



## NEW PATIENT ESTABLISHMENT DEMOGRAPHICS & CONSENT

### PATIENT IDENTIFICATION

- Full Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_
- Mailing Address: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_
- Email: \_\_\_\_\_
- Biological Gender:  Female  Male Gender Identity (if different): \_\_\_\_\_
- Ethnicity:  Hispanic / Latino / Spanish origin  All Other
- Race:  American Indian  Asian  Black  Hispanic  Pacific Islander  White  Other
- Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE & BILLING

- Primary Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_
- Secondary Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_
- Policy Holder Name (if not you): \_\_\_\_\_ DOB: \_\_\_\_\_ Rel: \_\_\_\_\_
- Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

1. **Payment:** Any co-payments, deductibles, and self-pay services are due at check-in.
2. **Plans with Deductibles, Indemnity Plans and Self-Pay Services** require a payment card on file.
3. **Cancellations:** A 24-hour notice for cancellations is required so we can accommodate another patient. A "*no charge*" reminder is sent on first occurrence; a **\$50.00 Fee** is charged for each occurrence after first. We utilize a reminder system that makes it very easy to notify us if your schedule changes.
4. **Administrative:** Trillium Medical Center may be required to release medical information to your insurance to support medical billing, periodic chart reviews and patient risk analysis. All insurance payments for services and procedures are contractually made directly to Trillium Medical Center. A copy of the Insurance EOB (Explanation of Benefits) is provided directly to you, that supports the payment made.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## CLINICAL HISTORY

**Current Health Concerns or Goals** (if any): \_\_\_\_\_

### PAST MEDICAL HISTORY (Check all that apply)

Hypertension    Diabetes    High Cholesterol    Heart Disease/CAD    Stroke

Asthma/COPD    Thyroid Disease    Kidney Disease    Anxiety    Depression

Cancer (Type: \_\_\_\_\_)    Acid Reflux/GERD    Arthritis    Other: \_\_\_\_\_

### SURGICAL AND/OR HOSPITALIZATION HISTORY (Last 5 Years)

1. \_\_\_\_\_ **Date:** \_\_\_\_\_ 3. \_\_\_\_\_ **Date:** \_\_\_\_\_

2. \_\_\_\_\_ **Date:** \_\_\_\_\_ 4. \_\_\_\_\_ **Date:** \_\_\_\_\_

### CURRENT MEDICATIONS AND SUPPLEMENTS (Include Dosage. Provide separate sheet if needed)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Known Allergies:** \_\_\_\_\_

### PREVENTIVE HEALTH TRACKING (List the last **Month/Year** completed, or state **Unknown / NA**)

**Physical Exam:** \_\_\_\_\_ **Blood Work:** \_\_\_\_\_ **Colonoscopy:** \_\_\_\_\_

**Mammogram:** \_\_\_\_\_ **Pap Smear:** \_\_\_\_\_ **Bone Density:** \_\_\_\_\_

**Flu Vax:** \_\_\_\_\_ **Pneumonia Vax:** \_\_\_\_\_ **Shingles Vax:** \_\_\_\_\_

### SOCIAL & FAMILY HISTORY

- **Tobacco:**  Never    Former - Quit Year: \_\_\_\_\_    Current   Packs/Day (Curr or Former): \_\_\_\_\_
- **Alcohol:**  Never    Occasional    Daily / Weekly   # of Drinks Daily \_\_\_\_\_
- **Drug Use (Non-Pharmaceutical):**  \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_
- **Exercise:**  Regular (2 plus times/week)    Sometimes (when I can)    Rarely / Never
- **Family (List relationship):** **Heart Disease:** \_\_\_\_\_   **Diabetes:** \_\_\_\_\_   **Cancer:** \_\_\_\_\_



## REVIEW OF SYSTEMS (ROS)

*(Please check symptoms you have experienced **in the last 90 days**)*

SYSTEM	SYMPTOMS
<b>CONSTITUTIONAL</b>	<input type="checkbox"/> Unexplained Weight Loss/Gain <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Chronic Fatigue
<b>EYES / ENT</b>	<input type="checkbox"/> Vision Changes <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Difficulty Swallowing
<b>HEART / LUNGS</b>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic Cough
<b>GASTRO</b>	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> Nausea
<b>URINARY</b>	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urgency
<b>MUSCULAR</b>	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Neck Pain
<b>SKIN</b>	<input type="checkbox"/> New Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Changing Moles <input type="checkbox"/> Easy Bruising
<b>NEURO / PSYCH</b>	<input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Memory Loss <input type="checkbox"/> Anxiety <input type="checkbox"/> Depressed Mood
<b>OTHER</b>	_____



## HIPAA AUTHORIZATION RELEASE OF HEALTH INFORMATION

### THE PATIENT:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**AUTHORIZATION:** I authorize Trillium Medical Center to request health information that will be used in my continuity of care. This includes any sensitive medical information (STD, HIV/AIDS, alcohol or substance dependence/abuse, and mental health treatment). I understand that I have the right to request that any sensitive medical information is not disclosed by another provider.

### \*\*\* FACILITIES / PHYSICIANS \*\*\*

*Florida SB 1606/HB 1083 has standardized the **response time** for practitioners to provide requested medical records to **no more than 14 days from the receipt of a request**. Should no records exist or you are unable to provide in the required time frame, please advise.*

\_\_\_\_\_  
Physician or Facility Name, PCP or Type of Specialty, City & State, Phone Number if available

\_\_\_\_\_  
Physician or Facility Name, PCP or Type of Specialty, City & State, Phone Number if available

### DISCLOSURE:

- Most recent Progress Note or Last 3 Encounter Notes       Complete Medication List (Current)
- Last 2 Lab Results/Reports within past 1 Year       Pathology Results within past 2 Years
- Imaging / Radiologist Reports within past 1 Year       Other \_\_\_\_\_

### ACKNOWLEDGMENT OF RIGHTS:

**Right to Revoke:** I understand that I may revoke this authorization at any time by delivering a written revocation to the releasing facility, except to the extent that action has already been taken.

**Voluntary Sign-off:** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**Redisclosure:** I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations (HIPAA).

**Expiration:** This authorization will automatically expire **one year** from the date of signature.

#### Statutory Fees:

**Continuity of Care (No Fee):** In accordance with **Florida Statute § 395.3025**, patients whose records are requested for the purpose of **continuing to receive medical care** are not required to pay a fee. As a professional courtesy, digital transfer of records to another medical facility for continuity of care is provided **free of charge**.

**Personal or Non-Medical Requests (Fees Apply):** If records are requested for personal use or non-medical purposes (legal or insurance), I understand that I (or the receiver) will be charged a fee as permitted by **Florida Statute § 456.057** and **Florida Administrative Code Rule 64B8-10.003**. *Current allowed fees: \$1.00 per page for the first 25 pages and \$0.25 per page thereafter.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Telehealth Informed Consent

### What is Telehealth

Telehealth allows you to interact with your healthcare provider remotely (Voice or Video) using a phone, computer, or tablet. There is no need to travel and is convenient when you are sick or need to discuss test or imaging results. For more information visit <https://trilliummedicalcenter.com/telehealth>

### Benefits

- Reduces exposure to infectious diseases.
- Medical consults wherever you are, saving travel time and reducing work & childcare disruptions
- Typically provides quicker physician access, shortening appointment wait times
- May eliminate need for an Urgent Care visit

### Risks

- Information may be insufficient for a proper medical decision, still requiring an office visit
- Lack of actual or incomplete records could cause errors in decisions
- The experience will feel different from in-person visits and primarily what you share
- Diagnosis may be limited without a physical exam and ask you follow up if symptoms persist
- While rare, technical issues may disrupt the session
- Today most networks and devices are secure, but the patient is responsible for what they use

### Privacy

- Telehealth's are NEVER recorded; notes are kept in secure medical records, the same as office visits
- Patients are responsible for being in a private place to avoid being overheard
- Our video technology is HIPAA compliant, but a very small risk of privacy breach exists

### Choice

- Use of Telehealth is OPTIONAL. You will be asked if you consent to a telehealth encounter.

### Cost

- Your insurance sets the rates and in most cases the same insurance co-pays or deductibles apply
- If both telehealth and office visits are needed, insurance treats each as separate visits

### Consent

- Signing means you understand how a telehealth is different, but you're not required to use it.

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**Signature**

*Date*



## HIPAA NOTICE OF PRIVACY PRACTICES (NPP)

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION.*

**PLEASE REVIEW IT CAREFULLY.**

### OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this practice to provide you with quality care and to comply with certain legal requirements.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION

- **For Treatment:** We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in taking care of you.
- **For Payment:** We may use and disclose medical information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations:** We may use and disclose medical information to run the practice and make sure that all of our patients receive quality care.

### YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care.
- **Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information.
- **Right to an Accounting of Disclosures:** You have the right to request a list of the disclosures we made of medical information about you.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations.

### PATIENT DISCLOSURE PREFERENCES

Who do you authorize us to speak with regarding your health. This includes test results and treatment plans.

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*It is okay to leave a detailed message on my voice mail.*

### ACKNOWLEDGEMENT OF RECEIPT

*By signing, I acknowledge that I have reviewed this Notice of Privacy Practices and understand that I am entitled to request a copy for my personal records, now or in the future.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_