MERIT MEDICAL CARE

PATIENT INFORMATION:

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____ Zip. Code _____

( ) _____ Home Phone (with area code) ___/___/___ Date of Birth *M S W D* Marital Status *Male Female* Gender (circle)

Driver's License # _____ State _____ Social Security Number _____

Employer _____ Occupation _____ ( ) _____ Work Phone (with area code)

Responsible Party if other than Patient _____ Relationship _____

RESPONSIBLE PARTY INFORMATION

Address: _____

_____

Social Security #: _____

Home Phone:( ) _____

Work Phone: ( ) _____

INSURANCE INFORMATION: PRIMARY

Insured Name: _____

Relationship: Self Spouse Parent Other

Card Holder's Date of Birth: / /

Carrier: _____

Carrier Address: _____

I.D. #: _____

Group #: _____

EMERGENCY CONTACT: PRIMARY

Name: _____

Relationship: _____

Home Phone:( ) _____

Work Phone: ( ) _____

Primary Language Spoken: _____

SPOUSE'S INFORMATION

Spouse's Name: _____

Occupation: _____

Employer: _____

Social Security #: _____

Work Phone: ( ) _____

SECONDARY

Insured Name: _____

Relationship: Self Spouse Parent Other

Card Holder's Date of Birth: / /

Carrier: _____

Carrier Address: _____

I.D. #: _____

Group #: _____

SECONDARY

Name: _____

Relationship: _____

Home Phone:( ) _____

Work Phone: ( ) _____

Are you in need of translation? Yes No

(Please circle)

MERIT MEDICAL CARE

San Thiha, MD
45 MCLEOD ST
Merritt Island, FL 32953
(321) 452-2016 phone (321) 452-5728 fax

AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Telephone #: _____
Purpose of Release: _____

I hereby authorize Merit Medical Care to: release to or obtain from
(Please Circle)

Name: _____
Address: _____
City, State, Zip: _____
Phone: Fax: _____
any information, including diagnosis and medical records of any treatment or examination rendered to me during the following period:

the past twelve (12) months, OR
from the time period from _____ to _____

and to include any Federal and State protected information under Florida Statute 3 94.459(9) Psychiatric information, Florida Statute 397.501 and Florida Statute 397.112 Drug and/or Alcohol Abuse information and Florida Statute 381.004 and FAC 1OD-93.064 Human Immunodeficiency Virus test results (HIV testing, AIDS and related conditions).

- I understand and direct that this authorization remain in effect until I revoke the authorization in writing to the Privacy Officer at the address above.
- I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.
- I hereby release Quality Medical Care and its employees from any and all liability that may arise from the release of this information as I have directed.

Signature: _____ Date: _____
(Patient, Parent if minor or legal guardian)

Relationship to Patient if signed by personal representative: _____
Witness: _____ Date: _____

Please check here if records will be picked up. Someone will call you when records are ready.
Please check here if records are to be mailed.
For Office Staff Only: Sent certified / return receipt. Date mailed:
Article #:

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Patient Name_____ Date_____

MEDICATION SHEET

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS, THE DOSE, AND HOW MANY TIMES A DAY YOU TAKE THEM

Name of Medicine	Dosage	Per Day

IF YOU NEED HELP FILLING OUT THIS FORM, PLEASE BRING ALL MEDICATIONS WITH YOU TO YOUR APPT.

S:\LINCOLN FORMS\Lincoln Front Office\New Patient Cataract Information\MEDICATION SHEET.doc

MERIT MEDICAL CARE
925 N.COURTENAY PKWY #12
MERRITT ISLAND, FL. 32953
321-452-2016
ADVANCE DIRECTIVE

Dear Patient:

In an attempt to serve you better, please answer the following questions.

Thank you!

[1] Does an Advance Directive exist for you? [ ] Yes [ ] No

If yes, who should we contact?

Name: _____

Telephone #: _____

[2] Do you have a Living Will? [ ] Yes [ ] No

If yes, who should we contact?

Name: _____

Telephone #: _____

Patient Name: _____

Patient Signature: _____

Date: _____

If you would like an information packet, including forms, please ask the receptionist.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

MERIT MEDICAL CARE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do as documented below:

Date: _____

Initials: _____

Reason: _____

_____

Merit Medical Care

PATIENT CONSENT FORM

Patient Consent for Use and Disclosures of Protected Health Information

I hereby give my consent Merit Medical Can to use and disclose protected health information (about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices (NOPP) provided by Merit Medical Care describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Merit Medical Care reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Merit Medical Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Merit Medical Can may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Merit Medical Care may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request in writing that Merit Medical Care restrict how it uses or discloses my PHI to carry out TPO.

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow Merit Medical Can to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Merit Medical Care may decline to provide treatment to me.

Signed by: _____ ___/___/_____ _____

Signature of Patient or Legal Guardian — Date — Relationship to Patient

_____ _____

Print Patient's Name — Print Name of Legal Guardian, if applicable

Patient/Guardian must be provided with a signed copy of this consent form.

Merit Medical Care

Office Policies

Most questions that you may have regarding our office policies will be found on these pages. If you have additional questions, please contact the office staff for more information.

Appointments

- To schedule an appointment, call the Merit Medical Care (321)452-2016 that you would like to establish as a new patient or continue your care. The telephone will be answered from 8AM to 5PM Monday through Friday.
- Established patients with an urgent problem are seen the same day. Routine office visits can be scheduled within one week.
- Patients "walking-in" to the office without an appointment will be worked in only as the schedule permits, and may be turned away or offered an appointment 'later that day if the schedule permits. It is strongly recommended that for true emergencies all patients go to the nearest emergency department
- For new patients, we require a complete physical examination. We can frequently work-in a new patient the same day, but established patients have priority.
- If you have moved since your last visit, or if you have changed insurance carriers recently, please be sure to notify the office staff.
- Cancellations are required no later than 24 hours before the scheduled visit. Exceptions are made for unusual circumstances. Please refer to our "No Show" policy.

Prescription Refills

- We prefer that you leave prescription refill requests with your pharmacist. We use electronic prescription that can be authorized online the same day when pharmacies send request.
- You may also leave a refill request in our voicemail (321) 458-9541. We check our voicemail at 8AM, 12PM, 4PM on weekdays. we will have the prescription written for you to pick up or call to the pharmacy of your request within 24 hours.
- For SCHEDULED DRUGS such as narcotic pain killers and tranquilizers, patient must be seen by physician. Random urine toxicology may need in such patients.
- We do not process routine prescriptions after hours. NO EXCEPTIONS. It is patient's responsibility to call in refill request timely before they run out.

Phone Calls

- If you need to speak with the office staff or the doctor about any matter, please call during our regular business hours.
- We encourage using our voicemail for non urgent message and prescription refill.
- When calling after office hours, you will be greeted by the answering machine then forward to physician's cell phone.

Emergencies and After Hours Care

- For life threatening emergencies such as chest pain, severe shortness of breath, or serious trauma, CALL 911. Do not drive yourself or have someone else drive you to the emergency room. The life squad is always safer. Do not come to the office; go to the nearest hospital emergency room.
- For serious or urgent matters, call the office and the doctor will be given your message personally during business hours.
- In the event that you need care after hours or on weekends, your call will be forwarded to the doctor's cell phone. We ask that you limit your after hours calls to urgent medical situations only.
- We intend to give the best service for our patient, but abusing this service on non urgent matter will result in the patient discharge from our practice.
- Depending on patient's presenting symptoms, we may call in some medications. There is patient responsibility to have followed up visit within reasonable time (a few days). For non-compliant patient, we will not offer such services in the future.

No Show Policy

- Due to an unusually large number of patients who do not show for their appointments and who do not call in advance to cancel those appointments, we have been forced to institute a "No Show" policy. This policy does not apply to patients who call to cancel their appointment 24 hours or more in advance of the scheduled visit, or to patients who have sudden emergencies less than 24 hours who present to the emergency room.
- After the first "No Show," the patient will receive a phone call and a friendly reminder that the office visit was missed.
- After the second and subsequent missed appointments, a "missed appointment" charge of forty-five dollars will be sent to the patient. This charge is not billable to the insurance company.
- The patient will not be permitted to schedule a routine office visit until the payment is received.
- Repeated "No Shows" may result in the doctor withdrawing from the patient's care requiring the patient to find a new physician in another group to provide that patient's heath care.

Insurance Referrals

- Some HMO's require a referral from the primary care physician before they will agree to pay for services provided by a specialist. This rule is often waived in the case of Gynecologic care, but each HMO makes its own rules, so you need to know what your HMO's policies are.
- We will process all referral requests for you, but we require at least 3 days notice before a scheduled visit.
- Referral requests may be made either at the time of an office visit, or by telephone.
- We cannot backdate insurance referrals. It is your responsibility to give us the correct insurance information at least 3 days before your visit to the specialist.

Health Insurance

- We will file insurance claims for you for services rendered by our office.
- Payment is expected at the time of service for all charges not covered by insurance.
- All co-payments must be made at the time of service.
- Some services we provide may not be paid by your insurance company. We will file the claim in case they do pay. However, we require you to sign a waiver permitting us to balance bill you if the insurance company denies the claim.
- We participate in most local insurances. If we do not have a contract with your insurance plan, they will deny the claim. In such a case, you are responsible for our charges, and payment is expected at the time of service.

Waivers

- What is a waiver? When you come for your office visit, you will be asked to sign a waiver that states you are accepting financial responsibility for "any charges incurred from rendered services" during that office visit which are not covered by your insurance company.
- Why do I need to sign a waiver? Many insurance companies, including Medicare, are denying payment to physicians for services, procedures, and/or testing, which they feel are routine or not necessary even though your doctor feels that they are reasonable and necessary. If you refuse to sign the waiver, we will be unable to see you for anything other than emergent care, since we do not know prior to receiving payment from your insurance company what services they will or will not pay.
- How do I know if I will have to pay for a non-covered service? You will not be billed at the time of service, but will receive a bill for non-covered services only after your insurance company and any applicable co-insurance has denied payment.

Billing and Account Information

- Any questions about your account, including billing problems, questions about coverage, past due notices, account balance, should be addressed by calling the billing office.
- You may pay your bills by mailing back payment in the envelope received with your bill, or via credit card in the office that you receive your care.

Records Release

- It takes our office fourteen business days to process records requests. Records will be released to any physician upon your written request and authorization as a courtesy. There is a charge of $1 per page for the first 25 pages, then $0.25 per page thereafter for any other requests for records.

Form Completion

- Our office charges $25 for the completion of forms. These charges are your responsibility and will be billed directly to you.

NOTICE OF PRIVACY PRACTICES SUMMARY

Merit Medical Care

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

PLEASE CAREFULLY REVIEW THIS NOTICE!

Who's required to abide by this notice?

- Any healthcare professional that is authorized to enter information into your medical record.
- All employees, staff, and other healthcare personnel who make up Merit Medical Care.
- All departments and units of Merit Medical Care, including the laboratory, billing and administration.

Our pledge regarding medical information
We understand that medical information about you and your health is personal; therefore we are committed to protecting this information. This notice also will tell you about the ways in which we may use and disclose your medical information.

We are required by law to make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to your medical information, and follow the terms of the notice currently in effect.

We may use and disclose medical information about you for: treatment, payment, healthcare operations, appointments reminders, treatment alternatives, health-related benefits and services, individuals involved in your care or payment for your care, research, as required by law, and to avert a serious treat to health or safety.

Special situations in which we may disclose information about include: to the military/veterans, worker's compensation, public health risks, health oversight activities, lawsuits and disputes, law enforcement, coroners, medical examiners, funeral directors, national security and intelligence activities, protective services for the United States president and others, and inmates.

Other uses and disclosure of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

You have the following rights regarding medical information we maintain about you including: the right to inspect and have a copy of your medical records, request an amendment to your medical records, request an accounting of disclosures for any disclosures outside normal Merit Medical Care operations, and/or request confidential communications in our dealings with you. You also have the right to receive a paper copy of this notice.

Changes to this notice: We reserve the right to change this notice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Merit Medical Care or with the Secretary of the US Department of Health and Human Services. To file a complaint with Merit Medical Care please write to Merit Medical Care, 925 N Courtenay Parkway Merritt Island FL 32953. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You will be given a copy of the complete Notice of Privacy Practices and be asked to sign that you have received that copy on your first office visit following the April 14, 2003 date as mandated by the Federal Government.

CONSENT TO TREATMENTS

My signature below indicates that I hereby give my consent to Merit Medical Care (MMC) to provide medical treatment to myself or the named patient.

INSURANCE AUTHORIZATION

My signature below indicates that I authorize MMC to release any pertinent medical or health information to the Social Security Administration or its intermediaries, carriers for Medicare claims, or to my insurance carrier or its representative, any information necessary to process an insurance claim I permit a copy of this authorization to be used in place of its original and request that payment of medical insurance benefits be made to Merit Medical Care. Regulations pertaining to Medicare Assignment of benefits apply.

MMC'S STATEMENT ON HIPAA

The Health Insurance Portability Accountability Act (BIPAA) was enacted to protect and enhance the rights of patients by providing them with access to their health information and controlling the inappropriate use of that information to reduce fraud and abuse, and to improve the quality of healthcare by restoring trust in the healthcare system. MMC will maintain your personal and health information in the strictest confidence; MMC will not sell, transfer, copy, distribute or share your personal and health information with any other persons not directly involved in the continuity of your health care without your expressed written consent to do so in accordance with HIPAA guidelines. MMC is committed to implementing measures to comply and adhere to the rules set forth by this act.

APPOINTMENT POLICY

Appointments are reserved especially for you. MMC makes every effort to schedule times that accommodate your needs. We make every effort to see all patients on time and request that you extend the same courtesy. Any changes in the schedule greatly affect other patients. If you are late for your appointment, you will need to reschedule. We require a 24 hour notice for any appointment change. We realize that situations arise which sometimes prevent you from giving as the courtesy of 24 hour notice, however, we ask that you make every effort to comply with this policy. Consistent missed appointments (no-shows) may result in a formal discharge from the practice. My signature below indicates that I have read and agree to abide by the terms of MMC's Appointment Policy.

FINANCIAL POLICY

MMC strives to maintain a high level of professional care while keeping costs at a minimum. Payment is expected a he time of treatment by either personal check with proper identification, credit card or cash. Insurance plans are accepted providing-that we are able to verify your eligibility prior to or at the time of visit. Deductibles and co-pays are collected at the time of service. All' fees are the responsibility of the patient or responsible party.. In the event your insurance carrier does not make payment within 90 days from the date of treatment, any remaining balance will be shifted to the patient or responsible party.

My signature below indicates that I have read and agree to abide by the terms of MMC's Financial Policy.

_____ ____/____/_____

Patient or Responsible Party Signature Date

MERIT MEDICAL CARE

HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from Merit Medical Center, please complete this form.

I authorize the persons listed below to have access to any and all of my health information, including HIV, drug and alcohol abuse and psychiatric records. Merit Medical Care is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons authorized to receive my medical information (full name and phone number):

_____

_____

_____

_____

You may notify me or the parties listed above with normal test results, appointment, reminders and other information regarding my health information as follows:

_____Message on answering machine - Phone number _____

_____Message on work voice mail - Phone number_____

_____Message pager - Phone number_____

_____Message on cell phone - Phone number_____

_____Other_____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____

Patient — Print Name Witness- Print Name

_____ _____

Patient — Signature Witness- Signature

_____ _____

Patient — Date of Birth MMC Patient account #

Date:

Merit Medical Care

I have received a current copy of Merit Medical Care office policies.

Print Name	Signature	Date