PATIENT PERSONAL HISTORY

Date:_____

Confidential Record: Information contained here will not be released unless you authorize us to do so.

Last Name	First	Middle	Birth Date	Age	Birth Place
Address	City	State	Zip	Home Phone	Business Phone
Occupation	SS Number		Cell Phone	E-Mail Address	
Sex	Race		Marital Status		

Person to Notify in case of Emergency:_____ Relationship:_____

Address:_____ Phone:_____

Date of your last Physical Examination:_____ Doctor:_____

FAMILY HISTORY

Father's Age: _____Living: _____ Deceased: _____Cause of Death/Age:_____

Mother's Age _____Living: _____ Deceased: _____Cause of Death/Age:_____

Do you or your direct family (blood relative) have/had any of the following? If so who? If deceased please provide age at death

Cancer:_____
High Blood Pressure: _____
Stroke: _____
Asthma: _____
Kidney Disease: _____
Mental Illness: _____
Seizures: _____
Diverticulitis: _____
Hernia: _____
Other Disease: _____

Heart Disease: _____
Diabetes: _____
Migraine: _____
Anemia: _____
Thyroid Disease: _____
Alcoholism: _____
Hepatitis: _____
Gout: _____
Kidney stones: _____
Leukemia: _____

PERSONAL HABITS (Circle Y or N)

Smoke: Y / N _____per day for_____years Year quit:_____

Alcohol: Y / N How many per week?_____

Exercise: Y /N How many days per week?_____

*****CONTINUE TO NEXT PAGE*****

List All Medications (including supplements – name, dosage, and regiment):

_____
_____
_____
_____

Allergies (drug or food) or N/A

_____
_____
_____
_____

Surgeries/Major Medical Illnesses:

_____
_____
_____
_____

Review of Systems (circle if you currently have any of the following symptoms or diseases):

Neck Stiffness	Heartburn	Anxiety
Shortness of breath	Nausea	Back pain
Breast pain / lump	Chest pain	Loss of appetite
Nosebleed	Rapid heart rate	Joint swelling
Numbness	Diarrhea	Urinary problem
Weakness	Cold intolerance	Hot intolerance
Cough	Easily bruising	Rash
Headache	Vomiting	Depression

Describe briefly your present medical symptoms:

_____
_____
_____
_____
_____
_____

I, the patient signed below, certify that the above information is correct. I understand and agree that: **1**. I am responsible to provide correct information on this form, and that I may become financially responsible for services if insurance information provided is incorrect or incomplete; **2.** I am responsible to pay all co-payments at the time of service; **3.** TMG will file my insurance as required by contract, where applicable, and that I am responsible for full payment to TMG for services provided when TMG is a non-participating provider; 5. TMG will hold me responsible to pay costs of collection through outside collection agencies or other legal means, should that become necessary; 6. TMG will release pertinent medical records to insurance companies for documentation of today's service in order to process medical insurance claims.

Patient Name (Please Print):_____

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 Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization: Taylor Larson MD	Name/Organization:_____
Address: 2056 Centre Point LN	Address:_____
City, State, Zip: Tallahassee, FL 32308	City, State, Zip_____
Phone: 850-792-3160 Fax: 850-792-3160	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 ____Paper 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 agents 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 pertaining 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 Office at ***Tallahassee Medical Group, Administrative Offices 1511 Surgeons Drive, Tallahassee, Florida 32308 Attn: Compliance Office*.** I understand that the revocation is not effective to the extent that my physician of 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 the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan eligibility for the 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 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
(If applicable, attach documentation of guardianship or Power of Attorney)

Patient's Communication Instructions, Patient's Release and Acknowledgement

Patient Name (PRINT): _____

Date of Birth: _____

Patient Address: _____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):

____ I would like to UPDATE or CHANGE my telephone number and/or email contact information

____ I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communications and disclosures concerning my healthcare

____ I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communications and disclosures concerning my healthcare

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Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

____ Home phone number – leave message to return call – NO particulars NUMBER:_(_____)_____

____ Home phone number – leave message with particulars NUMBER:_(____)_____

____ Cell number - leave message to return call – NO particulars NUMBER:_(_____)_____

____ Cell number – leave message with particulars NUMBER:_(_____)_____

____ I would like to receive text message for appointment reminders NUMBER:_(_____)_____

____ Email _____
(Please do not assume that email will be used by your physician for communication)

Who are you authorizing our office to discuss your health situation with? (Please list all names)

____ Discuss with no one

____ Spouse: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Child: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Child: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Sibling: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Sibling: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Other circle AUTHORIZED or UNAUTHORIZED Name:_____

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

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 a change to the information contained on this form via a completion of a new/replacement form).

_____ _____
Signature of Patient or Legal Guardian Date

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

Race Ethnicity Questionnaire

Patient Name _____ **Date of Birth** _____

Email Address _____

Due to changes in healthcare regulation, we are required to seek some additional information from our patients. Please assist us in updating your medical records as prescribed by the Federal Register:

"In general, we do require that all demographic elements that are listed in the objective be included in a record in certified EHR technology. However, we do not desire, nor could we require that a patient provide this information if they are otherwise unwilling to do so. If a patient declines to provide the information or if capturing a patient's ethnicity and race is prohibited by state law, such a notation entered as structured data would count as an entry for purposed of meeting the measure"

Wednesday, July 28, 2010
Part II
Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 412, 413, 422, et al.
Medicaid and Medicare Programs;
Electronic Health Record Incentive Program; Final Rule

Please note that providing the information below is completely voluntary. Simply check "Prefer not to share" for the information that you do not wish to provide. Thanks for your cooperation.

Gender: Male_____ Female_____

Ethnicity: Not Hispanic or Latino_____ Hispanic or Latino_____

Prefer not to share_____

Race: Caucasian_____ American Indian or Alaska Native_____

Asian_____ Black or African American_____

More than one race_____ Native Hawaiian_____

Other Pacific Islander_____ Prefer not to share_____

Your doctor would like to make sure that we provide education materials to you in your language of choice. Please indicate your language preference below:

Primary Language: English_____ Other (please specify):_____

_____ _____
Patient/Parent/Guardian Signature Date

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.centralishealth.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 Centralis Health activities directly to our Privacy Officer 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 by 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 Centralis Health (www.centralishealth.com)

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

Centralis Health 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 Centralis Health 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.centralishealth.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Patient name (Please Print): _____ **Patient DOB:** _____/_____/_____

Patient Signature: _____

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: _____