ORMOND MEDICAL CENTER INC.
545 West Granada Blvd.
Ormond Beach, FL 32174

PRINT PATIENT NAME:_____DATE:_____

SS#:_____Insured Party: _____DOB:_____

Address: _____City:_____

State:_____Zip Code:_____Phone:_____

Cell Ph:_____EMAIL:_____

ETHNICITY:_____PREFERRED LANGUAGE: _____

Marital Status:_____Spouse Name: _____

Employer: _____Employer Phone:_____

PATIENT SIGNATURE: _____DATE:_____

Financial Policy for Ormond Medical Center Inc.

Thank you for choosing our office to provide you with medical care. We are committed to servicing you with skill and high quality care. The services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

No Show: Appointments canceled less than 24 hours will be a charge of $45 for regular office visit, massage or chiropractic appoinments. CPE (Complete Medical Exams) and Hospital/Rehab Follow ups will be $75 charge. Initial _____

INSURANCE: All co-payments and deductible must be paid at the time of service. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full is required for each visit until we can verify your coverage. Please be sure you are assigned to our office. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. That does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for a service, or services not covered which you request to be done.

Self Pay: Office visit $105, Hospital/Rehab Follow up $165-225 all payments are due the day of service. Please be advised any Labs or procedures performed in office will be an additional charge. Initial_____

YOUR PAST MEDICAL HISTORY

_____Name

O Abdominal aortic aneurism	O Cholithiasis	O Liver Disease
O Abnormal PAP	O Chronic kidney disease	O Lymphoma
O Abnormal uterine bleeding	O Coarctation of the aorta	O Melanoma
O Allergic rhinitis	O Colon problems	O Migraine
O Alzheimer's disease	O COPD	O Obstructive sleep apnea
O Anemia	O Depression	O Obstructive uropathy
O Angina	O Diabetes	O Osteoporosis
O Anxiety	O Eating disorder	O Peptic ulcer
O Arthritis	O Eczema/atopic dermatitis	O Pneumonia
O Asthma	O Endometriosis	O Seizures
O Atrial fibrillation	O Environmental allergies	O Sexually tranmitted disease
O Back pain	O Glaucoma	O Sickle cell
O Blood clots	O GERD	O TIA
O Bronchopulmonary dysplasia	O Hay fever	O Thyroid disease
O Cancer of the breast	O Heart disease (CAD)	O Tuberculosis
O Cancer of the colon	O Hepatitis B	O Other
O Cancer of the lung	O Hepatitis C	
O Cancer of the ovaries	O Hernia	
O Cancer of the prostate	O High blood pressure	
O Cancer of the skin	O High cholesterol	
O Cancer of the uterus	O HIV	
	O HPV	

SOCIAL HISTORY

SOCIAL HISTORY

Do you drink alcohol?..... ☐ No ☐ Yes *If yes how much?* _____

Are others concerned about your drinking? ☐ No ☐ Yes

Diet: ☐Balanced ☐Vegetarian ☐Diabetic ☐Low salt ☐Low fat ☐Low carb ☐Other: _____

Education: ☐ High school ☐ College ☐ Some College ☐ Trade school ☐ Other: _____

Do you do some form of regular exercise every day? ☐ No ☐Yes

If yes, how much? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Occupation: _____ Do you take drugs?..... ☐ No ☐ Yes

List everyone in your household including pets:

_____ _____ _____ _____

_____ _____ _____ _____

Do you wear seatbelts? ..... ☐ No ☐ Yes

Have you ever smoked or chewed tobacco? ..... ☐No ☐ Yes *If yes, how much?* _____

ORMOND MEDICAL CENTER, INC.
545 West Granada Blvd.
Ormond Beach, FL 32174
(386) 672-6243 – Fax (386) 677-7463

HIPAA CONSENT FORM

Patient Name _____Date of Birth_____ Phone_____

HIPAA NOTICE OF PRIVACY PRACTICE

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Ormond Medical Center Inc. may use or disclose your health care information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Though Ormond Medical Center Inc. has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicate that you have received the Notice of Privacy Practice.

I hereby acknowledge that I have received a copy of Ormond Medical Center Inc. Notice of Privacy Practice: _____
Initials of Patient
Or Guardian

Permission to share medical information

My medical information may be obtained and exchanged verbally to:_____

Relationship:_____Initials of patient/guardian_____

Signature of Patient/Guardian: _____Date:_____

THIS IS A CONDENSED VERSION OF OUR SUMMARY OF NOTICES OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.
We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we give to you as our patient. By law, we are required to make sure that your protected health is kept private.

How will we use or disclose your information? Here are few examples:

For medical treatment
To obtain payment for our services
In emergency situations
For appointment and recall reminders
To run our Practice more efficiently and ensure our patients receive quality care
For research
To avert a serious threat to health or safety
For organ and tissue donation
For workers compensation programs
In response to certain requests arising out of lawsuits or other disputes.

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to request restrictions
- The right to amend
- The right to accounting of disclosures
- The right to a paper copy of this notice
- The right to request confidential communications

Signature Patient/Guardian: _____Date:_____

Print Name Patient/Guardian: _____

Rev. 11/2013

ORMOND MEDICAL CENTER INC.

NAME _____ DATE _____

LIST OF ALL CURRENT MEDICATIONS

MEDICATION NAME	DATE LAST FILLED	AMOUNT

MEDICATION ALLERGIES _____

CURRENT PHARMACY _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

To be completed by requester: ☐ Pick Up ☐ Mail ☐ Other: _____ ☐ E-Mail: _____

If requested health information is needed for a doctor's appointment, please specify date: _____

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE THE FOLLOWING:

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Admission/Discharge Date(s): _____

Forward to Health Information Management (Medical Records) for:

☐ Discharge Summary

☐ History & Physical

☐ Consultation ☐ Other (specify) _____

Forward to Patient Business Office for: ☐ Billing Information

Reason for requesting information: _____

Requests may be subject to copying fee

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Name: Ormond Medical Center Phone: 386-672-2243

Address: 545 WEST GRANADA BLVD Fax: 386-677-7463

City: ORMOND BEACH, FL 32174 State: _____ Zip Code: _____

Physician E-Mail: _____ Patient E-Mail: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or released, as provided in CFR 164.524. I understand that any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by Federal confidentiality rules. If I have questions about release of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, and all other sensitive information.

Patient Signature: _____ Date: _____

Authorized Representative/Parent: _____ Date: _____

Printed Name of Authorized Representative/Parent: _____

Relationship to Patient: _____

Address and Phone # of Authorized Representative/Parent: _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE AND
REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT LABEL