



PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____
LOCAL ADDRESS _____ DATE OF BIRTH ____/____/____ SEX ____
CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____
SOCIAL SECURITY _____ CELL PHONE () _____
ETHNICITY: ___ NOT HISPANIC/LATINO ___ HISPANIC/LATINO ___ REFUSED HOME PHONE () _____
RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___ WHITE WORK PHONE () _____
___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____
___ OTHER ___ OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____
PREFERRED LANGUAGE _____ PHONE () _____
___ MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED EMPLOYER _____
___ EMPLOYED ___ RETIRED ___ FULL TIME STUDENT ADDRESS _____

PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ HOME PHONE () _____
RELATIONSHIP _____ WORK PHONE () _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? YES NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE () _____
FIRST NAME _____ MIDDLE _____ EMPLOYER _____
LAST NAME _____ ADDRESS _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
CITY _____ STATE _____ ZIP _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? YES NO IF YES PLEASE COMPLETE THIS SECTION
NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.
PLEASE CHECK WHICH TYPE OF ACCIDENT: WORKMAN COMPENSATION AUTOMOBILE OTHER
DATE OF ACCIDENT ____/____/____ Place of accident _____ How did accident happen? _____
CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____
IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION
EMPLOYER NAME _____ EMPLOYER PHONE() _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____
INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____
ID# _____ GROUP # _____ PHONE () _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____
ID# _____ GROUP # _____ PHONE () _____
SIGNATURE _____ DATE _____



Your Life. Our Specialty.

FLORIDA MEDICAL CLINIC, LLC

Your Life, Our Specialty

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, LLC 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, LLC. I understand that diagnosis or treatment of me by Florida Medical Clinic, LLC 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, LLC *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, LLC *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, LLC. The *Notice of Privacy Practices* for Florida Medical Clinic, LLC 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, LLC with respect to my protected health information. Florida Medical Clinic, LLC 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, LLC

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

Financial Responsibility

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

Assignment of Benefits

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

Initials _____



Ownership Disclosure

I understand that Florida Medical Clinic, LLC is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic’s Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPPA) and FMC’s policies on use and disclosure of my protected health information.

Name of Patient

Name of Guardian or Personal Representative

Signature of Patient

Signature of Guardian or Personal Representative

Date

Florida Medical Clinic, LLC
Zephyrhills, FL 33542

Name: _____

Date: _____

DOB: _____

Acct #: _____

Medical/ Ocular History

Past Ocular History:

	Yes	No		Yes	No
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia/ Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Surgery/Other: _____		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Retinal/detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Past Medical/ Surgical History

	Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Type 1/ Type 2	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Surgery/ Other: _____		
Thyroid (hypo/ hyper)	<input type="checkbox"/>	<input type="checkbox"/>	_____		

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

Preferred Pharmacy: _____ Phone #: _____

Mail Order Pharmacy: _____ Phone #: _____

Medication or Drug Allergies: _____

Family Ocular/ Medical History: Indicate family member

Cataract _____	Diabetes _____
Hypertension _____	Glaucoma _____
Macular Degeneration _____	Amblyopia/ lazy eye _____
Retinal detachment _____	Blindness _____

Social History:

Alcohol Use: Yes No

Tobacco Use: None Circle: Current/Former/Never

Women: Pregnant Nursing

Frequency/ Amount: _____

Name: _____

Date: _____

DOB: _____

Acct #: _____

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

Yes

No

Allergy: Seasonal/ Year round: _____

Cardiovascular: High/ Low blood pressure/ chest pain/ irregular beat

Constitutional: Fever/ weight gain or loss/ fatigue _____

Endocrine: High sugar/ High thyroid/ low thyroid _____

ENT: Hearing loss/ sinus _____

Eye: Blurred vision/ eye pain/ flashes/ floaters _____

GI: Abdominal Pain/ nausea/ vomiting/ diarrhea _____

GU: FLOMAX use/ groin pain/ sores _____

Blood: Anemia/ easy bruising/ swollen lymph nodes _____

Skin: Rashes/ changing moles/ eczema _____

Musculoskeletal: Joint pain/ weakness/ back pain _____

Neurological: Headache/ scalp tenderness/ jaw pain _____

Psychiatric: Anxiety/ depression _____

Respiratory: Shortness of breath/ Sleep apnea/ CPAP _____



38135 Market Square
Zephyrhills, FL 33542

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

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB		Account #
COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS <u>NOT</u> THE PATIENT		
Name of Representative		
Relationship to Patient (parent, health proxy, etc.)		Phone #
Email Address		
I AUTHORIZE FLORIDA MEDICAL CLINIC, LLC TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:		
METHOD	CONTACT INFORMATION	
<input type="checkbox"/> TEXT		
<input type="checkbox"/> EMAIL		
<input type="checkbox"/> VIDEO CONFERENCE		
<input type="checkbox"/> I do not authorize Florida Medical Clinic, LLC to communicate with me via electronic means		
This Authorization to Communicate PHI via electronic means expires		
<input type="checkbox"/> Upon written revocation <input type="checkbox"/> Automatically one year from the date of signing <input type="checkbox"/> Another date/event:		
<p>I understand by selecting the method of communication above and signing below, I authorize Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.</p> <p>My signature on this Authorization indicates that I am giving permission for Florida Medical Clinic to communicate with me via the method checked above.</p> <p>I understand Florida Medical Clinic may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers at Florida Medical Clinic.</p> <p>I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic cannot sell or distribute my communication method or information with any third-party without my prior consent.</p> <p>I understand that, by federal law, the Florida Medical Clinic may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic's Notice of Privacy Practices.</p> <p>I hereby release Florida Medical Clinic and its employees from any and all liability that may arise from the release of information as I have directed.</p> <p>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.</p> <p>I understand that I may refuse to sign this Authorization, and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.</p>		
Signature		Date
Print Name:	Signature by: <input type="checkbox"/> Patient <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Proxy <input type="checkbox"/> Legal Representative	



38135 Market Square
Zephyrhills, FL 33542

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

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
Street Address		
City/State		Account #
Phone #	Email Address	
COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS <u>NOT</u> THE PATIENT		
Name of Representative		
Relationship to Patient (parent, health proxy, etc.)		Phone #
Email Address		
I DO NOT WISH FLORIDA MEDICAL CLINIC, LLC TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:		
METHOD	CONTACT INFORMATION	
<input type="checkbox"/> TEXT		
<input type="checkbox"/> EMAIL		
<input type="checkbox"/> VIDEO CONFERENCE		
<p>I understand by revoking the method of communication above and signing below, I revoke Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.</p> <p>I understand Florida Medical Clinic will no longer communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers at Florida Medical Clinic.</p> <p>I understand Florida Medical Clinic, LLC may be required by law to communicate with me about my lab results and other pertinent clinical information.</p> <p>I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic cannot sell or distribute my communication method or information with any third-party without my prior consent.</p> <p>I understand that, by federal law, the Florida Medical Clinic may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic’s Notice of Privacy Practices.</p> <p>I hereby release Florida Medical Clinic and its employees from any and all liability that may arise from the release of information as I have directed.</p> <p>I understand that I have the right to reinstate this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above.</p> <p>I understand that I may refuse to sign this Revocation, and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.</p>		
Signature		Date

Florida Medical Clinic, LLC
Authorization to Verbally Share Protected Health Information

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

I authorize FLORIDA MEDICAL CLINIC to verbally share protected health information with the following persons:

Last Name	First Name	Relationship	Phone #
1.			
2.			
3.			

This includes (please check all areas that apply)

- | | |
|--|--|
| <input type="checkbox"/> All Medical Information
<input type="checkbox"/> Lab Results
<input type="checkbox"/> X-ray Results
<input type="checkbox"/> Medication (Rx Renewal and Pickup)
<input type="checkbox"/> Telephone Consults | <input type="checkbox"/> Hospital Information
<input type="checkbox"/> Insurance Information
<input type="checkbox"/> Dialysis Clinic Information
<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Other (please specify) |
|--|--|

This authorization will be in effect until authorization is revoked.

Patient's Signature _____ Date _____

FMC Personnel _____ Date _____