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

Acknowledgement for Advanced Directives

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

FPG
Family Physicians Group

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

6416 Old Winter Garden Rd.
Orlando, FL 32835
PH: 866-222-0403

HIPAA Privacy Authorization Form

I, _____ _____ , give permission to: _____
Patient Name Date of Birth Name of Facility

To disclose and release my Protected Health Information (PHI) to the following individual(s):

Name	Address, City, State, Zip and Telephone	Relationship

I authorize the release of PHI for the following timeframe:

From _____ To: _____ -OR- ☐ All past and future dates
Start Date End Date

The following PHI can be disclosed (check all that apply):

☐ My complete health records (including: mental health, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse, diagnosis, lab tests, prognosis, treatment, and billing for all conditions)

☐ My complete health records, as above, with the exception of the following information (check all that apply)

- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Genetic counseling/Testing information
- ☐ Communicable diseases (including HIV, AIDS and STD)
- ☐ Other: _____

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HIPAA Privacy Authorization Form

Patient's Name: _____ DOB: _____

I understand the following:

- This authorization is valid for information already in my medical record and any information added while this authorization is effective.
- Authorizing this disclosure of information is voluntary and I can refuse to sign
- I may request to see this information during normal business hours.
- I do not have to sign this form to receive treatment.
- I can withdraw my approval by completing the **Revocation of Authorization** form at any time. The **Revocation of Authorization** form does not apply to:
  - Information that has already been released during this authorization.
  - My insurance company when the law provides my insurer the rights to contest a claim under my policy
- This medical information may be used by the persons I authorize to receive this information for:
  - Medical treatment or consultation
  - Billing or claims payment
  - Other purposes as I may direct
- 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 state laws that require the information to remain confidential.

Unless otherwise revoked, this authorization will expire **12 months** following the date of signature. I acknowledge that I have read this form or it has been read to me and I understand its content.

Signature _____ **Date** _____

Relationship to Patient:
If signed by a person other than yourself, please check the relationship and provide proof of authority.

☐ Self ☐ Legal Representative* ☐ Parent of Minor Child ☐ Other (specify)

_____ _____
****Name of Interpreter/Translator (If Required)** **Telephone**

***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.**

OFFICE USE ONLY

_____ _____ _____
Office Personnel Name (Print) Signature Date

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Authorization to Release or Request Protected Health Information

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

NAME OF PROVIDER OR HEALTHCARE FACILITY RELEASING INFORMATION:		
Provider:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax:	

From: ____/____/____ To: ____/____/____ ☐ All past and future Dates
Start Date End Date

NAME OF PROVIDER OR HEALTHCARE FACILITY REQUESTING INFORMATION: [SEND TO]		
Provider:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax:	

From: ____/____/____ To: ____/____/____ ☐ All past and future Dates
Start Date End Date

SIGNATURE REQUIRED:

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive or release my complete heath records, including the following:

_____
Name of Clinic

- **My complete health records including:**
  - ☐ Mental Health
  - ☐ HIV or AIDS
  - ☐ Communicable diseases
  - ☐ Treatment of alcohol/drug abuse
  - ☐ Diagnosis, lab tests, prognosis, treatment, and billing for all condition
- **For the purposes of:**
  - ☐ Medical Treatment or consultation
  - ☐ Billing or claims payment
- **Other purposes as I may direct:** _____

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Authorization to Release or Request Protected Health Information

I understand the following:

♦ This authorization is valid for the information already in existence and any information that may be generated while this authorization is effective.	♦ 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.
♦ I have the right to see any information that is disclosed pursuant to this authorization for release and I may request to see this information during normal business hours.	♦ Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization. ♦ I need not sign this form in order to assure treatment, payment or eligibility for services.
♦ I can revoke my authorization at any time and that the revocation will not apply to information that has already been released in response to this authorization.	♦ 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.

Unless otherwise revoked, this authorization shall expire **12 months** following the date of signature.

I acknowledge that I have read this form or it has been read to me and I understand its content.

Print Name _____ Date _____

Signature _____

Name of Interpreter/Translator (if required) _____ Phone Number _____

OFFICE USE ONLY

Office Personnel (Print Name) _____ Date _____

Office Personnel Signature _____

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Revocation of Authorization of Protected Health Information

PATIENT INFORMATION

Last Name		First Name
Address		
City	State	Zip Code
Phone Number	Date of Birth	

I hereby request _____ to revoke/cancel
Clinic Name

The current authorization on file, which permits the following person(s) or entity listed below to access my protected health information:

Name	Relationship

SIGNATURE REQUIRED

- I understand that signing and submitting this form ends my previous authorization to release information t the individual(s) or entity listed above.
- I understand that this revocation will be effective three (3) business days after receipt of this form.
- I understand that the revocation **will only apply to further disclosures or actions** regarding my protected health information and does not 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: _____

*Name of Interpreter/Translator (if required) _____ Phone Number _____

OFFICE USE ONLY

Office Personnel (Print Name) _____ Date _____

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Request for Confidential Handling of Protected Health Information

I, _____ Date of Birth _____
request an alternative means of communication of my health information (e.g., mail, telephone, facsimile) or communication of my health information to an alternate location.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by the organization and disclosure by alternative means may not be protected and could endanger me. I understand that request for FAX communication may be intercepted by others and the organization is not responsible if such intercepts occur.

Please describe the protected health information that requires alternative means or alternate location communications:

_____

_____

Please describe in detail your proposed alternative means or alternate location for receiving communications from the organization:

_____

_____

☐ **Alternative Mailing Address:**

_____
Street No.

_____
City State Zip code

☐ **Alternative Means of Contact (Please Specify):**

_____

( ) -
Alternative Phone Number:

Unless otherwise revoked, this authorization will expire **12 months** following the date of signature.
I acknowledge that I have read this form or it has been read to me and I understand its content.

Signature _____ **Date** _____

Relationship to Patient:
If signed by a person other than yourself, please check the relationship and provide proof of authority.

☐ Self ☐ Legal Representative* ☐ Parent of Minor Child ☐ Other (specify)

_____ _____
****Name of Interpreter/Translator (If Required)** **Telephone**

***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.**

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Orlando, FL 32835
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Request for Confidential Handling of Protected Health Information

FOR OFFICE USE ONLY

Request is: ☐ Approved ☐ Denied

Check reason for denial:
☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided
☐ Failure to provide information on how payment will be made (if applicable)
☐ Other (please explain)

Associate's Name: (Print)	Title
Associate's Signature	Date Completed

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Request for Restriction or Termination of Restriction on Uses and Disclosure of Protected Health Information (PHI)

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

I understand that by signing and submitting this form, I am hereby requesting the name of the clinic below to restriction on the use and disclosure or my protected health information.

_____

Name of Clinic

I understand the following:

• This restriction will not apply to any disclosures of PHI that occurred prior to implementation of this request.	• Restrictions will not apply when the restricted information is needed for emergency treatment.
• You may request termination of a previous restriction at any time.	• Restrictions cannot apply to workers' compensation.
• We may voluntarily agree to other requests for restrictions. Any restrictions to which we have voluntarily agreed may be terminated by informing you of the termination.	
• We are not required to agree to this restriction request, unless it is to restrict disclosure of your PHI to a health plan or carrier for treatment or services for which **you have paid in full**. We may remove the restriction if your payment is not honored.	

Request: ☐ Place a Restriction ☐ Remove a previous restriction

Date of Service: _____

Description of information to be restricted _____

_____

Name of Individual /Entity to whom PHI should not be disclosed:

_____

Other: _____

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Orlando, FL 32835
PH: 866-222-0403

Request for Restriction or Termination of Restriction on Uses and Disclosure of Protected Health Information (PHI)

Print Name _____ Date _____

Signature _____

Name of Interpreter/Translator (if required) _____ Phone Number _____

***If a translator or interpreter was required.**

OFFICE USE ONLY

Notice of Decision

Restriction(s) Status:

☐ We have accepted the restriction(s) as requested.

☐ We have accepted only the following portion of the restriction(s):

_____

_____

Termination of Restriction:

☐ Termination requested on previous restriction has been completed

Effective Date: _____

☐ We are informing you that the current restrictions are being terminated

Effective Date: _____

Date request was received: _____

Date request was processed/completed: _____

Facility Name

Office Personnel (Print Name) _____ Date _____

Office Personnel Signature

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Orlando, FL 32835
PH: 866-222-0403

Request For Accounting Disclosures of Protected Health Information

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

By signing below, I am requesting an accounting disclosure of health information for the following period: From: _____/_____/_____ To: _____/_____/_____
Start Date **End Date**

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive or release my accounting disclosures, including the following:

_____
Name of Clinic

I understand that this accounting for disclosures will include disclosures made only to those organizations or persons other than:

• Those occurring prior to April 14, 2003.	• For national security or intelligence purpose.
• To myself or persons involved in my care.	• Pursuant to my authorization.
• To correctional institutions or law enforcement officials under certain circumstances.	• Those exceeding a period of six years prior to the date of this request.
• Those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out your operation.	

I understand that my request for an accounting of disclosures will be processed within 60 days of submitting this form. I will be notified of the need for an extension of not more than 30 days to process the request, the reasons for the delay and the date when I can expect to receive the requested accounting.

Please send this accounting by:

☐ Paper copy ☐ Call at number above to pick up ☐ Mail to address above

☐ CD (must call for password)

☐ *Email: _____

*All emails are routinely sent encrypted, however, I understand that records sent through email poses a security risk and that is my requested method of receipt. (Please Initial) _____

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Request For Accounting Disclosures of Protected Health Information

Print Name _____ Date _____

Signature _____

*Name of Interpreter/Translator (if required) _____ Phone Number _____

***If a translator or interpreter was required.**

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Notice of Decision

Request is: ☐ Approved/Completed

☐ Denied

Reason for denial:

☐ Disclosures occurred prior to April 14, 2003.

☐ Disclosure exceeds more than a six-year period.

☐ No disclosures made for reasons other than those permitted as listed above.

Facility Name _____

Office Personnel (Print Name) _____ Date Request was Processed _____

Office Personnel Signature _____

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Orlando, FL 32835
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Privacy Complaint

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City	State	Zip Code
Phone Number:	Date of Birth	

Use this form to submit a complaint about the Clinic's (***list the name and location of the Clinic below***) privacy practices and/or our compliance with our Notice of Privacy Practices or state and federal privacy laws and regulation. The Clinic will not retaliate in any way and submitting a complaint will not influence your treatment, payment, enrollment or eligibility for benefits.

Once we receive the complaint form, we will conduct a timely and impartial investigation of your complaint and provide a written response upon completion of our review. Please provide all details related to the privacy complaint.

Date of Incident: _____

Name of Facility: _____

Location of Incident: _____

Please describe your Privacy Complaint in detail. Attach additional details on a separate sheet as needed: _____

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Orlando, FL 32835
PH: 866-222-0403

Privacy Complaint

SIGNATURE REQUIRED

Patient Signature: Date:

Legal Representative Signature (if needed): Date:

Name of Interpreter/Translator (if required): Date:

Please note: If you are a legal representative for the patient, you must attach copies of your authorization as required by state law to represent the patient – for example, healthcare power of attorney, healthcare surrogate, living will, or guardianship papers.

To prevent a delay in fulfilling your request, please verify all fields on this form are complete and accurate. If information is missing, we will return the form to you for completion. Please attach a separate sheet if you need more space.

Please send this form to:

Care Delivery Organization
Attn: Compliance Department
6416 Old Winter Garden Rd.
Orlando, FL 32835
1-866-222-0403

OFFICE USE ONLY

Employee Submitting Complaint

Date Submitted to Compliance Date received by Compliance

Compliance Professional

Investigation Started Investigation Completed

Compliance Professional Signature

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)