Male Patient Registration

Patient Name: _____ DOB _____ SS#_____

Gender: M F Race: _____ Marital Status: S M W Sep D

Religious Affiliation: _____ Email: _____

Ethnicity: Hispanic Non-Hispanic Other

Legal Parent or Guardian if a minor: _____

Street Address: _____ City:_____ Zip:_____

Mailing Address: _____ City:_____ Zip:_____

Home Phone: _____ Work: _____ Cell:_____ Other:_____

How did you hear about our office? ____ Friend _____ Newspaper _____ Internet _____ Other

Preferred Pharmacy: _____

Account Information

Responsible Party: _____ Relationship to Patient:_____

Address if different than above: _____ City: _____ Zip:_____

Driver's License# _____ SS#_____ DOB:_____

Home Phone: _____ Work:_____ Employer:_____

Insurance Company Name: _____ Phone: _____

Member ID# _____ Group# _____

Policy Holder Name: _____ DOB:_____ SS#:_____

Medicaid #: _____ Medicare #: _____

Secondary insurance information: _____

Emergency Contact: (must have different contact number other than patient's phone number)

Name: _____ Relationship to patient: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip:_____

Authority to Treat (please initial the appropriate statements)

_____ I hereby authorize Heart 2 Heart Family Practice to treat, perform and/or order such diagnostic, laboratory, medical, surgical and x-ray procedures as are necessary in the provider's judgement for my care or the care of my child.

_____ I am legally responsible for the above-named patient now and in the future when the child is brought in for care.

_____ I permit a copy of this authorization to be used in place of an original and such document will remain in effect until revoked by me in writing.

Patient/Parent Signature: _____ Date: _____

No-Show Policy

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Heart 2 Heart defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 15 minutes late and is consequently unable to be seen.

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-show" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient.
- Is unfair (and frustrating) to other patients that would have taken the appointment.
- Disrespects not only the provider's time, but also the time of the entire practice staff.

How to Avoid Getting a "No-Show"

- Confirm your appointment.
- Arrive 5-10 minutes early.
- Give 24 hours' notice to cancel appointment.

1. Appointment Confirmation

Our automated health record will send an email 1 week prior to your appt. It will also send a text message 3 days before your appointment.

- ❖ Heart 2 Heart staff will also contact you one business day prior to your scheduled appointment to confirm your visit.
- ❖ If we are unable to speak with you, we will leave a message. To cancel an appointment, you will need to contact Heart 2 Heart by 2:30pm the business day before the appointment — otherwise the appointment will be considered a "no-show".

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider.
2. If you are not dismissed and need an appt., you will have to call in and be seen as the schedule allows as a sick visit. You will not be able to reserve an appt. Only emergency medical treatment will be offered within the first 30 days of dismissal.

_____ _____

Patient Signature Date

I have read and understood the Heart 2 Heart Family Practice "No Show" Policy as described above.

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Pledge of Patient Responsibility

Thank you for choosing Heart 2 Heart Family Practice, PA as your healthcare provider. We are committed to fulfilling our responsibilities in your successful treatment. However, for our relationship to be successful, it is important that you understand your responsibilities as a patient. They are as follows:

Patient Responsibilities

1. You need to keep your appointment, however if for some reason you cannot, it is your responsibly to give a minimum of forty-eight (48) hours' notice. Repeated failure to give appropriate notice could result in your provider discharging you from care.
2. It is your responsibility to pay patient co-pays, deductible and other appropriate fees at the service. Failure to pay in a prompt fashion could result in charging of interest. If charged interest it is your responsibility to pay it promptly.
3. It is your responsibility to follow the treatment plan established by your provider. This means going to appointments for test, consults, attending recommended therapies and doing home activities that have been recommended for you.
4. Prescription medicine may be a part of your treatment. It is your responsibility to follow instructions closely. No early refills in narcotics will be provided. Prescriptions can only be refilled during work days, Monday through Friday 9AM to 4PM.

I pledge to fulfill my responsibilities as a patient.

Signature:_____ Date:_____

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

General Consent part 1

Heart 2 Heart Family Practice, PA is intended as an alternative approach to Childbearing, Primary care, well women and well man and well child care, in a small rural area where few services are available. It may appeal to and be desired by some people and not others. For this reason, we feel that you must be fully informed of our scope of services and limitations to more traditional physician services.

As our patient we require that you participate in orientation procedures generally performed on your first visit which includes but are not limited to 1. Your personal inspection of the facility. 2. Services, methods and procedures related to your healthcare. 3. Mutual expectations. 4. A discussion about recommendations and alternatives available to you or your child with regards to health decisions and lifestyle choices that affect your health. 5. Potential risks to the patients, childbearing couple and child that pertain to your personal history and circumstance and procedure for management of complications.

We have taken every reasonable precaution to ensure the safety, comfort and satisfaction of our essentially healthy client population that we service in this practice. We are not however a hospital and do not have extensive lifesaving equipment of highly specialized services that are needed in some crisis or emergencies that arise when people seek medical care. Basic lifesaving equipment and techniques will be used, and we will transfer all emergencies via 911 Ambulance to the nearest hospital.

Should consultation, referral or hospitalization become necessary during your care we will inform you in a timely manner of your options and make all of your records available to the referring physician and/or hospital. After your specialized care needs are met, you may return to us for continued healthcare management as long as you desire to do so and as long as your medical condition is stable.

It is the philosophy of this practice that whatever possible decisions about your health care are needed they will be made as a result of consultation with you the patient or patient's guardian. Do not hesitate at any time to ask questions you have about the practice and its services or functions as well as anything that concerns you, your child or your family. Continued enrollment in the practice is determined by your desire to work together with the clinical staff toward optimal health and your appropriateness as our patient. If the provider feels your care is more appropriate with another practice you will be informed, and the staff will help you to find care with a practice more appropriate for your healthcare needs.

I have read and agree with the above statements and have had opportunity to ask questions.

_____ _____

Patient/Guardian Signature Date

Financial Polices & Lifetime Authorization

1. **Release of Information** I, the below named patient or guardian do herby authorize any provider examining and/or treating me to release any third party, such as an insurance company or governmental agency, medical records generated at Heart 2 Heart Family Practice, PA related to diagnosis and treatment when such information is requested by such third party for its use in determining a claim for payment for such treatment and or diagnosis.

2. **Physician Insurance Assignment**: I, the below named patient or guardian herby authorize payment directly to ay provider examining and/or treating me for medical and/or surgical benefits herein specified and otherwise payable to me for their service as described.

3. **Medicare/Medicaid:** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Administration/Division of Family Services or its intermediaries any information needed to determine a Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the provider treating me. I also understand that certain procedures or injections may not be covered by my policy and therefore I will be responsible for payment for these services.

4. I permit a copy of these authorizations and assignment to be used in pace of the original which is on file at the provider's office. This assignment will remain in effect until revoked by me in writing.

5. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full at the time of service unless other arrangements are made in advance with the office.

6. I hereby assign all Medicaid and/or surgical benefits to include major medical benefits to wish I am entitled (Medicare, Medicaid, Private Insurance or other health plans) to Heart 2 Heart Family Practice, PA for payment for services rendered to me by its providers.

7. I request that payments of authorized Medigap benefits be made on my behalf to Heart 2 Heart Family Practice, PA for services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payables for related services.

You are responsible for any balances due for services rendered. We can only estimate insurance benefits and will file the insurance claims as a courtesy to our patients**. It is my responsibility to know my insurance yearly maximums, copays, and deductibles.** You are financially responsible for all charges not paid by your insurance company. You are financially responsible for any claims not paid by your insurance company within 90days.

Sliding fee Scale: Our office offers a sliding fee scale to those who qualify for a discount on services. Applications for this are available at the front office. Applications must be updated every six months.

Service Charge: A service charge of 1.5% per month will be charged unless prior arrangements have been made. Patient/Guardian understands that if this account is placed with a collection agency that he/she will be responsible for any collections and/or attorney's fees, plus costs.

Patient/Guardian Signature _____ Date _____

Signature of Guarantor if different than above: _____

Patient Consent For use and Disclosure of Protected Health Information

I allow Heart 2 Heart Family Practice, PA to use and disclose my protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Heart 2 Heart Family Practice, PA have the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy officer at 1326 SR 100, Melrose FL 32666.

Heart 2 Heart Family Practice, PA may call my home or other designed locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as but not limited to: appointment reminders, insurance items, clinical care, lab or clinical results etc.

Heart 2 Heart Family Practice, PA may mail to my home or other designated locations any items that assist the practice in carrying out TPO such as but limited to: appointment reminder cards and patient statements.

I have to right to request the restriction or disclosures of my Personal Health Information in an effort to carry out my treatment, payment and healthcare operations. However, I understand that the practice is not required to agree to my request but will comply to my request to best of its ability.

I have received a copy of Heart 2 Heart Family Practice, PA Privacy Practice Notice for my records.

By signing this for, I am consenting to Heart 2 Heart Family Practice, PA use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Please restrict the use of my records as follows:_____

_____

_____ _____

Signature Date

_____ _____

Patient's Name Date of Birth

_____ _____

Legal Guardian Date

1326 SR 100 Melrose, Florida 32666

Phone 386-659-2104 – Fax 386-659-2196

Authorization for use or disclosure of protected health information

Date:_____ Name: _____

DOB:_____ Social Security # _____

Purpose of disclosure

Specific items requested: _____

Purpose of release: _____ Changing physician _____ Consult/2nd Opinion ____ Legal _____ School

_____Insurance ____ Continuing Care _____ Other

1. I understand that this authorization will expire one (1) year or until after I revoke it in writing.

2. I understand that I may revoke this authorization at any time by notifying the Heart 2 Heart Family Practice, PA staff in writing and it will become effective the date the notification was received.

3. I understand the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by Federal Privacy regulations

_____ _____ _____ _____

Patient's Signature Date Parent/Guardian Signature Date

Patient Declines to request any previous medical records.

_____ _____ _____ _____

Patient's Signature Date Parent/Guardian Signature Date

_____

Previous Doctor or Practice Name: _____

Previous Doctor's Address: _____

Previous Doctor's Phone#: _____ Fax#_____