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 _____

FLORIDA MEDICAL CLINIC, P.A.

Your Life, Our Specialty

Consent for Purposes of Treatment, Payment 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

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

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 (HIPPA) 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

_____ Florida Medical Clinic, P.A.
Date Zephyrhills, FL 33542

cg / FMC Consent for Treatment, Payment & Health Care Operations

Name: _____ Date: _____

DOB:_____ Acct #:_____

Medical/ Ocular History

Past Ocular History:

	Yes	No		Yes	No
Cataracts	☐	☐	Amblyopia/ Lazy eye	☐	☐
Glaucoma	☐	☐	Surgery/Other: _____		
Macular Degeneration	☐	☐	_____		
Retinal/detachment	☐	☐	_____		

Past Medical/ Surgical History

	Yes	No		Yes	No
High blood pressure	☐	☐	Cancer (type:_____)	☐	☐
Diabetes: Type 1/ Type 2	☐	☐	Heart disease	☐	☐
High cholesterol	☐	☐	Surgery/ Other: _____		
Thyroid (hypo/ hyper)	☐	☐	_____		
			_____		

Medication with strength: (Including vitamins): *Attach list if applicable*

_____ _____

_____ _____

_____ _____

Preferred Pharmacy: _____ Phone #: _____

Mail Order Pharmacy: _____ Phone #: _____

Medication or Drug Allergies:_____

Family Ocular/ Medical History: Indicate family member

Cataract _____ Diabetes _____

Hypertension_____ Glaucoma _____

Macular Degeneration_____ Amblyopia/ lazy eye _____

Retinal detachment _____ Blindness _____

Social History:

Alcohol Use: Yes ☐ No ☐ **Tobacco Use**: None ☐ Circle: Current/Former/Never

Women: Pregnant ☐ Nursing ☐ Frequency/ Amount: _____

Name: _____ Date: _____

DOB:_____ Acct #:_____

Review of Systems: Do you have these now? If so circle condition and explain.

Yes	No	
☐	☐	**Allergy:** Seasonal/ Year round: _____
		_____
☐	☐	**Cardiovascular:** High/ Low blood pressure/ chest pain/ irregular beat
		_____
☐	☐	**Constitutional:** Fever/ weight gain or loss/ fatigue _____
		_____
☐	☐	**Endocrine:** High sugar/ High thyroid/ low thyroid _____
		_____
☐	☐	**ENT:** Hearing loss/ sinus _____
		_____
☐	☐	**Eye:** Blurred vision/ eye pain/ flashes/ floaters _____
		_____
☐	☐	**GI:** Abdominal Pain/ nausea/ vomiting/ diarrhea _____
		_____
☐	☐	**GU:** FLOMAX use/ groin pain/ sores _____
		_____
☐	☐	**Blood:** Anemia/ easy bruising/ swollen lymph nodes _____
		_____
☐	☐	**Skin:** Rashes/ changing moles/ eczema _____
		_____
☐	☐	**Musculoskeletal:** Joint pain/ weakness/ back pain _____
		_____
☐	☐	**Neurological:** Headache/ scalp tenderness/ jaw pain _____
		_____
☐	☐	**Psychiatric:** Anxiety/ depression _____
		_____
☐	☐	**Respiratory:** Shortness of breath/ Sleep apnea/ CPAP _____

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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

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

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
Street Address		
City/State		Account #
Phone #	Email Address	

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 DO NOT WISH FLORIDA MEDICAL CLINIC, PA TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:

METHOD	CONTACT INFORMATION
☐ TEXT	
☐ EMAIL	
☐ VIDEO CONFERENCE	

I understand by revoking the method of communication above and signing below, I revoke Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.

I understand Florida Medical Clinic will no longer 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 Florida Medical Clinic, PA may be required by law to communicate with me about my lab results and other pertinent clinical information.

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 reinstate this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above.

I understand that I may refuse to sign this Revocation, 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

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 _____