SUNSHINE STATE MEDICINE INC
265 CITRUS TOWER BLVD, STE 102, CLERMONT, FL.34711
PH# 352-394-3929 FAX# 352-394-6446 TOLL FREE# 1-866-394-3929

PATIENT INFORMATION SHEET

ALLERGIES TO MEDICATIONS? (IF YES, SPECIFY)________________________________
Patient Name: ____
D.O.B. _____/_____/_______ Age: _______ Sex: ______ SS#_______-_______-____________
Race [Optional]:_______________________Preferred language:__________________________
Home Tel :(___) ______-__________ Alternate phone #: (_____)__________-______________
Home address: ____
City:____ State: ________ Zip: _______________
Father's or spouse Name: ________________________________D. O. B. _____/_____/_______
SS#__________-__________-______________ Work ph# (_______) ________-_____________
Mother's or spouses Name: ________________________________ D. O. B. _____/_____/______
SS# _________-_________-______________ Work ph# (______) __________-_____________
In case of emergency call: ________________________________ Ph# (_____) _____-_________
Relationship to patient: ______________________________ Work Ph# (_____) _____-_________
Please list anyone other than parents authorized to bring patient to appointments:
Name:______________________Relation to patient:_____________________D.O.B___________
Name:______________________Relation to patient:_____________________D.O.B___________
Name:______________________Relation to patient:_____________________D.O.B___________
Email Address:____
* If you need additional space, please use the bottom of this page.

FINANCIAL RESPONSIBILITY/ GUARANTOR INFORMATION:
Who is financially responsible for the bill: ____
Insurance Name: __________________________________ Insured SS# _____-______-________
Insured D.O.B. _____/_____/_______Relationship to patient: ______________________________

CONSENT FOR MEDICAL TREATMENT
I hereby authorize and consent to any treatment, administration of necessary medications and /or immunizations my doctor deems advisable in the diagnosis and/or treatment of myself or child.
Signature: ____ Date: _____________________

FINANCIAL RESPONSIBILITY
I understand that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and completed all the above answers to the best of my knowledge.
Signature: ____ Date: _____________________

RECEIPT OF DOCUMENTS
I have received copies of the Office financial policy and the HIPPA privacy statement.
Signature: ____ Date: _____________________

HEALTH HISTORY

Name: ________________________Date of Birth: ____________Today's Date _______________

Pharmacy: ____________________

Address: ____
Phone Number: ______________________Fax #: __________________________

Previous Family Doctor: ____________________
Address: ____
Phone Number: _______________________Fax #: _________________________

Please list the Names and Phone Numbers for any Specialists (i.e. Cardiology, Pain Management) you are seeing and the condition you are seeing them for.

NAME	SPECIALTY	PHONE NUMBER	CONDITION

Name:__________________________
DOB:__________________________

PREVIOUS OR ONGOING MEDICAL PROBLEMS

PROBLEM	ONSET	RESOLVED/ONGOING

SURGERIES

TYPE OF SURGERY	WHY WAS IT PERFORMED?	DATE	SURGEON (IF KNOWN)

ALLERGIES

Are you allergic to any medications? YES NO If yes, what medication and what reaction do you have?

MEDICATION	REACTION

Name:___________________________

DOB:___________________________

CURRENT MEDICATIONS/VITAMINS

MEDICATION	WHAT IS IT FOR?	DOSE (mg)	DIRECTIONS

FAMILY HISTORY

Use the list of diseases below and any other significant findings to fill in the appropriate boxes below:

Examples: Alcoholism, aneurysm, arthritis, glaucoma, cancer (indicate type), diabetes, high cholesterol, high blood pressure, gallstones, heart disease, depression, anxiety, bipolar disorder, schizophrenia, polycystic kidney disease, seizures, bleeding or clotting disorder, anemia, thyroid disorder, tuberculosis.

FAMILY MEMBER	HEALTH PROBLEMS	AGE OF ONSET	CAUSE OF DEATH, IF DECEASED
Mother			
Father			
Brother			
Sister			
CHILD #1			
CHILD #2			
CHILD #3			

Name:___________________________

DOB:___________________________

SOCIAL HISTORY

Please circle and fill out appropriately

Do you smoke? YES NO PREVIOUSLY If yes, how many packs per day? ________________

For how long? ___________

Quit date: ______________________

Have you ever been exposed to second hand smoke? YES NO

Do you drink Alcohol? YES NO If yes, how many drinks per week?

____

Do you now or have you ever used illicit drugs? YES NO If yes, what kind?

____

Do you participate in any sexual activity that be considered risky?

____

Marital Status: _______________________ Sexual preference: HETEROSEXUAL HOMOSEXUAL BISEXUAL

Living arrangement: SINGLE SPOUSE FAMILY ROOMATE SIGNIFICANT OTHER

Do you have an advanced care directive?

____

Name:_________________________
DOB:_________________________

HEALTH MAINTENANCE

TEST OR IMMUNIZATION	DATE OF LAST	RESULT (IF KNOWN)
Physical Examination		
Cholesterol Test		
PSA (Prostate screening)		
Colonoscopy		
PAP Smear		
Mammogram		
Bone Density		
Tetanus or Tdap booster		
Hepatitis A series		
Hepatitis B series		
Pneumovax (Pneumonia)		
Other ______________________		

GYNECOLOGICAL HISTORY (WOMEN ONLY)

Age when first period occurred: ____
# of pregnancies: ____
# of live births: _____
# of miscarriages: _____
# of abortions: ______
# of living children: _____

Past infertility problems: YES NO

In planning for future health care for you, we would like to know what extra health services you feel you might want or need. In addition to caring for you when you are sick, what else would you like your provider to do for you?

____
____

LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

While we make every effort to provide a reminder call or email if provided at least 24 hours before your appointment, it is your responsibility to remember your appointment. We charge a $35 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel (or re-schedule) less than 24 hours in advance.

Signature: ______________________________ Date: ____________

HIPAA Notice of Privacy Practices

SUNSHINE STATE MEDICINE INC.
265 CITRUS TOWER BLVD , STE # 102
CLERMONT, FL. 34711
352-394-3929

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign in registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose you protected health information in the following situations without your authorization. These situations include: as required by the law, Public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or neglect: Food and Drug Administration requirements: Legal Proceedings: Law enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosers: Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.5000.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in Writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

Your have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You may have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i. e. electronically.

You may have the right to have your physician amend your protected health information If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature on the patient info sheet is only and acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:____________________________ Signature:_____________________ Date: _____________

Sunshine State Medicine Inc.
265 Citrus Tower Blvd Suite 102, Clermont, Fl. 34711
Phone # 352-394-3929 Fax # 352-394-6446

OFFICIAL FINANCIAL POLICY

The past few years have busy regarding health care reform. The insurance companies have initiated new changes that will affect your account. There are some billing guidelines and hints that allow us to survive health care reform. Please thoroughly read and sign this sheet.

1.) We will collect your deductible, co-pay, uncovered services, or percent responsibility (in full) before you see the doctor. Please be prepared to pay this before your visit with the doctor.

2.) Please be thorough and comprehensive with your insurance information, and bring your insurance card with you. You will be responsible for any unpaid balance due to lack of information.

3.) It is at our discretion that we will charge your account with a rebilling fee if we must re-file balances over 45 days old. This fee will be payable by you.

4.) As a courtesy we will file your insurance. It is your responsibility to make sure we receive a prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should.

5.) Your insurance will send you an explanation of benefits that explains what they have paid our office. This is the record that you must keep on file. If you do not agree with their payment, please contact the insurance company.

6.) If your insurance denies payment on your account, you will be asked to pay by money order, cash, or credit card to our office. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge.

7.) <u>Self pay patients:</u> This category includes people with no insurance or those who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the service is rendered, before your visit with the doctor. We accept cash, checks, money orders, and credit cards. If you are not able to pay for the services in full, you must contact our office to make payment arrangements before coming to see the doctor.

Signature: ____ Date: _______________