Health Care Services Agreement

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.

FPG
Family Physicians Group

The undersigned hereby request and consent to the services of Family Physicians Group (FPG), Including examination, treatment and other procedures deemed appropriate from dates onwards.

I agree to be responsible for all fees and costs related to these services, either directly or through my health care insurance provider. In this regard, I authorize their release of any information required by such provider for the processing of claims for payment. I further authorize payment of benefits directly to FPG.

It will be my responsibility to notify FPG of any insurance that I have and any changes I make with my insurance plans, plus, to submit to them my insurance cards for copying.

I understand that I will be individually responsible for fees incurrent, like co-pays and deductibles, regardless of insurance. I further understand that FPG will make every attempt to collect from the insurance that I have and will bill me for any balance due after insurance has made their determination of payment, this balance will be paid by me within 30 days of receiving my statement.

I understand that I will be responsible for any additional costs to collect my past dated account, but also any additional costs that may incur for the collection of my account, such as (interest, litigation cost and attorney's fees) if so necessary.

PERSON(S) RESPONSIBLE FOR BILL (OTHER THAN MEDICAL INSURANCE)

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	
ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

DATE OF AUTHORIZATION

FAMILY PHYSICIANS GROUP
6416 OLD WINTER GARDEN RD. ORLANDO, FL 32835
PH: (407) 447-4264 | FAX: (407) 447-4268

Acknowledgement for Advanced Directives

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.

FPG
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ACKNOWLEDGEMENT FOR ADVANCED DIRECTIVES

AS YOUR MEDICAL DOCTOR, WE NEED TO KNOW IF YOU HAVE EXECUTED AN ADVANCED MEDICAL DIRECTIVE:

☐ Yes ☐ No

IF YES, THIS DIRECTIVE IS IN THE FORM OF:

☐ A Living Will ☐ A Do Not Resuscitate Order ☐ A Health Care Surrogate ☐ An Anatomical Donor Form

If you answered **YES**, could you please provide us with a copy of the forms at your earliest convenience, sign below, and proceed to the next page.

If you answered **NO,** please read the following statement and sign below.

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about their health care will still be respected, Advance Directives were created. These directives outline in writing your wishes regarding future medical treatment. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. There are several types of advance directives:

Living Will: It is a written statement of the kind of medical care you want or do not want if you become unable to make your own decisions.

Health Care Surrogate: This document names another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will.

Anatomical donor form: It is a document that indicates your wish to donate, at death, all or part of your body. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card, signing a uniform donor form, or expressing your wish in a living will.

DNR form: This is a yellow form that identifies people who do not wish to be resuscitated in the event that they stop breathing of their heart stops beating.

The Advance Directives come into effect only if you become incapacitated and you can change it at any time. As long as you are capable, you should discuss your expectations for future medical care with your physician. However, before you fill out the Advance Directives you may also want to talk to your family, friends, lawyer, or spiritual advisor.

☐ Check here if you would like to receive advanced directive forms from our office

PATIENT'S LAST NAME	PATIENT'S FIRST NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH

PRINT PATIENT/LEGAL REPRESENTATIVE NAME

DATE OF AUTHORIZATION

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

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HIPAA Privacy Authorization Form

FPG
Family Physicians Group

1. I, _____, give permission to Family Physicians of Winter Park, Inc.
(Print Patient Name and Date of Birth)

To disclose and release my protected health information described below to:

NAME OF PERSON / ORGANIZATION	ADDRESS AND TELEPHONE:	FAX:	RELATIONSHIP:

2. Authorization to release of Personal Health Information (PHI) covering the period of health care (check one):

☐ a. From (date) …… to (date) …… OR

☐ b. All past, present, and future periods.

3. Health Information to be disclosed (check all that apply):

☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse, diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐ my complete health record, as above, *with the exception of the following information* (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV, AIDS and STD)
- ☐ Alcohol/drug abuse treatment
- ☐ Genetic Counseling/Testing Information
- ☐ Other (please specify): ……

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing FPG's Request to Revoke an Authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy**. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire one year after the date is signed**. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. I have read this form, or it has been read and explained to me, and I understand its content.

AUTHORIZING SIGNATURE _____ DATE _____ EXPIRATION DATE _____

RELATIONSHIP TO PATIENT: ☐ Self ☐ Legal Representative ☐ Parent of a minor child ☐ Other (Specify):

If signed by a person other than yourself, please check the relationship and provide proof of authority to do so
****If a translator or interpreter was required****:

NAME OF INTERPRETER / TRANSLATOR _____ TELEPHONE _____

OFFICE USE ONLY

OFFICE PERSONNEL PRINT NAME _____ SIGNATURE _____ DATE RECEIVED _____

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Authorization to Obtain Protected Health Information

FPG
Family Physicians Group

A. PERSONAL INFORMATION

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	PATIENT'S M.I.

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE

OBTAIN FROM (NAME OF INDIVIDUAL, HEALTHCARE FACILITY OR AGENCY)

ADDRESS	CITY	STATE	ZIP CODE

PHONE	FAX

DATES OF SERVICES

☐ From: To: ☐ All past, present and future periods

B. SIGNATURE REQUIRED

By signing this below, I hereby authorize Family Physicians Group to obtain my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse, diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) for the purpose of medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire one year after the date is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. I have read this form, or it has been read and explained to me, and I understand its content.

PRINT PATIENT / LEGAL REPRESENTATIVE NAME

DATE OF AUTHORIZATION

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

If a translator or interpreter was required

NAME OF INTERPRETER / TRANSLATOR

TELEPHONE

FAMILY PHYSICIANS GROUP
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Revocation of Authorization of Protected Health Information

FPG
Family Physicians Group

A. PATIENT INFORMATION

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	
ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER THAT WE MAY CONTACT YOU ☐ Home Phone ☐ Cell Phone	ALTERNATE NUMBER THAT WE MAY USE TO CONTACT YOU (OPTIONAL): ☐ Home Phone ☐ Cell Phone	

I request that Family Physicians Group revoke (cancel) the authorization that I have on file with Family Physicians Group, which permits the following person(s) or entity to access my protected health information.

Person(s)/Entity previously authorized to received my information:

B. SIGNATURE REQUIRED

I understand that signing and submitting this form will end my previous authorization to release information as described above. I understand that this revocation will be effective three business days after FPG receives it. I further understand that the revocation will only apply to further disclosures or actions regarding my protected health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.

I will retain a copy of the revocation form for personal reference, and the original will be kept on file in the medical record for the period of time designated for such retention.

PRINT NAME

DATE

SIGNATURE

If a translator or interpreter was required

NAME OF INTERPRETER / TRANSLATOR

TELEPHONE

OFFICE USE ONLY

OFFICE PERSONNEL PRINT NAME

DATE

OFFICE PERSONNEL SIGNATURE

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REV. 03-2018

Acknowledgement of Receipt of Notice of Privacy Practices

FPG
Family Physicians Group

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

PATIENT RECORD #	DATE OF BIRTH

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Family Physicians Group.
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

SIGNATURE OF PATIENT/LEGAL GUARDIAN/LEGALLY RESPONSIBLE PERSON

DATE

DESCRIPTION OF RELATIONSHIP TO PATIENT

TO BE COMPLETED BY STAFF (If patient or representative cannot sign)

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form

☐ Other:

SIGNATURE OF STAFF MEMBER

DATE

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Transportation Services Waiver and Release

FPG
Family Physicians Group

Please read this form carefully and be aware that in consideration for the Family Physicians of Winter Park, Inc., and FPG Senior Services, LLC (hereinafter collectively referred to as "FPG"), you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages, or loss which you might sustain as a result of said services, including but not limited to, vehicle operations and boarding and exiting the vehicle.

I recognize and acknowledge that FPG is neither a common carrier nor in the business of providing transportation services to the public. I also recognize and acknowledge that FPG is neither in the business of emergency transportation nor has held itself out to be an emergency transportation carrier. I further recognize and acknowledge that there are certain risks of physical injury to vehicle passengers, and I voluntarily agree to assume the full risk of any injuries, damages, or loss, regardless of severity, that I may sustain as a result of participating in any and all activities connected with or associated with receiving transportation services, including, but not limited to, injuries, damages, and loss arising out of negligent operation or supervision of the vehicle. I further agree to waive and relinquish all claims I may have (or accrue to me) against FPG, including its respective officials, agents, volunteers, and employees (hereinafter collectively referred to as "Party").

I do hereby fully release and forever discharge the Party from any and all claims for injuries, damages or loss that I may have or which may accrue to me and arising out of, connected with, or in any way associated with said transportation services.

I further agree that this agreement shall be governed by the laws of the State of Florida.
I have read and fully understand the above waiver and release of all claims. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.

PARTICIPATION WILL BE DENIED if the signature of adult participant or guardian and date are not on this waiver.

Return all forms along with proof of age and residency to: FPG, 6416 Old Winter Garden Rd., Orlando, Florida 32835.

PRINT PARTICIPANT'S NAME

DATE

PARTICIPANT'S SIGNATURE OR GUARDIAN'S SIGNATURE (18 YEARS OR OLDER)