Valrico Medical Clinic

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_______________________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

List Preferred PHARMACY ____________________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

❑ Welfare
(Please provide coupon)

❑ Other ____________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Valrico Medical Clinic** or insurance company to release any information required to process my claims.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Valrico Medical Clinic, P.A.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patients Name: ____

Patients Date of Birth:__________________________ Patient's SSN: ______________________

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) or Organization(s) authorized to receive the information:

Valrico Medical Clinic, P.A.
3119 Lithia Pinecrest Road
Valrico, FL 33594. Tel – (813) 643-3242.

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used:

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1) I understand that this authorization will **expire** on ___________________
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Valrico Medical Clinic, PA. in writing.
3) I understand that I can **refuse** to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (If applicable).
4) I may **Inspect or copy** any information used or disclosed under this agreement.
5) I understand that If the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

____ ___________________
Patients Signature or Patient's Representative Date

____ ___________________
Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab* test *performed on 1/4/O3"* or, *if your entire medical* record *is included, all health information.").*
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the* names *of your health* care *provider(s)).*
You have the right to know who is going to use it and what it is going to be used for. (e.g., *John Smith, PhD I Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY THIS FORM

Valrico Medical Clinic, P.A.
(813) 643-3242
Fax (813) 643-3090

3119 Lithia Pinecrest Road
Valrico, FL 33594

Financial Policy

This is an agreement between VMC, PA, a Florida Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Valrico Medical Clinic, P.A.

By executing this agreement, You are agreeing to pay for all services that are rendered.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, and any new charges to the account, and finance charge, if any.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Form Fees: Any forms that require the office staff or Doctors time other than the forms provided by Valrico Medical Clinic will be charged $25.00 (FMLA, Disability).

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. **Should we render services due to an urgent visit & co-payment is not collected at time of services, you will be billed a $10 fee.**

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company only if we are a contracted participating provider. We will file secondary insurances only if Medicare is your primary insurance. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Telephone Consults: At the physicians discretion a $30 fee will be charged to the patient when a patient calls after business hours for non-urgent issues (ex: prescription refills, canceling Appts). This fee must be paid before services are rendered for the next appointment. ________ (initials)

Leaving Messages:
Our office policy is to leave generic, innocuous information on answering machines. We would like to accommodate our patients and can do so, by **initialing** next to your preference.

1. ________Leave very little information.
2. ________Please call # ____ and leave specific details.
3. ________Please leave as much information as possible on machine or with anyone who answers my home phone.

The Financial Policy continues on the back side of this page.

Patient’s Name : ____

Responsible party
(if not the patient) : ____

Signature: ____ **Date:** ____

Co-Signature:
(if required): ____ **Date:** ____

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%). The finance charge on your account is computed by applying the periodic rate (1% to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance charge is $.50.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Hillsborough County, Florida.

Returned Checks: There is a fee (**currently $25**) for any checks returned by the bank.

Electronic Funds Transfer: Patient authorizes the merchant to convert check and debit personal account for the sale amount via draft or Electronic Funds Transfer (EFT). In the event that the draft or EFT is returned unpaid, patient agrees to pay and have personal account debited electronically for an item fee of $25 plus any applicable taxes.

Missed Appointment Fees: When a patient does not show up for an appointment, or cancels with less than 24 hours notice, a $10 fee will be charged. This fee must be paid before a new appointment is scheduled. Patient with three missed appointments will be asked to transfer their records to another doctor.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collections agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $1.00 per page for the first 25 pages and $.25 per page for pages 26 and up) If you want to have copies of your records. You authorize us to include all relevant information, including your payment history **upon request**. If you are requesting your records to be transferred from another doctor or organization to us, you authorize to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancellation is received; it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the parent's responsibility to collect from the other parent.

Valrico Medical Clinic, P.A.

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patients Name:____-

Patient's Date of Birth: ___________________________ Patient's SSN: ______________________

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. II there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to the health care information we maintain on you, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were &ready taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To *Be Completed by Patient or Patients Representative)*

I ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

____ ____________________
Patients Signature or Signature of Patients Representative Date

____ ____________________
Printed Name of Patients Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: **Sydney Shaw**

Practice Address: 3119 Lithia Pinecrest Road
Valrico, FL 33594
Phone: (813) 643-3242, Fax: (813) 643-3090

Valrico Medical Clinic, P.A.

PATIENT HISTORY FORM

Last Name ______________ First Name ________________________ DOB: __________ Date:______

Review of Systems

Do you now or have had any problems related to the following systems?

Circle **Y**es or **N**o

Constitutional Symptoms	NOW	PAST	(Comments)
Weight change	Y N	Y N	
Chills	Y N	Y N	
Sleep Disorder	Y N	Y N	
Other	Y N	Y N	

Genitourinary	NOW	PAST	(Comments)
Change in stream	Y N	Y N	
Nocturia (getting up at night)	Y N	Y N	
Urinary freq > 8 times/day	Y N	Y N	
Other	Y N	Y N	

Eyes	NOW	PAST
Double Vision	Y N	Y N
Glaucoma	Y N	Y N
Cataracts	Y N	Y N
Other	Y N	Y N

Musculoskeletal	NOW	PAST
Bone Pain	Y N	Y N
Muscle Pain	Y N	Y N
Joint Pain	Y N	Y N
Other	Y N	Y N

Ear / Nose /Throat / Mouth	NOW	PAST
Hearing Changes	Y N	Y N
Sore Throat	Y N	Y N
Sinus Problems	Y N	Y N
Other	Y N	Y N

Integumentary (Skin)	NOW	PAST
Rash	Y N	Y N
Lumps or Bumps	Y N	Y N
Moles, skin tags	Y N	Y N
Other	Y N	Y N

Cardiovascular	NOW	PAST
Chest Pain	Y N	Y N
Irregular heartbeat	Y N	Y N
Swelling in ankles	Y N	Y N
Other	Y N	Y N

Neurological	NOW	PAST
Tremors	Y N	Y N
Dizzy spells	Y N	Y N
Numbness / tingling	Y N	Y N
Other	Y N	Y N

Psychological	NOW	PAST
Are you generally happy?	Y N	Y N
Do you feel Depressed?	Y N	Y N
Do you feel anxious?	Y N	Y N
Do you feel safe in your home?	Y N	Y N

Respiratory	NOW	PAST
Wheezing	Y N	Y N
Frequent cough	Y N	Y N
Shortness of breath	Y N	Y N
Other	Y N	Y N

Endocrine	NOW	PAST
Excessive thirst	Y N	Y N
Too Hot/Cold	Y N	Y N
Tired / Sluggish	Y N	Y N
Other	Y N	Y N

Gastrointestinal	NOW	PAST
Abdominal pain	Y N	Y N
Nausea/VOMITING	Y N	Y N
Indigestion/heartburn	Y N	Y N
Other	Y N	Y N

Hematologic / Lymphatic	NOW	PAST
Swollen glands	Y N	Y N
Blood Clotting problems	Y N	Y N
Bruising	Y N	Y N
Other	Y N	Y N

Sexual History	NOW	PAST
Change in sex drive?	Y N	Y N
Sexual perf satisfactory?	Y N	Y N
Other (i.e. sexual trauma)		

Allergic / Immunologic	NOW	PAST
Hay Fever	Y N	Y N
Drug Allergies	Y N	Y N
Food	Y N	Y N

Last Exam or Lab Tests: **Please enter date (mo/yr)**

Dental:_________________ Eye:________________

Pelvic :_________________ PAP Smear: _________

Mammogram:_____________ Cholesterol:__________

Colonoscopy:_____________ Stool Test:___________

Prostate:_________________ PSA test:____________

Living Will ☐ Yes ☐ No Advanced Directive? ☐ Yes ☐ No Dr Sign:_______________________

Valrico Medical Clinic, P.A.

Medical History

Medical ☐ **None** *(High Blood Pressure, Diabetes, Cancer, Heart Disease, etc)*

Pregnancy History

Year	Sex	Complications
____	___	____________
____	___	____________
____	___	____________
____	___	____________
____	___	____________

Surgical ☐ *None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc – Please enter year was done if known)*

Allergies to medications? ☐ *None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc)*

Last Immunizations: FLU ___/___/___ PNEU ___/___/___ TETANUS ___/___/___ OTHER ___/___/___

Current prescription medicines: ☐**None**

Name of Drug	mg dose	#tablets	# times a day

Additional current prescription medicines:

Name of Drug	mg dose	#tablets	# times a day

Current Non Prescription Medicine (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins, anyi-acids, herbals)

Family History

Father ☐Living - Age: ______ ☐ Deceased, Age at Death ______ (Cause) ____________

Mother ☐Living - Age: ______ ☐ Deceased, Age at Death ______ (Cause) ____________

Siblings ☐Living - Age: ______ Number Deceased ____ ______ (Cause) ____________

List other illnesses in your family (ex. Diabetes, Heart Disease, colon, breast, or prostate cancer, arthritis, depression, etc.)

(Family Member) (Illness) (Family Member) (Illness) (Family Member) (Illness)

________ = ________ ________ = ________ ________ = ________

Social History

Caffiene? ☐ Yes ☐ No If Yes, how much?______

Smoke? ☐ Yes ☐ No If Yes, how much?______ # of packs/day ______ # of years When did you stop ____________

Alcohol? ☐ Yes ☐ No If Yes, how much?____________

Occupation. ____________________ ☐ Retired Significant prior industrial or agricultural exposures? ☐ Yes ☐ No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number Of Children ________ ☐None

Exercise regularly? ☐ Yes ☐ No If Yes, what and how frequently?

LIFETIME AUTHOURIZATION

INSURANCE ASSIGNMENTS AND AUTHOURIZATIONS TO RELEASE INFORMATION FORM

I. **RELEASE OF INFORMATION** – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. **PHYSICIAN INSURANCE ASSIGNMENT** – I, the below named patient, do hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. **MEDICARE / MEDICAID** – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. **I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE**. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE ______________________ PATIENT ____
Signature

SUBSCRIBER (if different from patient) ____
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

______________________________ ______________________________
NAME OF BENIFICIARY HEALTH INSURANCE COMPANY

____
MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on my behalf to ______________________________ for any services furnished by (physician/supplier). I authorize any holder of medical information about me to release to ____________________ Any information needed to determine these benefits or the benefits payable for related services.