NEW PATIENT PACKET

Patient's Name:

____

Last Middle First

Address: ____ **City:** ______________________________ **State:** ______ **Zip:** ___________

Home Phone: _________________________ **Cell Phone:** __________________________ **Primary Contact:**☐ Home Phone ☐Cell Phone

Email Address: ____ **Driver's License #:** _______________________

DOB: _________________________ **Gender:**☐ Male ☐Female **Social Security #:** ____

Employer: ____ **Work Phone:** _______________________________

Race: ☐White ☐Hispanic ☐Black or African American ☐Asian ☐Decline to Report ☐Other: ________________________________

Ethnicity: ☐Hispanic or Latino/a ☐Not Hispanic or Latino/a ☐Decline to Report ☐Other: _____________________________________

Whom may we call in Case of Emergency? Name: ____

Relationship to patient: ____ Primary Phone #: ____

Practice Policy: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect copayments, coinsurance and deductibles at time of service. Once a balance reaches 90 days old without payment, the balance may be transferred to a third party for further collections or other actions. Our office will obtain your insurance benefits; however, it is your responsibility to know your benefits per your contract with your health insurance carrier. It is your responsibility to provide our office with new insurance information prior to your appointment to avoid unnecessary wait times. There will be a charge for filling out forms that require more than a signature and $15.00 for writing letters each time these services are provided. Any prescription request the office receives after 12pm on Fridays will be refilled on the next business day. **All refills must be done before Friday at noon.**

Canceling/Rescheduling Appointments: If you are unable to keep your appointment, please notify our office at least twentyfour hours in advance to cancel or reschedule your appointment. Your courtesy will allow other patients seeking medical treatment the option to use your scheduled appointment time. Patients will be charged $25.00 for missed appointments unless the appointment was cancelled 24 or more hours in adva nce.

What if my child needs to see a provider? A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment on the account.

Patient's Initials: _____________

Insurance Information

Primary Insurance Company: ____ Insurance Phone: _________________________

Insured Name: ____ DOB: __________________ SS#: _________________________

Patient Relationship to Insured: _________________________ Insurance ID#: ____________________ Group#: ______________________

Address of Insured: ____

Secondary Insurance Company: ____ Insurance Phone: _________________________

Insured Name: ____ DOB: __________________ SS#: _________________________

Patient Relationship to Insured: _________________________ Insurance ID#: ____________________ Group#: ______________________

Address of Insured: ____

Suwannee Oaks Medical
112 Irvin Ave. SW Live Oak, Fl. 32064
Phone: (386) 339-6380 | Fax: (386) 330-0303

Consent for Purpose of Treatment, Payment, Health Care Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Suwannee Oaks Medical, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Aymee Wilson, APRN and Cheryl Abersold, APRN may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Suwannee Oaks Medical is not required to agree to the restrictions that I may request. However, if Suwannee Oaks Medical agrees to a restriction that I request, the restriction is binding between Suwannee Oaks Medical and

____.
(Write patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that Aymee Wilson, APRN and Cheryl Abersold, APRN or Suwannee Oaks Medical have taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Suwannee Oaks Medical's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my medical claims or in the performance of health care operations of Suwannee Oaks Medical. The Notice of Privacy Practices for Suwannee Oaks Medical is also available at the front desk of the clinic. This Notice of Privacy Practices also describes my rights and the Suwannee Oaks Medical duties with respect to my protected health information.

Suwannee Oaks Medical reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_______________________________________ ____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

_______________________________________ ____
Date Description of Personal Representative's Authority

I am giving authorization to Suwannee Oaks Medical to disclose my medical and insurance information to the below person(s).

_______________________________________ ____
Person(s) to whom information may be disclosed Person(s) to whom information may be disclosed

_______________________________________ ____
Signature of Patient or Personal Representative Date

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PATIENT INTAKE FORM

Name: ____ **Date of Birth**: ______________________

Date of Encounter: ____

Reason for visit / Current Problem: ____

____

Allergies? ☐Yes or ☐No

If yes, what? ____

Asthma? ☐Yes or ☐No **Diabetes**? ☐Yes or ☐No

List of Medications:

Past Medical History: ____

____

Surgical Medical History: ____

____

Family History: ____

____

Social History:

Smoker? ☐Yes or ☐No
If yes, how long? ____
Quantity: ____
Alcohol? ☐Yes or ☐No If yes, how often?

____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed
Exercise? ☐Yes or ☐No

If yes, how often? ____

Recreational Drug Use? ☐Yes or ☐No

If yes, how often? ____

Staff Initials and Date: ____________________________

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OFFICE AND COLLECTION POLICIES

Office Visits

We request that you make appointments for all your visits and be aware of the office hours. Our philosophy is to provide you the highest quality of care.

We know that your time is as valuable as ours and we make every effort to keep our schedule on time. Please notify us in advance if you are unable to keep your appointment. Appointments not canceled *at least three hours'* prior the scheduled appointment time may be subject to a cancellation fee of $25.00 for office visits. Medicaid patients will be charged a fee of $15.00 for no show/no call cancellations. Extenuating circumstances will be taken into consideration. There will be a $15.00 charge for filling out forms that require more than a signature and for writing letters each time these services are provided.

Always bring a current list of all your medications with the exact dosages to each office visit.

Office Hours

Monday - Friday: 8:30am-5:00pm

Saturdays: Telehealth- times vary by patient needs

Telephone Calls

Our office staff will be happy to answer your questions about office policy and scheduling. Medical questions will be referred to one of our experienced nurses or one of the providers. Extended phone consults or after-hour and weekend calls resulting in telephone treatment, may be billed a telephone consultation fee from $10.00 to $35.00.

Non-Urgent Pharmacy Request

It is very important that prescription medications are renewed in a timely manner. We operate a 24hour voicemail box for our patients to leave nonurgent prescription renewal requests. Prescription requests are retrieved twice daily during weekdays. Our policy is to complete your request by calling your pharmacy within 24 hours of the message being left.

Any prescription requested after 12pm on Friday will be refilled the following business day.

After Hours Calls

All routine matters should be handled during regular office hours. However, a physician from our call group can be reached at all times. If you believe your situation is critical, always go to an emergency room where you will receive assistance. Otherwise, call our office first before going to the emergence room; many problems can be handled over the telephone.

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Privacy and Security

Suwannee Oaks Medical Primary and Wellness Clinic holds all information pertaining to the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentiality. Suwannee Oaks Medical Primary and Wellness Clinic fully complies with the Federal Government's mandated HIPAA requirements for patient confidentiality and privacy of healthcare information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstance for which we can disclose protected health information without authorization. Only a patient can provide the authorization to release records necessary for Suwannee Oaks Medical to disclose protected health information for instances not related to your ongoing treatment and/or payment of claims. A patient may request to view a copy of their medical record in the office.

Collection Policy

All payments are due at time of services rendered. Providers of Suwannee Oaks Medical have a legal obligation to the insurance companies they are contracted with to collect copayments, deductibles, and coinsurance. Once a balance reaches 90 days old, regardless of payment received, it may be transferred to a third party for further collections or other actions.

I have read and understand the office and collection policies of Suwannee Oaks Medical Primary and Wellness Clinic.

____

Signature

____

Name **Date**

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ADVANCED PRACTICE NURSE

CONSENT FOR TREATMENT

Suwannee Oaks Medical has on staff advanced practice nurse's to assist in family medical care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

____

Signature of Patient/Legal Representative Date

____

Name of Patient/Legal Representative

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PATIENT PORTAL USER AGREEMENT

Suwannee Oaks Medical is pleased to provide a Patient Portal in partnership with our electronic medical records provider, eClinicalWorks for the exclusive use of patients in our practice. The Patient Portal is designed to enhance patient – physician communication. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services; which may or may not be utilized at this time:

- Request prescription refills
- Receive educational material
- View current and past statements
- Send messages to clinical staff
- Receive health maintenance reminders

The Patient Portal is **not** intended to provide internet based diagnostic medical services. The following limitations also apply:

- No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is SEEN by a medical provider in our office.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or calling 911 should the emergency be life threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 72 hours to receive a response to an email request. If you do not receive a response within 72 hours you should contact the office at (386)330-6380.
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
- Always remember to logout and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information.

YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.

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This Patient Portal is provided as a courtesy to our patients. While some offices charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

The Patient Portal is provided in partnership with eClinicalWorks, our EHR software vendor and provider. The data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. All patients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint yourself with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will be given our system generated unique user identification and password.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between Suwannee Oaks Medical and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Suwannee Oaks Medical may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction. I also understand this consent is valid for one year.

____

Patient/Guardian Signature and Date

____

Secure/Private Patient/Guardian Email

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Suwannee Oaks Medical Primary and Wellness Clinic provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions, which explains how my medical information will be used and disclosed.

____

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative and Relation (if not patient) Date

I am giving permission to Suwannee Oaks Medical Primary and Wellness Clinic to disclose my medical and insurance information to the below person(s).

____

Person(s) to whom information may be disclosed

____

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative and Relation (if not patient) Date