Patient Registration

PLEASE PRINT

CURRENT PATIENT INFORMATION

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Sex: _____ Date of Birth: _____ Social Security No.: _____

Email: _____

Required by government mandate (although you may refuse)

Language: _____ Race: _____

Ethnicity: _____ Marital Status: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Mobile Phone: _____

PHARMACY INFORMATION

Name: _____

Address: _____

Phone: _____

LAB INFORMATION

Name: _____

Address: _____

Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____

Member ID# _____

Subscriber's Information (If other than Patient)

Last Name: _____

First Name: _____

Sex: _____ Date of Birth: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____

Member ID# _____

Subscriber's Information (If other than Patient)

Last Name: _____

First Name: _____

Sex: _____ Date of Birth: _____

Relationship to Patient: _____

_____ _____

Signature of Patient or Parent, Guardian, Legally Authorized Representative

Date

LifeChoices Family Medical info@lifechoicesmedical.com FAX: 844-971-6901

Acknowledgment & Authorization of Medical Information

This notice describes how medical information about you may be disclosed. Please review carefully.

LifeChoices Family Medical, a DBA of LifeChoices Women's Care, Inc will use your medical information for the following purposes:

1. ***Treatment***: *Including providing your medical records to consulting clinicians and insurance companies.*
2. ***Payment***: *We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay your claim.*
3. ***Health Care Operations***: *Any others involved in your healthcare.*

*****Please initial each section, sign and date at bottom.*****

_____ The entire Privacy Policy Notice of LifeChoices Family Medical is available on the website: www.LifeChoicesMedical.com, from the receptionist and in the waiting room for my perusal. I acknowledge the Notice of Privacy Policies.

_____ I hereby assign my insurance benefits to be paid directly to LifeChoices Family Medical.

_____ I authorize LifeChoices Family Medical to release medical information required to process my claim.

_____ I have read and understand the Financial Policy of LifeChoices Family Medical.

_____ **I authorize LifeChoices Family Medical to permit the person listed below access to my health and/or billing information** ***(PLEASE CIRCLE THE LEVEL OF AUTHORIZATION)***

PORTAL & MESSAGING ACCESS LEVEL: ***FULL ACCESS*** ***BILLING ONLY***

_____

Name **Relationship** **Phone Number**

_____ I authorize LifeChoices Family Medical to obtain/have access to my medical history.

_____ I authorize LifeChoices Family Medical to communicate with me by a phone call, an email, by text and/or by mail.

_____ _____

Signature of Patient or Legal Guardian Date

Authorization for Release of Protected Health Information (PHI)

Name: _____ Date of Birth: _____

Address/City/ST/Zip: _____

By signing this form, I authorize the release of protected health information (e.g., medical records)

Release records FROM:

NAME OF PERSON/ORGANIZATION: _____

FAX: _____

CONTACT PHONE: _____

Send records TO: **LIFECHOICES FAMILY MEDICAL**
18560 NORTH DALE MABRY HWY
LUTZ, FL 33548

FAX: 844.971.6901
PHONE: 813.948.7734

Please select the type of information to be used or disclosed (include dates where appropriate)

- ☐Entire record
- ☐Medication list
- ☐Problem List
- ☐List of allergies
- ☐Immunization records
- ☐Most recent history & physical
- ☐Lab results
- ☐X-ray & Imaging reports
- ☐Other (please explain): _____

I further authorize the release of following information which may be included in my medical records

- ☐Alcohol/Substance Abuse treatment
- ☐STD/HIV/AIDS-related information
- ☐Genetic testing
- ☐Mental Health information (Excluding Psychotherapy)
- ☐Psychotherapy Notes
- ☐Other
- ☐Do not release alcohol/substance abuse, Mental health, STD, HIV/AIDS or genetic information

This authorization will be valid for one (1) year unless a shorter time period is listed below.

Expiration Date Period: _____

I understand the information in my health record may include information relating to sexually transmitted disease and other reportable disease, AIDS/HIV. It may also include psychiatric or mental health services, and treatment for alcohol and drug abuse. By not selecting any of these options above, I understand sexually transmitted diseases, mental health, and drug abuse will not be disclosed.
I have the right to revoke this authorization at any time by contacting LifeChoices Family Medical. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
I understand there is a fee for obtaining medical records and I agree to pay for such charges.
If I have any questions about disclosure of my PHI I can contact LifeChoices Family Medical's Privacy Officer at 813.948.7734.

Signature: _____ Date: _____

Print Name: _____ Signature by: ☐Patient ☐Legal Guardian ☐Proxy

Financial Policy

Self-pay patients
Patients who are self-pay are to pay in full prior to seeing the practitioner. An itemized receipt is available.

Insured patients
Your insurance policy is a contract between you and your insurance company. It is your responsibility to make sure we are accepted by your plan. Failure to disclose all active insurance health policies will result in claim denials and out-of-pocket patient responsibility. As a service to you, we will file your insurance claim, if you assign the benefits to our practice.

a. At the time of service, **we require a credit card to be on file to cover charges not paid by insurance**. If you choose not to have a credit card on file, we will charge you our self-pay rates and you will need to file the receipt with your insurance company. Upon receipt of notification by the insurance company, we will transfer the balance to your credit card on file.

b. **If you are required to pay a copayment it is due at the time of service.** If applicable, coinsurance/deductibles will be charged to your credit card on file after insurance claims are processed. In some instances, we will know in advance what to charge you for services.

c. Not all insurance plans cover all services. **In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge.**

d. **Combined Visits**: If you are scheduled for a preventive visit, and other health concerns are brought up that would typically require an office visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.

e. If your insurance company does not pay the practice within 90 days, we expect payment from you. The transfer of the cost will be put on your credit/debit card after 90 days. If we later receive a check from your insurer, we will refund any overpayment to you.

You will be responsible for the costs associated with any referrals for outside medical services. The practice reserves the right to bill you for any collection or attorney fees for unpaid debt.

NO SHOWS **--The practice reserves the right to bill you $50.00 for appointments not cancelled 24 business hours in advance.** You will need to cancel by phone call (813) 948-7734 and not by email, text or the patient portal. A Monday appt would need to be cancelled on the previous Friday**.** New patients who fail to show will not be rescheduled.

LATE FEE **-- If you are 10 or more minutes late to your appointment, out of respect for the other patients following your appointment, LifeChoices reserves the right to reschedule your appointment to a later time and a $25.00 fee will apply.**

SERVICE FEE FOR PAPERWORK **– You will be charged a $25.00 service fee for the completion of paperwork such as for FMLA, Disability, and the like**.

Fees will be directly billed to you and are not covered by insurance.

AFTER HOURS/TELEHEALTH/E-VISITS – Anticipate that there may be charges for after hours calls, for telehealth appointments and for e-visit interactions through the patient portal where the physician/nurse practitioner is providing medical services.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Responsible Party) **Date**

LifeChoices Family Medical info@LifeChoicesMedical.com FAX: 844-971-6901

Adult Care Informed Consent

I, the undersigned, hereby consent to the following treatment:

administration and performance of all treatments, administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests and cultures and performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I acknowledge that I have been given the opportunity to read and secure a copy of LifeChoices Family Medical's Notice of Privacy Practices (laminated copy displayed in waiting room and ask for a hardcopy from the front desk staff member). I understand that if I have questions or complaints that I should contact the Privacy Official.

By signing this consent, I authorize LifeChoices Family Medical to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. A photocopy of this consent shall be considered as valid as the original.

Patient Name	Signature of Patient or Parent, Guardian, Legally Authorized Representative	Date

FEMALE CONSENT FOR PELVIC EXAMINATION as mandated by FL Statute 456.51: A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I authorize and direct LifeChoices Family Medical and all its medical providers and medical students who will be performing the examination to perform a pelvic examination, including vaginal sonography, as described above.

Patient Name	Signature of Patient or Parent, Guardian, Legally Authorized Representative	Date

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to LifeChoices Family Medical.

Patient Name	Signature of Patient or Parent, Guardian, Legally Authorized Representative	Date

Pediatric Care Informed Consent

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize LifeChoices Family Medical to examine and treat the name referenced minor. Authorization shall remain in effect until the child reaches the age of maturity (18) or until revoked by legal parent/guardian.

CONSENT OF A MINOR WHEN PARENT NOT PRESENT

Person(s) over 18 authorized to accompany my child:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

I authorize LifeChoices Family Medical to render medical care to my child. I consent to any medical care and treatment for my child's health and well-being. This authorization will remain in effect until terminated by written notice.

CONSENT OF A MINOR 16-18 YR OLD TO BE TREATED WITHOUT MY PRESENCE

If applicable, I authorize my children who are 16 and up to 18 years old to be treated for medical services without my presence. **(Circle one)** YES I do not give permission

INSPECTION AND PALPATION OF THE EXTERNAL GENITALIA

PURSUANT TO FLORIDA STATUTES SECTION 456.51

The American Academy of Pediatrics recommends that all children and adolescents have an Annual Well Visit where screenings and a complete physical exam are completed. One component of a complete physical exam is inspection and palpation of the external genitalia to ensure normal age-appropriate development and to document that there are no abnormalities. We will verbally inform you/the patient prior to doing this part of the exam, as we know there is sensitivity, but we need to ensure each patient has been evaluated appropriately. Additionally, if a child or adolescent presents with complaints that could be attributed to the genital area or rectum, we may need to examine the genitals and/or complete a rectal exam to ensure an accurate diagnosis. Florida has passed a new law that requires any health care practitioner that is examining or treating a patient's pelvic region will need to obtain a written consent.

Though we do not perform examination of the ovaries, uterus, and fallopian tubes in our offices, given the broad definition of "pelvic examination" 1 in the passed Florida legislation, in an abundance of caution, we are choosing to obtain the consent of each patient or their legally authorized representative for examination of external genitalia. This consent applies regardless of gender.

CONSENT FOR EXAMINATION OF EXTERNAL GENITALIA

By signing below, the patient (or the patient's legal representative) acknowledges that he/she has been given the opportunity to ask questions about the external genitalia examination before signing this Informed Consent and that the patient (or the patient's legal representative) has voluntarily agreed to the external genitalia examination by a health care practitioner. If the patient lacks the capacity to sign this Informed Consent, this form will be signed by the person authorized to consent for the patient.

Under Florida law, prior to performing a pelvic examination, consent must be obtained. While we do not perform internal pelvic exams in our office, the components below are included in the Florida law and may be performed at this examination or work-up:

- External genitalia examination, including of the penis, scrotum, vagina, and/or labia
- Examination of the perineal area or perianal area or rectum
- Administration of a suppository or other rectally administered medication
- Taking of a rectal temperature in an infant
- Evaluation and reduction of labial adhesions or penile foreskin adhesions
- Placement of a Urinary Catheter
- Collection of rectal or vaginal samples via swab for laboratory analysis

The **RISKS** to the examination include (but are not limited to): discomfort or infection.

1 Florida Statutes §456.1 (Consent for Pelvic Examinations) broadly defines Pelvic Examination to include all the following: examination of the vagina, rectum, OR external pelvic tissue OR organs using any combination of modalities which many include the health care practitioner's gloved hand OR instrumentation.

The **RISKS** associated with failing or refusing to undergo the examination elements above include: the inability to obtain a diagnosis and/or delay in diagnosis of a medical condition; the inability for the health care provider to have accurate and complete information necessary to appropriately treat the patient; and, potential for infection for situations in which the provider is unable to take a rectal temperature.

The **REASONABLE ALTERNATIVES** include a refusal for the intervention assessment. In such case, shared decision making between the patient and his/her provider is vital to ensure health and wellbeing.

The **BENEFITS** include ability to obtain a diagnosis of a medical condition and the ability for the health care provider to have accurate and complete information necessary to appropriately treat the patient.

TREATMENT OF A MINOR FOR A SEXUALLY TRANSMITTED DISEASE

PURSUANT TO FLORIDA STATUTES SECTION 384.30(2)

Medical provider may examine and provide treatment for sexually transmissible diseases to any minor. The consent of the parents or guardians of a minor is not a prerequisite for an examination or treatment. The fact of consultation, examination, and treatment of a minor for a sexually transmissible disease is confidential and exempt from the provisions of s.119.07(1) and shall not be divulged in any direct or indirect manner, such as sending a bill for services rendered to a parent or guardian, except as provided in s.384.29.

CONSENT FOR PHOTO RELEASE OF A MINOR

I give permission to LifeChoices Family Medical to publish in print, electronic or video format the likeness of my child(ren). I release all claims against the practice with respect to copyright ownership and publication including any claim for compensation related to use of the materials. **(Circle one)** YES I do not give permission

I acknowledge that this consent was given freely and voluntarily. I also acknowledge that I understand the information in this form, including the purpose, risks, and benefits of the pelvic examination, and that I have had my questions answered.

Patient Name	Signature of Parent, Guardian, Legally Authorized Representative, Minor*, or Patient over the Age of 18	Date