MFPC Mid-Florida Primary Care 34748

401 W. North Blvd. Leesburg, Florida 34748 501 W. North Blvd. Leesburg, Florida

17809 SE 109th Ave. Summerfield, Florida 34491 Phone: 352-728-4242 Fax: 352-728-4868

Patient Name: _____ DOB: _____

Current Primary Care Physician: _____ Ph # _____ Fax#_____

Current Sub Specialist:

Cardiologist _____ Ph: _____ Pulmonologist _____ Ph _____

Neurologist _____Ph: _____ Orthopedics _____ Ph. _____

Oncologist/Hematologist _____ Ph: _____

Pain Medicine _____ Ph: _____ ENT _____ Ph: _____

Gastroenterologist _____ Ph: _____ DME Company _____

Other: _____ _____ _____

Past Surgical History: (with Month/Year)

_____ _____ _____

_____ _____ _____

List all Medications with Dosage:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Who may we thank for referring you to our practice: (please provide name)

Relative: _____ Insurance: _____Insurance agent: _____

Friend: _____ Website: _____ Other: _____

Existing patient of our practice: _____

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HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508 TO:

_____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address, City, State, and Zip Code

_____

Phone Number Fax Number

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All physical, occupational, and rehab requests, consultations, and progress notes. All disability, Medicaid, or Medicare records including claim forms and records of denial of benefits. All employment, personnel, or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records, and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels, and reports. All pharmacy/prescription records including NDC numbers and drug information handouts/monographs. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third-party payers and payment or denial of benefits for the period

_____ to _____. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human Page 1 of 2 immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes:

_____Continuing Medical Care _____

This authorization is given in compliance with the federal consent requirements for the release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____Mid-Florida Primary Care, 401 W. North Blvd, Leesburg, FL 34748_____

Name of Representative

_____Medical Provider _____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent that information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein.

This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative Date (See 45CFR § 164.508(c)(1)(vi))

_____

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR §164.508(c)(1)(iv))

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Patient Name: _____ DOB: _____

Primary Insurance: _____ Secondary Insurance: _____

Current Primary Care Physician: _____ Ph # _____ Fax#_____

Current Sub Specialist:
Cardiologist _____ Ph: _____ Pulmonologist _____ Ph _____

Neurologist _____Ph: _____ Orthopedics _____ Ph. _____

Oncologist/Hematologist _____ Ph: _____

Pain Medicine _____ Ph: _____ ENT _____ Ph: _____

Gastroenterologist _____ Ph: _____ DME Company _____

Other: _____ _____ _____

Current Problems/Diagnosis:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical History: (with Month/Year)

_____	_____	_____
_____	_____	_____

Current Medications with dose:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who may we thank for referring you to our practice: (please provide name)

Relative: _____ Insurance: _____Insurance agent: _____
Friend: _____ Website: _____ Other: _____
Existing patient of our practice: _____

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PATIENT INFORMATION: Please Print **Date**: _____

Name: _____ **DOB**: _____

Phone 1 (cell):_____ **Phone 2** (specify**)**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Social Security: _____

Email: _____**Preferred Language**: _____

Marital Status: Single, Partnered, Married, Separated, Divorced, Widowed

Race: African American, Asian, Native American, Native Hawaiian, Pacific Islander, White, Refuse to Answer

Ethnicity: Hispanic, Non-Hispanic, Other, Refuse to Answer

Gender Identity: Male, Female, Transgender (female to male or male to female), or Genderqueer, other, Refuse to Answer

Sexual Orientation: Heterosexual or Straight, Bisexual, Gay Lesbian or homosexual, other, Refuse to Answer

Seasonal: Yes or No

Spouse Name: _____ **DOB**: _____ **Phone**: _____

Parent/Guardian (if the patient is a Child_____ **DOB**: _____ **Phone**: _____

Occupation and Employer: _____ **Student Status**: Full-Time or Part-Time

INSURANCE INFORMATION:

Primary Insurance: _____ **ID Number**: _____ **Group**: _____

Insured's Name (if different from above): _____ **DOB**: _____

Social Security: _____ Employer: _____

Secondary Insurance: _____ **ID Number**: _____ **Group**: _____

Emergency Information: (someone not living with you)

Name: _____ **Relationship**: _____ **Phone**: _____

Address: _____

PHARMACY INFORMATION: Name: _____

Local Pharmacy: _____**Address**:_____ **Phone**: _____

Mail order Pharmacy Name: _____

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PLEASE KEEP A COPY OF THIS LETTER FOR YOUR RECORDS. It contains information on our policies and procedures

OUR GOAL: To help you and your family with your health care needs and provide the best possible care within the constraints of the health care system today.

APPOINTMENTS

1. Our office hours are 8-12:30 p.m. and 1:30-5 p.m. on Mon. - Fri. We prefer to see patients by appointment only. Same-day appointments are available in case of urgent care. It is best to call earlier in the day if you need to be seen.
2. If you are experiencing an emergency please call 911 and then have a family member or the hospital call our office. We request that you call the office if you are having a problem before going to an urgent care center.
3. Please call only 352-728-4242 for all your office calls. This is the only line answered by our answering service if the office is closed.

REFERRALS

1. When a referral for consultation or diagnostic testing is recommended we will coordinate your referral with your insurance company.
2. It takes 3-4 working days to process a referral or authorization depending upon the response from your insurance company unless an emergency exists. It is your responsibility to make sure that we send you to a participating provider for your Insurance plan or network. We have limited control over the referral process.
3. If we have difficulty getting authorization or a problem finding a participating provider, we will contact you for assistance. Authorization does not guarantee payment by your plan. Please make sure that the provider is still participating, and has the authorization prior to being seen.
4. You must be an established patient in the practice with a current signed medical release and correct insurance information for a referral to be processed. Most referrals require an in-office evaluation prior to the referral being processed.
5. In the instance you don't hear from us about your referral, we encourage you to call our office.

PRESCRIPTIONS Ongoing medical evaluation of the benefits and risks of each medication requires regular doctor's visits.

1. It is your responsibility to inform us of any and all medication you are taking. This includes prescriptions written by other providers, herbal supplements, over-the-counter medications, and any sample medication dispensed to you.
2. Please bring all your current medications with you at the time of your visit. This allows us to update your medication list, help eliminate duplication of medications, and better coordinate your refills.
3. Please request future refills needed at your visit. If you have specific pharmacy restrictions, mail in your prescriptions or need prescriptions written for 90 or 30 days at a time, please remind us each time the prescription is written.
4. It will take up to 3 working days to process all refill requests. A current visit must be on record. Your refill request is recorded upon review by our doctors and may or may not be approved. In certain instances, you may be called in for a visit prior to a medication refill.
   NO prescription refills will be processed at night or during weekends since our doctors do not have records available during those times. Please avoid running out of your medications by planning ahead.
   When calling in for a refill request you must leave your full name and date of birth with a current phone number. If we are not clear on who is making the request we will not process the refill.

LABORATORY TESTING

1. We draw and perform covered laboratory testing in our office if your insurance and our staffing permits. We charge a fee for the blood draw or you may go to your designated lab to have blood drawn.
2. Most labs are sent to QUEST or LabCorp. If you are not sure what laboratory you should use please check your policy information.
3. It is the patient's responsibility to advise MFPC staff of the lab preferred by your policy. We will provide the lab with the insurance information you provide to us, you might receive a separate bill from the laboratory depending on the policy guidelines. If you have billing questions, please contact the lab billing office.

OUR FINANCIAL POLICY

Thank you, for choosing us as your healthcare provider. We are committed to your treatment being successful.
Please understand that payment of your bills is considered part of your treatment. The following is a statement of
Our Financial Policy which we require you to read prior to any treatment.

ANY UNPAID INSURANCE CLAIMS OVER 60 DAYS OLD WILL BE PATIENT RESPONSIBILITY

INSURANCE:

1. Please provide accurate and current information BEFORE being seen. In order to avoid confusion you must understand YOUR policy, and information regarding network and benefits, so please carefully read your insurance manual.
2. Payment decisions for medical services received are based on your policy guidelines and may not be concordant with the medical recommendations we make. We endeavor to provide you with quality medical care that is consistent with your needs.
3. We may ask you to sign a waiver before performing specific services or procedures if the services or procedures may not be covered by your plan.

IN-NETWORK INSURANCE:

Regarding Insurance Plans where we are a participating provider, all co-payments and deductibles are due at the time services are rendered. In addition, if your plan is an HMO plan our office must be listed as your primary care provider on your insurance card. In the event your insurance coverage changes, please notify us prior to being seen or you will be responsible for payment of services denied by your insurance plan.

OUT of NETWORK INSURANCE:

Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a service to our patients, we may accept the assignment of insurance benefits after your second visit. We will file insurance claims for you; however, we do require 20% coinsurance and deductibles to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us accurate information. We will assist your insurance company with additional information they may need in order to process a payment. If we are having difficulties with your insurance company, we may call you and ask that you, as the customer of the company, contact the company to request payment. We will file claims to secondary insurance if the information is provided to us. In the event we do accept assignment as payment in full we require you to be pre-approved.

USUAL and CUSTOMARY RATES:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

COLLECTION SERVICE FEES:

Any past due balances turned to a collections agency are subject to a collection agency fee added to the past due balance. The collection service fees are 45% of any past-due balance, with a minimum fee of $25.00. Fees are subject to change without notice.

SELF-PATING PATIENTS and SERVICE TERMS:

All fees for services will be collected at the time services are rendered. No credit will be extended without prior approval of our Administration or Billing Supervisor. Approval should be arranged in advance of treatment; however, emergency credit may be extended on a case-by-case basis after services are rendered. Sometimes an advance payment will be collected for certain diagnostics or procedures. In case of account is transferred to the Collection agency, all discounts or adjustments given as private pay on all pending or past-due invoices will be taken off.

BILLING:

Your Copay is due at the Time of your Visit. We reserve the right to collect a Co-pay prior to being seen.

1) Payment is expected when services are rendered. You are directly responsible for payment of services given to you or your family member
   a.) Please provide us with accurate personal and insurance information before being seen. This includes secondary insurance.
   b.) If your visit is the result of an accident or work-related we must be notified prior to your being seen. You must
2) You must STOP at the checkout window to review charges and make sure all monies and accounts have been paid in full. Please avoid insurance collection company proceedings,
3) If your insurance company makes payment to you please forward the check payment to our office.
4) If we do not participate with your insurance company we ask that you pay us in full on the day of your visit, but we will file claims with the insurance carrier for you.
5) In instances you believe you have a refund due please contact our office, refunds are usually processed at the beginning of the month.

FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED
We accept Cash, Checks (with verification), Visa, Master Card and Discover

RETURNED CHECKS:

Dishonored checks will be returned to the patient only after acceptable payment is made. All Bank fees related to dishonored checks will be assessed to the patient. If the face value of the returned check, plus all related Bank charges cannot be collected within 30 days, this office will refer this matter to Small Claims Court.

Thank you for understanding our policies. Please let us know if at any time you have questions or concerns.

Signature of responsible party: _____ Printed Name: _____ Date: _____

Date of Birth: _____ Parent /Guardian Name: _____

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Privacy Practices and HIPAA Compliance Standards

Notice As per requirements we will provide you with a copy of our Notice of Privacy Practices. This states how your information will /may be used to provide proper health care. Your signature is an acknowledgment of the Notice.

I accept that Mid-Florida Primary care associates may need to leave information when trying to contact me I allow the following:

Home: _____Yes No leave Voice Mail

Cell: _____ Yes No leave voice Mail Send Text

Work: _____ Yes No leave Voice Mail

The Following individuals may obtain medical information on my behalf at any time unless I submit changes to this form.

Name: _____Number:_____ Relationship: _____

Name: _____Number:_____ Relationship: _____

Name: _____Number:_____ Relationship: _____

I have reviewed the copy of the Privacy Notice and understand I may be asked to update it on occasion. Mid-Florida Primary Care will not release my personal information to persons not listed above or a part of my healthcare team.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Relationship: _____

Received by: _____ Date: _____

ADVANCE DIRECTIVE NOTIFICATION

Name of patient: _____ DOB: _____

If you have a written advance directive, please give a copy to the nurse or front desk staff. Your advance directive will become a part of your Mid-Florida Primary Care practice record. You can request that it be removed or revised at any time in writing.

Please check all of the following that apply:

__ I do not have an Advance Directive and do not want one at this time,

__ I have provided a copy of the following advance directive today / previously:

a) Living will b) Health Care Surrogate c) Power of Attorney

__ I understand that my Advance Directive will not be observed until a copy is provided to the PCP clinic.

__ I have received an Advance Directive to complete.

__ I request assistance from the nursing staff to complete the forms.

Acknowledgment of Receipt: My signature acknowledges my receipt of written material about Advance Directives from the Mid-Florida Primary Care office and I have been asked whether I have advance directives.

__The patient unable to complete this form due to a medical condition

Signature of patient or person acting on behalf of the patient: _____

Relationship to patient: _____

Name of person/employee: _____ Date: _____