Family Medical Specialists of Florida, PLC

Thank you for choosing Family Medical Specialists of Florida, PLC for your health care needs.

We want to become your One-Stop Medical Home!

We have scheduled time prior to your first appointment to complete a brief, new patient registration. Please have your Driver's License or State ID card available. We will also need to make a copy of your insurance card (or cards) to ensure accurate billing.

PATIENT FORMS | **Completing the ques**tions below will speed the registration process.

Patient's Name:

_____

First M.I. Last

What is your Social Security Number? |___|___|___| – |___|___| – |___|___|___|___|

(We use your SSN to prevent fraud and account duplication.)

What is your marital status? ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

Who is your current employer?

☐ UNEMPLOYED, ☐ CHILD, ☐ STUDENT, ☐ RETIRED, ☐ DISABLED

Phone: |___|___|___| – |___|___|___| – |___|___|___|___|

What is your race?

☐ AFRICAN AMERICAN, ☐ ASIAN, ☐ CAUCASIAN, ☐ HISPANIC, ☐ NATIVE AMERICAN, ☐ NATIVE HAWAIIAN, ☐ PACIFIC ISLANDER, ❍ OTHER? _____

How would you describe your ethnicity?

☐ HISPANIC/LATINO, ☐ NOT HISPANIC/NON-LATINO, ☐ UNKNOWN, ☐ DECLINE

E-mail Address _____

What is your primary language? _____

Is the Patient the primary policy holder on the insurance plan? ◉ YES ❍ NO

If no, please provide us with the following information on the primary policy holder's name:

_____

First M.I. Last

What is the policy holder's date of birth?

___ ___/___ ___/___ ___ ___ ___

What is the policy holder's Social Security Number?

|___|___|___| – |___|___| – |___|___|___|___|

Who is the policy holder's employer? _____

Name of Prior Primary Care Physician? _____

CONSENT FORMS

Patient Name MRN#

I. Consent to Treatment

I consent to the examinations, treatments and procedures that may be performed during my affiliation with Family Medical Specialists of Florida, PLC(FMS). If I am the representative/responsible party for another person or a minor, I also provide such authorization. This will include radiological examinations, laboratory procedures, medical and non-invasive treatments or procedures, or other medical or medically related services rendered to the patient under the general and special instructions of the physicians or allied health provider(s) of Family Medical Specialists of Florida, PLC. Additional informed consent may be required for certain procedures. _____

II. Code of Conduct

I have read and understand FMS's **Patient Code of Conduct**. Requirements: In an effort to provide and maintain a safe and healthy environment for employees, visitors, patients and other occupants I have been informed that unacceptable, disruptive behaviors and/or communications (mail, telephonic, electronic, voicemail) of any form will not be tolerated and/or permitted within FMS facilities. The following behaviors are prohibited and will be resolved as indicated through proper public law enforcement assistance; destruction of property, verbal or gesturing threats and/or implications of violence, possession of any/all weapons, cursing/profanity, physical assault or threats and/or other derogatory verbal or non verbal remarks. No hostile communication or gestures regarding an individuals' race, ethnicity, language or sexuality is permitted within FMS facilities. Appropriate attire, shoes must be worn. Nudity and/or inappropriate exhibition and/or exposure will not be tolerated and removal from the premises will be requested.

Initial _____

III. Electronic Communication

I give my express consent to electronically receive voicemail messages, phone calls (cell phone and landline), text messages, and/or emails regarding my medical treatment and plan at FMS, including, but not limited to: messages reminding me of my appointments, preventative care recommendations, instructions on how to electronically access my summary of care record following my evaluations, and reminders regarding FMS policies and procedures. I realize I may opt out of these messages at any time by following directions contained in the texts, verbal automated messages and/or by calling FMS. I further consent to receive Protected Health Information ("PHI") under the terms of the Health Insurance Portability and Accountability Act ("HIPAA") electronically. Initial _____

By selecting electronic communication, you authorize us to release PHI to you electronically and agree that you are solely responsible and liable for the security of the email address or cell phone number you provide, the security of the device upon which you view the PHI, and the risks inherent in electronic communication. You have the right to designate a different email address or cell phone number at any time, and you should do so if you believe that the address/ phone number you are providing today is no longer secure. You understand that failing to update your e-mail address/phone number may result in a delay or failure of notification of important information and/or the possible release of PHI to an unintended recipient. Initial _____

IV Lifetime Authorization – Medicare Certification for Payment

I certify that the information given by me in applying for payment under Titles XVIII of the Social Security Act (i.e., Medicare) is accurate and correct. I authorize any holder of medical or other information about myself, or the patient I represent to release to the Social Security Administration or its intermediaries or carriers any information or documentation needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my or the represented patient's behalf. I hereby assign the benefits payable for physician services to the physician or organization furnishing the services, and hereby authorize such physician or organization to submit a claim to Medicare for payment. Initial _____

V. Assignment of Insurance or Third Party Benefits

I authorize direct payment to Family Medical Specialists of Florida, PLC(FMS) of any insurance, managed care, self-insured plan, or other third party benefits or state disability benefits otherwise payable to or on behalf of myself or the patient for services rendered, and assign to FMS, for application to patient's account, all such benefits, payable at a rate not to exceed FMS's regular rates and charges. I understand that I, or the patient I represent, will remain responsible for all charges or applicable co-payments not covered in whole or in part by the payor, subject to applicable law. Initial _____

VI. Financial Responsibility Agreement

By signing this agreement, whether as a patient, representative, or guarantor, I fully understand, acknowledge, and agree to each of the following:

- I will be fully financially responsible for any and all services rendered by Family Medical Specialists of Florida, PLC and its staff, **whether covered or not covered** by insurance, an employee benefit program, Medicare, Medicaid, or HMO.
- I agree to pay any additional account balances in full at the time of billing statement receipt
- I agree to pay any additional account balances in full at the time of my next visit even if I have not yet received a billing statement.
- I certify that I have read the foregoing, and I am the patient, guarantor, or the patient's representative duly authorized to execute this Agreement and accept its terms.

_____ ____ ____/____ ____/____ ____ ____ ____

Signature of Patient/Guarantor/Representative Date (MM/DD/YYYY)

_____

Relationship, if not self

NOTICE OF PRIVACY PRACTICES

For **Family Medical Specialists of Florida, PLC**(the "Provider").

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 EFFECTIVE ON SEPTEMBER 6, 2018.

This Notice describes the privacy policies of the Provider, and applies to the physicians, health care professionals, employees, staff and other personnel who provide services at the Provider. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by the terms of this notice. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It is intended to describe the policies that protect medical information relating to your past, present and future medical conditions, health care treatment and payment for that treatment (called "**Protected Health Information**" or "**PHI**"). It does not apply to information that could not reasonably be used to identify you.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

We may use your PHI, or disclose your PHI to others, for a number of different reasons. This notice describes the categories of reasons for using or disclosing your information. For each category, we have provided a brief explanation, and in many cases have provided examples. The examples given do not include all of the specific ways we may use or disclose your PHI. However, any time we use or disclose your PHI, it will be for one of the categories of listed below.

Treatment. We will use your health information to provide you with medical care and services. This means that our employees and staff and others who work under our direct control may read your health information to learn about your medical condition and use it to make decisions about your care. For instance, a medical assistant may read your medical chart in order to care for you properly. We will also give your information to others who need it in order to provide you with medical treatment or services. For instance, we may send your doctor the results of laboratory tests or x-rays we perform.

Payment. We will use your health information, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your health information to prepare a bill. And we may send that bill, and any health information it contains, to your insurance company. We may also disclose some of your health information to companies with whom we contract for payment-related services. We may give information about you to a health plan that pays for your benefits. We will not use or disclose more information for payment purposes than is necessary.

Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our Staff. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. For example, we may disclose your health information to a company that assists us with quality assurance. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

To Business Associates. The Provider may hire third parties that may need your PHI to perform certain services on behalf of the Provider. These third parties are "**Business Associates**" of the Provider. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, the Provider.

Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object. We may also disclose to your personal representatives who have authority to act on your behalf (for example, to parents of minors or to someone with a power of attorney).

Public Health Oversight. We may disclose your health information to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; licensure or disciplinary actions (for example, to investigate complaints against health care providers); inspections; and other activities necessary for appropriate oversight of governmentprograms (for example, to investigate Medicaid fraud).

To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by Medicare or Medicaid.

Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

For Lawsuits and Disputes. We may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. We may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if we have received adequate assurances that the information to be disclosed will be protected.

Specialized Purposes. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security and intelligence purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance). We may disclose PHI to organizations engaged in emergency and disaster relief efforts.

To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Research. We may disclose your health information in connection with medical research projects if allowed under federal and state laws and rules. The Provider may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

Information to Patients. We may use your health information to provide you with additional information. This may include sending you appointment reminders. This may also include giving you information about treatment options or other health-related services that we provide.

YOUR RIGHTS

Authorization. We will ask for your written authorization if we plan to use or disclose your health information for reasons not covered in this notice, including but not limited to uses and disclosures relating to psychotherapy notes, marketing activities, and any sale of your PHI. If you authorize us to use or disclose your health information, you have the right to revoke the authorization at any time. If you want to revoke an authorization, send a written notice to the Privacy Official listed at the end of this notice. You may not revoke an authorization to the extent that we have already given out your information or taken other action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. You must make this request in writing. We will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law. Right to Request Restrictions for Self-Pay Procedures. You have a right to request that we not disclose PHI to health plans because you paid for services or items out of pocket and in full. However, you should be aware that if you choose to use a medical expense reimbursement/flexible spending account (FSA) or a health savings account (HSA) to pay for the health care items or services that you wish to have restricted, those plans will still require you to provide the necessary substantiation of the expenses in order to receive reimbursement.

Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail. If you want us to communicate with you in a special way, you will need to give us details about how to contact you, including a valid alternative address. You also will need to give us information as to how payment will be handled. We may ask you to explain how disclosure of all or part of your health information could put you in danger. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

Access to and Copies of Health Information. You have a right to access certain PHI that we have in our records, which is limited to the medical and billing records, and any other information about you that is used in whole or part to make decisions about you (the “Designated Record Set”). To the extent PHI in your Designated Record Set is maintained electronically, you have a right to request an electronic copy of those records. We may charge a reasonable, cost-based fee for copying, mailing, and transmitting the records, and the cost of any specific media you request, to the extent allowed by state and federal law. To ask to inspect your records, or to receive a copy, send a written request to the Privacy Official listed at the end of this notice. We also have an authorization form for release of information available on our website. Your request should specifically list the information you want copied. We will respond to your request within a reasonable time, but generally no later than 30 days. If we cannot respond to your request within 30 days, an additional 30 days is allowed if we provide you with a written statement of the reason(s) for the delay and the date by which access will be provided. We may deny you access to certain information, such as if we believe it may endanger you or someone else, in which case we will also explain how you may appeal the decision.

Amend Health Information. You have the right to request us to amend health information about you in your Designated Record Set which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your PHI to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must request this list in writing. You must tell us the time period you want the list to cover, which may not exceed the most recent six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures incident to a permitted use or disclosure;

disclosures as part of a limited data set; disclosures to your family members, other relatives, or friends who are involved in your care or who otherwise need to be notified of your location, general condition, or death; disclosures for national security purposes; certain disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you or your representatives.

Right to Notification of Breach of Unsecured PHI. We will comply with the requirements of HIPAA and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if we or a business associate discover a breach of unsecured PHI.

State Rights More Stringent Than HIPAA. In certain instances, protections afforded under applicable state law may be more stringent than those provided by HIPAA and are therefore not preempted. For instance, certain records pertaining to substance abuse records are subject to more stringent protections pursuant to Section 397.501(7) F.S., and certain mental health records are protected under Section 394.4615(2) F.S. Disclosures of such records (i.e., if subpoenaed) typically require consent of the patient or a court order.

Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the privacy official listed at the end of this notice.

Complaints. You have a right to complain if you think your privacy has been violated. We encourage you to contact our Privacy Official if you have a complaint, or question how your PHI is being used or disclosed. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

OUR RIGHT TO CHANGE THIS NOTICE.

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. We will post the new notice in our office, and make copies available upon request. The new notice will include an effective date. A copy of the latest version of this notice will also be maintained on our website.

CONTACT THE PRIVACY OFFICER FOR MORE INFORMATION

If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at:

HIPAA Privacy Official
Family Medical Specialists of Florida,
PLC
1703 Thonotosassa Rd, Suite A
Plant City, Florida 33563
813-567-5679
Website: www.fmsflorida.com

Financial Policies Of Family Medical Specialists of Florida, PLC

Thank you for entrusting FMS to serve your health care needs! Please review our financial policies carefully. Should you have any questions, please allow us to assist you by calling **Patient Financial Services** at **813-567-5679**.

How should I prepare for a visit?

- Plan to arrive at least 15 minutes prior to your visit for check in and registration. (if you are new patient, please arrive 60 minutes early)
- Be prepared to present your up-to-date insurance card(s) at every visit.
- Have a means of paying for any balance that is the patient's responsibility (including co-pays, deductibles, or previous account balances).

For our patient's safety we will:
Always verify, the patient by full name, date of birth and/or patient's address.
Patient check in will ask for your ID and insurance card, on each visit.

Who is financially responsible for my bill?

- Most patients have health insurance but this is a contract between you and your insurer.
- We are pleased to file claims with your insurance company but **you** are personally financially responsible for health care services provided to you by Family Medical Specialists of Florida, PLC and its staff.

If I Have Insurance, Why Do I Have a Bill?

- Family Medical Specialists of Florida, PLC(FMS) will make an effort to advise you about services we provide for which you may be financially responsible.
- However, it is possible that your insurance will not cover all services recommended.
- Additionally, even when covered, we cannot guarantee that you will not have significant personal financial responsibility due to deductibles, co-payments, and co-insurance.
- **If your insurer does not pay your claim within 60 days of its submission, FMS will seek and expect payment directly from you since you are personally financially responsible for health care services provided to you by FMS and its staff.**
- Further discussion with the insurer becomes your responsibility.

When am I supposed to pay my bill?

- Payment of out-of-pocket expenses is expected at time of service, including:
  - Co-payments
  - Outstanding/current balance
  - Payment for services not covered by your insurance
- Be prepared to make co-payments prior to your visit.
- Additionally, we may request payment of deductibles, co-payments, and/or co-insurance for expensive testing prior to scheduling for some services.

How do I know if my services will be covered by insurance?

- All services are recommended based on medical need (not insurance coverage).
- We will attempt to verify your insurance eligibility, benefits coverage, and even pre-certify services when necessary. We will try to make you aware of our findings.
- If you have any questions about insurance coverage, please get them answered **BEFORE** having services provided

What if I don't have insurance or my coverage cannot be verified?

A deposit will be collected **prior** to services being provided if you are:

- Not insured or insurance eligibility cannot be verified
- Insured by a plan that has a high deductible
- Insured by a plan that does not list Family Medical Specialists of Florida, PLC as a participating provider

What if I have an outstanding balance?

- We will collect any account balance that is the patient's responsibility at the time of check in for the next visit **(even if a statement has not yet been sent or received)**.
- We are happy to schedule future visits or testing once an outstanding balance is paid or arrangements are made with Patient Financial Services.

How can I pay for my account balance?

- We gladly accept cash, major credit cards, debit cards, personal checks, and traveler's checks.

What about minors?

- The parent or guardian accompanying a minor is responsible for all out-of-pocket expenses at the time of service. This policy includes fees for office visits, laboratory and diagnostic services.

What about insurance payment delays?

- Family Medical Specialists of Florida, PLC partners with its patients to resolve insurance payment delays.
- If your insurance company delays payment beyond 60 days, we may request that you contact your insurance company directly.
- We are pleased to file claims with your insurance company but you are personally financially responsible for health care services provided to you by Family Medical Specialists of Florida, PLC and its staff.

I'm on Medicare. Is there more I should know?

- That I am responsible for my yearly Medicare deductible.
- Medicare covers 80% of the approved charges after the deductible has been met.
- Most covered laboratory services (except pathology) will be paid in full by Medicare.

What about Medicare supplemental coverage (secondary insurance)?

- Supplemental insurance may cover a portion of what is not covered by Medicare.
- If you do not have supplemental insurance, the 20% not covered by Medicare becomes your responsibility.
- Medicare will automatically forward claims to your carrier if there is Medigap or crossover supplemental coverage.
- In other situations, Family Medical Specialists of Florida, PLC will be happy to file your secondary claim.
- **Important Note:** If the supplemental carrier has not paid your claim within 60 days of the original claim submission to Medicare, **Family Medical Specialists of Florida, PLC will seek and expect payment from you since you are personally financially responsible for health care services provided to you by Family Medical Specialists of Florida, PLC and its staff.** Further discussions with the supplemental carrier become your responsibility.

Additional Important Medicare Facts:

- Medicare has many specific coverage limitations for diagnostic services including:
  - the reason for which a service is being performed (e.g., the diagnosis)
  - how many times a service may be provided within a given period of time.
- If a service is not covered by Medicare, you will be asked to read and sign an Advance Beneficiary Notice (ABN) which explains Medicare payment restrictions.
- By signing the ABN (waiver), you assume financial responsibility in the event Medicare denies payment.
- Certain non-covered services do not require pre-notification or ABN, including screening exams, preventive medicine services, eye refraction
- Please check with Medicare or speak with one of our representatives for questions.

Will I receive a billing statement in the mail?

- We mail billing statements on a regular basis. You are personally responsible for any account balance at the time of your next clinic visit or upon receipt of the billing statement.

What if I receive a collection letter?

- If you receive a collection letter, the most important thing you can do is pay the bill or **call us** right away so we can assist you with any questions or in setting up payment arrangements.

Can a patient be released from FMS for non-payment?

- Yes, we terminate patients who do not pay their bills.
- All balances not paid within 90 days may be placed with an outside collection agency.
- Patients who have accounts placed with a collection agency will no longer be seen by FMS.
- Reinstatement is sometimes possible but you must speak with a representative in our front office (813-567-5679).

What if I "bounce" a check intended to pay my bill at Family Medical Specialists of Florida, PLC?

- This is a serious issue because we have no way of knowing if it is unintentional or the result of check fraud.
- Returned checks are subject to a $35.00 charge.
- If you receive notification of a returned check, you must contact us immediately.
- If we have not been contacted by you within 14 days, we will notify the legal authorities regarding the occurrence.

A Word about Preventive Visits, Routine Physical Exams, and Testing

- This has been an ongoing source of confusion and we want to improve your understanding of this situation.
- The "yearly physical" or "preventive medicine visit" is covered by some insurance plans, but not by all (it is NOT covered by Medicare).
- Medicare only pays for an initial preventive physical exam upon initial enrollment (after meeting the deductible).
- Health care providers are **required by law** to accurately list the reason for a visit.
- If the purpose of your visit is for a yearly physical, the doctor must list the visit as "preventive medicine." If your insurance does not cover it, you will be fully responsible for payment.
- If during a routine physical exam, your provider also evaluates a known chronic medical condition or new medical complaint, we also have to list this as a separate reason for the visit. Not surprisingly, this may result in another charge.
- This is a part of the classification method developed by the federal government that we are **required by law** to follow.
- Our health care providers are sensitive to financial concerns. However, they base their medical decisions on what is best for you without consideration of insurance coverage. Therefore, please consider their advice and recommendations carefully.

Should you have any questions, please allow us to assist you by:

- **Calling Patient Financial Services(CHMB) at 1-844-365-9740**

TO ALL PATIENTS AND IN COMPLIANCE WITH FLORIDA STATUTE 408.810(5)(b):

To report a complaint regarding the services you receive, please call toll-free (1-800-962-2873).

To report abuse, neglect, or exploitation, please call toll-free (1-888-419-3456).

To report suspected Medicaid Fraud, please call toll-free (1-866-966-7226).

LIST OF MEDICATIONS

Patient Name | Date | Clinic#

Please List All Medications Including Prescribed, Over-the-Counter, Vitamins, And Herbal Remedies

Medication Name	**Dosage**	**How Taken**
Example: Lasik	*40 mg*	*Once in morning*

Any known allergies?

MISSED APPOINTMENT POLICY

Family Medical Specialists of Florida, PLC

We are here for you! Don't miss your appointment!

Thank you for entrusting us with your healthcare.

When you schedule an appointment, time is reserved specifically for you. Missing your scheduled appointment makes other wait longer for care. Family Medical Specialists of Florida, PLC will charge you for appointment "no shows."

Our 24-hour a day, 7 days a week cancellation line is 813-567-5679.

- **First time: We will call you to reschedule and will expect payment of the no-show fee ($250.00 new patients or any Diagnostic Testing and $50.00 existing patients).**
- **Second time:** We will call you to reschedule and you will be sent a second missed appointment letter. You will be charged $50.00 for established patient office visits or $250.00 for diagnostic testing.
- **Third time:** This could result in discharge from our practice and a $50.00 fee for established patient office visits or $250.00 for diagnostic testing.

Our main concern is to provide you and others easy access to superior health care.

If you have questions, our staff will be happy to answer them.

I _____ understand the missed appointment policy.

Signature _____

Medical Record Number _____

Date _____

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

Client # _____ Date of Birth ___ ___/___ ___/___ ___ ___ ___

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

FMS is committed to protecting the privacy and security of your health information. With your written permission, FMS staff may disclose (discuss) your health information with family members, other relatives, or other person(s) you identify below, when the health information is directly relevant to that person's involvement with your care. I understand that such person(s) will not have access to my written health records.

I, _____, authorize the release of verbal health information regarding my treatment and care to the following individuals.

Name	Relationship	Contact Number(s)

This form may be revoked at any time upon my written request to the Family Medical Specialists of Florida, PLC. If I refuse to sign this form, my information will not be released verbally except as required by law. I agree to hold the Family Medical Specialists of Florida, PLC harmless and release them from any liability for any claims or actions, which may occur as a result of the release of information. We will not condition treatment on the completion of the form.

Signature: _____ Date: _____

Print Name: _____

If signed by Representative, Description of Relationship to Patient and Authority: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the FMS's Notice of Privacy Practices

_____ ___ ___/___ ___/___ ___ ___ ___
Signature of Patient Date

_____
Print Name of Patient

_____ ___ ___/___ ___/___ ___ ___ ___
Signature of Patient Representative Date

_____ _____
Print Name of Patient Representative Relationship to Patient
(Required if the patient is a minor or an adult who is unable to sign this form)

OFFICE USE ONLY — SCAN THIS SIDE ONLY