REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION					
Patient's Last Name:	First:	M.I.:	Previous Name (If Applicable):		
			Miss. Mr. Ms. Mrs.		
Mailing Address: Apt. #			Zip Code:	City:	
				State:	
Home Phone:	Cell Phone:		Work Phone:		Ext:
Primary Care Physician:	Date of Birth: ____/______/_______ M D Y		Sex: M F T Other:	Marital Status: S M D Other:	
Employer:			Social Security Number:	Part Time Full Time	
				Student? Yes No	
Responsible Party: Self Other	Name (If Other)			Date of Birth: _____/_______/_______ M D Y	
	Address:			Phone #:	
Emergency Contact Name:			Relationship to Patient:		
			Cell Phone:		
Address:			Work Phone:		

INSURANCE INFORMATION				
Primary Insurance Company:	Effective Date: _____/_______/_______ M D Y		Policy no.:	
			Group no.:	
Insured Name:	Relationship to Patient:		Co-payment:	
Home Address (If different from mailing address):	Zip Code:		City:	
			State:	
Advance Directive: Yes No		Email:		
Best number to leave you a message: Home Cell Work Other Ph. number:			Mail Order Member ID:	
Race (Select One): American African Black Asian White Hispanic Native Hawaiian Pacific Islander Other Refuse to Respond			Ethnicity (Select One): Hispanic or Latin Not Hispanic or Latin Refused to Respond	
Language (Select One): English Spanish Creole Indian (Incl. Hindi & Tamil) Sign Language Russian Other Refuse to Respond	Employer:			
	Employer Address:			
City:	State:			Zip Code:

ORLANDO FAMILY PHYSICIANS

Secondary insurance (If applicable):		Subscriber's Name:
Policy no:	Group no.:	Preferred Pharmacy:
Address:		City:
State:	Zip Code:	Phone no.: Fax no.:
How did you hear about us: Doctor Insurance Plan Hospital Family/ Friend Location Health Fair Flyer TV Radio Press Other		Other family members seen here?: Yes No relationship to Patient: name:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Orlando Family Physicians for as long as I continue to receive services from them. If were to receive any checks (payments) intended as payment for services rendered by Orlando family physicians from Medicare or other insurance company (ies), will immediately endorse them and turn over to Orlando Family Physicians, Inc. for service rendered. Understand that I am financially responsible for any balance. Also, authorize Orlando Family Physicians, Inc. or insurance company to release any information required to process my claims.

I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare or other insurance company claim. Permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or to the party that accepts assignment. I understand that it is mandatory to notify the healthcare provider of any other party that may be responsible for paying for my treatment (Section 1128B of the social security act and 31 U.S.C. 38/01-3812 provides penalties for withholding this information.)

____ ______/_____________/____________

Parent / Guardian Signature **M** **D** **Y**

Date

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION AND ACKNOWLEDGEMENT OF NOTICE OF HEALTH INFORMATION PRIVACY POLICY.

Florida State Law guarantees that I have both the right and obligation to make decisions concerning my health care. Your physician can provide you with the necessary information and advice, but as a member of the health team, you must enter into the decision process. This form has been designed to acknowledge your acceptance of treatment as recommended by your physician.

Further acknowledge that I will have full opportunity to discuss this information with my physician and hereby consent to medical care/treatment and the release of pharmacy history. Also, acknowledge that the purpose of care, reasonable alternative forms of therapy; risks of the recommended and alternative care and the risks of foregoing care will be explained to me.

I hereby consent and authorize my physician and any of the health professionals as designated to perform examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless explicitly refuse, I consent that the diagnostic test (s), treatment (s), procedure (s), contraceptive method (s) and immunizations ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered. I understand that must tell the staff if language interpreter services are necessary for my understanding of the written and spoken information during my health care visits. I also, understand that interpretive services may not be immediately available. No guarantee has been given to me about the results of any of the services that I receive. I understand that if tests for certain sexually transmitted and other diseases are positive, report of positive results to public health agencies is required by law will be given referrals for further diagnoses and treatment if necessary.

I authorize Orlando Family Physicians to release/discuss my health information, either by phone or in person or via secure electronic format, with:

Name	Relationship	Cell Phone	Address
Name	**Relationship**	**Cell Phone**	**Address**
Name	**Relationship**	**Cell Phone**	**Address**

I may request and obtain a copy of this form. I have read, understand and agree with this entire form and I acknowledge I have read, understand and agree to the Notice of Health Information Privacy Policy of the Orlando Family Physicians.

Name of Patient or Guardian or Legal representative	Relationship	Signature	Date

I witness the fact that the patient received the above-mentioned information and said that he/she read and understood and had the chance to ask questions.

ORLANDO
FAMILY PHYSICIANS

Bill of Right

Dear Patient:

It is our obligation as a healthcare facility to inform you that you have the right to contact these toll-free numbers to report if you have any complains, abuse, neglect or exploitative practices.
Complaints: To report a complaint regarding the services you receive please call toll-free 1-888-419-3456 or visit ahca.myflorida.com/contact/call_center.shtml.Abuse, neglect or exploitative practices: To report abuse, neglect or exploitation, please call toll-free 1-800-96-ABUSE (962-2873)

Patient Printed Name: ___________________________

Patient Signature: ___________________________

Date: _______/_______/___________

M D Y

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that have been provided the Orlando Family Physicians Notice of Privacy Practice ("Notice")

- It tells me how Orlando Family Physicians will use my health information for the purpose of my treatment, payment for my treatment, and Orlando Family Physicians health care operations.
- The Notice explains in more detail how Orlando Family Physicians may use and share my health information for other than treatment, payment, and health care operations.
- Orlando Family Physicians will also use and share my health information as required/permitted by law.
- If I am a patient of Orlando Family Physician receiving health services, I consent to Orlando Family Physician using and disclosing my treatment and education records maintained by Orlando Family Physicians for the purposes detailed in the Orlando Family Physicians Notice of Privacy Practices.

____

Complete Patient legal Name: (Please Print)

_____/_______/________

M D Y

Patient's DOB:

____

Signature: (Patient or legal representative*)

* May be requested to show proof of representative status.
* File in Patient Chart.
* HIPAA Document.
* Retain for minimum of 6 years.

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION				
Patient's Last Name:	First:	Middle:	Previous Name (If Applicable):	
			Miss. Mr. Ms. Mrs.	
Mailing Address: Apt. #		Zip Code:	City:	
			State:	
Home Phone:	Cell Phone:		Work Phone:	Ext:
Date of Bith: / / .		Social Security Number:		

I, ____Hereby authorize Orlando Family Physicians at:

21 S. Charles Richard Beall Blvd. Debary, FL 32713. Ph. 386-516-0930 Fax. 386-668-6897	1130 S. Semoran Blvd., Ste. C, Orlando, FL 32807. Ph. 407-382-1376 Fax. 321-235-3232	790 Buenaventura Blvd., Kissimmee, FL 34743. Ph.407-344-9959 Fax. 407-344-9971
659 Douglas Ave., Altamonte Springs, FL 32714 Ph. 407-274-9777 Fax. 407-637-5114	7200 Curry Ford Rd., Orlando, FL 32822. Ph. 407-587-7552 Fax. 407-757-0483	1502 Village Oak Lane, Kissimmee, FL 34746 Ph. 4077-520-3588 Fax. 407-978-6756
829 Douglas Ave. Altamonte Springs, FL 32714 Ph. 407-3320003 Fax. 407-2957928	3162 S. Conway Rd., Unit 3, Orlando, FL 32812. Ph. 407-627-0056 Fax. 407-237-0355	910 W. Vine St., Kissimmee, FL 34741 Ph. 407-956-1920 Fax. 407-493-5844
1834 North Alafaya Trail, Orlando, FL 32826 Ph. 407-627-0062 Fax. 407-674-7346	5979 Vineland Rd., Ste. 209, Orlando, FL 32819. Ph. 407-627-0066 Fax. 407-440-4054	1931 S. Narcoossee Rd., St. Cloud, FL 34771 Ph. 407-986-9642 Fax. 407-593-6102
810 N. Nowell St., Orlando, FL 32808 Ph. 407-290-9556 Fax. 407-290-9509	5840 W. Colonial Dr., Orlando, FL 32808 Ph. 407-720-7302 Fax. 407-293-1355	920 N. John Young Parkway, Kissimmee, FL 34741. Ph. /Fax.
		121 S Orange Avenue Ste 940 Orlando, FL 32801. Ph. 407-685-9687 Fax: 407-658-9688

Release Copies of ALL Medical Records To: ____

Obtain ALL Medical Records From: ____

PURPOSE OF RELEASE				
Continuity of care	Copies for own use	Transfer to another provider	Legal	Other
SIGNATURE OF PATIENT OR REPRESENTATIVE				
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, must do so in writing. I understand that the revocation will NOT apply to insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that any disclosure of information carries with it the potential for any unauthorized disclosure and information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health insurance, I can contact the privacy office at (407) 477-5555. The facility, its employees, officers and physicians are hereby released from any legal responsibility of liability of the above information to the extent indicated and authorized herein. I also understand that this authorization expires within 1 (One) year of signature.				

Advanced Directives

What are Advanced Directives?
Advanced Directives is a general term that refers to your oral or written instructions about your future medical care in the event you are unable to speak or make decisions for yourself.

What is a Living Will?
A Living Will is a form of advance directive in which you put in writing your wishes about medical treatment at the event you become unable to communicate your wishes.

What is a Medical Power of Attorney?
A Medical Power of Attorney is a document that lets you appoint someone you must to make decisions about your medical care if are unable to those decisions for yourself.

Why do I need an Advanced Directive?
Advance Directives you a voice in decisions about the medical care you receive when you are unconscious or too ill to communicate. As long as you are able to communicate your own decisions your advanced directives will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

What happens if I do not have an Advance Directive?
In the event that you cannot speak and make decisions for yourself, someone not of your choice or may make health and medical decisions by the court.

Once I make an Advance Directive, can I cancel it?
Yes, your advance directive can be canceled or revoked in writing by you at any time.

Who should I talk about Advanced Directives?
Your Orlando Family Physicians Primary Care is the best person to answer any additional questions you might have. Your doctor has the knowledge and cares about you to put your concerns at ease. All the necessary paperwork and information is available at your Primary Care Center.

Living Will

Declaration made this day __________________________ of _________________________, 20 ____________,

I ____willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time, I am mentally or physically incapacitated and

_____(Initial) I have a terminal condition or

_____(Initial) I have an end-stage condition or

_____(Initial) I am in a persistent vegetative state.

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do____ I do not _____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal honor this declaration.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ____

Street Address ____

City ______________________ **State** ___________________________ **Zip Code** _______________

Phone #________________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):____

____

(Signed) ______________________________________

Witness

____

Street Address

____

City _______________ **State** _________________

Zip Code___________________

Phone# _______________________________

Witness

____

Street Address

____

City ______________ **State** _________________

Zip Code __________________

Phone# _____________________________

At least one witness must not be a husband or wife or a blood relative of the principal. Definitions for terms on the Living Will form. Definitions for terms on the Living Will form:

"End-stage conditioning' means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

"Persistent vegetative stat" means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment. Terminal condition' means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statues can be found in your local library or only at www.leg.state.fl.us

No Show Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows delay the delivery of health care to other patients, some who are quite ill.

A "no show" is missing a scheduled appointment or not contacting us to cancel 24 hours in advance of an office visit.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A charge of $25.00 will be assessed for each no-show office visit appointment if less than 24 hours' notice is given.

Please understand that insurance companies consider this charge to be entirely patient's responsibility.

Patient Name: ________________________________ **Date:** ____________________________

Patient Signature: _____________________________