FIRST NAME:_______________________________________
LAST NAME:_______________________________________
DOB:__/___/_____ GENDER: F or M
SS#____ - ___- ____
ADDRESS: ____________________________ ZIP:___________
CITY:________________ STATE: ____

EMAIL:_______________________________________
PHONE NUMBER: _____________________________
CONSENT TO CALL: YES or NO
CONSENT TO TEXT: YES or NO
EMPLOYER: _____________________ POSITION:_________________

EMERGENCY CONTACT:
NAME:______________________________
RELATIONSHIP:___________________
PHONE NUMBER:________________

PHARMACY:_____________________________________
PHONE NUMBER:________________________________
ADDRESS:_______________________________________
ALLERGIES: _____________________________________
CURRENT MEDICATIONS:
__________________________ DOSAGE:_____________
__________________________ DOSAGE:_____________
__________________________ DOSAGE:_____________
__________________________ DOSAGE:_____________
SIGNATURE:_____________________________________

HIPAA Privacy and Release of Information Authorization / Financial Authorization

I hereby authorize MTU PROPERTIES, LLC DBA FLORIDA WELLNESS GROUP and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it’s employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice’s Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member’s behalf with respect to this authorization form

____________________________________ ____________________________________

Patient Printed Name Date

____

Patient Signature

- I have read and understand the HIPAA/Privacy Policy for , hereby assign my insurance benefits to be paid directly to the healthcare provider, authorize to release medical information required to process my claim, read and understand the Financial Policy for , authorize to obtain/have access to my medication history, and authorize my providers office to contact me by mobile phone

Signed____ Date:_________________