AFM HEALTHCARE
Giving you a LIFETIME of CARE

Winter Park:407-657-2111 ***Oviedo:*** 407-537-9852
Fax Number: 866-725-4812
Locations:
Winter Park: 7221 Aloma Ave, Suite 200., Winter Park, FL 32792
Oviedo: 1410 W. Broadway St. Suite 201., Oviedo , FL 32765

DEMOGRAPHICS

***Last Name:** ***Date of Birth**

***First Name:** **Sex:** ◯ **Male** ◯ **Female**

***Street Address:** **SSN**:

City: **State**: **Zip code:**

Home Phone: ***Cellphone:** **Language:**

***Email**

Do you have a living will or advance directives? ☐ **Yes** ☐ **No**

***Emergency Contact**
Name: Phone Number:
Relationship to you:

PRIMARY INSURANCE CARRIER:

Member ID : Group No:

Policy Holder Name ☐ Self

Date of Birth:

Phone Number:

Relationship to Patient
☐ Spouse
☐ Child

SECONDARY INSURANCE CARRIER:

Member ID : Group No :

Policy Holder Name:

Date of Birth:

Relationship to Insured
☐ Spouse
☐ Child

How did you find us? (Please check one)
Doctor: Family:
Insurance Provider:
Web: ☐ Google ☐ Facebook ☐ Web MD ☐ Healthgrades

PHARMACY INFORMATION:
PRIMARY PHARMACY:
SECONDARY PHARMACY *only if applicable:*

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Number of Children

Race
☐ Asian
☐ Asian Indian
☐ Black
☐ White
☐ Decline to Specify
Other

Ethnicity
☐ Hispanic
☐ Non- Hispanic

Employment Status
☐ Full-time
☐ Part-Time
☐ Retired
☐ Unemployed
Other

Occupation

Student
☐ Full-time
☐ Part-time

Authorization for Treatment

I authorize **AFM Healthcare** to perform procedures and treatment including administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary. I authorize the release of any medical information necessary (including the release of HIV/ AIDS, Mental Health, Substance Abuse- to include alcohol and drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to AFM Healthcare in the event of another health insurance becoming primary over my health insurance. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by AFM Healthcare.

Signature of Patient or Legal Representative **Date**

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HEALTH QUESTIONNAIRE:

Name: _ DOB: _

MEDICATION LIST

Name	Dose	Frequency

Are you allergic to any Medication? _ YES _ NO

If ***yes,*** please list them and the reaction they cause**.**

Name of the Previous PCP and Specialists you follow with:

Name	Specialty	Phone Number

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HEALTH QUESTIONNAIRE:

Name: _____ DOB: _____

Past Medical History of Diagnosis

☐ High Blood Pressure	Please list any other medical problems:
☐ Heart Disease	
☐ Diabetes, Type ____	
☐ High Cholesterol	
☐ Cancer	
☐ Thyroid	
☐ Asthma	
☐ Lung Disease	

Please list any surgeries/Hospitalization (Including the year)

Family History

If any relative has suffered from the following conditions, please check the box, and indicate which relative)

☐ Heart Disease	☐ High Cholesterol	Other
☐ Diabetes	☐ Hypertension	
☐ Thyroid	☐ Cancer	
☐ Stroke	☐ Glaucoma	

Social History

Tobacco Use: ☐ Yes ☐ No _____ a day Number of years used: _____
Year Quit: _____

Alcohol Use: ☐ Yes ☐ No _____ drinks per week Street Drugs: ☐ Yes ☐ No
Specify: _____

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HEALTH QUESTIONNAIRE:

Name: _____ DOB: _____

Please place a checkmark next to any symptoms that you are currently having.

GENERAL	☐ Fever ☐ Night Sweats ☐ Weight loss/Gain ☐ Fatigue
SKIN	☐ Rashes ☐ Cancer ☐ Change in Hair, Skin or Nails
EYES	☐ Glasses ☐ Contact Lens ☐ Pain ☐ Changing Vision
EAR NOSE AND THROAT	☐ Ear Pain ☐ Change in Hearing ☐ Persistent Runny Nose ☐ Sore Throat ☐ Change of Voice ☐ Sinus Trouble
HEART	☐ Chest Pain ☐ Swelling in Ankles ☐ Palpitations ☐ Murmur
LUNGS	☐ Cough ☐ Shortness of breath ☐ Wheezing
GASTRO-INTERESTINAL	☐ Nausea ☐ Blood in Stool ☐ Ulcers ☐ Heartburn
GENITO-URINARY **Women:** **Men:**	☐ Blood in Urine ☐ STD ☐ Painful Urination ☐ Incontinence ☐ Vaginal Discharge ☐ Change in menstrual Cycle ☐ Testicular Pain ☐ Decreased Urinary Stream ☐ Penile Discharge
ORTHOPEDIC	☐ Painful Joints ☐ Muscle Weakness
NEURO/PSYCH	☐ Seizures ☐ Tremor ☐ Paralysis ☐ Frequent Headaches
	☐ Depression ☐ Anxiety
ALLERGY	☐ Hives ☐ Hay Fever
CIRCULATION	☐ Leg Swelling ☐ Blood Clots

Preventive Health Screening

Procedure			DATE
Mammogram (Female Only)	YES ☐	NO ☐	
Pap Smear (Female Only)	YES ☐	NO ☐	
Prostate Test (Male Only)	YES ☐	NO ☐	
Colonoscopy	YES ☐	NO ☐	

IMMUNIZATION	**DATE**		
Tetanus			
Hepatitis			
COVID-19			
Flu Shot			
Shingles/Zoster Vaccine			
Pneumonia Vaccine			

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AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION/MEDICAL RECORDS

Patients Name: _____ DOB: _____
Telephone No. _____ SS#: _____

I hereby authorize AFM HEALTHCARE to:

☐ Request Information from ☐ Release Information to

DOCTOR/ NAME/ORGANIZATION _____ TEL. _____
ADDRESS: _____ FAX: _____
SPECIALIST: _____

PLEASE RELEASE THE FOLLOWING:

☐ All records in the past 2 years of treatment
☐ Lab Results/Pathology Reports
☐ Radiology Reports
☐ Drug abuse
☐ Alcohol abuse
☐ Mental health
☐ Others: _____
☐ HIV test results
☐ Immunization Records
☐ Pharmacy/Prescription Records

**NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, Ca DX, Drug/Alcohol abuse, or sexually transmitted disease, you are hereby authoring disclosure of this information.*

REASON FOR RELEASE/ REQUEST:

☐ Continuation of patient care
☐ Specialist Consult
☐ Personal Use
☐ Other: _____
☐ Attorney/Legal

RELEASE BY: *only use this for release of information only*

☐ FAX
☐ EMAIL: _____ ENCRYPTED ☐ YES ☐ NO
☐ PRINT

Consent:

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization at any time in writing. I have the right to receive a copy of this information. I understand that I may be charged for copies provided, for personal use ($1/page for the first 25pgs and $0.25 per page thereafter). This authorization is valid for one year from the date it was signed.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient or Legal Representative

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Patients Name: _____ DOB:_____

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

I give permission for the following person(s) to pick up prescriptions, schedule and receive any of my personal health information on my behalf. I understand that no prescriptions or health information will be released other than to the person(s) listed below.

- **Persons listed below will be required to present a driver's license or other state/ federally issued photo ID when picking up prescriptions, billing information, and /or any personal health information.**

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

_____

_____ _____

Signature of Patient or Legal Representative **Date**

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Name: _____ DOB: _____

Financial Agreement

Please read <u>each</u> item contained in our payment policy.

1. For **<u>MEDICARE ONLY</u>**: AFM is a Medicare Participating Provider, which means Medicare tells us the amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay 80% and you (or your supplemental insurance) will pay 20%. Your out-of-pocket expense is limited to the yearly deductible that you need to pay before Medicare pays and the 20 percent do-payment mandated by Medicare. The 20% may be covered by another secondary insurance if you have one.
If you have a secondary insurance policy, we will file with that secondary insurer after we receive a response from Medicare. You will receive a bill from us the month following Medicare's response. We allow 60 days from the date Medicare responds for your supplemental policy to pay. After 60 days, the balance becomes your responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Copayments and Deductibles. All copayments and deductibles must be upon the visit. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying your co-payment.

3. Proof of Insurance. All patients must complete their patient information form before seeing the doctor. We must obtain a ***<u>copy of your driver's license and current valid insurance to provide proof of insurance</u>***. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. Claims. Please be aware that the balance of your claim is **<u>your responsibility</u>** whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

5. Non-payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may discharge you from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

6. Payment plan. We offer a monthly payment plan if you meet the criteria. If you are interested just call our office and we will be glad to assist you through the process and explain the options available.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Legal Representative **Date**

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(A) NOTIFIER(S):AFM HEALTHCARE

(B)PATIENT NAME:

{C)IDENTIFICATION NUMBER:

FOR MEDICARE PATIENTS ONLY

ADVANCE BENEFICIARY NOTICE OF N0NC0VERAGE **(ABN)**

NOTE: If **Medicare** doesn't pay for *Injections and Lab Test,* you may have to pay.
Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the Office Visit and Lab Test below.

(D) Laboratory Test	*(E)* **Reason Medicare May Not Pay:**	*(F)* **Estimated cost:**
- Hemoglobin AlC	- Medicare does not pay for this test	$100 - $200
- PSA (Prostate Specific Antigen)	for your condition.	$100
- PTH (Parathyroid Hormone)	- Medicare does not pay for this test as often (denied as too frequent)	$100 - $200
-Testosterone Level		$100-$200
-Injections		$100-$200

WHAT You NEED To Do Now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the laboratory test and injection listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance you might have, but Medicare cannot require us to do this.

{G} OPTIONS: Check only one box. We cannot choose a box for you.

D OPTION 1. I want the laboratory test and injection listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund and payments I made for you, less copays or deductibles.

D OPTION 2. I want the laboratory test and injection listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare is not billed**.

D OPTION 3.1 don't want the laboratory test and injection listed above. I understand with this choice I am not responsible for payment, and I **cannot appeal to see if Medicare would pay**.

{H) **Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) **Signature:**	*(J)* **Date:**

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AFM Healthcare Office Protocol

1. Patient's Right and Responsibilities - A copy of our "Patient's Rights and Responsibilities" is included with this package and is available at our website www.afmhealthcare.com. Please read over these as they address our responsibilities to you as a patient and your responsibilities as a recipient of AFM Healthcare services.

2. Communication

2.1 **Telephone Calls**- We are very committed to providing you with fast and easy communication; however, we need your assistance to make it possible. Always say your "name, telephone numbers where you can be reached, the reason for the call and convenient times to reach you". **Please be reminded that we will return your phone call within 24-48 hours.**

2.2 **Healow**- We are using Healow as the fastest way to communicate with us. Using this portal, you can send us a message, ask for a refill, check your appointment times and view your progress notes. Please sign up for secure messaging via the patient portal. Check with our office staff for detailed information about this service.

3. Emergencies

Office Hours: If there is an emergency during normal working hours (8:30-5:00pm), please contact the office and tell the staff members the nature of the emergency. You will be assisted in obtaining the services you need.

After Hours: I**f** you need emergency assistance after hours, please call our office and follow the prompts. Phone calls to the main office will be forwarded to our answering service. The on-call physician will be paged for calls requiring immediate attention. All other calls will be directed to our office during regular office hours.
Life threatening emergencies: If the situation is life threatening, please call 911 or go to the nearest ER.

4. Cancellation of appointments- We send you reminders 48 hours before your appointment, via text, call and Healow patient portal. We have reserved the time for you and will not be able to offer that time slot to another patient. For this reason, you are asked to contact us **24 hours in advance if you need to cancel a scheduled appointment, to avoid the late cancellation charges of $25.00. A fee of $25.00 will be charged if you miss the appointment.** Please make every effort to make and keep timely appointments with your provider.

5. Prescriptions - For routine medication refill, please be reminded to call our office 1 week before your medication is completely gone.

Please do not go to the pharmacy and wait for your prescription. Please allow 24-48 hours for your request to be processed.

Medications such as **Antibiotics or Narcotics** will not be refilled by phone and **require an office visit unless stated by your provider.**

In accordance with our pain policy AFM Healthcare will not prescribe or manage chronic pain with narcotics or opioids until you've been seen by your primary care provider. In addition, no narcotics will be maintained on the clinic premises. In accordance with recommendations by the Federation of State Medical Boards, we will direct those patients in need of the use of controlled substances to pain specialists and experts for further evaluation, treatment, and monitoring.

6. Fees - Please make sure that every time you visit our office you are aware of your insurance benefits and patient due responsibilities. It will be important for us to have that information as well as any changes, so we may assist you in using your benefits appropriately.

Please give your insurance information and changes to office staff as soon as it is available. Failure to provide updated insurance information may result in non-payment by insurance payors and you will be responsible for the full amount.

Co-payment and co-insurance fees are due and payable in full before seeing the provider. We accept cash, credit cards and checks. Make checks payable to "AFM Healthcare". We will submit claims to your insurance companies for processing. However, if we do not work with your insurance carrier you can opt for self-pay. **We charge a $35 service fee for returned checks.**

7. Confidentiality- We comply strictly with your Healthcare records, and we follow HIPAA rules. No records of your treatment will be released outside AFM Healthcare, without written permission from you. You should know that there are some unusual circumstances under which your clinician may release treatment information without your authorization. These situations are (1) an emergency involving imminent danger or harm to self or another. (2) court order (3) physical or sexual abuse of a minor, and (4) if a crime is threatened or committed at one of our sites against any of our staff. Our patient care coordinator will discuss these conditions with you if you have any concerns.

8. Referrals- If other specialty care is required your family doctor will:
Refer to another specialist, if it is medically appropriate.
If you are a member of a managed care health plan (or HMO), you are responsible for following the rules of your plan. Generally, an HMO requires that you call our office for a referral before seeing a specialist. Each plan has its own regulations. So be sure you understand your responsibilities.
Please allow at least five business days to process a referral. A written referral will be completed for you by the referral coordinator.

9. Forms -We charge the following fees for forms:

1. FMLA, Short Term Disability Form, Employment Accommodation form, Animal Support Letter - $35.00
2. Medical Records - Retrieval Fee $25 + (First 25 pages $1.00, $0.25 for the subsequent pages)

10. Lab Test- Insurance plans cover certain preventive services with no cost sharing for the patient. "No cost sharing" means you are not responsible for a copayment, co-insurance, or deductible for these services. Our office does not know the specific benefits of every insurance plan. Each patient is unique. Any lab test order during your preventive/annual visit is specific to you individually and is determined by your encounter with your physician. There is a lab test we believe is important for every patient to have when they come in for a preventive/annual visit, regardless of age and current health status. These lab tests can provide information about health problems at a stage that has not yet produced any physical signs or symptoms of illness. A wide variety of conditions can be identified including liver disorder, diabetes, thyroid disease, anemia, leukemia, and blood clotting factors. If it is possible that you may be responsible for a portion of the charges for these tests. If you do not want to have these tests performed, then please inform your physician or medical assistant. You may choose to contact your insurance company to see what your coverage level.

11. In-office Procedures – Our practice provides in-office procedures such as **Joint injections, Eye Exam, ABI, Spirometry, EKG testing, Blood draw, Urine test, Pregnancy test, Flu swab, Strep Throat Swab, Skin Biopsy, PAP Exam, Vaccine Administration.** Your insurance will be billed for these procedures. If it is possible that you may be responsible for a portion or a full amount for these tests If the service is not covered by your insurance. If you do not want to have this procedure performed, then please inform your physician or medical assistant. You may choose to contact your insurance company to see what your coverage level is.

I have had the full opportunity to read and consider the contents of:

- AFM Healthcare *Notice of HIPAA Privacy Practices* containing a description of the uses and disclosures of my health information.
- AFM Healthcare *Office Policy*
- AFM Healthcare *Payment Policy*
- AFM Healthcare *Patient's Rights and Responsibilities*
- *AFM Healthcare Consent of Medical Treatment*
- AFM Healthcare *ABN (Advance Beneficiary Notice of Non-Coverage for Medicare)*

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HIPAA PRIVACY NOTICE:

AFM Healthcare is required by law to keep the privacy of your health information and to provide individuals with notice of its legal duties and privacy practices with respect to health information. AFM Healthcare must abide by the terms of the Notice currently in effect. AFM Healthcare reserves the right to change the terms of its notice and to make the new notice provisions effective for all PHI (Protected Health Information) that it supports. This Notice of Privacy Practices and Policies outlines our practices, policies and legal duties to maintain confidentiality and protect against prohibited disclosure of protected health information ("PHI") under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").PHI includes your demographic information such as name, address, telephone number, and family; past, present, or future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information may be used to identify you. Your PHI may be kept by us electronically and/or on paper. We may amend this Notice of Privacy Practices and Policies periodically. The new notice will be effective for all PHI that we keep at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices or you may obtain a copy by accessing our website at www.afmhealthcare.com, by calling the office, 407-657-2111 and asking that a revised copy will be sent to you in the mail or asking for one at the time of your next appointment.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI.

If a representative is a court appointed legal guardian, a copy of court documents must be supplied and kept in medical records.

Your health records may be released to the following:

- *To other health- care professionals within the organization for the purpose of providing you with quality health care.*
- *To your insurance provider for the purpose of the organization receiving payment for providing you with needed health care services.*
- *To public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.*
- *To other health care providers in the event, you need emergency care.*
- *To a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication)*

Your confidential health-care information may be released only after receiving written authorization from you.

The following are your rights:

- *You may revoke your permission to release confidential health care information anytime.*
- *You may restrict the disclosure of your protected health information for any services provided whereby you or somebody else pays. "Out of pocket", in full, for the services.*
- *You may be contacted by AFM Healthcare to remind you of any appointments.*
- *You have the right to opt out of any notifications about healthcare treatment options and marketing that are offered to you.*
- *Right to receive confidential communication about your health status.*
- *Right to review and photocopy any/all portions of your healthcare information.*
- *Right to make changes to your health care information*
- *Right to know who has accessed your health care information and to know what purpose.*
- *Right to own a copy of this privacy notice upon request.*
- *Right to complain to AFM Health care if you believe your rights to privacy have been violated. Please mail your complaint to*

AFM Healthcare
7221 Aloma Ave, Suite 200-400 B
Winter Park , FL 32792

For further information about this HIPAA Privacy notice please call 407-657-2111 and www.afmhealthcare.com
This notice is effective. 02/18/2020.