Lake Mary Family Practice

FLORIDA HOSPITAL MEDICAL GROUP

David Nerness, MD
Robert Rodgers, MD
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OFFICE POLICY

Patients Name______________________

Thank you for choosing Lake Mary Family Practice as your health care provider. Please read this office policy thoroughly. Due to the constant changes and demands of healthcare plans, we ask for your cooperation in providing us with the following at each visit:

- **Your co-payment is expected to be paid at the time of service.** You may be rescheduled if you cannot pay your co-payment or any outstanding balances from a previous visit that is solely your responsibility.
- Returned checks are subject to a $25.00 service fee.
- All self-pay and non-participating insurance patients must pay in full at time of visit. You can file your receipt from us to try to seek reimbursement. We invite all PPO plans, but you must remember with a PPO plan out-of-network benefits are applied to your deductible, coinsurance and out-of-pocket before they will pay any benefits.
- **Cancellations will need to be arranged 24 business hours in advance.** If you fail to cancel your appointment your account will be assessed a **$25.00 "No Show" fee.**
- If the provider is not at fault there will be no changes of diagnosis or procedure codes
- We ask for five (5) business days to complete any form or any paper work brought into the office.
- **Please allow 24-48 hours for prescription refills.**

Laboratory (please check only one):

FL Path ____ Quest Diagnostic ____ Labcorp ____ Other ____

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical information to my self, insurance carriers and/or for continuing patient care.

I have read, understand, and agree to this Office Policy:

________________________________ ________________________________

Signature **Date**

Health Insurance Portability and Accountability Act

HIPPA FORM

Attached you will receive the FHMG's Notice of Patient Privacy Practice. By signing this Written Acknowledgment of Receipt of Florida Hospital Medical group (FHMG) Notice of Patient Privacy Practice, I hereby expressly acknowledge my receipt of FHMG's Notice of Patient Privacy Practice.

Signature ________________________ Date ________________________

4106 W. Lake Mary Boulevard, Suite 215, Lake Mary, FL 32746

407.333.1550 *office* | 407.333.3081 *fax*

www.LakeMaryFamilyPractice.com

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ______________________ DATE ______________

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida Hospital Medical Group. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

PATIENT SIGNATURE ______________________ DATE ______________

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION - LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

PATIENT NAME ______________________ PATIENT SIGNATURE ______________________

MEDICARE B# ______________________ DATE ______________________

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

( ) I HAVE executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

( ) I HAVE NOT executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Signature:______________________ Date:______________

Lake Mary Family Practice
4106 West Lake Mary Blvd., Ste. 215, Lake Mary, FL 32746
(407) 333-1550 Fax (407) 333-3081

COMMUNICATION
USE AND DISCLOSURE AUTHORIZATION

Section A: Please complete the following information for all requests

1. Today's date:____

2. Patient name:____

3. Date of Birth:____________________ 4. Patient SSN:____________

5. Address:____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may leave the following messages on answering machines:

   ☐ Referral Information
   ☐ Prescription refill information
   ☐ Test results
   ☐ Other:____________________________________

2. You may discuss information regarding my treatment and care with the following family members and/or friends:

   ____

   ____

   ____

   ____

3. You may contact me regarding my treatment and care at the following numbers:

   ____

   ____

   ____

   ____

______________________________ ________________
Signature of Patient or Guardian Date

____
Signature of Staff Person and Title

____
Printed Name of Staff Person and Title