TALLAHASSEE MEDICAL GROUP

**Thomas A. Zorn, M.D.**
**317 Norton Drive, Suite 101**
**Tallahassee, Fl 32308**
**(P) 850.702.5940**
**(F) 850.325.6022**

## Dear New Patient,

Welcome to our practice!

All of us at Dr. Thomas Zorn's office are excited that you have chosen us to become part of your healthcare family.

Before your appointment, there are a few things that we need from you. Enclosed with this letter you will find your new patient information. Please fill out the forms and return them to our office as soon as you can. It is vital that we have this information well before your appointment so that we can be prepared to take care of you.

If you have not already done so, please request your records to be transferred to our office. If you need a records release form, you will find it enclosed at the end of this packet. Just fill it out and take or mail/fax it to your prior doctor's office. This way we will have your past medical records before you arrive. Please let us know if you need help with filling out the release or would like us to fax it for you.

We look forward to meeting you soon! If you have any questions prior to your appointment, please feel free to contact us at 850-702-5940, Option 1.

Have a wonderful day!

Dr Thomas A. Zorn and Staff

# Thomas A. Zorn, M.D.

## Registration Form

First name_____ MI____ Last Name_____ Suffix____

Mailing Address _____Apt_____City_____ ST____ Zip _____

Date Of Birth_____ Social Security #_____ Gender ☐ Male ☐ Female

Home Phone_____ Cell_____ Work _____

☐ Employed Occupation _____ ☐ Not currently working ☐ Retired ☐ Disabled ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse/Partner Name:_____

Primary Insurance: _____ ID# _____ Group # _____

Secondary Insurance: _____ ID# _____ Group # _____

Subscriber Name: _____ Subscriber D.O.B. _____ Subscriber Social:_____

**Medical History:** Please check any medical conditions you have experienced in the past or are currently experiencing.

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Dementia | ☐ High Blood Pressure | ☐ Thyroid disease |
| ☐ Anemia | ☐ Depression | ☐ High Cholesterol | ☐ Other: _____ |
| ☐ Anxiety | ☐ Diabetes | ☐ Liver disease | _____ |
| ☐ Asthma | ☐ Epilepsy | ☐ Pacemaker | _____ |
| ☐ Cancer | ☐ Gout | ☐ Sleep Apnea | ☐ Pediatric Patients: Any issues at birth? |
| Type:_____ | ☐ Heart disease | ☐ STD/STI | _____ |
| ☐ COPD/Emphysema | ☐ Hepatitis | ☐ Stroke | _____ |

**Social History:**

Level of Education: ☐ Completed High school/GED ☐ Some College ☐ Completed AA/ BA/ MA ☐ Other_____

Faith/ Religion: _____

Exercise: ☐ Yes ☐ No How Many Times per Week? _____

Tobacco: ☐ Yes ☐ No How many packs per day? _____ For How many years? _____

Have you quit? ☐ Yes ☐ No If so, when? _____ If not, are you interested in trying? ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No How many servings per week? _____

Sexual Activity: ☐ Active ☐ Inactive

**Demographics:** Simply check "Prefer not to share" for the information you do not wish to provide. Thank you for your cooperation.

Primary Language:_____ Do you need an interpreter? ☐ Yes ☐ No

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Prefer not to share

Race: ☐ Caucasian/White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More Than One Race ☐ Prefer not to share

**Preferred Pharmacy Information**

**Local Pharmacy: _____ Location: _____**

**Mail Order Pharmacy: _____ Location: _____**

**Medications:** Please list or attach a current list of all medications you are taking including prescription, over the counter and herbals/supplements.

| *Name of medication:* | *Dose:* | *Frequency:* | *Name of medication:* | *Dose:* | *Frequency:* |
|---|---|---|---|---|---|
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**Immunizations:** Please check shots you have had and list the year or attach records.

☐ Pneumovax 23 _____ ☐ Prevnar 13 _____ ☐ Shingles/"Shingrix"_____

☐ Tetanus _____ ☐ Whooping Cough _____ Pediatric Patients: Up to date on shots? ☐ Yes ☐ No

**Please indicate the appointment date or year of your last exam and with whom:**

Annual "Physical" Exam _____ Eye Exam _____

Dental Exam _____ Colonoscopy _____

***Females only:***

Pap Smear _____ Mammogram _____

Bone Density _____

**Allergies:** Please list all medication/food allergies and their associated reactions.

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

**Surgical History:** Please list all surgeries with dates/year.

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

**Family History:** Please list any blood relatives with the following chronic illnesses. ( Example: Diabetes: *Sister, maternal aunt* )

Alcoholism: _____ High Blood Pressure: _____

Asthma: _____ High Cholesterol: _____

Cancer: _____

Diabetes: _____ Kidney Disease: _____

Heart Disease: _____ Mental Illness: _____

Other: _____

**Would you like to receive a portal invite? Please provide your email if so: _____**

# Patient's communication Instructions, Patient's Release and Acknowledgment

Patient Name (Please PRINT): _____
Date of Birth: _____/_____/_____
Patient Address: _____
City: _____ State: _____ Zip Code: _____

**INSTRUCTIONS FOR THIS FORM ARE AS FOLLOWS:**
I would like to **UPDATE, AUTHORIZE, or CHANGE MY AUTHORIZATION** for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare. Effective: _____/_____/_____

**Which of the following communication means are acceptable for our office?** *(*Please select all that apply*)*

_____HOME Number: _(_____)_____
_____WORK Number: _(_____)_____
_____CELL Number: _(_____)_____

_____TEXT **YES** ☐ **NO** ☐ Number: _(_____)_____ (*for appointment*)

_____EMAIL _____
*(Emails will be used for portal communication/access ONLY)*

Who are you **AUTHORIZING** our office to discuss your health situation with? *(Please list ALL names)*
_____Discuss with **NO ONE**

_____Spouse Name: _____ Relationship: _____
_____Parent Name: _____ Relationship: _____
_____Parent Name: _____ Relationship: _____
_____Child Name: _____ Relationship: _____
_____Sibling Name: _____ Relationship: _____
_____Other Name: _____ Relationship: _____
_____Other Name: _____ Relationship: _____

**IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?** (This person is only authorized in case of emergency unless listed above)
Name: _____ Relationship: _____ Phone: _(_____)_____

This authorization will expire on: _____/_____/_____ (If no date is specified, it will expire upon your written amendment and instructions through your execution of change to the information contained on this form via a completion of a new/replacement form).

**By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Medical Groups Notice of Privacy Policies.**

_____ _____/_____/_____
**Signature of Patient or Legal Guardian** **Date**

If not the patient, explain relationship/legal authority: _____

TALLAHASSEE MEDICAL GROUP

**PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION**

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Medical Group ("TMG") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Medical Group prior to signing this document, and I acknowledge that the TMG Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Medical Group is also available on the website for TMG at www.TallahasseeMedicalGroup.com. I understand that my physician is a part of TMG, and that this notice applies to the protected health information that my physician, as a part of TMG, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TMG, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TMG participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.hienetworks.com is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. **I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Privacy Officer to TMG Privacy Office at 1511 Surgeons Drive, Tallahassee, FL 32308.**

TMG reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseeMedicalGroup.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TMG of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

**A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.**

**IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE**

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange (“HIE”).

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Medical Group. participates in and provides patient information to HIE’s in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through HIE Networks (www.hienetworks.com)

**PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION**

HIE Networks is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction
Unless you specifically opt out as provided below your personal health information will be provided to organizations such as HIE Networks under secure methods with HIPAA compliant agreements. Tallahassee Medical Group and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation can be found at www.HIENetworks.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Patient name: Print: _____ Sign: _____

Parent/legal guardian name (*if patient is of minor age*): Print: _____ Sign: _____

Date: _____ Explain your relationship to patient: _____

*Tallahassee Medical Group (TMG) does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.*

# Consent for Services of a Minor Child

In almost all cases, Tallahassee Medical Group (TMG) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services at physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Tallahassee Medical Group, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing TMG and its medical professional to provide medical care must be signed by the appropriate person.

I, (We) _____ and _____ do hereby state that I am (we are) the parents or legal guardians of (child's name) _____, of minor age born on _____.

***Please Initial options below****

_____ (I) We authorize and consent to all professional services provided at or arranged within the primary care office and their ancillary department(s).

_____ (I) We authorize and consent to any medically necessary treatment within the primary care office only and not ancillary department(s).

_____ (I) We do not give consent for _____(list specific test/services) services.

**The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parent and/or legal guardian.**

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

**Consent expires on: _____** *(If not dated, then it will expire one year from signed date)*

Patient name: Print: _____ Sign: _____

Parent/legal guardian name (*if patient is of minor age*): Print: _____ Sign: _____

Date: _____ Explain your relationship to patient: _____

# *Tallahassee Medical Group*

## FINANCIAL POLICY

- **Payment is due at time of service**: We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are processed by the insurer. We will notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you an unable to make payment in full at the time of service.**
- **Our Billing Services:** We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our website for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. **PLEASE NOTE TMG IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY HMO PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMNT WITH THE HMO PLAN. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR HMO.**
- **Co-Pays, Deductibles, and Co-Insurances:** Your share of co-pays, deductibles, and co-insurance are your responsibility and payment are due at time of service. The portions of our charges that are your responsibility are based on your contract with your insurer and are your part of the contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- **Secondary Insurances:** If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- **Tertiary Insurance, if applicable:** Tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at time of the appointment.
- **Charges for missed appointments (generally termed "no-show fees"):** A **$25.00** fee will apply if you fail to present to an appointment without notifying us at least 24 hours in advance:
- **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question or believe there is an error on your statement, or if you have any concern about your statement transactions, please contact us in a timely manner. We reserve the right to avoid the cost of sending statement to patient who have a small balance outstanding (usually less than $5.00). Our front staff will collect the balance at your next office visit for small balances.
- **Financial Promissory Agreement:** If you are unable to make payment in full for your portion of financial responsibility at time of service, you will be required to sign **a Financial Promissory Agreement** giving you 14 calendar days to submit payment in full**. If you do not make payment within 14 calendar days, we will assess an additional $25.00 administrative fee to the original co-pay, deductible, or co-insurance due.**
- **Collections**: If no payment is received within 90 days, your account is considered delinquent and may be referred to an outside collection agency. **Referral to outside collections may damage your credit, so we strongly urge you to contact our office to work out a payment arrangement in order to avoid this.**

*If you have questions or concerns about of Financial Policy procedures or fees your physician's office or billing department can help.

**My signature below certifies that I have read, understand, and agree to the terms and conditions of this Financial Policy.**

**Patient Name (PLEASE PRINT): _____ Patient DOB _____/_____/_____**

**Patient Signature: _____**

## Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name _____ Date of Birth _____

(Last, First, Middle/Maiden)

Patient's Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: _____

I authorize my physician and/or administrative and clinical staff at **Tallahassee Medical Group** or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

| **Person or Healthcare Facility to Receive Information:** | **Physician or Healthcare Facility to Disclose Information:** |
|---|---|
| Name/Organization: TMG- Dr. Thomas A. Zorn, MD | Name/Organization: _____ |
| Address: 317 Norton Drive, Suite 101 | Address: _____ |
| City, State, Zip: Tallahassee, FL 32308 | City, State, Zip: _____ |
| Phone: 850-702-5940 Fax: 850-325-6022 | Phone: _____ Fax: _____ |

**SPECIFIC INFORMATION TO BE DISCLOSED** (check all that apply):

___ Complete Medical Record ___ Billing Records ___ Office Notes ___ Ultrasound Reports

___ Lab Reports ___ Surgery Records ___Mammogram Reports

___ Obstetrical (OB) Records ___ Pap Smear / Biopsy Reports ___Other (specify): _____

**DATES OF SERVICE:** _____

**PURPOSE**:_____ Changing Physicians _____ Personal Copy to Patient _____ Attorney _____ Insurance_____ Workers' Compensation

Other _____

**This authorization will expire on**: _____(If no date is specified, it will expire 60 days after date signed).

**CHECK AND INITIAL BELOW:**

_____ I DO_____ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.

*Initials of individual giving authorization*: _____

_____ I DO_____ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**.

*Initials of individual giving authorization*: _____

_____ I DO___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.

*Initials of individual giving authorization.* _____

I have read and understand the nature of this authorization and I have been provided a copy of TMG's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at ***Tallahassee Medical Group, Administrative Offices 1511 Surgeons Drive, Tallahassee, Florida 32308, Attn: Compliance Officer or email Compliance@TallahasseeMedicalGroup.com.*** I understand that a revocation is not effective to the extent that my physician or Tallahassee Medical Group has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect TMG's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____

Signature of Patient or Patient's Representative Witness

_____ _____

Relationship to Patient Date