



WELCOME TO OUR FAMILY

OFFICE HOURS

Our office hours are Monday through Thursday from 7:00 a.m. to 5:00 p.m. Friday 7:a.m to 2:00 p.m. excluding Holidays. This is subject to change. See our after hours section for emergencies.

APPOINTMENTS

Even though our practice is by appointment only, our Advance Access System allows established ill patients to be seen by a doctor within 24 hours. This method of scheduling allows us to quickly see patients when they are ill. Appointments may be made anytime during normal office hours.

Courtesy: TFH asks that you, the patient, contact the office at least 24 hours in advance of your scheduled appointment if you are unable to keep it. This will allow our Advance Access System to function efficiently.

According to office policy, there will be a penalty for not notifying TFH of a cancellation or not showing up for an appointment:

- You will be charged \$50.00.

TFH is aware that emergencies occur, but please try to comply with the policy because we are here to provide an efficient, caring and professional service to all of our patients.

MEDICATION AND PRESCRIPTION REQUEST

Request for medication or prescription refills should be made during your office visit. Please bring all your medicines in a bag with you to each office visit. This will allow us to verify your medicines, correct dosages, and that you have enough refills. It is important you plan ahead so no delays occur in taking your regularly scheduled medication. Should you run low, schedule follow up appointment for refills. You will be requested to come into the office for a written prescription to mail out for medication or to personally deliver to the pharmacy. We will accept phone calls in some instances, but only during regular business hours. Please do not call for prescription refills after hours. Also, phone calls for medication refills after 3:00 p.m. on any weekday will not be processed until the following business day. Prescriptions for pick-up at our office will not be ready until after 3:00 p.m. the following business day.



AFTER HOURS COVERAGE

For life threatening emergencies dial 911. Our physicians are available 24 hours a day, 7 days a week for non-life threatening emergencies. Calling our regular office number and selecting the “doctor” prompt can reach the “on-call” physician. Please do not call any of our doctors at their home numbers since they may not be home. Prescription refill request are not a medical emergency and will not be filled after hours.

HOSPITAL INFORMATION

We use an internal medicine group that specializes in hospital medicine to admit our patients to South Lake Hospital, in partnership with Orlando Regional Healthcare. We are also affiliated with Florida Hospital, Celebration.

BILLING & INSURANCE INFORMATION

Unless we participate with your particular insurance carrier, medical services that are provided are expected to be paid for at the time of service. We accept cash, personal checks, Visa and Master Card as appropriate forms of payment. Payment is expected same day of service rendered: self-pay, co-pay and/or co- insurance. Also, the yearly deductible not met at time of service.

Insurance payments vary with the type of policy and insurance carrier. Check with your carrier if you have questions regarding your coverage. As a service to you, insurance claim forms will be filed for you if you need. However, your medical bill is ultimately your responsibility. By upholding your financial responsibilities we can hold costs down and spend more time on medical care and not trying to collect debts due.

If more than one insurance company covers you, please let us know which company is primary (to be filed first), and which is secondary (filed after the primary has paid). We cannot be responsible for knowing which insurance should be filed first. TFH would appreciate your assistance in properly sequencing your insurances. Also, if the patient is not the policyholder, please provide the name, date of birth and social security number of the policyholder.

Please advise our office of any changes in your address, phone number, marital status and insurance information that have occurred since your last visit. Any additional information requested by the insurance is your responsibility. If payment of the claim is held up because of information you needed to supply to your carrier, we will process the account and deal with it accordingly.



FORMS & CLEARANCES

Our office will be glad to complete other forms for you. Depending on the situation (such as complexity and urgency), we may charge you an additional fee for filling out forms not directly related to insurance filing. The charge will be collected when the form is collected, so please be sure to see us as soon as possible. If you have not been seen in relation to the form, please call to schedule an appointment and therefore, you will be able to collect the form at the end of the office visit. The fee for forms is \$25.00.

TEST RESULTS

TFH expects test results to be received and reviewed by the provider within a two weeks time frame. Once the test results are received, the provider reviews them and informs the medical assistant to contact the patient with the results or to contact the patient to schedule an appointment to come into the office to talk with the provider about the results. If the patient has not heard from the office in two weeks from the time test was administered, the patient should call the office to inquire about results.

MEDICAL RECORDS

TFH have in the **Welcome to Our Family** package, a form to request medical records from your previous healthcare provider. It is very important that you fill out the form in its entirety. The more accurate information you give on this form will speed of the process of retrieving the medical records for the provider. If you would like for THF to request medical records from more than one of your previous providers, request more medical records release forms at the reception desk.

If you are referred onto another provider by one of TFH providers, we will forward office notes and test results for your appointment at no charge. If you would like to collect medical records for your personal record, you will have to fill out a medical records release and there is a charge.

Charges:

\$1.00 a page up to 25 pages.

Additional pages \$.25 each.

Total Family Healthcare

Our Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Your Health Information

We understand that medical information about you and your health is personal. We create a record of the care and services you receive from us. We need this record to provide you with quality care, obtain payment for the services we provide, and to comply with legal requirements. This Notice applies to all of the records of your care generated by us, whether made by your personal doctor, other Practice doctors, or Practice staff. We are required by law to 1) make sure that medical information that identifies you is kept private; 2) give you this Notice of our legal duties and privacy practices; and 3) follow the terms of the Notice that is currently in effect. The professional and non-professional staff at Practice will follow the terms of this Notice.

How We May Use And Disclose Medical Information About You

The following categories and examples describe the different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Category:

Description and Examples:

Treatment

We may share medical information about you with another physician, a hospital, or other health care provider involved in your care. For example, a hospital may need to see a part of your medical record before you have surgery.

For payment

We may share medical information with Medicare or other health plan to obtain payment for services provided to you, to verify insurance coverage, or to obtain authorization for further treatment. For example, an insurance company may need to see part of your medical record before they will pay for the services.

For Practice operations

We may share medical information as necessary to manage the *operations* medical, legal and financial affairs of the Practice and to monitor the quality of services provided to our patients. For example, our attorney or accountant may need patient information in order to provide legal and financial services to the Practice. Any business associate with whom we share medical information will agree in writing to protect your privacy.

Appointment reminders

We may disclose medical information to remind you of an appointment. We will disclose only the date, time and location of the appointment.

Family members and friends

We will share medical information to a friend or family member that is involved in your care or payment of your bill. We will give you an opportunity to agree or object to these disclosures unless it is clear from the circumstances that you do not object.

Worker compensation

We may report a work-related injury to a worker compensation carrier or to advise your employer about a work-related injury.

To meet legal requirements and health

We may disclose medical information to a government agency that oversees medical practice in the State such as the Florida Agency for *for public* Health Care Administration or the Board of Medicine. We are also *activities* required to report certain diseases and conditions to the local unit of the

Department of Health for its public health activities.

Law enforcement, lawsuits, disputes reports of abuse

We may disclose medical information to an attorney or a law enforcement official to comply with a court order, subpoena, discovery and request or other legal mandate. We may also disclose medical

or neglect information to assist law enforcement with investigating crime. For example we are required to report wounds resulting from violence and incidents of abuse or neglect.

To avert a serious threat to health or safety We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure, however, would only be to someone able to respond to the threat

Category:
For special government functions

Description and Examples:

We may be required to disclose medical information to a government agency for national security purposes, a correctional facility in which you may be incarcerated, or to a military authority if you are in the service or a veteran.

Organ and tissue donation

We may disclose medical information to an organization that handles organ, eye or tissue transplantation.

***Medical Examiners
Funeral
Directors***

We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about individuals to funeral directors as necessary to carry out their duties.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Medical Information

You may access your Information

To access your medical information, you must submit your request to us at the address listed at the end of this Notice. If you request copies We may charge a fee allowed by law. We may deny your request in certain Very limited circumstances. For example, we might deny access to psychotherapy Notes that might be a part of your record.

You may amend or Correct your medical Information

You may ask us to amend or correct your medical information. Please make your request in writing and submit it to: 3115 Citrus Tower Blvd, Suite A, Clermont, FL 34711.

You may request an “accounting of disclosure”

You may request a list of the disclosures we made of medical information about you, other than for treatment, payment or Practice operations as described above, and without your written authorization.



FINANCIAL POLICY

Purpose:

The purpose of this Policy is to outline our financial and collection protocol within our office.

Procedures:

- I. At the time of service, our staff will make appropriate and informed decisions regarding billing to insurance carriers or billing patients directly based upon the service rendered.
- II. Regarding insurance plans where we **are** a participating provider, all co-payments are due prior to or immediately after treatment. By the terms of our insurance contracts, where there is a co-payment or co-insurance, it **MUST** be collected.
- III. For patients having secondary insurance with which we **do not** participate, those patients are responsible for sending claims to their insurance companies. If help is needed with this effort, our office will be happy to offer assistance. The insurance policy is a contract between the patient and the insurance company. We are not a party to that contract.
- IV. All GYN/ANNUAL/ROUTINE patients with a **non-participating** insurance company are required to pay in full at the time of service.
- V. Insurance carriers will be billed within **three (3) days** of a surgical service or procedure. Insurance carriers who do not respond within 45 days will be contacted relative to claim status and appropriate follow up. Insurance carriers who have not responded appropriately to claims within 50 days will have their claims transferred to a patient responsible balance and the patient appropriately notified of such responsibilities. The patient responsible balance will then be followed to completion and ultimate collection. (See item X for further explanation) This procedure does not apply to claims that are disputed.
- VIII. Patient responsible accounts will be billed at the time of service. Patients not making payments or other financial arrangements will be sent a collection letter following **60 days** or the **second 30-day billing cycle**. Thereafter, our patient collection procedure will be followed.
- IX. Delinquent accounts will be reviewed to determine the need for additional collection activity, distribution to our collection agency or other financial alternatives such a credit adjusting or Small Claims Court action, etc.
- X. Our practice is committed to providing the best treatment for our patients. The patient is responsible for paying their portion of any bill, regardless of any insurance company's arbitrary determination of "usual and customary" fees.
- XI. We reserve the right to bill for missed appointments. A charge of \$50.00 will be assessed for missed appointments without proper notice for established patients and \$50.00 for new patients. Please provide us with 24 hours notice for cancellations as outlined in Office Procedures.
- XII. There will be a **\$25.00** charge for processing checks returned for insufficient funds.
- XIII. **Last, we apologize for the length and complexity of this policy, but it is highly important that we comply with the legal terms of our contracts and that our patients understand their financial responsibilities.**

Credit Balances- If payment of your account should result in a credit balance, unless otherwise requested, we will hold payment of your refund for one billing cycle to ensure that additional charges are not incurred during that time

No-Shows - We reserve the right to bill for missed appointments. A charge of \$50.00 may be assessed for missed appointments without prior notice for established patients and \$50.00 for new patients.

We appreciate the time you have taken to read and understand this policy. If you have any questions about any aspect of this policy, please ask to speak with someone from the Business Office. We feel that it is important for you to understand our financial policy clearly and that you feel comfortable agreeing to uphold it.



Appointment Date: _____
Appointment Time: _____
Provider: _____

NEW PATIENT INFORMATION

Patient Name: _____ Male Female
Parent or Guardian Name: _____
Street Address: _____ M S D W
City, State, Zip: _____
Do you go by any other names: _____ Date of Birth: _____
Social Security: _____ Home Telephone: _____
Mobile Telephone: _____ Work Telephone: _____
Place of employment: _____
Emergency Contact: _____ Telephone: _____
Your Email Address: _____
Can we contact you via email with results? Yes No
How did you hear about us? _____

Insurance Information

Insurance Company: _____ Telephone: _____
Policy Holder: _____ Relation to Subscriber: _____
Policy Number: _____ Group: _____
Date of Birth: _____ Social Security: _____

ASSIGNMENT OF BENEFITS: I authorize the release of any medical or other information necessary to process claims. I authorize payment directly to **Total Family Health Care**, the physician examining or treating me for medical benefits. Any service for which assignment is not accepted, I acknowledge as my full and complete financial responsibility.

X Signature of Patient/Guardian: _____ **Date:** _____

I acknowledge I have received a copy and understand all policies set forth in Total Family Healthcare's Welcome Packet, which include Office Protocols, Financial Policy and Notice of Privacy Practices.

X Signature of Patient/Guardian: _____ **Date:** _____

Release to Treat A Minor Patient

I authorize Total Family Healthcare to treat the minor dependent listed above.

X Signature of Patient/Guardian: _____ **Date:** _____

FOR OFFICE USE ONLY

Insurance Rep: _____ Network: _____
Effective: Yes No Date: _____ Pre-Existing: _____
Copay/Deductible/%Amount: _____ Amount Deductible Met: _____
Insurance Address: _____
Labs, Diagnostics, Dexa: _____ Routine: _____
Chiropractic/Phys Ther. Benefits: _____ #Mod Covered: _____

PHARMACY INFO: _____



PATIENT HEALTH HISTORY

(PLEASE PRINT LEGIBLY) Write name as it appears on your insurance card

Patient Name: _____ Nickname: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of Last Office Visit: _____ Date of Last Physical: _____

Reason for this visit: _____

Current Symptom (s) -: (Please check all that apply):

General

- Chills, Dizziness, Fainting, Fever, Forgetfulness, Headache, Insomnia, Loss of Sleep, Loss of Weight, Nervousness, Numbness, Sweats

Gastrointestinal

- Appetite, poor, Bloating, Bowel Changes, Constipation, Diarrhea, Excessive Hunger, Excessive Thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal Bleeding, Stomach Pain, Vomiting, Vomiting Blood

Eye, Ear, Nose, Throat

- Bleeding Gums, Blurred Vision, Crossed Eyes, Difficulty Swallowing, Double Vision, Earache, Ear Discharge, Hay Fever, Hoarseness, Loss of Hearing, Nosebleed, Persistent Cough, Ringing in Ears, Vision Flashes, Vision Halos, Snoring

Men Only

- Breast Lump, Erection Difficulties, Lump in Testicles, Penis Discharge, Sore on Penis, Venereal Disease / Other

Women Only

- Abnormal Pap Smear, Bleeding Between Cycles, Breast Lump, Extreme Menstrual Pain, Hot Flashes, Painful Intercourse, Vaginal Discharge, Venereal Disease / Other

Muscle, Joint, Bone

- Pain, Weakness, Numbness in: Arms, Hips, Legs, Back, Feet, Neck, Hands, Shoulders

Cardiovascular

- Chest Pain, Irregular Heart Beat, Low Blood Pressure, Poor Circulation, Rapid Heart Beat, Swelling of Ankles, Varicose Veins

Skin

- Bruise Easily, Hives, Itching, Rash, Scars, Change in Moles, Sores That Won't Heal

Pulmonary

- Cough, Wheezing, Shortness of Breath

Genito-Urinary

- Blood in Urine, Frequent Urination, Lack of Bladder Control, Painful Urination

Endocrine

- Weight Gain (or) Loss, Neck Swelling

Mental Health:

- Anxiety, Depression, Nervousness, Worries, Thoughts of Hurting Yourself or Others

**Conditions: (Please check all medical problems listed below that you have or had in the past. In additional, please CIRCLE those that are CURRENT medical problems:

- AIDS, Alcoholism, Allergies, Anemia, Anxiety, Anorexia, Appendicitis, Arthritis (Osteo or Rheumatoid), Asthma, Atrial Fibrillation, Bleeding Disorders (Specify), Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Depression, Diabetes - Type 1 or Type II, Emphysema (COPD), Epilepsy (Seizures), Glaucoma, Gonorrhea, Gout, Heart Disease (coronary artery disease), Hepatitis A, B or C, Hernia, Herpes, High Cholesterol, HIV Positive, High Blood Pressure, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Osteoporosis, Pacemaker, Pneumonia, Polio, Positive PD (Tuberculosis skin test), Prostrate Enlargement, Rheumatic Fever, Stroke, Suicide Attempt, Thyroid-Over or under active?, Tonsillitis, Tuberculosis, Ulcers, Vaginal Infections, Other

Allergies To Medications:

Drug Name	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to: ___ Latex ___ Tape ___ Eggs

Medications: Please list medications you are currently taking.

Drug Name	Dosage (mg)	Times Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____ Phone: (_____) _____

Vitamins & Herbal Supplements: Please list supplements you are currently taking.

Supplement Name	Dosage	Times Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalization / Surgeries; Please list any hospital admissions or surgeries:

Year	Hospital	Doctor	Reason for Hospitalization
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a blood transfusion? ___ Yes or ___ No

If yes, please give approximate date: _____

Other Serious Illness / Injury, Please list any other illness or injuries:

Year	Description of Illness or Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pregnancies, Please list all pregnancies:

Year	Sex of Child	Complications If Any
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently pregnant? Yes or No

Health Maintenance, Please complete:

Have you ever had the following:

Colonoscopy	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Dexascan (Bone Density Test)	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Stress Test	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Eye Exam	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Stool Testing	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Tetanus Vaccine	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Flu Vaccine	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Pneumonia Vaccine	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Zostavax (shingles/herpes zoster) Vaccine	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____
Gardasil (Genital Warts / HPV) Vaccine	<input type="checkbox"/> Yes	or	<input type="checkbox"/> No	Date: _____

Men:

Prostate Screening Yes or No Date: _____

Women:

Pap Smear Yes or No Date: _____
Mammogram Yes or No Date: _____
Last Menstrual Period Yes or No Date: _____

Social History:

Where were you born? City, State and County: _____

Who lives with you? _____

Single, Married, Divorced, Separated, Widowed, or do you have a domestic partner? _____

Please list any pets you have: _____

Have you had any exposure to any chemical or biologic agents? _____

Health Habits: Please check all that apply.

	1-2 Per Week	3-5 Per Week	6-10 Per Week	> 10 Per Week
Caffeine				
Tobacco				
Alcohol				
Drugs				
Exercise				

Please indicate if you have the following Advance Directives:

DNR: (Do not resuscitate) _____
 (If my heart stops, do I want it restarted)

LIVING WILL: _____
 (Directs medical treatment, in the event that I become Incapacitated)

Family History:

Please complete the following and check off the appropriate box.

Relation and Age	Heart Attack	Stroke	Cancer (specify)	Blood Disorder	Diabetes	High Blood Pressure	Mental Illness	Alcoholism	Eye Disease	Other
Father										
Mother										
Sister										
Brother										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

I certify that the above information is correct to the best of my knowledge, I will not hold my doctor or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____

Date: _____

Reviewed By: _____

Date: _____



Patient Authorization for Use and Disclosure of Protected Health Information to Patient-Approved Entities.

By signing this authorization, I authorize TFHC to use and/or disclose protected health information (PHI) about me to persons or groups listed below OTHER THAN PHYSICIANS. Provide a date of birth or other identification for any person listed:

Spouse/Significant Other: _____

Family Friend / Relative: _____

Other: (specify) _____

The authorization permits TFHC to use and / or disclose the following individually identifiable health information about me. **Check all that apply.**

- TFHC may leave messages on an answering machine to call "Total Family Healthcare".
- TFHC may leave messages with another person. Please specify who: _____
- TFHC may leave messages either on a machine or with another person about coumadin doses or other treatment.
- TFHC may leave message at _____ for "Normal Lab Results".
- TFHC may send e-mail messages to the following address:

- Other (Please be specific, i.e., disability insurance carrier):

- SUBOXONE PATIENT records will be audited by the DEA per federal regulation and suboxone patients authorize TFHC to disclose medical records to the DEA.

The authorization will be used or disclosed for the following purpose (s): "**At the request of the patient**". The purpose (s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will remain "indefinite unless otherwise noted." The Practice may in the course of business receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. If this turns out to be the case, we will notify you.

I do not have to sign this authorization in order to receive services from TFHC. In fact, I have the right to refuse to sign this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at: **Total Family Healthcare**

Patients Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____
Relationship to Patient: _____