AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I _____ _____ hereby authorize the release or use of my individually identifiable health information ("Protected Health Information") and medical record information by Osceola Physician Management in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for more information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not requires to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I acknowledge and agree that the Practice any disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates or have power of attorney on my behalf:

_____

_____

I agree that the practice may also disclose the following information contained in my medical records (please initial the appropriate categories listed below):

_____ HIV/ AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s) (please initial in the appropriate spaces below):

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.
_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).
_____ Via fax to my designated fax number which is: _____

At all times, you can retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this consent form. If you (or authorized representative) sign this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to you as the time of the revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and fully understand the information in this consent. I have received a coy of this consent and I am the patient or authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM / PM

Signature of Patient : _____

Patient Name: _____ - _____

- Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

_____

_____

_____

_____

HIPAA Notice of Privacy Practices

OSCEOLA PHYSICIAN MANAGEMENT
801 W. OAK STREET, SUITE 202
KISSIMMEE, FLORIDA 34741

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, that may identify you and that relates 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 staff 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 health care 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 your 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 physian 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 discussed 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 disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at front 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 your protected health information in the following situations without your authorization. These situations include: as Required By 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 Disclosures: 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 164.500

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 file use or disclosure indicated in the authorization.

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

You 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 the 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 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 mad 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 disclosure 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 ms 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 filing a complaint,**

Tins 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 Phone Number.

Signature below is an acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name:_____ _____ Signature_____

Date: _____

OSCEOLA PHYSICIAN MANAGEMENT, INC.
PHONE: (407) 933-7119 – FAX (407) 933-7732
801 W. OAK STREET, SUITE 202 – KISSIMMEE, FL 34741

Patient Registration

Name: _____ SS# _____

Street Address _____ Date of Birth_____ Marital Status: S M W Sep D

City_____ State_____ Zip _____

Telephone: Home _____ Office_____

Referred By _____

Spouse's Name _____

Spouse's Employer/ Address _____

Emergency Contact _____

Patient Employer

Employer Name _____ Tel # _____

Employer Street Address _____ City / State _____ Zip _____

Patient's Occupation_____

Insured Person

Name _____ Tel # _____

Employer Street Address _____ City / State _____ Zip _____

Relationship to Patient _____

Insurance

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Tel # _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Tel # _____

Authorization to Release Information and Assignment of Benefits

ASSIGNMENT OF BENEFITS

I hereby authorize all medical or surgical benefits, to include major medical benefits which I am entitled, including Medicare,private insurance and any other health plans to Osceola Physician Management Inc. 801 W. Oak Street, Kissimmee, Florida34741. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible, after 90 days, for all charges whether paid or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. It also authorizes release of complete medical records concerning my illness and/or treatment to said assignee or other medical providers and institutions that may become involved in my diagnosis and treatment.

Patient Name: _____ Signature: _____

Date: _____

PATIENT HISTORY FORM

Note: This is a confidential report and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization or as required by law.

Last Name_____ _____ First Name_____ DOB: _____ Date: _____

REVIEW OF SYSTEMS

Do you know or have you had any problems relating to the following systems?

CONSTITUTIONAL	Circle Yes or No		Comments
Weight change	Y	N	
Chills	Y	N	
Sleep disorder	Y	N	
Other	Y	N	

EYES			
Double vision	Y	N	
Glaucoma	Y	N	
Cataracts	Y	N	
Other	Y	N	

EAR/NOSE/THROAT/MOUTH			
Hearing changes	Y	N	
Sore throat	Y	N	
Sinus problems	Y	N	
Other	Y	N	

CARDIOVASCULAR			
Chest pain	Y	N	
Irregular heartbeat	Y	N	
Swelling in ankles	Y	N	
Other	Y	N	

PSYCHOLOGIC			
Are you generally happy?	Y	N	
Do you feel depressed?	Y	N	
Do you feel anxious?	Y	N	
Do you feel safe in your home?	Y	N	

ENDOCRINE			
Excessive thirst	Y	N	
Too hot/cold	Y	N	
Tired/Sluggish	Y	N	
Other	Y	N	

HEMATOLOGIC/LYMPHATIC			
Swollen glands	Y	N	
Blood clotting problem	Y	N	
Bruising	Y	N	
Other	Y	N	

ALLERGIC/IMMUNOLOGIC			
Hay fever	Y	N	
Drug allergies	Y	N	
Food	Y	N	
Other	Y	N	

GENITOURINARY	Circle Yes or No		Comments
Change in stream	Y	N	
Nocturia (getting up at night)	Y	N	
Urinary frequency > 8 times/day	Y	N	
Other	Y	N	

MUSCULOSKELETAL			
Bone pain	Y	N	
Muscle pain	Y	N	
Joint pain	Y	N	
Other	Y	N	

INTEGUMENTARY (SKIN)			
Rash	Y	N	
Lumps or Bumps	Y	N	
Moles, Skin tags	Y	N	
Other	Y	N	

NEUROLOGICAL			
Tremors	Y	N	
Dizzy spells	Y	N	
Numbness/Tingling	Y	N	
Other	Y	N	

RESPIRATORY			
Wheezing	Y	N	
Frequent cough	Y	N	
Shortness of breath	Y	N	
Other	Y	N	

GASTROINTESTINAL			
Abdominal pain	Y	N	
Nausea/Vomiting	Y	N	
Indigestion/Heartburn	Y	N	
Other	Y	N	

SEXUAL HISTORY			
Change in sex drive?	Y	N	
Sexual performance satisfactory?	Y	N	
Other (i.e. sexual trauma)			

LAST EYE & DENTAL EXAM

Date - Last Eye Exam: _____

Date - Last Dental Exam: _____

MEDICAL HISTORY

Medical ___ None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)

Pregnancy History

		Year	Sex	Complications

Surgical ____ None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

Allergies to medicines _____ None

Current prescription medicines

Name of Drug	mg dose	# tablets	# times per day	Name of Drug	mg dose	# tablets	# times per day

OTC medicines (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals)

FAMILY HISTORY

Father: __ Living – Age: _____ __ Deceased – Age of Death: ____ Cause _____

Mother: __ Living – Age: _____ __ Deceased – Age of Death: ____ Cause _____

Siblings: Number Living: _____ Number Deceased: _____ Cause _____

List other illnesses in your family (Example – Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc.)

Family Member	Illness	Family Member	Illness	Family Member	Illness

SOCIAL HISTORY

Smoke? Yes ____ No ____ If yes how much? _____ # of packs/day _____# of years When did you stop smoking?_____

Alcohol? Yes ____ No ____ If yes how much? _____

Domestic Violence? _____

Exercise regularly? Yes _____ No ____ If yes, what and how frequently? _____

Routinely wear **seatbelts**? Yes _____ No ____ Routinely wear **helmets**? Yes _____ No ____

Physician: _____

OSCEOLA PHYSICIAN MANAGEMENT
PHONE (407) 933-7119 – FAX (407) 933-7732
801 W. OAK STREET, SUITE 202 – KISSIMMEE, FL 34741

AUTHORIZATION FOR RELEASE OF INFORMATION

Autorizacion Para Proporcionar Informacion

I HEREBY GIVE MY PERMISSION TO: _____
Yo por este medio doy permiso a:

_____

TO RELEASE A COPY OF (LIST SPECIFIC INFORMATION/DOCUMENTS): __ALL__
A que propcione una copia de (liste informacion/documentos especificos):

PHONE : 407-933-7119 FAX: 407-933-7732

TO: _____ OSCEOLA PHYSICIAN MANAGEMENT
A: (Agency, Mental health Professional, Attorney)
(Agencia, Profesional de Salud Mental, Abogado)

ADDRESS: 801 West Oak Street, Suite 202
Kissimmee, FL 34741

FOR THE PUPOSE(S) OF (ALCOHOL & DRUG ABUSE CLIENTS ONLY): _____
Con el proposito de (Clientes de Abuso de Alcohol & Drogas solamente):

THIS IS _____ A SINGLE DISCLOSURE OR _____A CONTINUING DISCLOSURE FOR 90 DAYS. (Check 1)

Esta es _____ una sola autorizacion o _____ una autorizacion continua por 90 dias. (Maque una)

DATE ON WHICH CONSENT IS GIVEN : _____
Fecha en que se dio consentimiento:

RELEASE EXPIRATION DATE: _____
Fecha de experacion del consentimiento: CONSENT IS SUBJECT TO REVOCATION AT ANY TIME.
CONSENTIMIENTO ESTA SUJECTO A SER REVOCADO EN CUALQUIER MOMENTO.

I HERBY RELEASE THE FACILITY FROM ANY LIABILITY WHICH MAY ARISE AS A RESULT OF THE USE OF THE INFORMATION CONTAINED IN THE RECORDS RELEASE.
Yo por este medio relevo a esta empresa de cualquier responsibilidad que pueda surgir como resuitado del uso de la infomacion contenida en los documentos remitidos.

NAME OF PATIENT: _____ BIRTHDATE: _____
Nombre del paciente: Fecha de nacimiento:

SIGNATURE OF PATIENT: _____ DATE: _____
Firma del paciente: Fecha:

SIGNATURE OF GUARDIAN: _____ DATE: _____
Firma del custido: Fecha:

SIGNATURE OF WITNESS: _____ DATE: _____
Firma del testigo: Fecha:

TO RECEIVING AGENCY: PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORS WHOSE CONFIDENTIALITY IS PROTECTED. ANY FURTHER REDISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT INFORMATION.

OSCEOLA PHYSICIAN MANAGEMENT

PHONE (407) 933-7119 - FAX (407) 933-7732
801 W. OAK STREET, SUITE 202 – KISSIMMEE, FL 34741

DECLARATION TO DECLINE LIFE PROLONGING PROCEDURES
(Living Will)

____ I have made a Living Will

____ I do **NOT** have a Living Will

HEALTH CARE SURROGATE

_____ I have designated a Health Care Surrogate

_____ I have **NOT** designated a Health Care Surrogate

DURABLE POWER OF ATTORNEY

_____ I have appointed a Durable Power of Attorney for Health Care decisions.

_____ I have **NOT** appointed a Durable Power for Attorney for Health Care decisions.

Patient Name: _____

Patient Signature: _____ Date: _____

If you any further questions, you can contact your family Attorney, Local Hospital or Local Medical Association for additional information.

OSCEOLA PHYSICIAN MANAGEMENT, INC

PHONE (407) 933-7119 • FAX (407) 933-7732
801 W. OAK STREET, SUITE 202 • KISSIMMEE, FL 34741

OFFICE POLICIES

MEDICARE: Osceola Physician Management participates with Medicare and accepts Medicare assignment. We file charges on behalf of our Medicare patients. You will be responsible for your deductible of $135 on an annual basis. If you have a supplemental policy, we will file that as well.

HMO / PPO: We currently participate with several different plans such as Cigna, BCBS Health Options, and Healthchoice. Some of these plans require referrals for visits to a specialist the Doctor may send you to. If your carrier requires you to have one it is your responsibility to obtain the authorization for referral prior to the scheduled visit and to have the information forms with you at the time of your visit with the specialist. Please do not call the day of your visit with a specialist for a referral, it will not be completed or faxed to your visit. You must also be prepared to pay your co-payment, as requited by your carrier, at the time of service. We do not write off co-payments.

COMMERCIAL / OTHER INSURANCE: If you have a commercial or group policy, we will gladly submit your claim as a courtesy to you but we ask that you pay your estimated portion and deductible when services are rendered unless previous arrangements have been made with our billing department. You will he responsible for the entire amount due if the services rendered are not covered by your policy.

AUTO INSURANCE: We do not file auto accidents. Full payment is due at the time services are rendered.

COLLECTION INFORMATION: There will be a $40 service charge for all returned checks. Any amounts which are 60 days past due will be eligible to be turned over to a collection agency. We will be happy to discuss any questions you may have regarding this policy. Please call the billing department between 10:00 a.m. and 4:00 p.m. All past due accounts must be paid before the next appointment.

NO CALL /NO SHOW: We charge a $35 fee for appointment time that is held and the patient does not call or show. This time costs the practice income and prevents other patients from being seen.

Patient Name: _____

Patient Signature: _____ Date: _____