imited 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.

Florida Medical Clinic
Your Life. Our Specialty.
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

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 _____