FLORIDA WELLNESS GROUP

FULL NAME: _____ **DOB:**__/___/_____

GENDER: F or **M** **SSN#:** ____ - ____- ____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

EMAIL:_____

PHONE NUMBER: _____

CONSENT TO CALL/TEXT? YES __ NO __

EMPLOYER: _____ **POSITION:**_____

EMERGENCY CONTACT NAME:_____
RELATIONSHIP:_____ **PHONE NUMBER:**_____

PHARMACY NAME AND LOCATION: _____

MEDICATION ALLERGIES: _____

LIST CURRENT MEDICATIONS:

_____

_____

_____

_____

PAST MEDICAL HISTORY: _____

_____

PREVIOUS SURGERIES: _____

_____

TOBACCO USE: YES ___ NO ___
ALCOHOL USE: YES ___ NO ___

SIGNATURE: _____ **DATE:** _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
Obtaining payment from third party payers (e.g. my insurance company);
The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize the following family/friends to retrieve/discuss my medical condition in my absence. Without their names on this list, Florida Wellness Group WILL NOT be allowed to release ANY information. I can refuse to sign this form, or revoke it at any time by completing a new form. I understand that if information is shared with the below individuals it may be subject to exposure by the individual.

Name_____**Relationship**_____

Name_____**Relationship**_____

Signed this _____day of _____20_____.

Print Patient Name_____

Signature_____

Relationship to Patient_____

FINANCIAL POLICY

Thank you for selecting Florida Wellness Group as your healthcare provider. We are committed to providing you the best possible care. Your clear understanding of this financial policy is important to our professional relationship. Our staff will be pleased to discuss our fees and this policy with you at any time. Please read and sign this policy prior to being seen.

1. Payment for services is due at the time services are rendered. For any of your portion that is not covered by insurance, or for our private pay patients, we accept cash, check, MasterCard and VISA.

2. Federal guidelines (Red Flag Rules) require us to have proof of identification of the patient prior to treatment.

3. We are contracted with many insurance plans. Please present your insurance card at the front desk so that we can accurately determine your benefits and file a claim on your behalf. We will follow the insurers guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual differences will be deducted from your balance. Patients covered by any type of insurance plan should remember that they are responsible for all charges incurred, regardless of their plan coverage.

4. **Insurance Claims: Florida Wellness Group; therefore, insurance claims are filed and covered under your Primary Care Provider (PCP) benefits. Please be aware that the balance of your claim is your responsibility regardless of the amount paid by your insurance. Insurance benefits are a contract between you and your insurance company; we are not party to that contract.**

5. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Insurance companies and employers decide what procedures are covered benefits and which are not. Please check your insurance plan documents for any questions. Fees for uncovered services and unmet deductibles and copayments are due at the time of treatment.

6. Your insurance policy is a contract among you, your employer, and the insurance company. We are not party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, copayments, covered charges, secondary insurance and "usual and customary charges"

7. Returned checks and balances older than 90 days are subject to placement with a collection agency.

8. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to our staff so that we can assist you in the management of your account.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Signature: _____Date: _____