ofm Orlando Family Medical, Inc.

How do you hear about us: _____

Last Name: _____

First Name: _____

Address: _____

Apt.: _____

City: _____

State: _____, Zip Code: _____

Home Phone: _____

Cell Phone: _____

Responsible Party: _____ DOB:_____

Relation to Patient: _____

Date of Birth: _____

Sex: _____

Marital Status:_____

SS#: _____

Employer Name: _____

Employer Phone: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Relation to Patient: _____

Do you have Health Insurance? Yes No

Primary Ins: _____

Do you have a secondary insurance? Yes No

Secondary Ins: _____

Race: __Asian, __Native Hawaiin or other Pacific, __Black or African American, __White, __Hispanic, __Other

Ethnicity: __Hispanic or Latin, __Not Hispanic or Latin, __Refused to Report

Language: __ English, __Spanish, __Other

Email: _____

Pharmacy Name: _____, Phone: _____, Fax: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of authorized Medicare or other insurance company benefits be made in my behalf to **Orlando Family Medical, Inc.** for any services furnished to me by that party which accepts assignment/physician regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries of carriers any information needed for this or a related Medicare claim /other insurance company claim. I authorize **Orlando Family Medical** to view and obtain external medication reconciliation from other providers. I 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 health care 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.)

I request that payment under the Medicare or other medical insurance program(s) be made to **Orlando Family Medical,** Inc. for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by **Orlando Family Medical, Inc.** from Medicare or other insurance company(ies), I will immediately endorse them and turn over to **Orlando Family Medical, Inc.** for services rendered.

I understand that I am responsible for payment of all charges and fees to **Orlando Family Medical, Inc.** to which they are entitled to collect which are not paid by Medicare or any other insurance.

Signature of Patient/Guardian _____ Date_____

931 W. Oak Street, Ste 103, Kissimmee, FL 34741, O-407-931-044, F-407-962-4446
1718 Woolco Way, Orlando, FL 32822, O-407-931-0444, 407-674-7887
900 Towne Center Dr., O-407-931-0444, F-407-978-6639

ofm Orlando Family Medical, Inc.

CONSENT FOR TREATMENT

Florida State Law guarantees that you have both the right and obligation to make decisions concerning your 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 making process. This form has been design to acknowledge your acceptance of treatment recommended by your physician.

I further acknowledge that I will have full opportunity to discuss this information with my physician and hereby consent to medical care / treatment.

I also acknowledge that the purpose of the care, reasonable alternative form of therapy, risk 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 other health professional as designated to perform any physical 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 I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) 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 authorize **Orlando Family Medical** to view and obtain external medication reconciliation from other providers.

Complaint Number toll free # 1-888-419-3456 The Abuse line is 1-800-96-Abuse (962-2873)

Signature of Patient / Guardian _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I _____ authorize Orlando Family Medical, Inc to release / discuss my health information, either by phone or in person, with:

Name	Relationship	Identifier
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization is valid until: _____ or until _____
Date Event

_____ _____
Patient's Signature Date

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Orlando Family Medical, Inc.

ADVANCE DIRECTIVES

For Compliance with the Patient Self-Determination Act

Have you executed an Advance Directive? Yes No

If yes, is this directive in the form of:

_____ A Living Will
_____ A Durable Power of Attorney
_____ A HealthCare Surrogate

If you have executed an Advance Directive in any of the above formats, have you provided this office with a copy? Yes No

If you would like more information regarding Advance Directives, please ask the receptionist or Medical Assistant.

I have been provided with information regarding the Patient Self-Determination Act

_____ _____
Signature of Patient or Representative Date

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ofm Orlando Family Medical, Inc.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME:_____ **DOB:** _____

PHONE#:_____ **SS#:** _____

PLEASE OBTAIN INFORMATION FROM:

PROVIDER: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PH: _____ **FAX:** _____

PLEASE SEND INFORMATION TO:

PROVIDER: **ORLANDO FAMILY MEDICAL, INC.**

ADDRESS: **931 W. OAK STREET, STE 103**

CITY, STATE, ZIP: **KISSIMMEE, FL 34741**

PH: **407-931-0444,** FAX: **407-962-4446**

I AUTHORIZE the following information to be disclosed: (please initial all that apply)

_____ **Entire Record**
_____ **Immunization Record**
_____ **Lab Test**
_____ **TB Test**
_____ **HIV Records**
_____ **STD Record**
_____ **Psychiatric/ Mental Health**
_____ **Alcohol/Substance Use**
_____ **Billing Records**
_____ **Other**
_____ **Date(s)**

REASON for disclosure of health information: (Please Initial)

_____ **At my request**
_____ **Continuing Care**
_____ **Legal**
_____ **Job**
_____ **Scholl**
_____ **Insurance**
_____ **Other**_____

EXPIRATION of this Authorization: (please initial one)

_____ **90days after signature date**
_____ **When this event happens**_____
_____ **On this date:** _____

ADDITIONAL PATIENT INFORMANTION:

- ☐ **I understand that I have the right to withdraw this authorization. To withdraw, please sign below.**
- ☐ **I understand that I do not have to sign this authorization to get treatment.**
- ☐ **I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Orlando Family Medical.**
- ☐ **I understand that signing this authorization does not cancel any rights I have under other state or federal laws.**

X_____ _____

Patient Signature (Parent or Legal Representative, if applicable) **Relationship** **Date**

ofm Orlando Family Medical, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand **Orlando Family Medical, Inc.**'s *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that **Orlando Family Medical, Inc.** may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of **Orlando Family Medical, Inc.** *Notice of Privacy Practices* by submitting a request in writing for a current copy of **Orlando Family Medical, Inc.** *Notice of Privacy Practices*.

_____ _____ _____

Printed Patient Name | Patient Signature | Date

If completed by patient's personal representative, please print name and sign below.

_____ _____

Printed Patient Personal Representative Name | Relationship to Patient

_____ _____

Patient Personal Representative Signature | Date

For Orlando Family Medical, Inc. Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Orlando Family Medical, Inc. made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____

Employee Name (printed)

_____ _____

Employee Signature | Date

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ofm Orlando Family Medical, Inc.

Prescription Drug Policy

Patient Name: _____, DOB: _____

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amounts, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. **We will accept NO excuses for their loss or theft and will not order replacements.** We will not prescribe them if you are using them other than exactly as prescribed or are receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first store may be canceled. Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialist to help decide on the correct course of action. We reserve the right to do random drug testing for anyone taking narcotic medications.

Our office also requires a 24-48 hour call-in policy for the refill of your non-narcotic prescriptions. When your medications are getting low and you feel you will need a refill, please have the pharmacy send us a fax of the medications that you need or call our office with the name of your pharmacy and pharmacy phone number 24-48 hours prior so that we will have ample time to consult your treating physician and then call your medication into your pharmacy. **Controlled substances are not prescribed from this office as we are not a Licensed Pain Management Clinic.**

Failure to follow these policies will force our office to terminate our professional relationship with you and may require us to file a report with the United States Department of Justice Drug Enforcement Administration (DEA) or the Local Police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

_____ _____

Patient's Signature/Patient's Guardian **Date**

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