veriMED Health Group

Seminole

Please Print

Today's Date:_____/_____/_____Prior Physician:_____

Whom may we thank for referring you to us?_____

Patient's Name:_____DOB:_____/_____/_____Age:_____

Mailing Address:_____Sex: ☐ Male ☐ Female

City:_____State:_____Zip Code:_____Social Security#:_____

Home Phone#:_____Work #:_____

Email:_____

By listing my e-mail address above, I certify that I am allowing veriMED to contact me via e-mail. If at any time you do not want to receive this information or need to change the e-mail address on file, please contact the office. WE TREAT YOUR EMAIL WITH HIPAA STANDARDS – IT IS NOT SHARED AND IS NOT FOR SALE.

Pharmacy Name/City:_____Pharmacy Phone #:_____

Race:_____Ethnic:_____Language:_____

Employer Address (**If employed**):_____

Phone #: _____Occupation:_____

Driver's License# / State:_____/_____

Insurance Company Name and Policy#:_____

Group #:_____Insurance Claims Address:_____

Secondary Insurance Name and Policy# (**if applicable**):_____

Group #:_____Insurance Claims Address:_____

Please present insurance card to front office staff.

Marital Status:_____Spouse Name:_____

Spouse DOB_____/_____/_____ Spouse Phone #:_____

Primary Emergency Contact:
Nearest relative not living with you:_____Phone#:_____

Address:_____

May we contact the above person in case of emergency? ☐ Yes ☐ No

Patient Name:_____ DOB: _____

Secondary Emergency Contact:

Name:_____Phone#:_____

Address:_____

Relationship:_____ May we contact the above person in case of emergency? ☐ Yes ☐ No

Medical History

Medications/Prescriptions including all over the counter:

Name of Drug	Dose (milligrams)	How many times a day?

Do you have allergies to medications, x-ray dyes, or other substances: □ Yes □ No

If yes, what was the reaction:_____

_____

Please check the circle next to any medical conditions you have been diagnosed with in the past:

○Asthma	○Drug or Alcohol Addiction	○Hepatitis	○STDs (VD)
○Arthritis **Where**:	○Epilepsy	○High Cholesterol	○Stroke or TIA
○Blood Disorders	○Gallbladder Disease	○Hypertension	○TB or TB Exposure
○Cancer **Where**:	○Glaucoma or Blindness	○Kidney Disease	○Thyroid Disease
○Colitis	○Gout	○Mental Disease	○Transfusion **Date**:
○COPD	○Heart Disease	○Pneumonia	○Ulcers
○Diabetes	○Hemorrhoids	○Skin Disease	○Other:

Patient Name:_____ DOB: _____

Past medical history and review of symptoms:

Please list and date all operations/surgery:_____

_____

_____

Hospitalizations other than surgery:_____

_____

_____

Medical History (Continued)

Family History

Mother: □ Living □ Died at (age):_____ Reason:_____

Father: □ Living □ Died at (age):_____ Reason:_____

Sibling: □ Brother □ Sister □ Living □ Died at (age):_____ Reason:_____

Sibling: □ Brother □ Sister □ Living □ Died at (age):_____ Reason:_____

Sibling: □ Brother □ Sister □ Living □ Died at (age):_____ Reason:_____

Sibling: □ Brother □ Sister □ Living □ Died at (age):_____ Reason:_____

Has any family member (parents, grandparents and siblings) ever had the following? If so, which family member?

○Blood Disorders Family Member:_____	○Epilepsy Family Member:_____	○High Cholesterol Family Member:_____	○Stroke or TIA Family Member:_____
○Cancer Family Member:_____ Type:_____ Where:_____	○Gallbladder Disease Family Member:_____	○Hypertension Family Member:_____	○TB or TB Exposure Family Member:_____
	○Glaucoma or Blindness Family Member:_____	○Kidney Disease Family Member:_____	○Thyroid Disease Family Member:_____
○Diabetes Family Member:_____	○Gout Family Member:_____	○Mental Disease Family Member:_____	○Ulcers Family Member:_____
○Drug or Alcohol Addiction Family Member:_____	○Heart Disease Family Member:_____	○Pneumonia Family Member:_____	○Other: Family Member:_____

Social History

Do you drink alcohol? □ YES – Drinks per day _____ □ NO

Do you drink caffeine (coffee, tea, colas)? □ YES – Drinks per day _____ □ NO

Do you use tobacco? □ YES – Pack per day_____ □ NO

Are you a **current** smoker? □ YES – Pack per day_____ □ NO

Are you a **former** smoker? □ YES – Years since you quit?_____ □ NO

Patient Name:_____ DOB: _____

Medical History (Continued)

Immunization History

Flu Vaccine	O Yes — Date: _____/_____/_____ O No	Other Vaccines? O Yes Please list others below if 'Yes' O No	
Hepatitis A	O Yes — Date: _____/_____/_____ O No	Vaccine Name: _____	Date: _____/_____/_____
Hepatitis B	O Yes — Date: _____/_____/_____ O No	Vaccine Name: _____	Date: _____/_____/_____
Pneumonia Vaccine	O Yes — Date: _____/_____/_____ O No	Vaccine Name: _____	Date: _____/_____/_____
Shingles Vaccine	O Yes — Date: _____/_____/_____ O No	Vaccine Name: _____	Date: _____/_____/_____
Tetanus Vaccine	O Yes — Date: _____/_____/_____ O No	Vaccine Name: _____	Date: _____/_____/_____

Please list any other concerns you would like to discuss with your doctor:_____

_____

_____

_____

Patient Signature:_____Date:_____

Legal Guardian/POA: _____Relationship:_____

For Physician Use Only
Physician Signature:_____ Date:_____

Patient Name:_____ DOB: _____

verMED Health Group

List of previous providers and specialists:

- Physicians Name: _____

  Office Phone Number: _____ Fax Number: _____

  Specialty: _____

  City: _____ State: _____

- Physicians Name: _____

  Office Phone Number: _____ Fax Number: _____

  Specialty: _____

  City: _____ State: _____

- Physicians Name: _____

  Office Phone Number: _____ Fax Number: _____

  Specialty: _____

  City: _____ State: _____

- Physicians Name: _____

  Office Phone Number: _____ Fax Number: _____

  Specialty: _____

  City: _____ State: _____

- Physicians Name: _____

  Office Phone Number: _____ Fax Number: _____

  Specialty: _____

  City: _____ State: _____

Patient Name:_____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OR NOTICE OF PRIVACY PRACTICES

I, _____, Have received a copy of this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Patient Name:_____ DOB: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights

You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means,

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information, you may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you, provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at (800) 957-9882.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information and send relevant pans to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior

Authorization.
However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required by Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation- We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

- Fundraising. Should our practice use patient information for fund raising we will Inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in should with written notice.
- Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require will require a separate written authorization.
- Use or Disclosure of Psychotherapy Notes, Written authorization is required if our practice intends to use or disclose psychotherapy notes.
- Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health Information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you,

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Patient Name:_____ DOB: _____

VI. Our Duties

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the light to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health

Information even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government

You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services (DHHS) if you believe your rights have been violated,

We review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information

You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: (800) 957-9882

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington- D.C. 20201, Telephone: 202-619057, Toll Free: 1-877-696-6775

Patient Name:_____ DOB: _____

verIMED Health Group

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

2. I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and healthcare operations) with: ( ) Spouse ( ) Children ( ) Other

   Name(s): _____

3. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

4. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent *if other than your home*. **(Confidential Communications)**

   _____

   _____

5. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL":** ( ) Yes ( ) No

6. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information *if other than your home phone number* (___) _____

7. I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ( ) Yes ( ) No

8. I authorize the pick-up of my medical records / prescriptions / test results by:
   ( ) Spouse ( ) Children ( ) Other

Name(s): _____

This Authorization is only valid for the person(s) I have listed above.

PATIENT NAME: _____ DATE: _____
(Guardian, if patient is a minor)

PATIENT/ GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____ DATE: _____
(Staff employee/office manager)

Patient Name:_____ DOB: _____

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

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

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care

A patient has the right to what support services are available, including whether an interpreter is available if he or she doesn't speak English.

A patient has the right to know what rules and regulations apply to his or her conduct

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given upon request full information and necessary counseling on the availability of known financial resources to his or her care:

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of reasonable clear and understandable, itemized bill and upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation or his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or facility in which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information and present complaints, past illnesses, hospitalizations, medications, and other matter relating to his or her health.

A patient is responsible for reporting unexpected changes to his or her condition to the health care provider.

A patient IS responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct

PATIENT
SIGNATURE:_____DOB:_____Date:_____

Patient Name:_____ DOB: _____

veriMED Health Group

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care.

Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** -Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that veriMED Health Group Seminole can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to veriMED Health Group Seminole to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____/_____/_____

Print Patient Name Date

_____ _____/_____/_____

Signature of Patient or Guardian Date

_____

Relationship to Patient

Patient Name:_____ DOB: _____

verIMED Health Group

To our VA Patients:

Due to the confusion and complexities of having multiple physicians taking care of you, we are requesting that you choose one of the following options for the physician management of your chronic conditions.

_____ 1. The VA will manage all of my chronic conditions, and I, the patient, release Dr. _____ from any responsibility with regard to chronic conditions. I will see Dr. _____ only to satisfy my insurance obligation, and/or for any acute conditions that may arise.

_____ 2. I want Dr. _____ to manage all my chronic conditions and acute conditions. I will provide all test results done by the VA, but understand that Dr. _____ may need to repeat some tests or do additional testing as the need arises. I will not allow the VA to make any changes to my medications without first notifying and checking the medication with Dr. _____.

_____ 3. While I have chosen an option (#1 or #2) above, I would like the following exceptions (*fill in the condition or disorder*):

Dr. _____ to do: _____
_____
_____

VA to do: _____
_____
_____

If you have any of the following done at the VA, please make sure to bring a copy to us so we can add to your record.

• Eye Exam • Colonoscopy •Lab Work

Note: None of the above options will in any way affect where you get your medications/supplies.

_____ _____
Signature of Patient Date

_____
Name of Patient

Patient Name:_____ DOB: _____

veriMED Health Group

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Name of Patient:	**SSN#:**
	DOB:

TO: (Name, Address, Phone of RECIPIENT of Records)						
Name	veriMED Health Group Seminole			**Phone**	727-319-8900	
Address	9555 Seminole Blvd. Ste: 205			**Fax**	727-319-8700	
City/State/Zip	**City**	Seminole	**State**	FL	**Zip**	33772

RECORDS FROM (Who is **RELEASING** the records):						
Name				**Phone**		
Address				**Fax**		
City/State/Zip	**City**		**State**		**Zip**	

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-Up
☐	Disability Insurance	☐	Other:		

By checking the boxes below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

☐	Please send the entire Medical Record (all information to the above-named recipient.				
☐	Office Notes and Reports	☐	Most recent one-year history	☐	Most recent three-year history
☐	RX History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Billing Statements	☐	Diagnostic Reports	☐	Diagnostic Films
☐	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use and/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB, or Other Communicable Diseases
_____ Mental Health Information and/or records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment, or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign the authorization and that my refusal to sign will not affect my ability to obtain treatment of payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in six (6) months from the date of signing or until (insert date) _____.

Print Patient's Name: _____ Date: _____

Signature of Patient's or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable) :_____ Relationship: _____

Patient Name:_____ DOB: _____

veriMED Health Group

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Name of Patient:	**SSN#:**
	DOB:

TO: (Name, Address, Phone of RECIPIENT of Records)						
Name				**Phone**		
Address				**Fax**		
City/State/Zip	**City**		**State**	FL	**Zip**	

RECORDS FROM (Who is **RELEASING** the records):						
Name	veriMED Health Group Seminole			**Phone**	727-319-8900	
Address	9555 Seminole Blvd. Ste: 205			**Fax**	727-319-8700	
City/State/Zip	**City**	Seminole	**State**	FL	**Zip**	33772

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-Up
☐	Disability Insurance	☐	Other:		

By checking the boxes below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

☐	Please send the entire Medical Record (all information to the above-named recipient.				
☐	Office Notes and Reports	☐	Most recent one-year history	☐	Most recent three-year history
☐	RX History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Billing Statements	☐	Diagnostic Reports	☐	Diagnostic Films
☐	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use and/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB, or Other Communicable Diseases
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_____ Domestic Violence
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Print Patient's Name: _____ Date: _____

Signature of Patient's or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable) :_____ Relationship: _____

Patient Name:_____ DOB: _____

Financial Policy

As your physician, we are committed to providing you with the best possible medical care and assist you with timely insurance filing and payment on your account. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payments for Service is Due at Time Services are Rendered / Self Pay: We accept cash, credit card, and personal checks, and returned checks less than $50.00 is subject to a service charge (per Florida statute 832.08) of $25.00. Checks between $50.00 and $300.00 have a fee of $30.00. For check greater than $300.00, the fee is $40.00. You may also lose your privilege to write checks in our office. If you do not have insurance, a pre-payment amount will be required before you visit. At the end of your visit, the physician will indicate what services were rendered and the balance of your visit is due ***prior*** to leaving.

Cancelled / Missed Appointments: Please provide at least 24 hours notification if an appointment must be cancelled. As a courtesy to our patients, we will attempt to contact you the day before your scheduled appointment. Patients who do not cancel appointments will be charged a fee, please refer to the clinic's fee schedule for the amount. If you miss three or more appointments, you may be dismissed from the practice.

Insurance: Our office participates with most insurance companies. For your protection, we will require your current/valid insurance card along with your photo identification. This information will be kept in our records and assist us in filing your insurance claim. Please keep us informed of any changes in your health care coverage. Co-payment and Deductible's must be paid at the time of service. These amounts are determined by your insurance company depending on your plan. Because we are under contract with specific insurance companies, we will file your insurance claim directly. After filing your claim, we will allow sixty days for your insurance company to make the payment. If your insurance company fails to render payment, you will responsible for the payment in full.

Medicare: You are responsible for your annual deductible and 20% of the allowable charges due at the time of service, unless you have supplementary insurance.

Please bring your Medicare Explanation of Benefits (EOB) showing that you have met your deductible.

HMO/MCO: If you are required to select a PCP by your insurance carrier, then you must change your PCP prior to scheduling an appointment with our office. If this is not done and your insurance carrier declines payment you will be responsible for the office visit in full based on our fee schedule.

Financial Agreement: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. At the time of your visit, we will verify your insurance benefits. This information obtained is not a guarantee of payment and final eligibility/benefits are not determined until the claim is received and processed by your insurance company.

- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. If we are unable to verify coverage and/or eligibility, you will be required to make a pre-payment. Please refer to the clinic's fee schedule for this amount.

We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company.

Forms Completion: Any form requiring completion will have a fee associated with it and must be pre-paid. We do understand form completion may be time sensitive and will be processed as quickly as possible. According to the Florida Statute 395.3025, we are allowed to charge for coping of medical records, actual postage, and sales tax. Please refer to the clinic's fee schedule for these amounts.

Worker's Compensation/Automobile Accidents: We are unable to treat any patient that is seeking treatment related to an accident, injury, and/or illness involving but not limited to: Worker's Compensation, Automobile Accidents, and any other circumstance that may have present or future litigation.

All charges are your responsibility from the date services are rendered.

Any balance on your account after 90 days, including those that insurance has not paid, may result in a collection action. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, **please contact our billing staff promptly for assistance in the management of your account.** We are willing to work with you on setting up a payment plan. A late penalty of 1.5% monthly (18% annually) is added to any unpaid personal balances after sixty days. All accounts with balances over ninety days will be referred to our collection agency.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above referenced information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you. **BY SIGNING BELOW, YOU ACCEPT AND CONFIRM THAT YOU HAVE READ AND FULLY UNDERSTAND OUR FINANCIAL POLICY.**

Signature_____**Date**_____

Patient Name:_____ DOB: _____

General Consent for Care and Treatment Consent TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended. I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s}.

RELEASE OF INFORMATION

I agree to the release of information from my medical record for reimbursement for health care services provided, follow up evaluation, and/or patient specific benefits, to any of the following as necessary:

- Social Security Administration, or those operating on their behalf (includes Medicare and disability)
- Any insurance organization, compensation carrier or welfare agency providing financial assistance for services provided.
- Identified referring

I also agree to authorize *veriMED Health Group – Seminole* and their respective employees and agents to obtain information form my physician(s), transferring facility (ies), and rehabilitation centers for the purposes of follow up evaluation.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient / Personal Representative of Patient | Date

_____ _____

Printed Name of Patient / Personal Representative of Patient | Relationship to Patient

_____

Patient Date of Birth