ORLANDO FAMILY PHYSICIANS

| OFFICE USE ONLY | |
|---|---|
| Today's Date: | |
| Reviewed By: | |
| Uploaded to EMR Date: | |

## PATIENT INFORMATION

❑ *New Patient* ❑ *Established Patient*

Patient's First Name: | Middle Name: | Last Name: | Social Security #:

Date of Birth: / / (mm) (dd) (yyyy)

Sex: ❑ Male ❑ Female ❑ Trans ❑ Unknown

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widowed ❑ Unknown

Employment Status: ❑ Employed ❑ Retired ❑ Student ❑ Disabled ❑ Not-Employed

Employer Name:

Your Address: | City: | State: | Zip Code:

Race: ❑ White ❑Hispanic ❑ Asian ❑ American Indian /Alaska Nat. ❑ Black/African American ❑ Nat.Hawaiian/Othr Pac Islander ❑Other ❑Decline

Ethnicity: ❑ Non-Hispanic/Latino ❑ Hispanic/Latino ❑ Decline

Language: ❑ English ❑ Spanish ❑ Other:

Primary Phone#: ❑ Cell ❑ Work ❑Home ( )

Alternate Phone#: ❑ Cell ❑ Work ❑ Home ( )

Email Address:

Previous Physician Name:

Primary Physician Name:

How did you hear about our office? ❑ TV ❑ Radio ❑ Patient Referral ❑ Flyer ❑ Insurance ❑ Internet ❑ Health Fairs ❑ Post Cards ❑ Walk-In

**Preferred Pharmacy Name:** | Phone #: ( ) | Address: | City: | State: | Zip Code:

## RESPONSIBLE PARTY

Person Financially Responsible [Guarantor]:
❑ Self Only→Skip to insurance section
❑ Other Guarantor→Complete this section

Guarantor's Full Name:

Patient's Relationship to Guarantor:
❑ Child ❑ Spouse
❑ Other:

Address (if different):

Date of Birth: / /

Social Security #:

Emergency Contact's Full Name:

❑ I authorize Orlando Family Physicians to release health information to my Emergency contact.

Phone Number:

Address:

## INSURANCE INFORMATION

**Primary** Insurance Company Name: | Plan Name | Phone #: ( )

Claims Address: | **Co-pay:** $ | Effective Date: / /

Policy#: | Group #: | Group Name:

Is plan through employer? ❑ No ❑ Yes

Employer Name: | Employer Address:

Subscriber's Name: | Relationship to Patient:

**Secondary** Insurance Company Name: | Plan Name | Phone #: ( )

Claims Address: | **Co-pay:** $ | Effective Date: / /

Policy#: | Group #: | Group Name:

Is plan through employer? ❑ No ❑ Yes

Employer Name: | Employer Address:

Subscriber's Name: | Relationship to Patient:

## ACKNOWLEDGEMENT

**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), I will immediately endorse them and turn over to Orlando Family Physicians, Inc. for service rendered. I 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.)**

/ Today's Date: / /

Patient/Guardian Signature | Patient/Guardian Printed Name | (mm) (dd) (yyyy)

ORLANDO FAMILY PHYSICIANS

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

(AUTORIZACION PARA OBTENER, LIBERAR O REVISAR INFORMACION DE SALUD PROTEGIDA)

**Patient Name:** _____ **Social Security Number:** _____
(Nombre del Paciente) (Numero de Seguro Social)

**Telephone Number:** _____ **Date of Birth:** ___/___/_____
(Numero de Telefono ) (Fecha de Nacimiento)

**Address:** _____
(Direccion)

I,_____hereby authorize Orlando Family Physicians at:
(Yo, __autorizo a Orlando Family Physicians en:)

| | | |
|---|---|---|
| ☐ **1834 North Alafaya Trail**<br>**Orlando, FL 32826**<br>**Tel: 407.627.0062**<br>**Fax: 407.674.7346** | ☐ **829 Douglas Avenue**<br>**Altamonte Springs, FL 32714**<br>**Tel: 407.332.0003**<br>**Fax: 321.295.7928** | ☐ **790 Buenaventura Blvd.**<br>**Kissimmee, FL 34743**<br>**Tel: 407.344.9959**<br>**Fax: 407.344.9971** |
| ☐ **3162 S. Conway Rd., Unit 3**<br>**Orlando, FL 32812**<br>**Tel: 407.627.0056**<br>**Fax: 407.237.0355** | ☐ **7200 Curry Ford Road**<br>**Orlando, FL 32822**<br>**Tel: 407.587.7552**<br>**Fax: 407.757.0483** | ☐ **21 S. Charles Richard Beall Blvd**<br>**DeBary, FL 32713**<br>**Tel: 386.516.0930**<br>**Fax: 386.668.6897** |
| ☐ **659 Douglas Avenue**<br>**Altamonte Springs, FL 32714**<br>**Tel: 407.274.9777**<br>**Fax: 407.637.5114** | ☐ **920 N. John Young Parkway**<br>**Kissimmee, FL 34741**<br>**Tel: 407.956.1920**<br>**Fax: 407.483.5844** | ☐ **810 N. Nowell Street**<br>**Orlando, FL 32808**<br>**Tel: 407.290.9556**<br>**Fax: 407.290.9509** |
| ☐ **1502 Village Oak Lane**<br>**Kissimmee, FL 34746**<br>**Tel: 407.520.3588**<br>**Fax: 407.978.6757** | ☐ **1130 S. Semoran Blvd., Ste. C**<br>**Orlando, FL 32807**<br>**Tel: 407.382.1376**<br>**Fax: 321.235.3232** | ☐ **1931 S. Narcoossee Road**<br>**St. Cloud, FL 34771**<br>**Tel: 407.986.9642**<br>**Fax.407.593.6102** |
| ☐ **5979 Vineland Rd., Ste. 209**<br>**Orlando, FL 32819**<br>**Tel: 407.627.0066**<br>**Fax: 407.440.4054** | ☐ **5840 W. Colonial Dr**<br>**Orlando, FL 32808**<br>**Tel: 407.720.7302**<br>**Fax: 407.293.1355** | ☐ **910 West Vine Street**<br>**Kissimmee, FL 34741**<br>**Tel: 407.517.9582**<br>**Fax: 407.978.6644** |
| | | ☐ **121 S. Orange Avenue, Ste 940**<br>**Orlando, FL 32801**<br>**Tel: 407.685.9687**<br>**Fax: 407.658.9688** |

☐ **Release Copies of ALL Medical Records To:**
(Enviar Copias de mi Historial Medico Completo a:)

☐ **Obtain ALL Medical Records From:**
(Obtener Todo mi Historial Medico de:)

**Person/Organization:** _____ **Date(s) of Service:** _____
(Persona/Organizacion) (Fecha del servicio)
**Address:** _____
(Direccion)
**City:** _____ **State:** _____ **Zip Code:** _____
(Ciudad) (Estado Postal) (Codigo Postal)
**Phone:** _____ **Fax:** _____
(No. Telefono) (No. Fax)

ORLANDO FAMILY PHYSICIANS

**Reason for Disclosure** (Motivo de divulgacion):

_____Continuing Care (Continuidad de cuidado) _____Insurance (Seguro) _____Legal (Legal) _____Personal Use (Uso Personal) _____ Other (Otros)

**Choose All That Apply (Elija todos los que apliquen)**

| | | | |
|---|---|---|---|
| | Complete Record (Informe Completo) | | Radiology Reports (Informess de Radiologia) |
| | Therapy Physical/ Occupational (Terapia Fisica/Ocupacional) | | Pathology Reports (Informes de Patologia) |
| | Lab Reports (Informes de Laboratorio) | | Electrocardiogram (Electrocardiograma) |
| | Other (Otros) | | Surgical Report (Informes de Cirugias) |

**Specific Authorizations**

**The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:**

(La siguiente informacion no puede ser revelada sin la especifica autorizacion, marcando la caja(s) siguientes:)

| | | | |
|---|---|---|---|
| | HIV/AIDS (VIH/SIDA) | | Genetic Testing Information (Informacion sobre Pruebas Geneticas) |
| | Drug/ Alcohol Abuse or Treatment (Abuso o Tratamiento de Droga/ Alcohol) | | Psychotherapy Notes (Notas sobre Psicoterapia) |

**This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.**

(Este consentimiento puede ser revocado en cualquier momento excepto cuando la accion ya ha sido tomada. Esta autorizacion y consentimiento vencera a un año de la firma del presente formulario.)

**Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.**

(Su cuidado de salud (o pagos por el mismo) no se veran afectados aun firmando o no esta autorizacion. Una vez su informacion sea entregada, ya no estara cubierta legalmente.)

_____

**Signature of Patient or Legal Representative**
(Firma del Paciente o Representante Legal)

**Date Signed:** _____/_____/_____
(Fecha de hoy) (mm) (dd) (yyyy)

_____

**Printed of Patient or Legal Representative**
(Firma del Paciente o Representante Legal)

**Relationship to Patient:** _____
(Relacion a el paciente:)

ORLANDO FAMILY PHYSICIANS

## 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** |
| | | | |

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 Orlando Family Physicians.

| Name of Patient or Guardian or Legal representative | Relationship | Signature | Date |
|---|---|---|---|
| | | | |
| | | | |

**OFFICE USE ONLY**

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.

_____ _____

Office Personnel Printed Name Office Personnel Signature

Date Received: ____/____/_____

(mm) (dd) (yyyy)

ORLANDO FAMILY PHYSICIANS

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that have been provided the Notice of Privacy Practices for Orlando Family Physicians.

- 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.

## PATIENT INFORMATION

| PATIENT FIRST NAME: | MIDDLE NAME: | LAST NAME: |
|---|---|---|
| | | |

DATE OF BIRTH: _______________
(mm) (dd) (yyyy)

_____ _____ Date: _______________
Signature of Patient/Legal Guardian Printed Name of Patient/Legal Guardian (mm) (dd) (yyyy)

_____
Relationship to Patient

## TO BE COMPLETED BY STAFF MEMBER(If patient or representative cannot sign)

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/ Personal Representative refused to sign form

☐ Other: _____

_____

ORLANDO FAMILY PHYSICIANS

# ACKNOWLEDGEMENT FOR ADVANCED DIRECTIVES

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about their health care will still be respected, Advance Directives were created. These directives outline in writing your wishes regarding future medical treatment. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. There are several types of advance directives:

**Living Will**: It is a written statement of the kind of medical care you want or do not want if you become unable to make your own decisions.

**Health Care Surrogate:** This document names another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will.

**Anatomical donor form:** It is a document that indicates your wish to donate, at death, all or part of your body. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card, signing a uniform donor form, or expressing your wish in a living will.

**DNR form:** This is a yellow form that identifies people who do not wish to be resuscitated in the event that they stop breathing of their heart stops beating.

The Advance Directives come into effect only if you become incapacitated and you can change it at any time. As long as you are capable, you should discuss your expectations for future medical care with your physician. However, before you fill out the Advance Directives you may also want to talk to your family, friends, lawyer, or spiritual advisor.

AS YOUR MEDICAL DOCTOR, WE NEED TO KNOW IF YOU HAVE EXECUTED AN ADVANCED MEDICAL DIRECTIVE: A

❑ Yes ❑ No

IF YES, THIS DIRECTIVE IS IN THE FORM OF:

❑ A Living Will ❑ A Do Not Resuscitate Order ❑ A Health Care Surrogate ❑ An Anatomical Donor

If you answered **YES**, could you please provide us with a copy of the forms at your earliest convenience, sign below, and proceed to the next page.

If you answered **NO,** please sign below.

| Patient's First Name: | Middle Name: | Last Name: |
|---|---|---|
| | | |

| Social Security #: | Date of Birth: |
|---|---|
| | |

| Print Patient/Legal Representative Name: | Date of Authorization: |
|---|---|
| | |

Signature of Patient/Legal Representative:

ORLANDO FAMILY PHYSICIANS

## Bill of Rights

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 complaints, 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:** _____/_____/_____
(mm) (dd) (yyyy)

---

## No Show Policy

Dear Patient,

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 Printed Name:** _____

**Patient Signature:** _____

**Date:** _____/_____/_____
(mm) (dd) (yyyy)

ORLANDO FAMILY PHYSICIANS

# Consent to Obtain External Prescription History

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

Prescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

I,_____, whose signature appears below, authorize Orlando Family Physicians and its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

**Patient Name:**_____**Date:** _____

**Patient Signature:**_____

ORLANDO FAMILY PHYSICIANS

# 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 wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on My behalf:

**Name** _____

**Street Address** _____

**City**_____**State**_____**Zip Code** _____

**Phone #**_____

**(Signed)**_____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional Instructions (optional):_____

_____

**Witness 1:**

Signed:_____

Name:_____

**Witness 2:**

Signed:_____

Name:_____

**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.**