MHC MEDICAL HEALTH CENTER

SUPER URGENT CARE

KUNAL PATEL, MD / PAUL KILPATRICK, PA / VALERIE TANNER, ARNP
ROBERT MATHIS, MD / RANDALL TAUBMAN, MD

PLEASE PRINT CLEARLY (Please bring your Driver's License and current Insurance cards)

Last name: _____ First Name: _____ Mid Initials.: _____

Social Security Number: _____ DL/ State ID#: _____ DOB: ____ / _____ / _____

Sex: ____ Race: _____ Ethnicity: _____ Preferred Language: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Physical address: _____ City: _____ State: ___ Zip: _____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Email address: _____

Marital Status: _____ Spouse's name: _____ DOB: _____ SSN: _____

If under 18: Parent/ Guardian's name: _____DOB: _____SSN: _____

Employed: Yes/No Full-time student: Yes/ No Part-time student: Yes/ No

Employer/ School name: _____

Employer/ School address: _____ City: _____ State: ___ Zip: _____

Primary Insurance name (attach copy of card): _____
Primary Insurance Policy#: _____ Group#: _____
Primary Insured's name: _____ Primary Insured's SSN: _____

Secondary Insurance name (attach copy of card): _____
Secondary Insurance Policy#: _____ Group#: _____
Secondary Insured's name: _____ Secondary Insured's SSN: _____

If you are being referred to us by another physician, please complete below:
Referring Physician Full name (no abbreviations): _____ Phone #: _____
Referring Physician Fax number: _____ Fax notes to referring physician: Yes/ No

Emergency contact (someone who does not live in your home)
Emergency contact name: _____
Emergency address: _____ City: _____ State: ___ Zip: _____
Emergency Home Phone: (____) ____-_____ Emergency Cell Phone: (____) ____-_____

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PATIENT QUESTIONNAIRE

Please fill out this form ***Print clearly and carefully***

Patient Name: _____ **Date of Birth: ___/____/_____**

Name of your Pharmacy:	**Phone #:**	**Fax #:**
Name of your Primary Care Physician:	**Phone #:**	
ALLERGIES:		
REASON FOR TODAY'S VISIT:		

Past Medical History/ Family History							**CURRENT MEDICATION DETAILS**		
Condition	**Self**	**Father**	**Mother**	**Siblings**	**Children**		**Medication**	**Dose**	**Times/day**
Heart Attack									
Valve disorder									
High Blood Pressure									
Diabetes									
Colon Cancer									
Breast Cancer									
Prostate Cancer									
Other cancer (specify)									
High cholesterol									
Mental illness									
Depression									
Stroke									
Osteoporosis									
Seizures/ Epilepsy									
Migraine									
Liver Disease									
Kidney Disease									
Neuro problems									
Arthritis									
Bleeding disorder									
Thyroid problems									
Alcohol or Drug abuse									
Accidents (specify)									
Surgery (Specify)									
Hospitalization (Specify)									
Hospitalization (Specify)									

Social History

Do you smoke? Yes/ No. If Yes, How many? _____; if not, are you a past smoker? Yes/ No. When did you quit? _____.

Do you drink alcohol? Yes/ No. If Yes, How much? _____

When was your last test/ exam/ shot/ treatment for (Please provide exact dates and where you got it – This is IMPORTANT).

Mammogram:	Eye:	Dental:	Cholesterol:
Colonoscopy:	Glaucoma:	Prostate:	Breast:
Stool Blood:	PAP Smear:	Ear:	

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INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION: I, the below named patient, do hereby authorize ay physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g., BC/BS 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 it use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASIGNMENT: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or 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.

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 XVIIXIX of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician threatening me.

PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE: The assignment will remain in effect until revoked by me in writing.

CONCENT FOR TRETMENT: I, the below named patient hereby give my consent for treatment to all physicians associated with Physician Partners Specialty Services, LLC.

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize SupER Urgent care, LLC., to discuss my medical condition with, or release my medical records to the below named person(s):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

NO SHOWS / LAST MINUTE CANCELATIONS / LAST MINUTE RESCHEDULES: Providers and staff of SupER Urgent care, LLC., rely on the pre-schedule appointments to plan day to day activities. Last minute reschedules or cancelations and no-shows disrupt the daily activities and also curtail the ability to schedule another patient in your pre-scheduled slot. If you have to cancel or re-schedule your appointment, **we may charge a $25.00 fee** directly to you. Please note that this charge will not be billed to any third party (including your insurance) but directly to you and you will be responsible for payment of this charge prior to any further encounters.
COLLECTION AGENCY: In the event your account becomes delinquent and is turned over to a collections agency and/or attorney, you will be financially responsible for all associated collection fee and legal fees that SupER Urgent care, LLC., incurs through the process utilized to collect the delinquent balance. Please be aware if your account is turned over to a collections agency, you may be discharged from the practice.
RETURNED CHECK: Checks returned to SupER Urgent care, LLC., by the bank will be assessed a return check fee, in addition to the original amount of the check. You have the (10) days to clear up the outstanding check. If you fail to pay the due amount, your account will be referred to the collections agency and we may discharge you from the practice.

Please remember that insurance is considered a method of reimbursing the services provided. You are responsible to pay any co-pay, deductible amount, co-insurance or any other balance not paid for by your insurance or third party payer within a reasonable period of time not to exceed sixty (60) days from the day you receive notification.

Acknowledgement:

Patient / Legal representative signature: _____ Date: _____

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HIPAA Authorization Consent for Release of Medical Information

Patient Name: _____

Address: _____

Date of Birth: _____ Medical Records #: _____

Date(s) of Treatment: _____ Release Information to: _____
(Name of individual or organization)

Address: _____ Phone #: _____ Fax #:_____

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care
_____ Drug and alcohol treatment care
_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*
_____ Emergency room visit
_____ Psychiatric care *requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)
_____ Entire medical record
_____ Other: _____Labs _____Slides ** _____X-rays**

I authorize permission for this confidential information to be released for the following purpose:

_____ Continue medical treatment _____ Litigation for review _____ Insurance _____

Other: Specify Reason: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I Understand the following: See CFR 164.508(c) (2) (I-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____
Signature of Patient or Legally Authorized Representative **Date**

_____ _____
Name of Legally Authorized Representative to Patient **Relationship to Patient**

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc. A request may take 30 working days to process. If you do not receive the records within 30 days, you should call MHC Medical Records Department at #352.274.9900

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HIPAA AUTHORIZATION TO OBTAIN PATIENT MEDICAL INFORMATION

PLEASE FAX BACK TO # 877-405-0955

Records to be released from: _____

Fax #: _____ **Phone #**: _____

Patient Name: _____

DOB: _____ **Social Security Number**: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation from the above-named doctor or health care provider to:

Requesting Provider: _____ **Phone #: 352.274.9900**

Requested Information

- All records
- Office Visit notes – last two only
- Cardiology reports only
- Consults notes only
- Office notes only
- Lab reports only
- Radiology reports only
- Hospital records only
- Other _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS - I understand the following (see CFR 164.508(c)(2)(i-iii)):

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____ _____

Name of Legally Authorized Representative for Patient **Relationship to Patient**

SUPER URGENT CARE

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14**,** 2003, and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Ram Moorthy. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

- **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
- **Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you *choose* to involve in your care, only if you agree that we may do so.
- **Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
- **Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
- **Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
- **Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.
- **Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.
- **National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

- **Access:** Upon written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the form.
- You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed if you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.
- **Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- **Non-Routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations.
- You can request non-routine disclosures going back six (6) years starting on April 14. 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)
- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Privacy Officer: Ram Moorthy

Mailing address: PO Box 4590, Ocala, FL 34478-4590 Phone: (352) 509-9900; Fax: (352) 484-1159 Website: www.fmahealth.com

This form does not constitute legal advice and covers only federal, not state, law.