NEW PATIENT FORMS

INSTRUCTIONS:

1. Please fill out the following forms to the best of your knowledge.
2. Please print legibly with blue or black ink.
3. If you have questions, please ask a staff member for assistance.
4. Please return completed forms to the front desk and have proper identification and insurance cards available on the day of your visit.

THANK YOU FOR TRUSTING US WITH YOUR HEALTHCARE.

537 NW Lake Whitney Pl #103
Port St. Lucie, FL 34986
PH: 772-877-8578
tlchearts.com

Patient Information and Consent

Patient Name

_____

Legal First Name Legal Last Name Suffix Preferred First Name

Today's Visit

What is the reason for your visit today?_____
Have there been any changes to your information in the past 6 months? [ ] Yes [ ] No

Patient Demographics

_____

Permanent Address City State Zip Code

_____

Phone Number Social Secnurty Number Gender Birth Date

_____

Language Marital Status Email Address (we will never rent or sell you email address)

Race: [ ] African Americal [ ] American Indian/Alaska Native [ ] Asian [ ] Hispanic
[ ] Mixed Race [ ] White [ ] Refused to Report

Ethnicity: [ ] Hispanic [ ] Not Hispanic [ ] Refused to Report

Emergency Contact Information

_____

Contact Name Phone Number Relationship to Patient

Patient Employment Information

_____

Employer Name Employer Phone Number

Responsible Party's Information (if other than the patient)

_____

Legal Name of Responsible Party Social Security # Address City State Zip

Preffered Pharmacy

_____

Company Name Address Phone Number

Medical Insurance Information

_____

Insurance Company Policy Holder's Name Policy Holder's Relationship to the Patient

_____

Policy Holder's Address City State Zip

_____

Policy Holder's Birth Date Policy Holder's Social Security # Policy Holder's Employer

I consent to the use or disclosure of my protected health information by TLC Medical Group, Inc for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TLC Medical Group. I understand that diagnosis or treatment of me by TLC may be conditioned upon consent as evidenced by my signature on this document. My "protected health information" means health information including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits, be made to TLC Medical Group, Inc. I authorize any holder of medical information about me, release to CMS and its agents, any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient Signature Date

_____

Patient Printed Name

_____ I have reviewed a copy of TLCMG's Privacy Notice.

Initials

ADULT HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: [ ] M [ ] F

Who was your previous Cardiologist? _____

What is your preferred Pharmacy? _____

CURRENT MEDICATIONS: (May bring own list if preferred)

Name of Medication	Strength of Medication	Dosing Instructions

*Note: This information may be taken directly from the pharmacy label on prescription products

ALLERGIES

[ ] No Known Allergies [ ] Medication Allergies [ ] Environmental/Seasonal Allergies [ ] Latex Allergy

List Allergies	Reaction

PAST MEDICAL HISTORY (check all that apply)

- Acid Reflux/GERD
- ADHD
- Alcoholism
- Allergies
- Anemia
- Anxiety
- Arthritis
- Asthma
- High Cholesterol
- Irritable Bowel
- Stroke
- Thyroid Disease
- Chronic Pain
- Cancer
- Depression
- Diabetes
- Emphysema/Bronchitis
- High Blood Pressure
- Thyroid Disease
- Glaucoma/Cataracts
- Headaches
- Other:_____

PAST SURGICAL HISTORY

Date of Surgery	Type of Surgery

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Date of Visit: _____ Provider: _____

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than ½ the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling Down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure	0	1	2	3
7. Trouble concentrating on things	0	1	2	3
8. Moving or speaking so slowly that other could have noticed. Or opposite, being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? **Please circle your answer.**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

PERSONAL HISTORY

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Name of Significant Other (if applicable):

Do you have Children? [ ] Yes [ ] No _____ # of Sons _____ # of Daughters

Names of Children	Age

Living Situation: [ ] Alone [ ] Spouse [ ] w/children or family [ ] Other

Occupation:

Hobbies and Interests:

Tobacco

Have you ever smoked? [ ] Yes [ ] No

If no, how many years ago did you quit?

How many years did you smoke?

How many packs/day did you smoke?

If yes, how many years have you smoked?

How many packs/day do you smoke?

Have you ever tried to quit?

Alcohol

Do you drink alcohol including beer, wine or other alcohol? [ ] Yes [ ] No

If yes, please specify frequency: [ ] Daily [ ] Almost Daily [ ] 1-3 times/week [ ] less than one time/week

Do you drink caffeine? [ ] Yes [ ] No

If yes, how many cups per day?

Diet/Activity

Are you on any special diet? [ ] Yes [ ] No Please describe your diet (South beach, Atkins, low fat etc)

Do you currently participate in any regular activity to improve or maintain your physical fitness (either on your own or in a formal class): [ ] Yes [ ] No

If yes, please describe:

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? (including marijuana, cocaine, pain med etc.) [ ] Yes [ ] No

Health Planning

If yes, which types: [ ] Living Will [ ] Durable Power of Atty [ ] Health Care Attorney [ ] Advanced Directives

FAMILY HISTORY (Check all that apply)

- o Asthma
- o Heart Disease
- o Stroke
- o Alzheimer's
- o High Blood Pressure
- o Cancer (specify): _____
- o Depression
- o High Cholesterol
- o Diabetes
- o Thyroid
- o Other: _____

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations and tests to the best of your ability. If you have not had one of these services, please indicate NA (not applicable)

All Patients:

Last Tetanus booster	__Within past 10 years	__More than 10 years ago		__Unknown
Last Eye Exam	Date_____	__Normal	__ Abnormal	__Unknown
Last Hearing Exam	Date_____	__Normal	__ Abnormal	__Unknown
Last sigmoidoscopy/colonoscopy	Date_____	__Normal	__ Abnormal	__Unknown
Last DEXA Bone Scan	Date_____	__Normal	__ Abnormal	__Unknown
Last Pneumonia Vaccine	Date_____	__Normal	__ Abnormal	__Unknown
Flu Shot this Season	Date_____	__Normal	__ Abnormal	__Unknown

Women:

Last Pap Smear	Date_____	__Normal	__Abnormal	__Unknown
Last Mammogram	Date_____	__Normal	__Abnormal	__Unknown

Men:

Last prostate Specific Antigen-PSA	Date_____	__ Normal	__Abnormal	__ Unknown
Last Prostate Exam	Date_____	__ Normal	__Abnormal	__ Unknown

CONCERNS:

Please indicate any concerns regarding your health in the space provided:

_____

_____

_____

_____

_____ _____

PATIENT SIGNATURE DATE

_____

PATIENT NAME (please print)

RECORDS REQUEST

I, the undersigned patient or legal representative, hereby authorizes TLC Medical Group, Inc. to request my health information/records/examinations rendered to me.

Patient Name:_____ Date Of Birth: _____
PLEASE PRINT CLEARLY

OFFICE USE ONLY: *This information may be disclosed to and used by the following:*

TLC Medical Group, Inc.
537 NW Lake Whitney Place; Suite 103
Pt. St. Lucie, FL 34986
P: (772)877-8578; **F**: (772)877-8549

The dates of service and the type(s) of information to be used or disclosed are as follows:

DATE(S) OF SERVICE: _____

RECORDS REQUESTED: _____

This request is for the purpose of treatment, payment, and/or Health Care Operations.

1. This authorization will be valid while I am a current patient with TLC Medical Group, Inc.
2. I understand that I may revoke this authorization at any time by notifying TLC Medical Group, Inc.
3. I understand that I may inspect or copy the information to be used or disclosed.

Signature of Patient or Legal Representative: _____ Date: _____

If individual is unable to sign this authorization, please complete the information below:

_____ _____ _____
Name of Guardian/Representative Relationship to Patient Date

Witness: _____

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice. We have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

1. As a courtesy, we fill file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.
2. Your insurance policy is a contract between you and your insurance company, the doctor is not involved
3. We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment at the time of the service.
4. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
5. Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience, we will accept VISA and MasterCard
6. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible or the complete charge.
7. For all services provided by our physician(s), in the hospital, we will bill your health plan. Any balance due is your responsibility.
8. For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
9. In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to reschedule your appointment. There is a late cancellation fee if you do not cancel or reschedule your appointment within 24 hours.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I hereby state that I have listed ALL the MEDICAL INSURANCE COVERAGE that I currently have and is aware of no other insurance (s). Otherwise, I am responsible for any claims not paid because of not informing this clinical of all medical coverage.

_____ _____

Signature of party who filled out the registration forms and is responsible for this agreement.

Date

_____

Please Print Name

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name: _____ Date:_____

[ ] Check here if minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record for purposes of medical teaching or for publication in medical textbooks or journals as I have designated below. By consenting to the medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photograph will in no way affect the medical care I will receive.

If I have any questions or wish to withdraw my consent in the future I may contact:

_____

By signing this form below, I confirm that this consent form has been explained to me in term which I understand.

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____ _____
Patient Signature Witness

2. I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication:

_____ _____
Patient Signature Witness

3. I agree to use of my image for medical records ONLY

_____ _____
Patient Signature Witness

PATIENT E-MAIL OR TEXT MESSAGE AUTHORIZATION FORM

I, _____ TLC Medical Group, Inc. to contact me at the following email address or phone number: _____.

Risks:

- I understand that if TLCMG contacts me by email or text, the most likely risk to my personal health information is that information intended for me could be sent to the wrong person by mistake
- I also understand that there is a risk that my email account could be hacked, and that email sent to me could be monitored, intercepted, read and/or altered before it reaches my email in box
- I have been informed that internet email is sent via relay servers and that anyone with access to a relay server has the ability to read an email saved on the relay server. I have also been informed some relay servers stores copies of the messages even after they have been sent to the final recipient.

Acknowledgement and Agreements:

- I have read and understand the risks associated with email communications and I understand there may be additional risks not described here
- I understand that TLCMG cannot control who reads my email or text messages, while in route or when delivered to my email account or phone
- I hold TLCMG harmless from any liability for ending my protected health information by email or text message, or for any unintentional misdirection of email or text messages to someone other than me.

I have read and understand the risk associated with email and text communications. By signing this authorization, I confirm that it accurately reflect my wish to receive health information by email to text message, and I will not hold TLCMG liable for any unintentional disclosure of my health information in a email or text message. I understand that I may revoke this authorization in writing at any time.

_____ Name of Patient

_____ Patient Date of Birth

_____ Signature of Patient or Representative

_____ Date

_____ Printed Name of Patient's Legal Rep

_____ Relationship to Patient

If not signed by patient, description of authority: _____

PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s)of spouse, child(ren) and any others involved in your care

[ ] You have permission to leave information on my answering machine regarding my medical care and test results

[ ] You have my permission to speak with my spouse about my medical care

[ ] You have my permission to talk with my children or other family members involved with my medical care

[ ] Other, please explain _____

Name_____ Relationship _____ Contact # _____

Name_____ Relationship _____ Contact # _____

Name_____ Relationship _____ Contact # _____

Upon request, I may limit the amount of time that this consent for release of information is valid.

I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

_____ _____

Patient Name, please print Date of Birth

_____ _____

Patient Name, please print Date

HIPAA NOTICE 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 REVIEW IT CAREFULLY.

When this Notice of Privacy Practices refers to "we" or "us". It is referring to TLC Medical Group and all of the employees of our company. We are required by law to maintain the privacy of your protected health information (Phi), follow the terms of the Notice currently in effect, to give you this Notice setting forth our legal duties and privacy practices concerning your PHI and to notify affected in individuals following a breach of unsecure PHI. This Notice describes how we may use and disclose your PHI. Additionally, this Notice explains the rights you have with respect to your PHI, and certain obligations we must abide by in accordance with the law. We reserve the right to amend this Notice. If we make any material revisions to this Notice, we will post a copy of the revised Notice in lobby on our patient communication board.

I. USE AND DISCLOSURE OF YOUR PHI – We will use and disclose your PHI for treatment, payment and health care operations. We may also use your PHI for other purposes that are permitted and/or required by law and pursuant to your written authorization. The following lists examples of how we may use and/or disclose your PHI. Any other uses not described in this Notice will only be made with your explicit authorization, which you may revoke at any time by providing us written notice of your revocation.

a) Treatment - We may use and disclose your PHI in order to provide medical care services. We may disclose your PHI to your other treating physicians at either their or your request (with written authorization)

b) Payment - We will use and disclose your PHI in order to obtain payment for the health care services we provide to you. We may also need to disclose your PHI to receive prior approval from your health plan for your care and treatment

c) Family Members, Relatives or Close Friends - Unless you object to such disclosure, we may disclose your PHI to your family members, relatives or close personal friends, or any other persons you identified by you as being involved in the treatment or payment for your medical care. If you are not present to agree or object to our disclosure of your PHI to a family member, relative or friend, we may exercise our professional judgement to determine whether the disclosure is in your best interest. If we decide to disclose your PHI, we will only disclose the PHI that is relevant to your treatment tor payment

d) Other Permitted and Required Uses and Disclosures – We may use your PHI without obtaining your authorization and with offering you the opportunity to agree or object as follows:

- As required by law, provided however, the use or disclosure will be made in compliance with applicable law;
- To a public health authority that is authorized by law to collect or receive such information, or to a foreign government agency that is acting in collaboration with a public health authority and these health activities generally include preventing or controlling disease, reporting deaths, reporting adverse effects of medications, notification of communicable disease and reporting abuse r neglect under certain circumstances
- To a health oversight agency for oversight activities authorized by law, including audits and inspections, and civil, administrative or criminal investigations, proceedings or actions
- For judicial or administrative proceedings purposes in response to a subpoena, court order, discovery requests, etc…but only if efforts have been made to inform you about the request or to obtain an order protecting the information request
- To law enforcement to report certain injuries, comply with court orders or warrants or similar process, to identify a suspect, fugitive, issuing person or victim or to report a crime
- To a coroner or medical examiner to perform duties authorized by law such as identification of a deceased person or determining the cause of death
- To funeral directors consistent with applicable law, as necessary to carry out their duties
- To organ procurement organizations or similar entities for the facilitating organ, eye or tissue donation and transplantation
- For research purpose provided that certain approvals take place and assurances are given

- To avert a serious threat to health or safety, so long as the disclosure is only to a person who is reasonably able to prevent or lessen such treat
- For military and veterans activities (including foreign military personnel) to assure the proper execution of a military mission and to determine eligibility of benefits
- For national security and intelligence activities for the purpose of conducting lawful intelligence, counter intelligence and other nation security activities
- To a correctional institution or law enforcement custodian if you are an inmate or under custody and;
- To the extent necessary to comply with laws relating to workers' compensation and work-related injuries

II. YOUR RIGHTS AS OUR PATIENT – As our patient, you have of rights associated with your PHI. The following describes your rights

a) You have the right to request restrictions or limitations on how we use and/or disclose your PHI, however, we do not have to agree to your request restriction or limitation (except for any transaction you paid for in full out of pocket). You written request must specify: 1. If you would like to restrict or limit our use and/or disclosure 2. What information you want restricted or limited and 3. To whom the restriction or limitation applies. If we agree to your request, it will not prevent us from disclosing your PHI as follows: 1. To you if you request access or an accounting of disclosure 2. For purposes required or permitted by law or 3. In case of an emergency

b) You have the right to receive confidential communications concerning your PHI by alternative means or via alternative locations. If you wish to receive confidential communications via alternative means or locations , please submit your request in writing to the Privacy Officer and set for the alternative means by which you wish to receive communication or the alternative location at which you wish to receive such communications. We will accommodate all reasonable requests.

c) You have the right to access, inspect and obtain a copy of your PHI, including any electronic PHI; provided, however, you are not entitled to access certain PHI exempted under HIPAA. To the extent we maintain electronic PHI, upon request, we will provide you with a copy of your PHI in the format requested. If we do not have your PHI in our possession, we will provide you with the appropriate contact information when your request is received. If you request a copy of your PHI, you will receive a response to your request in a timely fashion but may be charged a reasonable, cost based fee to cover copy costs and postage. In some limited circumstances, we may deny our request for access to PHI in which case you may request for the denial to be reviewed. If access is ultimately denied, you are entitled to a written explanation with the reason for the denial.

d) You have the right to receive an accounting of disclosure of your PHI made by us, including disclosures to or by our business associate(s) for a period of six years prior to the date on which you request an accounting of disclosures or such lesser period you indicate. You will receive a request annually, free of charge and, thereafter, we may charge you a reasonable cost based fee for each subsequent request for accounting of disclosures within the same twelve-month period. We will notify you of the cost for an accounting of disclosures and you may choose to withdraw or modify your request before we charge you.

e) You have the right at any time to obtain a paper copy of the Notice, even if you received this Notice electronically. Request for a paper copy of this notice in writing to the Privacy Officer at the address listed below

III. Additional Information

a) If you need any additional information about this Notice or which to exercise any of your rights set for this notice, please contact the Privacy Officer at the following address: TLC Medical Group, attention Nancy Witherow, 1391 NW St. Lucie West Blvd. #216, Pt. St. Lucie, FL 34986
If you believe your rights have been violated, you may file a complaint without retaliation to:

Secretary of the Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201