PATIENT INFORMATION

First Name: ____________________________ Middle: ____________________ Last Name: ________________________
Preferred Name: ____ Birth/Legal Sex: ____________________________________
Local Address: ____ Date of Birth: _______/_______/_______
City: _________________ State: ___________ Zip: ______________ Email Address: ____________________________________
Social Security: ____ Cell Phone: (   ) ________________________________
☐ Married ☐ Single ☐ Widowed ☐ Divorced Home Phone: (   ) ______________________________
☐ Legally Separated ☐ Domestic Partner Work Phone: (   ) ______________________________
☐ Employed ☐ Retired ☐ Full-Time Student Referring Physician: ______________________________
Employer: ____ Primary Physician: ______________________________
Address: ____ Phone: (   ) ____________________________________

PERMANENT ADDRESS

Address: ___________________________________ City: _______________________ State: __________ Zip: ___________

In an effort to know more about the people we serve, we would appreciate the following information:

Preferred Language (if other than English): ____

Race: ☐American Indian/Alaska Native ☐Asian ☐White ☐Black/African American ☐Native Hawaiian/Other Pacific Islander
☐ More than one race ☐Other ☐ Declined to state

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Refused

Current Gender Identity: ☐ Male ☐ Female ☐ Gender Queer ☐ Other: ________________
☐ Transgender Man/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Choose not to disclose

Pronoun Preference: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: ________________

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 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 the accident happen? ______________

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 DOB: _______/_______/_______
Insurance/Card Holder's Name: ____ Relationship: ________________________
ID#: ______________________________ Group #: ___________________________ Phone: (   ) ___________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ____ Insured DOB: _______/_______/_______
Insurance/Card Holder's Name: ____ Relationship: ________________________
ID#: ______________________________ Group #: ___________________________ Phone: (   ) ___________________

Patient or Guardian Signature: ____ Date: ________________________________

Financial Responsibility

This is an agreement between Florida Medical Clinic Orlando Health, 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 are credited. The words "we," "us," and "our" refer to Florida Medical Clinic Orlando Health 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 your insurance reimbursement may 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 Florida Medical Clinic Orlando Health. We will NOT under any circumstances falsify or change a diagnosis or symptom in order to convince an insurer to 'pay' for care that is not covered, no 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.

_______ Initials PPO Plans: Florida Medical Clinic Orlando Health has agreed to accept the discounted rate from your plan, and we will **estimate** balances to the best of our 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 Florida Medical Clinic Orlando Health. Your appointment may be rescheduled if your estimated amount due is not paid upon 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 hours' notice (48-hour notice for Florida Medical Clinic Orlando Health Ambulatory Surgery Center procedures), may result in a no-show fee assessed to my account. The no show fee varies by FMCOH 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 Florida Medical Clinic Orlando Health practice location.

_______ Initials After Hours Service: 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 by not limited to the services rendered, I agree to guarantee and promise to pay Florida Medical Clinic Orlando Health 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 Florida Medical Clinic Orlando Health. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. I understand and agree that if Florida Medical Clinic Orlando Health is required to bring a claim or file an action to enforce this agreement, Florida Medical Clinic Orlando Health 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 owned Florida Medical Clinic Orlando Health for its services. Based on permissible purpose under the Fair Credit Reporting Act, Florida Medical Clinic Orlando Health 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.

<u>Payments received will be posted to the oldest outstanding balance on your account.</u>

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 Florida Medical Clinic Orlando Health 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 Florida Medical Clinic Orlando Health, 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 of any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payer for those costs I incur in receiving services from Florida Medical Clinic Orlando Health. 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, judgement or verdict which is obtained as a result of the injury or medical condition for which my debt to Florida Medical Clinic Orlando Health was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to Florida Medical Clinic Orlando Health 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 Florida Medical Clinic Orlando Health be insufficient to cover the entire expense of service, including the co-payment and deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of services rendered by Florida Medical Clinic Orlando Health are not covered by said insurance policy, I am responsible to Florida Medical Clinic Orlando Health for payment of the entire bill.

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 Orlando Health 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 Orlando Health. I understand that diagnosis or treatment of me by Florida Medical Clinic Orlando Health 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 Orlando Health *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic Orlando Health *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 Orlando Health. The *Notice of Privacy Practices* for Florida Medical Clinic Orlando Health 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 Orlando Health with respect to my protected health information. Florida Medical Clinic Orlando Health 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 Orlando Health.

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

Patient/Guarantor *(Print):* ____

Patient/Guarantor *(Signature):* ____ Date: ____________________

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

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB	Phone#	

I AUTHORIZE FLORIDA MEDICAL CLINIC ORLANDO HEALTH TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:

METHOD	CONTACT INFORMATION
☐ TEXT	
☐ EMAIL	
☐ VIDEO CONFERENCE	

☐ I do not authorize Florida Medical Clinic Orlando Health to communicate with me via electronic means

This Authorization to Communicate PHI via electronic means expires

☐ Upon written revocation ☐ Other

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

I understand Florida Medical Clinic Orlando Health 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 Orlando Health.

I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic Orlando Health 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 Orlando Health may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic Orlando Health's Notice of Privacy Practices.

I hereby release Florida Medical Clinic Orlando Health and its employees from any and all liability that may arise from the release of information as I have directed.

I understand emailing and texting are not secure forms of communication and I release Florida Medical Clinic Orlando Health from any liability.

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 to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Notice of Billing Efforts Conducted Via Electronic Means		
I understand that in its regular course of billing and collection efforts, Florida Medical Clinic Orlando Health may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to Florida Medical Clinic Orlando Health may be used for these purposes. I consent to the use of e-mail, text or automated voicemail communication by Florida Medical Clinic Orlando Health if I have any balances due on my account, regardless of my preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system" or "autodialer". I understand that message and data rates may be assessed by my mobile provider. By signing this form, you represent that you are the cellular subscriber or customary user with respect to the cellular number(s) provided and that you have the authority to provide consent.		
Signature		Date
Print Name:	Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative	

Florida Medical Clinic Orlando Health
Authorization to Verbally Share Protected Health Information

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

I authorize FLORIDA MEDICAL CLINIC ORLANDO HEALTH 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 ________________