



PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____

LOCAL ADDRESS _____ DATE OF BIRTH ____/____/____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SOCIAL SECURITY _____ CELL PHONE () _____

ETHNICITY: ___ NOT HISPANIC/LATINO ___ HISPANIC/LATINO ___ REFUSED HOME PHONE () _____

RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___ WHITE WORK PHONE () _____

___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

___ OTHER ___ OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

PREFERRED LANGUAGE _____ PHONE () _____

___ MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED EMPLOYER _____

___ EMPLOYED ___ RETIRED ___ FULL TIME STUDENT ADDRESS _____

PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ HOME PHONE () _____

RELATIONSHIP _____ WORK PHONE () _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? YES NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE () _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? YES NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: WORKMAN COMPENSATION AUTOMOBILE OTHER

DATE OF ACCIDENT ____/____/____ Place of accident _____ How did accident happen? _____

CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME _____ EMPLOYER PHONE() _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE () _____

SECONDARY INSURANCE INFORMATION INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE () _____

SIGNATURE _____ DATE _____



Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, P.A. Notice of Privacy Practices has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The *Notice of Privacy Practices* for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This *Notice of Privacy Practices* also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials _____

Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, infusion services, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department. I may obtain these services in the out-patient department of the local hospitals, such as Florida Hospital Zephyrhills, Pasco Regional Medical Center, University Community Hospital or St. Joseph's Hospital North.

Acknowledgment of Receipt Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPAA) and FMC's policies on use and disclosure of my protected health information.

Name of Patient

Name of Guardian or Personal Representative

Signature of Patient

Signature of Guardian or Personal Representative

Date

Florida Medical Clinic, P.A.