Appointment:_____

- **Arrive 30 minutes to your appointment time.**
- **Bring all bottles for your medication, supplements and vitamins.**

WELCOME!

Thank you for choosing us to serve your healthcare needs. You can trust that we will work extraordinarily hard to provide you with the absolute best in healthcare services and support. Our goal is simple – to help you feel as good as you can and be as healthy as you can be!

Thank you so much for your help in getting this paperwork back to us before your appointment.

We have designed a number of tailored programs and solutions to deliver a true patient-centered medical home experience just for you:

- Our schedules are open when you need to be seen – ***Just Call Us***!
- Our doctors are on call for your urgent care needs (nights and weekends).
- Annual wellness and comprehensive health review program.
- Care coordination program.
- Screening Test Evaluation Program (STEP) – for early detection of disease
- Post-admission follow-up program.
- And many more!

If you have not already done so, please call us to schedule your first appointment and get started on your road to better health.

Making a Difference!

Service | Integrity | Leadership

PLEASE PRINT CLEARLY - *BRING YOUR DRIVER'S LICENSE AND CURRENT INSURANCE CARDS*

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Sex: Male / Female / _____

Social Security Number: _____ DL / State ID#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact (person who does not live in your home): _____

Emergency Address: _____ City:_____ State: ____ Zip: _____

Emergency Home Phone: (_____) _____-_____ Emergency Cell Phone: (_____) _____-_____

Other physicians that you normally see – please provide full names and specialties

Dr. _____ Seeing for what condition? _____

Dr. _____ Seeing for what condition? _____

Dr. _____ Seeing for what condition? _____

Dr. _____ Seeing for what condition? _____

By signing below, I acknowledge that I have received, read and understood the **HIPAA Notice of Privacy Practices** of **Florida Medical Associates, LLC** (available on the website - copy available on request at the offices) and authorize Florida Medical Associates, LLC to release or obtain any relevant information to or from any related third-party. I also authorize Florida Medical Associates, LLC to bill any relevant third party for the services rendered and to bill me for any balances after payment from such third-parties. I also authorize Florida Medical Associates, LLC to bill me for any fees, costs or charges associated with collecting monies due to them on my behalf. I further authorize Florida Medical Associates, LLC to provide the person(s) named above and discuss my medical conditions as necessary.

Signature: _____ **Date**: _____

Making a Difference!
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MEDICAL RECORDS RELEASE
RECORDS FAX: 844 - 388 - 6186

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Records to be released from: _____ NO DISCS PLEASE

Fax #: _____ Phone #: _____

Patient Name: _____

DOB: _____ S. S. Number: * * * - * * - _____ (last four)

I authorize and request the disclosure of all protected information for the purpose of review and evaluation from the above-named doctor or healthcare provider to:

Requesting Provider:

Requested Information (if more than 25 pages, please mail):

Dates from _____ to _____

- All records
- Office Visit notes - last two only
- Cardiology Reports Only
- Consults Notes Only
- Office Notes Only
- Lab reports only
- Radiology reports only
- Hospital records only
- Other: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I understand the following (see CFR 164.508(c)(2)(i-iii)):

• I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.

• The information released in response to this authorization may be re-disclosed to other parties.

• My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____ _____

Name of Legally Authorized Representative for Patient Relationship to Patient

vipcare

Patient Questionnaire

Patient Name: _____ Date of Birth: ___/___/_____

Sex: _____ SSN: _____

Other doctors that you are currently seeing (Note: If you need referrals in future, you need to identify your doctors here)		
Doctor's full name	**Address, City, State, Zip**	**For what condition?**

Name of your Pharmacy:		
Address of your Pharmacy:		

Past Medical History/ Family History						**Current Medication Details**		
Condition	**Self**	**Father**	**Mother**	**Siblings**	**Children**	**Medication**	**Dose**	**Times/day**
Heart Attack								
Valve disorder								
High Blood Pressure								
Diabetes								
Colon Cancer								
Breast Cancer								
Prostate Cancer								
Other cancer (specify)								
High cholesterol								
Mental illness								
Depression								
Stroke								
Osteoporosis								
Seizures/ Epilepsy								
Migrane								
Liver Disease								
Kidney Disease								
Neuro problems								
Arthritis								
Bleeding disorder								
Thyroid problems								
Alcohol or Drug abuse								
Accidents (specify)								
Surgery (Specify)								
Hospitalization (Specify)								
Hospitalization (Specify)								

Social History

Do you smoke? Yes/ No. If Yes, How many?_____; If not, are you a past smoker? Yes/ No. When did you quit? _____.

Do you drink alcohol? Yes/ No. If Yes, How much? _____

Do you have any drug or other allergies (please specify) _____

When was your last test/ exam/ shot/ treatment for (Please provide exact dates and where you got it – This is IMPORTANT).

Mammogram:	Eye:	Dental:	Cholesterol:
Colonoscopy:	Glaucoma:	Prostate:	Breast:
Stool Blood:	PAP Smear:	Ear:	

SCREENING FORM

PATIENT NAME: _____ **DOB:** _____ **Date:** _____

Please circle your answers:

Do you have Oxygen / CPAP / BiPAP machine? Yes or No

Do you have any of the following :

Living Will / Advanced Directive / Power Of Attorney / None

Do you need Aide with walking (such as a Walker or Cane): Yes or No

Do you need help with daily living activities? Yes or No

How are your senses:

Vision - Good Fair Poor Glasses
Hearing - Good Fair Poor Hearing Aides
Touch – Good Fair Poor
Taste – Good Fair Poor
Smell – Good Fair Poor

Is there any pain that you have all the time, or often? Y or N If yes, where?: _____

Pain scale: Mild 1 – 3 Moderate 4 – 6 Heavy 7-8 Severe 9-10

When was your last:	**Date...?**	**Where...?**
Mammogram		
Bone Density		
Colonoscopy		
Stool Cards		
Eye Exam		
Blood Work		
Pap Smear		
PSA		

Immunizations:	
Influenza (FLU) Vaccine	Tetanus Vaccine
Shingles Vaccine	Tuberculosis Test (PPD)
Pneumonia Vaccine	

OFFICE POLICY AGREEMENT

(Initial)

_____ COMMIT TO A MINIMUM OF ONE ROUTINE APPOINTMENT(S) YEARLY

To provide the quality of care you deserve, you must have an routine office visit with the physician at least once yearly. This does not include urgent, or sick appointments. This also includes yearly fasting blood tests, and electrocardiogram (EKG). If you do not keep yearly appointments, you may be considered as an inactive patient if the lapse is over 1 year (12 months). At which time you may be asked to establish care with another primary care physician. It is the physician's discretion to allow anyone to re-establish care.

_____ TARDINESS TO AN APPOINTMENT MAY LEAD TO RESCHEDULING.

In the event that you are 10 minutes late to an appointment, you may be rescheduled. If you are habitually late, you will be rescheduled. If you run into an emergency, or know you will be late please call ahead as we may have an appointment later in the day. It is not fair to other patients to be rushed, or wait unknown amounts of time because one person was late.

_____ NO SHOWS / LAST MINUTE CANCELLATIONS / LAST MINUTE RESCHEDULES:

Providers and staff of VIP Care rely on the pre-scheduled appointments to plan their day to day activities and also curtail the ability to schedule another member/patient in you pre-scheduled slot. If you have to cancel or reschedule your appointment, please provide us with at least 48 hour notice. If you reschedule, cancel or are a no-show to your pre-scheduled appointment, we may charge a $25.00 fee directly to you. Please note that this charge will not be billed to a third party (including your insurance) but directly to you. You as the patient will be responsible for payment of this charge prior to any further encounters.

_____ LEAVING THE PRACTICE:

VIP Care is part of a large company with multiple partners. If you leave the practice of one of our partners, you cannot establish with another partner. If changing practices/partners is agreed upon between both partners, this will be null and void

_____ MEDICATION REFILLS

The physicians try their best to get all medication refills sent to the pharmacy as quickly as possible. Keep in mind this is done between patients, or at the end of the day (time permitting). If you see you are running low on medication please call ASAP, as a refill may take 24 to 48 hours.

By signing this form, I am in agreement with the above terms, or understand the office policies.

SIGNATURE: _____ **DATE:**_____

SUBSCRIBER SIGNATURE: _____ DATE:_____

(If different that patient)

LIVING WILL / ADVANCED DIRECTIVE

Florida statutes require that we provide our patients with information concerning their rights to a Living Will and/or Advanced Directive.

An **ADVANCED DIRECTIVE** is a witnessed statement made by a competent member regarding his/her wishes or desires in regards to future health care, (for example-Provide artificial life support)

A **LIVING WILL** is a formalized version of an **ADVANCED DIRECTIVE**.

Please take this information home and carefully review it. If you wish to execute an Advanced Directive or Living Will, please notify this office on your next visit.

PLEASE CHECK ONE:

_____ **I DO NOT HAVE a Living Will**

_____ **I HAVE a Living Will and will provide a copy to this office**

Florida Law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare providers, or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility.

Signature: _____ Date: _____

Printed Name: _____

Witness: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received Florida Medical Associates, LLC HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

___ **RELEASE OF INFORMATION-I**, the below named patient, do hereby authorize any physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g. Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

___ **PHYSICIAN INSURANCE ASSIGNMENT-** I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

___ **MEDICARE/MEDICAID** - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIIXIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

___ **PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** The assignment will remain in effect until revoked by me in writing.

___ **CONSENT FOR TREATMENT-** I, the below named patient hereby give my consent for treatment to all physicians associated with Florida Medical Associates, LLC.

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Florida Medical Associates, LLC. To discuss my medical condition with, or release my medical records to the below named person (s):

NAME _____**Relationship** _____ **Phone:** _____

NAME _____**Relationship** _____ **Phone:** _____

___ **NO SHOWS/ LAST MINUTE CANCELLATIONS/ LAST MINUTE RESCHEDULES:** Providers and staff of Florida Medical Associates, LLC rely on the pre-scheduled appointments to plan their day to day activities. Last minute reschedules or cancellations and no-shows disrupt the daily activities and also curtail the ability to schedule another member/ patient in your pre-scheduled slot. If you have to cancel or reschedule your appointment, please provide us with at least 48 hour prior notice. If you reschedule, cancel or are a no-show to your pre-scheduled appointment, we may charge a $25.00 fee directly to you. Please note that this charge will not be billed to any third party (including your insurance) but directly to you and you will be responsible for payment of this charge prior to any further encounters.

___ **COLLECTION AGENCY-** In the event your account becomes delinquent and is turned over to a collection agency and/or attorney, you will be financially responsible for all associated collection fee and legal fees that Florida Medical Associates, LLC incurs through the process utilized to collect the delinquent balance. Please be aware if your account is turned over to a collection agency you can be discharged from the practice.

___ **RETURNED CHECK**- Checks returned to Florida Medical Associates, LLC by the bank will be assessed a return check fee, in addition to the original amount of the check. You have ten (10) days to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time the check will be sent to the State's Attorney's Office for further collection.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days. All entities partnered with Florida Medical Associates, LLC are covered under this document.

DATE _____ PATIENT or SUBSCRIBER: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003, and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by asking our Privacy Officer, Ram Moorthy-CEO. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION: We will keep your health information confidential, using it only for the following purposes: **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your health care information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.con

HIPAA Notice of Privacy Practices:

This form does not constitute legal advice and covers only federal, not state, law.

YOUR PRIVACY RIGHTS AS OUR PATIENT: Access: Upon written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed if you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back six (6) years starting on April 14. 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US: Privacy Officer: Ram Moorthy Practice Name: Florida Medical Associates,LLC Ocala: 2955 SE 3rd Ct, Ocala, FL 34471
Phone: 352-509-9900 Fax: 352-387-2584 Website: www.fmahealth.com

HIPAA Notice of Privacy Practices:

This form does not constitute legal advice and covers only federal, not state, law.