NEW PATIENT REGISTRATION FORMS

(Please Print)

Today's date:	❑ Clearwater ❑ Palm Harbor ❑ Seminole

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle Initial:**	❑ Mr. ❑ Mrs. ❑ Ms.	**Marital Status (circle one)** Single/ Mar / Div / Sep / Wid

Street Address:	**Social Security:**	**Birth Date:** / /	**Age:**	**Sex:** ❑ M ❑ F

City:	**State:**	**Zip Code:**	**Race:** ❑ American Indian or Alaska Native ❑ Asian ❑ White ❑ Hispanic ❑ African American ❑ Other Race **Ethnicity:** ❑ Hispanic ❑ Not Hispanic

Primary Phone: **Secondary Phone:**	**Email (Patient Portal Access):**	**E-News Letter Opt –In:** Yes, I wish to receive health information and upcoming event notifications through email from the office. **Initials**____________
Occupation: ☐ Retired ☐ Student ☐Disabled- ☐ Employed	**How did you hear about us?** ❑ Insurance Representative or Website ❑ Internet Search ❑ Magazine or News Paper ❑Other ❑ Personal Referral (Who can we thank)	

Primary Insurance Company:____

Policy Holder's Name:____**Policy Holder's DOB:**_____________________

Policy Holder's Relationship to Patient:____________________________**Policy Holder's Employer:**_________________

Secondary Insurance Company:____

Policy Holder's Name:____**Policy Holder's DOB:**_____________________

Policy Holder's Relationship to Patient:____________________________**Policy Holder's Employer:** _________________

ADVANCED DIRECTIVES

Do you want to receive the following forms:

____Living Will_____Do Not Resuscitate (DNR)______Health Care Surrogate
_____I have one (Please give copy to front desk for your chart)

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):____

Relationship to Patient:____Primary Phone: ______________________________________

Patient/Guardian signature *Date*

AUTHORIZATION FOR TREATMENT

I hereby request and consent to the services of All Care Medical Consultants, PA, including examination, treatment, and other procedures deemed appropriate from this date forward.

Patient/Guardian signature *Date*

HEALTH HISTORY

CONFIDENTIAL

Patient Name:____________________________________ **Today's Date:** ________________

Chief Complaint(s):____

MEDICATIONS List current medications and dosages

NAME	Mg/Mcg	Tab/Cap	Times a Day

ALLERGIES To medications or substances with reaction.

____

Pharmacy Name: __________________________
Cross Streets:________________________________
Phone:

MEDICAL CONDITIONS Check (✓) conditions you currently have or have had in the past.

CARDIAC
- ☐ AAA
- ☐ Angina/Chest Pain
- ☐ Arrhythmia
- ☐ Atherosclerosis
- ☐ Blood Pressure
  - ☐ Hypertension
  - ☐ Hypotension
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Pacemaker

CIRCULATORY
- ☐ Anemia
- ☐ Blood Clots
  - ☐ Deep Vein Thrombosis
  - ☐ Pulmonary Embolism
- ☐ Peripheral Artery Disease

ENDOCRINE
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
- ☐ Thyroid
  - ☐ Hypothyroid
  - ☐ Hyperthyroid
  - ☐ Goiter

GASTRIC
- ☐ GERD
- ☐ Barrett's Esophagus
- ☐ Hepatitis
  - ☐ A ☐ B ☐ C
- ☐ Liver Cirrhosis

MUSCULOSKELETAL
- ☐ Gout
- ☐ Arthritis
  - ☐Osteoarthritis
  - ☐Rheumatoid

NEPHROLOGY
- ☐ Kidney Disease
  - ☐ Acute
  - ☐ Chronic

NEUROLOGIC
- ☐ Epilepsy/Seizure Disorder
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Stroke
  - ☐ Full Recovery
  - ☐ Deficits

OPTHALMIC
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

PULMONARY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD/Emphysema

PSYCHIATRIC
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Schizophrenia
- ☐ Suicide Attempt

OTHER
- ☐ Cancer
- ☐ Chemical Dependency
  - ☐ Drugs____________
  - ☐ Alcohol
  - ☐ Narcotics
- ☐ HIV/AIDS positive
- ☐ Ulcers
  - ☐ Skin
  - ☐ Gastric
- ☐ __________________
- ☐ __________________
- ☐ __________________

PREVENTATIVE SCREENINGS

Testing/Immunizations	Date	Result
Flu Shot *Date:* Pneumonia *Date:*	Tuberculosis (TB) *Date:*	Tetanus *Date:* Shingles *Date:*
Mammogram		
Eye Exam		
Colonoscopy		
Bone Density (DEXA)		
Pulmonary Function Test (PFT)		
Pap Smear		
Last Menstrual Cycle		☐**Normal** ☐**Heavy** ☐ **Irregular**

SURGICAL / HOSPITAL HISTORY

I have had no surgeries or hospital stays. ☐

Date (Mo/Yr)	Type of Surgery	Reason for Hospital Stay

FAMILY HISTORY Check (✓) if, your blood relative had any of the following:

Member	Status (Deceased/ Alive)	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Other
Father									
Mother									
Siblings									
Children									
Grand Father									
Grand Mother									

Please tell us how many siblings and/or children you have and if check (✓) they are healthy.

Siblings	Brothers	Sisters	☐ Healthy
Children	Sons	Daughters	☐ Healthy

Notes:

SOCIAL HISTORY Check (✓) all that apply.

Smoking:

Former Smoker ☐ Yes ☐ No
☐ < 1month ☐1-3 months ☐3-6 months
☐6-12 months ☐1-5 years ☐5-10 years ☐ >10 years

Current Smoker ☐ Yes ☐ No
Type: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Vape
Frequency:
☐ Daily ☐ Weekly ☐ Other

Recreational Drug Use: ☐ Yes ☐ No
☐ Marijuana ☐ Cocaine ☐ Heroin/Narcotics
☐ Xanax ☐ Other______________________________

Alcohol Use: ☐ Yes ☐ No

☐ Occasional ☐ Daily ☐ # of drinks ______
☐ Beer ☐ Wine ☐ Liquor
☐ History of Alcoholism ☐ Active Alcoholism

Caffeine: ☐ Yes ☐ No
☐ Soda ☐ Coffee ☐ Tea
Frequency:
☐ Daily ☐ Weekly ☐ Other_____________________

Diet:
☐ Healthy diet rich in fresh vegetables and fruit

☐ Diabetic diet ☐ Low Fat ☐ Low Carbohydrate

☐ Kidney diet ☐ Low in Protein

☐ Low Salt ☐ Poor diet compliance

☐ Other____

Exercise: ☐ Yes ☐ No
☐Water Exercises ☐Swimming ☐ Walking ☐ Jogging
☐ Weights ☐ Stretching/Yoga ☐Recreation

Frequency:
☐ Weekly ☐ Daily ☐ Other_____________________
☐ Light activity some of the days.

Occupation:
☐ Retired ☐ Student ☐ Disabled-Reason___________

Currently employed as______________________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ____________________
Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ____________________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

____ ____________________
Reviewed By — Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To (Previous Physician): ____

Address: ____

City: ____________________________ State: __________ Zip Code: _____________

Phone:____________________________Fax: _____________________________________

PLEASE SEND ALL OF MY MEDICAL RECORDS FOR CONTINUITY OF CARE:

In this request, "All" refers to:

NO DISCS

- ☐ Past Five Years of Hospital Records (If Applicable)
- ☐ Past Year of Office Notes/Progress Notes
- ☐ Past Year of Laboratory Testing (Bloodwork, Pathology, Etc.)
- ☐ All Diagnostic Imaging (CT Scans, Mammograms, Ultrasounds, X-Rays, Etc.)
- ☐ Any Eye Exams on File
- Advance Directives & DNR's

Initial:_____Mental Health_____Communicable diseases_____HIV/AIDS_____Alcohol or drug abuse treatment

***** If Medical records exceed 100 pages, please mail *****

This authorization shall be in force and in effect until I give written permission or twelve (12) months from signature, at which time this authorization expires unless otherwise specified below:

Expiration Date: ______________________

Patient Signature:___________________________________ Date: ____________

Print Patient Name: _________________________________

Witness:____ Date: _____________

SS#:____ DOB: _____________

www.allcare4u.com

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Fax (727) 259-2305

8900 Park Boulevard N
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HIPAA PRIVACY AUTHORIZATION FORM

****Authorization for Use or Disclosure of Protected Health Information**
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. AUTHORIZATION

_______I authorize **All Care Medical Consultants, PA** to use and disclose the protected health information described below to

____
(Individual seeking the information)

_______I **do not** authorize **All Care Medical Consultants, PA** to use and disclose my protected health information to anyone other than a medical provider, insurance company or health care professional, for the purpose of continuing care.

2. EXTENT OF AUTHORIZATION

_______I authorize the release of my ***complete*** health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

_______I authorize the release of only specific information (please specify):____________________________

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and in effect until I give ***written*** permission, at which time this authorization expires.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal privacy regulations.

_______I request a copy of All Care Medical Consultants, PA, HIPAA Health Information Notice

____
Signature of patient or personal representative

____
Date

CONSENT TO REVIEW PRESCRIPTION HISTORY

Medicare has mandated that all physicians' offices and pharmacies use an electronic system to prescribe medications and refill medications.

Surescripts is an electronic system used by pharmacies to request refills and new prescriptions from physicians' offices. We have implemented this into our practice and have found out that we need your consent in order to review your prescription history.

I,_____________________________________, understand that by signing this consent, I give All Care Medical Consultants, PA, permission to review my prescription history.

This is part of my medical record and will be treated according to HIPAA regulations.

____
Print Name

_________________________________ __________
Signature Date

HIPAA HEALTH INFORMATION NOTICE

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

1. All Care Medical Consultants, PA may use and disclose protected health information for planning patient's care, treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers, and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assessing quality and re viewing the competence of healthcare professionals.
2. All Care Medical Consultants, PA is permitted or required to disclose protected health information without the individual's written authorization in certain circumstances. Two examples of such are for public health requirements or court orders. All Care Medical Consultants, PA will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
3. All Care Medical Consultants, PA may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

All Care Medical Consultants, PA will abide by the terms of this notice or the notice currently in effect at the time of the disclosure and reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information of the patient. I understand that I may revokes this consent in writing except to the extent that the practice has already taken action on reliance thereon.

All Care Medical Consultants, PA will provide each patient with a copy of any revisions, if requested by patient, of the **HIPAA Health Information Notice** at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

Any person/patient may file a complaint to the practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice please contact the Office Manager at the following address and/or phone number: 1745 South Highland Avenue, Clearwater, Florida 33756, (727) 587-0377. All complaint will be addressed.

All Care Medical Consultants, PA has a policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Cheryl Lewis, our Office Administrator and HIPAA Compliance Officer can be reached at (727) 587-0377.
The effective date of the **HIPAA Health Information Notice** is August 1, 2002.
Revised on January 29, 2019

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WELCOME TO ALL CARE MEDICAL CONSULTANTS
THINGS YOU NEED TO KNOW

1. **Referrals can take up to 72 hours to submit to your insurance plan**. It is important that we are aware far enough in advance of any appointments you may have so that we can process your referral.

2. **All Care Medical Consultants have their own network of specialists**. We have a great working relationship with a group of specialists that keep us informed of what is going on with our patients as well as participate at the same hospitals.

3. **Follow up appointments**. Follow up appointments to specialists will be determined by your Primary Care Physician not the specialist.

4. **Participating hospitals.** We participate with Largo Medical Center and Morton Plant Hospitals.

5. **We have same day appointments available for emergencies and are <u>always on call 24/7</u>.**

6. **Out of State.** If you are going out of state, please notify the office for any refills while you are gone. *Your benefits will cover you for Urgent and Emergent care only. Urgent Care Centers can be used.

*For certain insurances- please check with you plan

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For Your First Visit With Us, Please….

- Arrive a minimum of 15 minutes before your scheduled appointment IF you have your paperwork completed, 30 minutes if NO paperwork

- Bring your Picture ID

- Bring your Health Insurance Card(s)

- Bring your prescriptions, supplements in their bottles

- Be prepared to pay your copay (if applicable), we accept cash, checks, and credit/debit cards

If you have any questions, please call the office in which you are scheduled prior to your appointment.

ALL CARE MEDICAL CONSULTANTS P.A.

Acknowledgement for Advanced Directives

Introduction: As a part of a person's right to self-determination, every adult may accept or refuse any recommended medical treatment. This is relatively easy when people are well and can speak. Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes at the time when many critical decisions need to be made.

During the time, important decisions about your medical care may have to be made. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. You can help your family and physicians by telling them, in advance, what you would want done in certain situations. This planning ahead for future healthcare decisions is known as an Advance Directive.

The Advanced Directives states your wishes regarding various types of medical treatment in several representative situations so that your desires can be respected. It comes into effect only if you become incompetent (unable to make decisions or express your wishes), and you can change it at any time until then. As long as you are competent, you should discuss your care directly with your physician. Before you fill out the Advanced Directive-Living Will, Healthcare Surrogate/or DNR form, you may want to talk to your family, friends, physician, lawyer or spiritual advisor. The Advanced Directives also lets you appoint someone to make medical decisions for you, if you should become unable to make your own; this is a proxy or durable power of attorney. Additionally, it contains a statement of your wishes concerning organ donation.

When you make your personal choices in the Directive, you may want to consider one question. Is there a condition or set of circumstances which could exist in which you would refuse efforts to prolong your life? The Directive describes situations and allows you to indicate which treatments you would or would not want if your physician recommended them. If a situation you are particularly concerned about is not included; you can make additional comments in the section provided.

As your Medical-Doctor, we need to know if you have executed an Advanced Medical Directive:

Yes_____________or No _____________

If yes, this Directive is in the form of:

______A Living Will
______A Durable Power of Attorney
______A Health Care Surrogate
______An Executor/Minister of your Estate

If you have executed an Advanced Directive in any of the above format and have not yet provided our office with a copy, could you please do so at your next visit?

_______________________________________   _______________________
Patient Signature   Date

Designation of Health Care Surrogate

Name: ____
(Last) (First) (MI)

In the event that I have been determined by my physician to be incompetent/incapacitated (lack of ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including, but not limited to, the withholding, withdrawal, or continuation of life – prolonging procedures, I wish to designate as my decision maker (surrogate) to make health care decisions.

Name:_______________________________ / _______________________________
(Relationship)

Address: ____

Phone: ____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name:_______________________________ / _______________________________
(Relationship)

Address: ____

Phone: ____

I fully understand that this designation will permit my decision maker to make all health care decisions on my behalf until I regain the ability to make healthcare decisions. The health care may also include if necessary the decisions to withhold, withdraw, or continue life prolonging procedures. My decision maker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or incompetency I may experience.

Nutrition and Hydration

I do ( ) I do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

Additional instructions (optional):

____

____

____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they know who my surrogate is.

Name: _______________________________

Name: _______________________________

Name: _______________________________

Patient Signature:_______________________________Date: _______________

Witnesses (required): 1. _______________________________

2. _______________________________

(At least one witness must be neither a spouse nor blood relative of the signatory)

Living Will

Declaration made this___________________________day of_________________________________, 20________

I, ____, willfully and voluntarily 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 mentally or physically incapacitated and

_________________(initial) I have a terminal condition, or

_________________(initial) I have an end-state condition, or

_________________(initial) I am in a persistent vegetative state

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

It is my intension 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.

In the event 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 the provisions of this declaration.

Name:____/ ____
(Relationship)

Address: ____

Phone: ____

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

Nutrition and Hydration

I do ( ) I do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

I do ( ) I do not ( ) desire to donate my organs.

Additional Instructions (optional):

____

____

____
(Patient Signature)

____ (Witness)

Address:____________________________________

____

Phone:_______________________________

____ (Witness)

Address:______________________________

____

Phone:________________

(At least one witness must be neither a spouse nor blood relative of the signatory.)

All Care Medical Consultants, PA
Financial Policy

Thank you for choosing All Care Medical Consultants, PA as your health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. **Carefully review the following information and return this form to us with your signature and todays' date.**

INSURANCE:
It is the patient's responsibility to provide the office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We will occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. You are responsible for notifying us of any changes in your insurance coverage. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the clinic.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

CO-PAYS:
Co-payments are due at the time you check in at the front desk PRIOR to being seen by the Physician or Physician Extender. You will also be asked to make a payment on any balance you may have from previous services.

UN-PAID BALANCES:

We require that full payment be made at the time of service. If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. For balances over $50.00, payment arrangements can be made with our office. Acceptable payment arrangements require that the balance be paid within 3 to 6 months depending on balance. Any overdue balances may be considered for further collection activity if not paid. If your account is turned over to a Collection Agency you will be discharged from the practice. At that time a 30% agency fee will be added to your account balance. We accept cash, checks, money order, Visa, MasterCard, Discover and American Express.

RETURNED CHECKS:
The charge for a returned check is $25 payable by cash, money order or credit card. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a "Cash Only" basis following any returned check.

I authorize my insurance company to pay the Physician directly. I understand that I am financially responsible for any balance. I also authorize All Care Medical Consultants, PA, or my insurance company to release any information to process my claims.

I have read and agree with All Care Medical Consultants Financial Policy.

____ ____________________
Patient Name (please print) Date of Birth

____ ____________________
Patient/Responsible Party Signature Date

Prescription Medication Policy

The practitioners and staff at All Care Medical Consultants value the relationship we have with our patients. We strive to do our best when it comes to making sure you receive proper treatment including your medications. It is important you are aware of our medication dispensing policies that will apply for *all* medication prescribed by our office.

- **Please bring all of your medications to each appointment**, especially if you are on multiple medications or have seen other doctors in the months or weeks prior to your last appointment with us. It is important for us to know all of the medicine you are taking at all times. Simply saying "it's the same as last time" is not enough since even the smallest change (as in dosage or frequency) is important for us to know.

- Understand that if you are receiving any medications from our office, **you will need to be seen by the physician or PA at least every 3-6 months.** Your visit frequency will depend on your diagnosis and is at the discretion of the physician. This is necessary for many reasons, but especially to assure the medication is working properly.

- For refills on *routine* medications, call your pharmacy and notify them of your refill request. The pharmacy will contact our office for approval. **Allow 2 days (excluding weekends) for your refill to be processed!** ***Do not wait until your medication is out***! Also note that medication refills will be processed during regular office hours only.

- For refills on any controlled substance/narcotic, it is our policy to ***not approve early refills*** **on controlled medications unless expressed permission is given by the doctor.** *Never* take any medication more frequently than it was prescribed. All patients are to sign a narcotics contract if they are receiving controlled substances from our practice. In that contract it states, "Medications lost or stolen will NOT be replaced. It is the sole responsibility of the patient to keep them in a safe place."

If you have any questions or need further clarification of this policy, please let us know.

By my signature below, I verify that I understand and agree to the above medication policy.

Printed Patient Name :___________________________________DOB______________
Signature :___________________________________Date ______________

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AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with All Care Medical Consultants.

1) Purpose and Benefits. The purpose of this project is to use telemedicine to enable patients who are unable or unwilling to commute to the physician's office the opportunity to get medical care without the inconvenience and expense of traveling to the office.

2) Nature of Telemedicine Consultation. During the telemedicine consultation: a) Details of your medical history, examinations, x-rays, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. b) Physical examination may take place. c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission. d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) Medical Information and Records. All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) Confidentiality. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal privacy rules also known as HIPAA as well as all applicable Florida State law apply to information disclosed during this telemedicine consultation.

5) Risks and Consequences. The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact.

6) Rights. You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

7) Financial Agreement. This telemedicine consultation may be paid for by your insurance company if it is a covered benefit under your plan. We will submit a claim on your behalf and balance bill your for any share of cost above and beyond your copay amount. Your copay will be collected prior to services being rendered.
I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:____ **Date:**_________________
Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient:_________________

Witness:____ **Date:**_________________