Family Medicine & Rehab

PATIENT INFORMATION

Date:_____

Patient Name:_____Date of Birth:_____Sex:_____Marital Status:_____

Address:_____City:_____State:____Zip:_____

Home Phone:_____Cell Phone:_____Social Security #:_____

State of Driver's License:_____Driver's License Number:_____

Primary Care Physician:_____Referring Physician:_____

Employer's Name & Address:_____Employer's Phone:_____

Pharmacy Name:_____Pharmacy Phone:_____

Pharmacy Address: _____ City:_____State:_____ Zip:_____

If Patient is Married, Spouse's Name:_____Spouse's Phone#_____

Language: □ English □ Spanish □ Other:_____

Does the patient have health insurance? (Pleasecheck one) Yes___No___

Health Insurance:

Primary Health Insurance Carrier:_____

Policy/ID #:_____ Group #:_____

Policy Holders Name: Date of Birth:_____ Secondary Insurance Carrier(s):_____

Secondary Health Insurance Carrier:_____

Policy/ID #:_____ Group #:_____

Policy Holders Name: Date of Birth:_____ Secondary Insurance Carrier(s):_____

FINANCIAL INFORMATION

Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient and he or she is responsible for payment. We will prepare any necessary forms to assist in making collections from your primary insurance company and will credit such collections to your account. You will also be expected to pay any benefit proceeds from your insurance to this office. However, we cannot render services on the assumption that your charges will be paid solely by your insurance. Most misunderstandings about insurance can be avoided if you understand what yo ur policy provides. Many insurance policies pay according to a schedule of benefits that is based on various criterion. This office charges fees which are reasonable le in th is community. Not all insurance wi ll pay I 00% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees and appellate attorney's fees , whether suit is filed or not. All past due balances will accrue interest at the rate of 1.5 % per month (18% per annum). The patient authorizes the release of any information acquired in the course of treatment as necessary to file insurance claims and for the collection of their account.

Patient:_____**Witness:**_____

Parents or Guarantours:_____

Family Medicine & Rehab

Please List PAST AND CURRENT MEDICAL PROBLEMS

Social History

Do you currently work? Yes____ No_____ What is/was your occupation _____Marital

Status: Married _____ Divorced _____ Single _____ Widowed _____ Number of children: _____

Education _____ Dominate Hand: Right _____ Left _____
Do you use any of the following? Cigarettes _____ Alcohol _____ Cocaine _____ Marijuana _____ Heroin _____
Club Drugs _____Methamphetamine _____Prescription drugs _____Other _____If yes, The last time used: _____

Current Medications: Check here if none ( )

Name of Pain Medication — Dosage

_____ _____

_____ _____

_____ _____

Name of other Medication:

_____ _____

_____ _____

_____ _____

_____

Allergies:

	Yes	No
No Known Drug Allergies	___	___
IV Dye	___	___
Iodine	___	___
Seafood/Shellfish	___	___
Adhesive Tape	___	___
NSAIDS	___	___
Penicillin	___	___

Other ----------

Are you taking any Blood thinner medication Plavix/Clopidogrel, Warfarin, Coumadin, or Effient/Prasurgel or others? Yes-----No----

Pharmacy Name: _____ Pharmacy phone # _____

Pharmacy Address: _____

Medical History: Check here if none ( )

	Yes	No		Yes	No		Yes	No
High blood pressure	___	___	Hepatitis/liver disease	___	___	Phlebitis/blood clots	___	___
Heart disease	___	___	Kidney problems/Stones	___	___	Stomach Ulcer disease	___	___
Heart attack	___	___	Thyroid disease	___	___	Bleeding disorder	___	___
Irregular heart rhythm	___	___	Diabetes	___	___	Asthma	___	___
Stroke	___	___	Osteoporosis	___	___	Emphysema/COPD	___	___
Seizures	___	___	Rheumatoid Arthritis	___	___	Cancer	___	___
Glaucoma	___	___	Depression	___	___	Trauma	___	___
Fibromyalgia	___	___	HIV positive	___	___	Other: _____		

Family Medicine & Rehab

Patient Name:_____ DOB:_____

Surgical History: Check here if none ( )

( ) Low back surgery (Date)_____Surgeon _____

( ) Neck surgery (Date)_____Surgeon _____

( ) Heart surgery ( ) Joint replacement (Which)_____( ) Cancer surgery

( ) Appendix ( ) Hernia ( ) Gallbladder ( ) Hysterectomy ( ) OTHER SURGERY _____

Social History: Right Handed **( )** Left Handed **( )**

Alcohol: ( ) YES ( ) NO ( ) Daily ( ) Few per week ( ) Once per week ( ) Few per month

Illicit Drug Use: ( ) YES ( ) NO ( ) Type _____

Drug/Alcohol treatment? ( ) YES ( ) NO If yes, name of facility:_____Year _____

Past Suicide Attempt? ( )YES ( ) NO If yes when _____

Smoker: ( ) YES ( ) NO # packs daily:_____How many years: _____

Occupation:_____ None( ) Full Time( ) Part time ( ) disabled ( ) Retired ( )

Family History:

Mother ( ) Alive ( ) Deceased Age:_____ Cause/medical conditions:_____

Father ( ) Alive ( ) Deceased Age:_____ Cause/medical conditions: _____

Family Medical Problems ( ) Diabetes ( ) Heart Disease ( ) Cancer (type):_____( ) Other: _____

Review of Systems: (circle all that apply): Pregnant ( ) Yes ( ) No

General: Weight changes, fatigue

HEAD/EYES: Headache, Blurry vision

Lung: Chronic cough, Shortness of breath

ENT: Ears ringing, Sinusitis, Sore throat

Heart: Chest pain, Palpitations

Blood: Anemia, Easy bruising, Bleeding

Abdomen: Heartburn, Nausea, Constipation

Urinary: Blood in urine, Painful urination

Neurology: Stroke, Seizures, Weakness

Psych.: Depression, Anxiety, Sleepproblems

Endocrine: Thyroid problems, Diabetes

Vascular: Leg cramps, Aneurysms Skin: Bruising, rashes, sores

Immunologic: Itching, Frequent colds or infections

I certify that the information given on the Initial Visit Intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this paperwork.

_____ **Date:** _____

Patient/Family/Legal Guardian Signature

Family Medicine & Rehab

CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at **FAMILY MEDICINE & REHAB INC.**

PRIVACY NOTICE ACKNOWLEDGEMENT

During your treatment it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During your treatment, a referral to other services may be necessary.
- During health care operations, we may need a second opinion.
- During the payment process, we may need to release notes and other laboratory results.
- Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the **FAMILY MEDICINE & REHAB NOTICE OF PRIVACY PRACTICES**. I understand that I am responsible for reading this notice and for notifying Family Medicine & Rehab Inc. in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. Family Medicine & Rehab Inc. has the right to revise this notice at any time and will post a copy of the current notice in the office in a visible location at all times. Family Medicine & Rehab Inc. may also provide me with a copy of its most recent notice upon my request.

CONSENT FOR DISCLOSURES

We understand that at times you may need members of your family or friends to contact the office to make inquiries about your health status, diagnosis, treatment options, schedule, reschedule, cancel appointments or to be contacted in the event of an emergency. To do so, please list the person, or persons you are authorizing to make such inquires or changes. Please be advised that we may require them to confirm personal information to verify their authorization, such as your date of birth.

Name:_____Relationship:_____Contact #: _____

Name:_____Relationship:_____Contact #: _____

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone_____.
(Your Initials)

MEDICAID INSURANCE WAIVER

This notice is to inform all patients that we are **only STAYWELL MEDICAID PROVIDERS.** If you decide to seek treatment at Family Medicine & Rehab Inc. **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid insurance),** and that you will be responsible for any portion of your bill that is not covered by any other insurance.

Family Medicine & Rehab

Payment Policy

It is the policy of Family Medicine and Rehab that all services be paid for at the time of visit. We accept Cash, Check, Visa and MasterCard. However, if we have made other arrangements with you the following outlines our billing and collection policy.

Insurance Advance Notice Form

This is a provider notice to the beneficiary regarding the services that may or may not be covered by your insurance company. Medical insurance is for your protection against the cost of medical care. Your insurance policy is a contract between you and your insurance company. There are literally thousands of insurance programs in existence. It is impossible for us to be familiar with all the programs. It is your responsibility to know if our office is covered by your insurance. If our office is not covered by your insurance, upon leaving our office we will supply you with a bill for the services that you received. It is then your responsibility to file the claim with your insurance company. You may contact your insurance company for information on submitting your claim.

If we elect to accept,,,your insurance and file your claim, it does not guarantee that your insurance will pay the claim. You are still .responsible for any unpaid balance. All balances that remain unpaid for a period of 90 (ninety) days or longer will be considered delinquent and turned over to our collection agency.

_____I understand my insurance may not pay for Injections, Drug Screening or Durable Medical Equipment.
_____I understand I may be billed for any other charges not covered by my insurance.

Medicare

Our office accepts assignment on Medicare claims, that we will file your claim with Medicare and accept the approved Medicare rate as our total charge. However, by law we must collect the applicable co-insurance and deductible. If you have a Medicare supplement that Medi-Gaps over, we will file with them for your deductible and co-insurance. If your supplemental policy does not cover the deductible and co-insurance or other non-covered services, Payment for these services will still be your responsibility. Also you may be billed for additional services that are not covered by Medicare, which may include Trigger Point Injections.

_____I understand I have a right to appeal directly to my insurance company, not to Family Medicine and Rehab.

Workers Compensation

We will bill your workers compensation insurance carrier and accept this as payment in full. However, if your worker's compensation carrier denies benefits (such as dete1mination that the injury is not work related), then you will be responsible for any unpaid balance. If you have any questions concerning the payment policy, please feel free to contact Family Medicine and Rehab, Monday-Friday 8:30am to 4:30pm at (904) 771-1116.

Patient/Legal Guardian Signature:_____ **Date:** _____

Family Medicine & Rehab

NOTICE TO ALL PATIENTS REGARDING CANCELLATION POLICY

You MUST give 24-hour advance notice for any appoinment cancellation. No charge will be posted to your account if appointment is canceeled within 24 hours with a valid reason. Failure to inform us 24-hours prior to sheduled appointment will result in a service charge of $25. All future appointments will be cancelled until the fee is paid. I understand that I may be discharged from the care of FMR if I cancel with less than 24 hours notice, or no-show more than 3 times in a 6 month period.

You must call between the hours of 9:00 am and 4:30 pm Monday through Friday and speak to an attendant. Do not leave a message with our answering service.

This policy is enforced with the consideration of all other patients who are currently on the waiting list. Enforcement of this cancellation policy will lead to better overall patient care.

Method of payment: Cash, check, or credit card only. We cannot accept insurance as a mode of payment.

Please sign and date below and a copy of this notice will be kept in your chart.

By signing, you are agreeing to our policy.

Patient Name: _____

Patient Signature: _____

Date: _____

Family Medicine & Rehab

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed - The information covered by this authorization includes:
Patient's entire medical history, mental or physical condition, diagnoses, treatment including psychiatric, drug or alcohol abuse treatment.

Persons Authorized to Use or Disclose Information - Information listed above will be used or disclosed by:
Physicians and Personnel of Family Medicine and Rehab

Persons to Whom Information May be Disclosed:
Please list anyone that Family Medicine and Rehab will be able to release medical information to regarding your care:

1. My referring physician
2. My primary care physician
3. Mental health care provider
4. Spouse
5.
6.

Exp(ration date of Autlwrization
This authorization is effective indefinitely unless revoked or terminated by the patient or the patient's personal representatives.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Family Medicine and Rehab. You should contact the Family Medicine and Rehab Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Overall, by signing this form you are giving Family Medicine and Rehab permission to release or receive your medical records to or from any physician office, hospital, attorney, or any persons name from above you approved us to disclose information to. Your signature confirms that you have received a Notice of Privacy Practices.

_____ _____
Name of Patient (please print) DOB

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative Relationship to Patient

_____
Signature of Family Medicine and Rehab employee confirming that this was explained and signed by patient.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the company.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. FMR may deny your request, in whole or part, if it finds the protected health information:
•Was not created by the company,
• Is not protected health information,
• Is by law not available for your inspection, or
• Is accurate and complete.
If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you' disagree with the decision. The company will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures FMR may have made of your protected health information. This summary does **not** include:
• Disclosures made to you.
• Disclosures to individuals involved with your care.
• Disclosures authorized by you.
• Disclosures made to carry out treatment, payment, and health care operations.
• Disclosures for'.public health.
• Disclosures for health professional regulatory purposes.
·• Disclosures to report abuse of children, adults, or disabled.
• Disclosures prior to January 1, 2013.
This summary **does** include disclosures made for:
• Purposes of res·earch, other than those you authorized in writing.
• Responses to court orders, subpoenas, or warrants.
You may request a summary for not more than a 6-year period from the date of your request.
If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

For Further Information
Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of Florida Medical Pain Management facility where you received the notice.
HIPAA compliance officer: Laura Kohler

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the: Florida Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/telephone 850-245-4141 and with the Secretary of the U.S. Department of Rights and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission 0ccurred. The company will not retaliate against you for filing a complaint.

Effective Date
This Notice of Privacy Practices is effective beginning March, 2008 and updated January 23, 2019, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

Notice of Privacy Practices

Family Medicine and Rehab Duties

Family Medicine and Rehab (FMR) is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how FMR keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the company's legal duties this Notice of Privacy Practices must be given to you. The company is required to follow the terms of the Notice of Privacy Practices currently in effect. FMR may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted at all FMR buildings and will be availableby email upon request.

Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. FMR can act as each of the above business types. This medical information is used by FMR in many ways while performing normal business activities. Your protected health information may be used or disclosed by FMR for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. FMR may use or disclose your health information for case management and services.*

Your information may be used by certain personnel to improve the company's health care operations. The company also may send you appointment reminders, information about treatment options or other health-related benefits and services. Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

• Reporting abuse of children, adults, or disabled persons.
• Investigations related to a missing child.
• Internal investigations and audits by the company.
• Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
• Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
• District medical examiner investigations.
• Court orders, warrants, or subpoenas.
• Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written I authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request FMR to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The company is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. FMR may mail or call you with health care appointment reminders. We will make contact with you m the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

Family Medicine & Rehab

ASSIGNMENT OF BENEFITS

Patient Name: _____SSN: _____

Date of Birth: _____

For treatment provided and other goods and valuable consideration,

I, _____, (Hereinafter Patient) hereby assign all rights and benefits that PATIENT has under any group health, HMO plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay benefits for services and treatment that PATIENT has received or will receive.

This assignment includes but is not limited to, all rights to collect benefits directly from PATIENT'S insurance company or HMO for services and treatment that PATIENT has received and all rights to proceed against PATIENT'S insurance company or HMO in any action including legal suit if for any reason PATIENT'S insurance company or HMO fails to make payments of benefits to which PATIENT is due. This assignment also includes the right to recover attorney's fees and cost for such action brought by the provider as PATIENT'S assignee.

I also authorize the release of any information perinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date:_____

_____ _____

Signature of Policyholder **Witness**

_____

Signature If Other Than Policyholder

Acknowledgment of Receipt of Notice of Privacy Practices

PATIENT:

I certify that I have been offered to receive a copy of the Notice of Privacy Practices and I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information.

***Printed Patient Name: _____ Patient Date of Birth: _____

***Patient Signature: _____ Date: _____

AUTHORIZED PATIENT REPRESENTATIVE:

I certify that I am the authorized representative of the above-mentioned Patient and I have received the Notice of Privacy Practices on behalf of this individual. I had the opportunity to review this document and ask questions to assist me in understanding his/her rights relative to the protection of his/her health information.

Representative Name: _____

Representative Signature: _____

Printed Patient Name: _____

Relationship to Patient: _____

Date: _____

Patient or Representative refused to sign or declined Acknowledgement of Privacy Notice.

***Patient Signature or Representative Signature: _____

***Date: _____

FOR OFFICE USE ONLY:

Witness, Office Personnel Printed Name: _____

Date: _____

Family Medicine & Rehab

OFFICE RULES AND POLICIES

CO-PAYMENTS
Co-payments are due at the time of your visit.
Insurance regulations REQUIRE us to collect co-payment.
Under no circumstance are we able to waive co-payment. If you do not have your co-pay for your visit, your appointment may be re-scheduled.

BOUNCED CHECK
A $25.00 CHARGE WILL BE ASSESSED FOR RETURNED CHECKS.

NO SHOW OR CANCELLATIONS
A $100 (New Consult) or $50 (Follow-up, Procedure) charge will be assessed if you fail to keep your appointment and do not notify the office. Failure to provide 24-hour advance notification for a cancellation or rescheduled appointment will result in a fee charged.
Established Patients: Patient may be discharged from the practice after THREE "NO SHOWS" or CANCELLATIONS occurring within 24 hours.

PHONE CALLS
Patients are limited to a maximum of two phone calls per day. Callbacks from the Hartford Hospital Pain Treatment Center Staff will be returned within 24 hours depending on the urgency of the call.

LANGUAGE
Rude or disrespectful language will not be tolerated.

AGREEMENT
In order to become and continue as a patient of the Hartford Hospital Pain Treatment Center, I understand the rules and policies set by the Practice and agree to abide by set office rules and policies.
Thank you for your consideration.
Printed Name Signature Date

PLEASE SIGN AND BRING THIS WITH YOU TO YOUR FIRST VISIT.

PATIENT NAME: _____ DOB:_____

DATE OF SERVICE:_____