Office policies and procedures

**Office’s Hours, Policies and Procedures:** Our regular office hours are Monday thru Friday from 8:00 AM to 5:00 PM. We close for all major holidays and occasionally open late due to staff meetings.

**Phone Messages and Refill Requests:** Due to the high volume of call we receive daily, we ask each patient to comply with our policy regarding medication refills and phone calls to the office. All urgent medical calls will be returned the same day, all other calls may take 24 to 48 hours to process. To request a medication refill, please contact your pharmacy and have them fax a request to 863-385-2330. Medication refills will be completed within 24 to 48 business hours of the request. If the prescription must be hand written, leave a detailed message and you will be contacted when it is completed.

**After Hours Emergency:** For a true medical emergency call 911 immediately or proceed to the nearest Emergency Room. We do have an answering service available for urgent reasons. The phone number is 863-382-8004. The answering service cannot process medication refills. The answering service is intended only for urgent medical issues.

**Confidentiality:** If you have a family member or friend who you would like us to release information to (including appointment times) we required to have that person on your Authorization to Treat Form.

**Medical Records:** We are happy to provide you with a hard copy of your records upon receipt of the proper request form. The charge will be $1.00 for the first 25 pages and 0.25 cents for each additional page. Please allow 10 days for your request to be processed.

**Paperwork and Miscellaneous Charges:** There will be a $15.00 charge, payable in advance for each form the doctor is requested to fill out (i.e. Disability, FMLA, Medical Necessity, etc). These forms should be turned in at the front desk. Please allow 7 business days for processing.

**No Show-Fee:** A no show-fee of $25.00 will be billed to you if 24 hours notice is not given.

**I HAVE READ AND UNDERSTAND SUN ‘N LAKE MEDICAL GROUP OFFICE POLICIES AND PROCEDURES OUTLINED ABOVE. I AGREE TO THE GUIDELINES OUTLINED IN THE ABOVE DOCUMENT.**

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Records Request

**Patient Name: Patient Date of Birth:**

**Patient Address:**

**Phone #: (City, State Zip)**

**For Record Release or copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.**

This authorization permits:

To use or disclose to **Sun ‘N Lake Medical Group Internal Medicine**

(Provider’s Name)

4958 Sun ‘N Lake Blvd Suite A

(Street Address)

Sebring, FL 33872

(City, State, Zip)

**Phone: (863)-385-8004 Fax: (863)385-2330**

(Phone Number)

**Information to be released/copied:**

( )All pertinent medical records including immunizations and lab tests

( ) Day sheets- Dates: ( ) Lab Information- Dates:

( ) Other:

**Information to be excluded/not released:**

**( )** Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV Testing

( ) Sexual Assault/Victimization records ( ) other:

\*\*\*Be sure to review any restrictions prior to copying/releasing\*\*\*

**Reason for Record Release or Copy:**

**(Please see below, charges could apply.)**

**For patient or Guardian Inspection/Copy Requests: ( ) Check Here**

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: $1.00 per page for the first 25 pages, then $0.25 for each page thereafter.

**(Parent/Legal Guardian Signature)**   **(Date)**

\*Inspection requests are valid on the date of signature only

**(Parent/Legal Guardian Name Printed)** \*Release/Copy requests expire 30 days from signature date

*Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentially is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent from subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).*

**For Internal Purposes Only: Name and Title of Person Releasing Records:**

**Method of transfer: ( ) Mailed on: ( ) Certified? (Certification #)**

**( ) Picked up by: / (Date) Form of ID:**

**( ) Faxed: / (Date) Verification of ID Performed: ( ) Yes ( ) No**

**Date:**  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is responsible for patient: ( ) Self ( ) Spouse ( ) Other

Patient’s Last Name: First Name: MI:

Address: Apt #:

City: State: Zip Code:

Phone # ( ) Home ( ) Cell /Alternate Phone #:

Patient’s SSN: - - Date of Birth: ( ) Male ( ) Female

Do you have an alternate address? ( ) Yes ( ) No/ If yes, please print here:

**Spouse’s Information:**

Last Name: First Name:

SSN: - - Date of Birth:

Address: Phone #:

Employed By:

**Employment Status: \_\_\_ Full time \_\_\_ Part time \_\_\_Retired \_\_\_Other**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student: \_\_\_ Full time \_\_\_Part time**

**Please have your insurance card and driver’s license ready for the receptionist. Payment for professional services is due and payable when services are rendered.**

**Emergency Contact:**

Name of close relative not living with you:

Relationship to patient: Phone #:

Address:

**Insurance Assignment**

**I hereby authorized benefits to be paid directly to Sun ‘N Lake Medical Group, I understand and agee that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.**

Patient/Guardian Signature: Date:

**Consent for Evaluation or Treatment**

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient named above.

Patient/Guardian Signature: Date:

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

* Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, and Discover.
* Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor- in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
* We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the copayment at the time of service. We will collect the copayment when you arrive for your appointment.
* If you have insurance coverage with a plan with whom we do not have a prior agreement, we will prepare and sent the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
* All health plans are not the same and don not cover the same services. In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
* For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
* In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.
* *I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.*

**Signature of Patient or Responsible Party Date**

**Please Print Patient’s Name**

Hippa compliance patient consent form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our Notice before signing this consent.

The terms of the Notice3 may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree whit this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
* The practice reserves the right to change the privacy policy as allowed by law.
* The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
* The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
* The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If **YES**, please name the members allowed

|  |  |  |
| --- | --- | --- |
| **Name and Last Name:** | **Relationship:** | **Phone Number:** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |

This consent was signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(PRINT NAME PLEASE) (D.O.B)**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR OFFICE USE ONLY**

**\_\_\_\_\_\_\_\_\_**

**(Witness Signature) (Date)**

Medical History

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialists: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark all that applies:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ADD/ADHD |  | Anxiety |  | Thyroid Disorder |  | Hypertension |
|  | Anemia |  | Alcoholism |  | Back pain |  | High Cholesterol |
|  | Asthma |  | Prostate Disorder |  | Headaches |  | Respiratory Disease |
|  | Arthritis |  | Stomach disorder |  | Diabetes(what type) |  | Stroke |
|  | Gynecological disease |  | Kidney disease |  | Liver disease |  | Neurological disorder |
|  | Osteopenia |  | Osteoporosis |  | Skin disorder |  | Seizure disorder |
|  | Colon disorder |  | Depression |  | Migraines |  | Allergies/Hay fever |

Fractures\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hear attack\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Clots\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer\_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Transmitted Disease\_\_\_\_ What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Colonoscopy Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Mammogram Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Flu Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Pneumonia Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Tetanus Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_ Last Shingles Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Vaccines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Family Medical History

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative** | **Age (if living)** | **Age at death** | **Major Illness or Cause of Death** |
| Mother |  |  |  |
| Father |  |  |  |
| Brothers |  |  |  |
| Sisters |  |  |  |
| Children |  |  |  |

Social History

|  |  |
| --- | --- |
| Tobacco Use | \_\_Never \_\_ Current User \_\_Quit(when)\_\_\_\_\_\_\_ \_\_ E-cigarettes \_\_Other |
| Alcohol Use | \_\_None \_\_Social Drinker \_\_Occasional drinker Number of drinks daily\_\_\_ |
| Drug Use | \_\_Never \_\_ Current User(which drug)\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Quit(when) \_\_\_\_\_\_\_\_\_ |
| Caffeine Use | \_\_Yes \_\_No How many daily? \_\_\_ |
| Exercise | \_\_None \_\_Light \_\_Moderate \_\_Vigorous How many times a week? \_\_\_\_ |
| Do you live | \_\_Alone \_\_Spouse \_\_Family \_\_Assistant Living \_\_Other\_\_\_\_\_\_\_\_\_ |
| Sexual Active | \_\_No \_\_Yes (with?) \_\_Men \_\_Woman \_\_Both Number of partners in last 12 months \_\_\_\_\_ |

Current Medications

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** | **Prescriber** |
| 1- |  |  |  |
| 2- |  |  |  |
| 3- |  |  |  |
| 4- |  |  |  |
| 5- |  |  |  |
| 6- |  |  |  |
| 7- |  |  |  |
| 8- |  |  |  |
| 9- |  |  |  |
| 10- |  |  |  |

Values/Beliefs Assessment

**Please check if you have any of the following documents:**

Donor Card\_\_\_\_ Living Will\_\_\_\_\_ Durable Power Of Attorney for Health Care\_\_\_\_\_

Do you have any religious or cultural practices we should be aware of? Yes\_\_\_\_ No\_\_\_\_\_

Please, specify if YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**