WELCOME TO OUR FAMILY

OFFICE HOURS

Our office hours are Monday through Thursday 8 a.m. to 5 p.m. and Fridays 7 a.m. to 2 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. You will be charged a $50.00 fee for failure to give 24 hours notice as well as failing to show for your appointment.

TFH is aware that emergencies occur, and your compliance with these policies help TFH provide an efficient, caring and professional service for 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. **No refills of controlled medicines will be given without an appointment.** 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 and/or 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 will be collected at the 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 assistant 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 we have the form 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 inquiry 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.

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. **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.

Note this is a NPP that reflects Omnibus changes as of March 2013

NOTICE OF PRIVACY PRACTICES
Effective Date**:** *9/1/2013*

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.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:
Privacy Officer: Kevin Jakob
Phone Number: *(352) 394 - 4237*

Section A: Who Will Follow This Notice?
This Notice describes **Total Family Healthcare** (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice

Section B: Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You
The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. 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.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider, such as family members, clergy or others we use to provide services that are part of your care.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health & Related Benefits and Services.** We may use and disclose medical information to tell you about health & related benefits or services that may be of interest to you.

- **Fundraising Activities.** If we intend to use your medical information for fund-raising purposes, we will inform you of such intent and that you have a right to opt out of receiving fundraising communications. We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you into raising money for the Provider. We only would release only contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to 'opt-out' of these communications.

- **Authorizations Required.** We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization; Specifically the following types of uses and disclosures of your medical information require an authorization; 1) disclosure of psychotherapy notes; 2) disclosures for marketing purposes; and 3) disclosures that constitute a sale of protected health information. Other uses and disclosures not described in the NPP will not be made unless an individual provides an authorization and that authorizations may be revoked prospectively at any time by written revocation.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **Provider Directory.** We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object and ask us not to provide this information to specific individuals, in writing. , In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **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 the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **E-mail Use.**

E-mail will only be used for communications with you following this organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the Provider; and
- in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes.

- If we maintain your information electronically you may request a copy of your records via a mutually agreed upon electronic format. If we fail to agree upon an electronic format for delivery of electronic copies we will provide you with a paper copy for your records. If you request a copy of the information in either paper or electronic format, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may request us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- We may deny your request for an amendment if; it is not in writing or does not include a reason to support the request or for other reasons. Typical reasons for denial of an amendment request include if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Provider;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically, if available). The first list you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. We require that any requests for use or disclosure of medical information be made in writing. In some cases we will not we are not required to agree to these types of request, however if we do agree to them we will abide by these restrictions. We will always notify you of our decisions regarding restriction requests in writing. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

You have the right to request, in writing, a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply, for example, disclosures to your spouse.

You also have the right, which we may not refuse, to restrict use and disclosure of your medical information about a service or item for which you have paid completely out of pocket, for payment (i.e. your insurance company) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We are not required to accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these types of restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by e-mail (if we offered and you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website. *www.totalfamilyhealthcare.com.*

To exercise the above rights, please contact **Total Family Healthcare: 3115 Citrus Tower Blvd., Ste. A, Clermont, FL 34711 or call (352) 394-4237** to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes To This Notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services; http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: 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.

Section I: Organized Healthcare Arrangement (OHCA)
The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations, enabling us to better address your healthcare needs. Providers participating in an Organized Healthcare Arrangement may share the same Notice of Privacy Practices.
Revised Date: April 20, 2013. Compliant with HIPAA Omnibus Privacy Rules

Original Effective Date: April 14, 2003

Total Family
Healthcare &
Wellness Centers

NEW PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

(Please Circle) Sex: Male Female Marital Status: Married Single Divorced Widowed

Street Address: _____

City, State, Zip: _____

Social Security #: _____ Home Telephone: _____

Mobile Telephone: _____ Work Telephone: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Preferred Method of Contact/Reminders *(please circle)*: Printed Electronic (Patient Portal) Phone

Email Address: _____

Preferred Method of Contact/Reminders *(please circle)*: Printed Electronic Phone

Place of employment:_____

Emergency Contact: _____ Telephone: _____

Parent/Guardian/Guarantor Name: _____ *Date of Birth:* _____

Street Address: _____*City, State, Zip:* _____

Race: _____ *Ethnicity:* _____ *Preferred Language:* _____

Social Security #: _____ *Home Telephone:* _____

Mobile Telephone: _____ *Work Telephone:* _____

*Place of employment:*_____

Email Address: _____

Insurance Information

Insurance Company: _____ Telephone: _____

Policy Number: _____ Group: _____

Policy Holder: _____ Relation to Subscriber: _____

Date of Birth: _____ Social Security: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Contact #: _____

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.

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.

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

Release to Treat a Minor Patient

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

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

How Did You Hear About Total Family Healthcare?

(Please circle)

Newspaper	Mail-out
Search Engine (Google, etc)	Drive-by
TV Commercial	Friend/Family
TotalFamilyHealthcare.com	Insurance Company

Total Family Healthcare & Wellness Centers

PATIENT HEALTH HISTORY

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

Patient Name: _____ **Nickname:** _____ **Date of Birth:** _____

What are you here for TODAY?

Please check the following
(please be advised that an additional appointment may be required to address all of your concerns)

☐ **Chronic Medical Conditions** _____, _____, _____

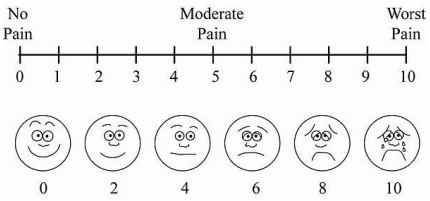
☐ **Medication Refills** **Pharmacy Name:** _____ **Phone #** _____

☐ **Sick Visit (Please provide the following information)**

Symptoms: _____

Is the symptom located in a specific place? _____ For how long? _____

What is your pain level?



What makes it worse or better? _____

Does it interfere with your daily activities? Y / N

Is the problem getting: ☐ worse ☐ better ☐ stays the same

Medications:

Please list medications you are currently taking.

Refill Needed	Drug Name	Condition	Dosage (mg)	Times per Day
☐				
☐				
☐				
☐				
☐				
☐				
☐				

Vitamins & Herbal Supplements:

Please list supplements you are currently taking.

Supplement Name	Dosage	Times Per Day

Allergies to Medications:

Drug Name	Reaction

Are you allergic to: ___ Latex ___ Tape ___ Eggs **OTHER ALLERGIES:** _____

Conditions:

Please **CIRCLE** your **CURRENT** medical problems. Please **CHECK** those you have had in the **PAST**.

__ AIDS
__ Alcoholism
__ Allergies
__ Anemia
__ Anxiety
__ Anorexia
__ Appendicitis
__ Arthritis
(Osteo or Rheumatoid)
__ Asthma
__ Atrial Fibrillation
__ Bleeding Disorders
(Specify) _____
__ Breast Lump
__ Bronchitis
__ Bulimia
__ Cancer
_____ (Type)
__ 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
_____
_____

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

Health Maintenance:

Please complete:

Have you ever had the following?	YES	NO	DATE	WHERE
Annual Physical or Annual Wellness visit				
Colonoscopy				
Dexascan (Bone Density Test)				
Stress Test				
Eye Exam				
Stool Testing				
Tetanus Vaccine				
Flu Vaccine				
Pneumonia Vaccine				
Zostavax (shingles/herpes zoster) Vaccine				
Gardasil (Genital Warts / HPV) Vaccine				
MEN	**YES**	**NO**	**DATE**	**WHERE**
Prostate Screening				
WOMEN	**YES**	**NO**	**DATE**	**WHERE**
Pap Smear				
Mammogram				
Las Menstrual Period				
Are you currently pregnant?				**N/A**

Pregnancies:

Please list all pregnancies including any miscarriages

Year	Sex of Child	Any Complications?

Social History:

Where were you born? City, State and County _____
How long have you lived in this area? _____
Who lives with you? _____
Are you Single, Married, Divorced, Separated, Widowed Domestic partner? _____
How many (if any) children do you have? _____
Please list any pets you have? _____
Have you had any exposure to any chemical or biologic agents? _____
What is your occupation? _____
What is your religion or religious preference? _____
Any other important information we should know? _____

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 by **INCLUDING** the approx **AGE** of **Diagnosis Onset**.
If unknown, Check 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: _____