Patient Information Form

❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

ALL SECTIONS MUST BE COMPLETED FOR ALL PATIENTS: Today's Date___/___/___

Patient Name: _____
Last First Middle Initial

Date of Birth:___/___/___ Age: _____ Social Security #: _____ Sex: ❑ Male ❑ Female

ADDRESS:

Mailing Address: _____
Street City State Zip

Secondary Address: _____
Street City State Zip

Home Phone: ( )_____Work Phone: ( )_____Cell Phone: ( ) _____

Emergency Contact Phone: ( )_____Email Address: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Pharmacy: _____

Primary Care Physician:_____Referred by: _____

INSURANCE COVERAGE – PRIMARY HOLDER INFORMATION

Insurance Co. Name:_____Phone: ( )_____Ext: _____

Address of Claim Center: _____

City, State, Zip: _____

Policy Type: ❑ HMO ❑ PPO Policy #:_____Group Name or #:_____

Name Policy Holder (Insured):_____Date of Birth:___/___/___Social Security #: _____

Address: _____
Street City State Zip

Check relationship: ❑ Mother ❑ Father ❑ Other_____ Sex: ❑ Male ❑ Female
Identify

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name:_____Phone: ( )_____Ext:_____

Address of Claim Center: _____

City, State, Zip: _____

Policy Type: ❑ HMO ❑ PPO Policy #:_____Group Name or #: _____

Policy Holder (Insured):_____Date of Birth: ___/___/___ Social Security #: _____

Address: _____
Street City State Zip

Please Attach a Copy of Patient's Insurance Card (Both Sides)

Medical History & Medication Form

PATIENT NAME:_____ DATE: _____

CHIEF COMPLAINT:

Please describe the reason for visiting:

_____

_____

PAST AND PRESENT MEDICAL HISTORY:

	Yes	No	Add'l Comments		Yes	No	Add'l Comments
Adopted				Gastro Disease/Ulcers			
Alcohol/Drug Problem				Hepatitis			
Anemia				High Blood Pressure			
Anxiety				High Cholesterol			
Arthritis				Kidney Disease			
Asthma				Liver Disease			
Atrial Fibrillation				Osteoporosis			
Autoimmune Disorder				Peripheral Artery Disease			
Blood Clots/Bleeding Disorder				Positive TB Test			
Cancer				Prostate Problem			
Coronary Artery/Heart Disease				Seizure Disorder			
Congestive Heart Failure				Sexually Transmitted Disease			
Dementia				Sleep Apnea			
Depression				Stroke			
Diabetes				Thyroid Disease			
Emphysema				Other(Not Listed)			

FAMILY HEALTH HISTORY (If Deceased, please indicate age)

Family Member	Living(L) Deceased (D) Unknown (U)	Medical Conditions Please specify premature Heart Disease, Diabetes, Cancer of any type, Prostate, Breast or Ovarian Problems
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		

SURGICAL HISTORY	Yes	No	Complications		Yes	No	Complications
Appendectomy				Shoulder			
Cardiac Angioplasty, Stent or Bypass				Hysterectomy			
Cardiac Catheterization				Hernia			
Knee				Prostate			
Hip							

OTHER SURGICAL HISTORY

_____

_____

IMMUNIZATIONS	Date Received
Flu Vaccine	
Pneumococcal Vaccine	
Tetanus/Diptheria-with or without Whooping Cough (circle one)	
Shingles	
Covid-19	
Other	

MEDICATIONS-including OVER THE COUNTER medications

Name	Dose and Directions	Reason

ALLERGIES TO MEDICATIONS or FOODS

ADDITIONAL QUESTIONS: (circle appropriate answer)

SMOKING: Never Previous Date Quit_____

Current Packs per Day_____

ALCOHOL: Never Occasional Excessive

How many drinks (Beer, Wine or Mixed) per day_____ per week_____

DRUG USE: YES/NO

Patient Financial Policy

Welcome to Restorative Pain Medicine Physicians. We are dedicated to providing the best possible care and service to you at our practice. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. Please read carefully the Financial Policies as described below.

Payment of Services

Payment for services rendered is ultimately the patient's responsibility. Your insurance is a contract between you and your insurance company. It is YOUR responsibility to give us the correct information about your insurance plan. If you cannot provide a current medical insurance card, full payment must be made at the time of service. For your convenience we accept cash, personal checks, most major credit and debit cards. Quick Pay and CareCredit are an extended payment option.

Co-Payments and Deductibles

Your insurance company requires you to pay your co-pay at the time of service. Failure to pay is a violation of your contract with your insurance company. Please do not ask us to bill you for co-pay. **Procedures(e.g., injections, ultrasounds etc.)** are considered **"**surgical procedures" and the fees for these services may require separate surgical deductible, copayment or co-insurance. Any deductible, co-insurance, or full payment is due at the time services are rendered. We **cannot** waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans. We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service that is denied, we have no choice but to bill you directly for those charges. If payment is not received from your insurance company within 45 days, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. Non-emergency treatment will be denied unless non-covered charges and co-pays have been paid and insurance billing is approved under the insured's policy.

Collections Policy

If you have an outstanding balance, we will mail you a statement monthly. A prompt response is expected. Failure to pay your portion of insurance allowable is a violation of your insurance contract and could result in insurance cancellation. If you default on your promised payment, our policy is to refer to a **collection agency.** The balance will accrue a monthly interest fee and an additional fee for the expenses related to collections. Checks returned to our office for non-sufficient funds (NSF) will incur a $50 service charge.

Cancellation/Missed Appointments

Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. Appointments not cancelled 24 hours in advance will automatically be charged $25.00. Appointments not cancelled 24 hours in advance for Procedures/Injections may be charged $200.00

Laboratory Fees

We try to utilize contracted laboratories for all lab specimens. If you have questions about these additional lab fees, please contact the lab directly as these fees are not charged by our office.

Miscellaneous Policies

- Unaccompanied minors must have a consent signed by a parent or guardian and be sent with a method of payment for their co- pay. The parent or guardian who signs the consent and authorization form is responsible for any balance on the account.
- Should you request copies of your medical records, there is a fee charged as allowed by current Florida statutes. There is also a cost associated with your request for physician "narrative reports" and/or letters not related to our insurance claims. These fees would be based on the complexity and amount of time involved.

Our staff will be happy to answer any questions you may have about our policies. Thank you for allowing us to serve you.

I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Bunch Health, LLC dba Restorative Pain Medicine Physicians. I authorize the release of medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

X_____ _____

Signature of Patient or Responsible Party Date

Medicare Improvements for Patients and Providers Act Form

Per Federal Regulations, under the new Medicare Improvements for Patients and Providers Act, we are now required to ask our patients for additional information. This relates to the Federal mandate regarding electronic health records (EHR).

Patient Name:_____ DOB: _____

Today's Date _____

Please answer the following questions:

HISPANIC ETHNICITY:

- Declined
- Not Hispanic or Latino
- Hispanic or Latino
- Unknown

RACE:

- White
- American Indian/Alaska Native
- Black/African American
- Native Hawaiian/Pacific Islander
- Unknown
- Asian
- Declined
- Other Race: _____

PREFERRED COMMUNICATION: * Make **TWO** choices

- Declined
- Fax
- Phone
- Other
- Email
- Mail
- Patient Portal

MARITAL STATUS:

- Married
- Separated
- Married
- Divorced
- Single
- Widowed

PRIMARY LANGUAGE:

- English
- Arabic
- French
- Hindi
- Korean
- Polish
- Vietnamese
- Spanish
- Chinese
- German
- Italian
- NA
- Portuguese
- Declined
- Filipino
- Greek
- Japanese
- Other
- Russian

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to provide you with this confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law we must follow the terms of the notice that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this notice. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice of Privacy Practices in our most current Notice at any time.

1. HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. Uses and Disclosures for Treatment, Payment, and Health Care Operation:

Treatment. We may use or disclose your PHI to physicians, nurses, and all other health care personnel who provide you with your health care services or are involved in your care. For example, we may ask you to have a laboratory test (such as blood or urine tests), and we may use the results to help us reach a diagnosis and treat you accordingly.

Payment. We may use and disclose your PHI to obtain payment for your health care services. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.

Health Care Operations. We may use and disclose your PHI to operate our practice. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

B. Others Involved in Your Healthcare:

Unless you object, we may disclose your PHI to a family member, other relative, friend or any other person that you identify that directly relates to that person's involvement in your health care. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

C. Emergencies

We may use or disclose your PHI in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures that may be made without your authorization or opportunity to object:

We may use or disclose your PHI in the following situations without your authorization, these situations include:

1. **Required by law, legal proceedings, or law enforcement.** We make disclosure when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered by a judicial or administrative proceeding.

2. **Public Health.** We report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, organ procurement entities, and funeral directors, necessary information relating to an individual's death.

3. **Health Oversight Activities.** We may disclose your PHI to assist the government when it conducts an investigation or inspection of a health care provider or organization.

4. **Research.** We may disclose your PHI to researchers conducting research that has been approved by an Institutional Review Board or Privacy Board.

5. **Public Safety.** We may disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

6. **Military.** We may disclose your PHI for military and or national security purposes.

7. **Worker's Compensation.** We may disclose your PHI as necessary to comply with worker's compensation laws.

8. **Appointment Reminders.** We may disclose your PHI to contact you and remind you of appointment.

I. YOUR HEALTH INFORMATION RIGHTS

1. **You have the right to inspect and have the office copy PHI.** You have the right the inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
2. **You have the right to request restriction on certain uses and disclosures of your PHI.** We will consider your request, but are not required to accept it. These requests must be in writing.

3. **You have the right to obtain a paper copy of this notice.** Ask the front desk for a copy of this notice.

4. **You have the right to Amend.** You may ask us to amend your PHI if you believe it is incorrect or incomplete. To request an amendment your request must be made in writing. You must provide us with a reason that supports your request. Our practice will deny your request if it is not submitted in writing or does not state the reason for the request. We may also deny your request if the information is accurate and complete in our opinion.

5. **You have the right to receive a list of disclosures we have made.** Such as disclosures required by law, disclosures to government officials, and disclosures for worker's compensation. The request must be made in writing and must state the time period. The time period may not be longer than six years and may not be before April 14, 2003. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

II. QUESTIONS

If you have any questions about any part of this notice, or if you want more information about our privacy practices, please contact the Privacy Officer.

Anne M. Murphy-Office Manager
727-495-6085 ext. 207

III. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to change this notice at any time in the future. We will post a current copy of this Notice of Privacy Practices in our waiting room as well as on our website.

Patient Notice of Privacy Practices

This notice describes how medical information about you may be disclosed. Please review it carefully.

Restorative Pain Medicine Physicians will use your medical information for the following purposes:

1. **TREATMENT:** Including providing your medical records to consulting clinicians and insurance companies
2. **PAYMENT:** We will file necessary claims to insurance companies in your name to obtain payment They may request part or all of your medical record to pay your claim
3. **HEALTH CARE OPERATIONS:** Any others involved in your healthcare

The entire **PRIVACY POLICY NOTICE** of Restorative Pain Medicine Physicians is posted in the reception room for your perusal.

☐ **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES** _____(initial)

QUESTIONS #1, #2, and #3 MUST BE COMPLETED

In conjunction with these privacy practices you will need to provide us with the following information:

1. **Name of person(s) we may speak to regarding your health, including their telephone number:**

_____

Name **relationship** **phone number**

_____

Name **relationship** **phone number**

2. **Emergency Contact (relative or person not living with you):**

_____

Name **relationship** **phone number**

_____

Address

3. **May we leave a message regarding your health, test results or an upcoming appointment on your answering machine and/or send you an email? YES _____ NO _____**

_____

E-mail address

_____ _____

Signature of Patient or Legal Guardian **Relationship to patient**

_____ _____

Print Patient's Name or Legal Guardian **Patient's Date of Birth**

_____ _____

Witness **Date**

Patient Portal Authorization Agreement

Purpose of this Form

Restorative Pain Medicine Physicians offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate

You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal. We will assign you a username and password. Our staff will then view your Clinical Summary and send a secure message through the Portal to our office. You may then login to the Patient Portal through our website at www.doctorbunch.com.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information

Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Restorative Pain Medicine Physicians or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. If you have questions, we will gladly provide more information.

Patient Acknowledgement

Patient Name:_____ Email Address: _____

Signature:_____ Date: _____

Username:_____ Password: _____