PATIENT REGISTRATION

Patient Name: _____Date of Birth: _____

Mailing Address: _____City:_____State/Zip:_____

Home Phone:_____Cell Number:_____ Work Phone _____

Hispanic or Latino _____ Race _____ Ethnicity _____ Declined _____

Email address: _____ Social Security #: _____

Sex: M_____F_____ Unknown _____ Marital Status: Unmarried____, M____, D____, W____, Other___

Occupation: ____Employees, ____Full-Time Student, ____Part-Time Student, ___Retired___, Self-Employed___, Unemployed_____

Employer:_____Occupation:_____Business Phone:_____

Emergency Contact: _____ **Phone:**_____

Emergency Contact Relationship to Patient:_____

Emergency Address:_____

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____

Insurance Company Name _____
Telephone Number _____

Subscriber ID (Policy Number)_____ Group ID: _____Copay:_____

Effective Date_____ Termination Date:_____

Insurance Company
Address:_____

SECOND INSURANCE INFORMATION:

Name of Insured:_____

Insurance Company Name _____
Telephone Number:_____

Subscriber ID (Policy Number)_____ Group ID: _____Copay:_____

Effective Date_____ Termination Date:_____

Insurance Company
Address:_____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature:_____Date:_____

Patient Consent for Use & Disclosure of Protected Health Information & HIPAA Privacy

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

I have the right to review the Notice of Privacy Practices prior to signing this consent. Internal Medicine Practices reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Internal Medicine Practices.

With this consent, Internal Medicine Practices may call my place of residence 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, Internal Medicine Practices may mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that Internal Medicine Practices 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 the agreement.

By signing this form, I am consenting to allow Internal Medicine Practices 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, Internal Medicine Practices may decline to provide treatment to me.

TPO Definition: Treatment, Payment, Operation

Patient/Parent/Guardian/Patient Representative Signature: _____ Date: _____

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

Please list all the people whom we may inform about your general medical condition and diagnosis:_____

Please list all the persons that we may inform about your condition in an emergency situation only:_____

I, the undersigned certify that I or my dependent have insurance with

(name of insurance):_____

And assigned directly to Dr._____, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of the signature on ALL insurance submissions.

Responsible Party Signature:_____ Relationship to Patient:_____ Date:_____

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship

Prescription Order Pick-up.

There may be times when you need a friend or family member to pick-up a prescription order (script) form your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient/Representative Initials) **I wish** to designate the following individual to pick up a prescription order on my behalf:

Name:_____Date:_____

Name:_____Date:_____

(Patient/Representative Initials) **I do not want** to designate anyone to pick-up my prescription order (script)

Patient/Parent/Guardian/Patient Representative Signature: _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed): _____

Advance Directive/ Living Will/ Power of Attorney/ 5 Wishes/ DNR

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply: We would like a copy for our records.

_____ I have executed an Advanced Directive

_____I have NOT executed an Advance Directive

Check the one(s) you have and can provide copies of to our office:

_____Living Will

_____Durable Medical Power of Attorney

_____5 Wishes

_____Do Not Resuscitate (DNR)

Internal Medicine Practices
Quality Care for Better Quality of Life

Consent to Release Confidential Information

Patient Name: _____Date of Birth: _____

I hereby authorize request that a copy of my medical records be released as follows: (check one)

RECORDS TO BE RELEASED TO: INTERNAL MEDICINE PRACTICES

( ) 8550 NE 138th Lane, Bldg. 800
Lady Lake, FL 32159 Tel: 352-391-5299

( ) 2736 Dora Avenue, Tavares, FL 32778
Tel: 352-742-1707

Fax (if less than 10 pages): 949-543-2074 or Email: info@impmd.com

RECORDS TO BE RELEASED FROM:

1. _____ Fax: _____
2. _____ Fax: _____
3. _____ Fax: _____

_____This release is to cover **ALL records** contained in my file.

_____This release is to cover **ALL hospital records** needed for continuum of care

_____This release is to cover ALL records contained in my medical chart EXCEPT:

_____ Any psychiatric records/ treatment
_____ Any drug related records/ treatment
_____ Any alcohol related records/ treatment

I understand that the purpose of the record release is for continuity of my medical care. The information contained in my medical records (s) may include diagnosis, evaluation and/ or treatment of any mental or emotional condition (s). This may also include alcohol and/ or drug related addictions. Information regarding HIV infection with any probable causative agent of AIDS are also considered a part of my medical record. The expiration of this release is one year from the date of signature. I may revoke this authorization at any time by notifying and providing Internal Medicine Practices in writing. The written revocation will be effective on the date of notification except to any actions already taken. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal privacy regulations. By authorizing the use or disclosure if information, there will be no conditions placed on my health care of payment of my health care. I have the right to receive a copy of this form after I have signed it. In compliance with Florida State Law, I may be required to pay a fee for any retrieval and photocopying of records and/ or supervising inspections of medical records.

_____ _____

Patient/Parent/Guardian/Patient Representative Signature Date

_____ _____

Witness Date

Patient Responsibility Form

The patient is responsible for providing Internal Medicine Practices with the most correct, active and up to date information about their insurance prior to each visit.

Internal Medicine Practices will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines by providing correct information at tine time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.

Patients are responsible for the payment of co-pays at the time of service.

Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.

Internal Medicine Practices is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance

In the event a patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.

Patients have the right to check with their insurance about coverage before receiving any service provided at Internal Medicine Practices.

The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether our physicians participate.

The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.

If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.

Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.

The patient agrees that in return for the services provided to them by Internal Medicine Practices, they will pay their account at the time service is rendered or upon insurance claim processing- If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If copayments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to Internal Medicine Practices.

Worker's Compensation and Automobile Claims. Internal Medicine Practices does not accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding Internal Medicine Practices policies regarding patient responsibilities.

_____ _____

Patient/Parent/Guardian/Patient Representative Signature Date

HEALTH HISTORY QUESTIONNAIRE

Internal Medicine Practices
Quality Care for Better Quality of Life

Please complete this entire questionnaire. It will provide your care team with important information about your health.
All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:_____ ☐ M ☐ F **DOB:**_____

Date:_____ **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children:_____ **How many live with you?**_____ **Occupation is/was:**_____

Previous or referring doctor:_____ **Date of last physical exam:** _____

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ None

Immunizations and Dates: ☐ Tetanus_____ ☐ Pneumonia_____ ☐ Hepatitis A_____ ☐ Hepatitis B_____

☐ Chickenpox_____ ☐ Influenza_____ ☐ MMR *Measles, Mumps, Rubella*_____ ☐ Meningococcal_____ ☐ None

Tests/Screenings and Dates: ☐ Eye Exam_____ ☐ Colonoscopy_____ ☐ Dexa Scan_____

Surgeries

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have had no surgeries

Other hospitalizations

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have never been hospitalized

Have you ever had a blood transfusion? ☐ Y ☐ N

Please list other physicians you have seen in the last 12 months, and for what reason.

_____

_____

_____

_____

_____

Name (Last, First, M.I.):_____ DOB _____

YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pain/Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ H IV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease, Cancer, or Significant Medical Illness
- ☐ NONE of the Above

List other past medical problems:_____

_____

_____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

☐ List additional drugs on back of questionnaire

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Allergies

Name_____ Reaction You Had _____

☐ I have no known **drug** allergies

FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: ***(ONLY** include parents, grandparents, siblings, and children)*

☐ I am adopted and do not know biological family history

- ☐ Family History Unknown
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Other Cancer
- ☐ Rectal Cancer
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Stroke/CVA of the Brain
- ☐ Thyroid Problems
- ☐ NONE of the Above

☐ Mother, Grandmother, or Sister developed heart disease before the age of 65

☐ Father, Grandfather, or Brother developed heart disease before the age of 55

Father: Alive _____ Deceased _____
Mother: Alive _____ Deceased _____

Name (Last, First, M.I.):_____ DOB _____

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise

Do you exercise? ☐ Y ☐ N

If yes, how many minutes per week?_____

Diet

Are you dieting? ☐ Y ☐ N If yes, are you on a physician prescribed medical diet? ☐ Y ☐ N

# of meals you eat in an average day?_____

Rank salt intake ☐ Hi ☐ Med ☐ Low

Rank fat intake ☐ Hi ☐ Med ☐ Low

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day?_____

Alcohol

Do you drink alcohol? ☐ Y ☐ N

If yes, what kind?_____ How many drinks per week?_____

Are you concerned about the amount you drink? ☐ Y ☐ N

Have you considered stopping? ☐ Y ☐ N

Have you ever experienced blackouts? ☐ Y ☐ N

Are you prone to "binge" drinking? ☐ Y ☐ N

Do you drive after drinking? ☐ Y ☐ N

Tobacco

Do you use tobacco? ☐ Y ☐ N

☐ Cigarettes – pks./day_____ **or** pks./week _____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____

☐ # of years_____ ☐ Previous tobacco user - year quit _____

Drugs

Do you currently use recreational or street drugs? ☐ Y ☐ N

Have you ever given yourself street drugs with a needle? ☐ Y ☐ N

☐ I prefer to discuss with the physician

Sex

Are you sexually active? ☐ Y ☐ N

If yes, are you and your partner trying for a pregnancy? ☐ Y ☐ N

If not trying for a pregnancy list contraceptive or barrier method used:_____

Any discomfort with intercourse? ☐ Y ☐ N

Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Y ☐ N

Mental Health

Is stress a major problem for you? ☐ Y ☐ N

Do you feel depressed? ☐ Y ☐ N

Do you panic when stressed? ☐ Y ☐ N

Do you have problems with eating or your appetite? ☐ Y ☐ N

Do you cry frequently? ☐ Y ☐ N

Have you ever attempted suicide? ☐ Y ☐ N

Have you ever seriously thought about hurting yourself? ☐ Y ☐ N

Do you have trouble sleeping? ☐ Y ☐ N

Have you ever been to a counselor? ☐ Y ☐ N

Name (Last, First, M.I.):_____ DOB _____

Personal Safety

Do you live alone? ☐ Y ☐ N

Do you have frequent falls? ☐ Y ☐ N

Do you have vision or hearing loss? ☐ Y ☐ N

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Y ☐ N

How often do you have sun exposure? ☐ Occasionally ☐ Frequently ☐ Rarely

Have you ever experienced a sunburn? ☐ Y ☐ N

How often do you wear your seatbelt? ☐ Occasionally ☐ Frequently ☐ Always

These questions are for WOMEN ONLY

Age at onset of menstruation:_____ Date of last menstruation:_____ Period every_____days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Y ☐ N

Number of pregnancies:_____ Number of live births:_____

Are you pregnant or breastfeeding? ☐ Y ☐ N

Have you had a D&C, hysterectomy, or Cesarean? ☐ Y ☐ N

Any urinary tract, bladder, or kidney infections within the last year? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Any problems with control of urination? ☐ Y ☐ N

Any hot flashes or sweating at night? ☐ Y ☐ N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Y ☐ N

Do you perform monthly breast self exams? ☐ Y ☐ N

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Y ☐ N

Date of last papsmear or pelvic exam:_____ Mammogram _____

These questions are for MEN ONLY

Do you usually get up to urinate during the night? ☐ Y ☐ N

Do you feel pain or burning with urination? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Do you feel burning discharge from penis? ☐ Y ☐ N

Has the force of your urination decreased? ☐ Y ☐ N

Have you had any kidney, bladder, or prostrate infections within the last 12 months? ☐ Y ☐ N

Do you have any problems emptying your bladder completely? ☐ Y ☐ N

Any difficulty with erection or ejaculation? ☐ Y ☐ N

Any testicle pain or swelling? ☐ Y ☐ N

Date of last prostate and rectal exam:_____ PSA _____

Name (Last, First, M.I.):_____ DOB _____

Other Information

Your healthcare provider needs to know:

Do you have Advanced Directives? *(Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive.)*..... ☐ Y ☐ N

If no, would you like additional details about Advanced Directives? ..... ☐ Y ☐ N

Do you have any religious or cultural beliefs that may impact your healthcare? ..... ☐ Y ☐ N

If yes, please describe:_____

I best learn new information by: ☐ Verbal instructions ☐ Written instructions ☐ Pictures

Level of education completed: ☐ Less than High School ☐ High School diploma or GED ☐ 1-4 years of college ☐ > 4 years of college

I understand English well? ☐ Y ☐ N If no, what language do you prefer?_____

Please circle any symptoms you are currently experiencing or symptoms you have frequently experienced in the past.

Fever Chills	Feeling poorly Feeling tired/fatigued	Recent weight gain Recent weight loss	
Eye pain Red eyes	Eyesight problems Discharge from eyes	Dry eyes Eyes itch	Vision changes
Earache Loss of hearing	Nosebleeds Discharge from nose	Sore throat Hoarseness	Ringing in ears Sinus problems
Chest pain Palpitations	Fast/slow heartbeat Cold hands/feet	Muscle pain Swelling in legs	History of heart murmur History of heart attack
Shortness of breath Wheezing	Cough Shortness of breath with activity	Difficulty breathing while lying down/sleeping	Coughing up phlegm/blood
Abdominal pain Vomiting	Constipation Diarrhea	Heartburn Black, tarry stools	Blood per rectum
Pain with urination Urinary incontinence	Frequent urination at night		Urinary frequency
Muscle/joint pain	Joint swelling Joint stiffness	Limb pain	Back pain
Skin lesions Skin wound	Itching Change in mole		Nail discoloration/deformity
Confusion Convulsions/seizures	Dizziness Fainting	Limb weakness Difficulty walking	Numbness/tingling Frequent falls
Suicidal Sleep disturbances	Anxiety Depression	Change in personality Emotional problems	
Decreased libido/sexual desire		Deepening of voice	Hair loss
Easy bleeding or bruising	Swollen glands		

Other symptoms: _____

_____

Patient's Signature:_____ Date:_____

Reviewed By: _____ Date:_____

LIVING WILL ☐ I decline to make this declaration

Declaration made this _____day of _____202 , I _____ willfully and voluntary make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated **and/or** I have a terminal condition **or** I have an end stage condition **or** I am in a persistent vegetative state,

and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal honor this declaration.

HEALTH CARE SURROGATE ☐ I decline to make this declaration

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Surrogate Full Legal Name: _____ Phone: _____

Address: _____

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

_____

_____

Your Signature: _____ **Date**: _____/_____/_____

Witness: _____ Witness: _____

Printed Name: _____ Printed Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

The principal's failure to designate a surrogate shall not invalidate the living will.

Patient Consent Agreement for Chronic Care Management Services

My physician/provider has recommended that I receive **Chronic Care Management (CCM)** services because I have been diagnosed with two or more chronic conditions, which are expected to last at least twelve months, and place my health at risk of decline.

I understand that CCM services include 24/7 access to a member of my care team via phone or other non-face to face means; a designated practitioner or care team member with whom I am able to get successive routine appointments; systematic assessment of my health care needs; processes to ensure timely receipt of preventative care services; oversight of my medication regimen; a jointly created and comprehensive care plan that is congruent with my choices and values; management of care transitions across all of my providers and settings; coordination with home and community based clinical service providers.

By signing this agreement, I consent to receive these services and agree to the following:

- My provider has explained to me the availability and the elements of the CCM services that are relevant for my condition(s).
- I consent to receive CCM services from the provider listed above and/or any associates he/she may designate to assist in providing me with CCM services.
- I understand that I have the right to stop CCM services at any time (effective at the end of a calendar month) with this provider and the effect of a revocation of this agreement. I may revoke this agreement verbally by calling **352-391-5299** or in writing to **Internal Medicine Practices**. After revocation of this agreement, I may opt to receive CCM services from another healthcare provider in the month following revocation of this agreement.
- I understand that Medicare permits only one practitioner to furnish and be paid for these services during a calendar month.
- I understand that I will receive a written or electronic copy of my comprehensive care plan.
- I authorize electronic communication of my medical information with other treating providers.
- My provider has explained to me any potential cost-sharing obligations that may apply when receiving CCM services.

Patient Name (print)_____ Date of Birth_____

Patient Signature_____ Date _____

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Internal Medicine Practices reserves the right to charge a fee of $25.00 for all missed appointments.

- Missed without notice
- Cancelled with less than 24 hours' notice
- Cancelled in 24 hours after previously being confirmed.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Show" in any 12 months period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand the policy.

_____ _____

Printed Name Date

_____

Signature

CONTROLLED SUBSTANCE AGREEMENT

1. I understand that this agreement is essential to the trust & confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this agreement.
2. I understand that if I breach this agreement my physician will be forced to stop prescribing controlled substances.
3. I will not share, sell, or trade my medication with anyone.
4. I will not obtain and use medication not prescribed to me.
5. I understand that my medications are my responsibility; I will safeguard my medication from "loss" or "theft". I understand that lost or stolen medications will only be replaced after I present evidence that a **police report has been filed.**
6. I understand that refills of controlled substances will be made only at the time of an office appointment during normal business hours.
7. No refills will be made during evenings (after hours) or on weekends.
8. I agree to take my medication exactly as prescribed. I understand that use of my medication as a greater rate will result in me being without medication for a period. Our office does not provide early refills for medications; the doctor must approve any medication changes.
9. I agree to always conduct myself in a courteous manner when in the doctor's office. Inappropriate language or behavior towards administrative or clinical staff will not be tolerated.
10. I understand that violation of the above may be grounds for termination from this practice. **Internal Medicine Practices** will make all notifications of termination of care in writing.

I understand that non-adherence to the above conditions will result in my termination from the practice.

_____ _____

PATIENT SIGNATURE DATE

_____

PATIENT NAME (PRINT)

Internal Medicine Practices

Quality Care for Better Quality of Life

Ask Us About The Patient Portal

- View Your Personal Health Records
- Access and View your Lab Results
- Request Prescription Refills
- Update Your Demographic Information
- View Your Billing Statements
- Send Messages To Our Healthcare Team
- Request and View Appointments

Ask a Team Member To Sign You Up

Access Patient Portal

After the account is activated, patients can log into the *Patient Portal* anytime through your mobile device or computer.

1. You open portal.kareo.com in a web browser. The *Patient Portal* page opens.
2. You enters their *Email* and *Password*.
3. You click **Sign in**. The *Dashboard* opens.