AFM HEALTHCARE
Giving you a LIFETIME OF CARE

Phone Number: ***Winter Park:*** 407-657-2111 ***Oviedo:*** *407-537-9852* ***Lake Nona:*** *407-657-2111*
Fax Number: 866-725-4812
Location:
Winter Park: 7221 Aloma Ave, Suite 200, Winter Park FL 32792
Oviedo: 1410 W. Broadway St., Suite 201, Oviedo FL 32765

New Patient Information Packet
Welcome to AFM Healthcare, thank you for selecting us to assist you in your health and wellbeing.

Please read this entire packet carefully, as it contains important information concerning your treatment at AFM Healthcare. If you have any questions concerning any information presented here, please be sure to ask a member of our office staff.

Please sign and date the forms which accompany this packet and return them to our office before your first session. You may fax the completed and signed forms to 866-725-4812 or bring it to your first visit.

Thank you for your cooperation and we look forward to working with you.

For your first visit:

Please don't forget to bring the following

- Identification card
- Insurance card
- Completed New Patient Information Packet
- Medications

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DEMOGRAPHICS

*Last Name:	*Date of Birth
*First Name:	*Sex: Male Female
*Street Address:	*SSN:
City:	Zip Code:
State:	
Home Phone:	*Cellphone
*Email:	

EMERGENCY CONTACT

Name :	Phone Number:
Relationship to Patient:	

INSURANCE

Member ID :	Group No :
Insured's Name:	Relationship to Insured ○ Self ○ Spouse ○ Child
Date of Birth:	
Phone Number:	

How did you know about us?

Doctor : _____
Hospital: _____
Friend:_____
Family:_____
Insurance Plan :_____
Web: [ ] Google [ ] Web MD
[ ] Healthgrades [ ] Facebook

PHARMACY INFORMATION: ***Please try to add your pharmacy information.***

PRIMARY PHARMACY: _____

SECONDARY PHARMACY *only if applicable:* _____

TERTIARY PHARMACY *only if applicable:* _____

_____ _____
Signature of Patient or Legal Representative **Date**

Marital Status
- ○ Single
- ○ Married
- ○ Partner
- ○ Divorced
- ○ Widowed

Language
- ○ English
- ○ Filipino
- ○ Spanish
- ○ Other_____

Race
- ○ Asian
- ○ Asian Indian
- ○ Black
- ○ Caucasian
- ○ Decline to Specify
- ○ Other_____

Ethnicity
- ○ Hispanic
- ○ Not Hispanic

Employment Status
- ○ Full-time
- ○ Part-Time
- ○ Retired

Student
- ○ Full-time
- ○ Not a student
- ○ Part-time

Are you a V.A Patient?
- ○ Yes
- ○ No

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HEALTH QUESTIONNAIRE:

Name: _____ DOB: _____

Past Medical History of Diagnosis

_____ _____
_____ _____
_____ _____
_____ _____

Surgical History (including the year)

_____ _____
_____ _____
_____ _____
_____ _____

Hospitalization/ Urgent Care/ ER Visit for the last 2 months:

_____ _____
_____ _____
_____ _____
_____ _____

Family History

(If any relative has suffered from the following conditions, please check box and indicate which relative)

_Heart Disease	_Stroke	_Asthma	_Kidney Disease
_Diabetes	_High Blood P.	_Lung Disease	_Glaucoma
_Thyroid	_High Cholesterol	_Cancer	

Are you allergic to any medications? (If yes, please list them and the reaction they cause)

Social History

Marital Status: _____ Occupation _____ No. Of Children _____
Do you Smoke? [ ] Yes [ ] No [ ] former smoker
If yes: when was the last time you smoked? _____
If a former smoker: when was the last time you smoked?
Alcohol? _____ Drinks per day? _____
Drugs? _____ What kind? _____ Exercise? _____ Times/Week? _____

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Review of Systems

Name: _____ DOB: _____

Constitutional ___ Fever ___ Weight Loss ___ Weight Gain ___ Fatigue **Musculoskeletal** ___ Bone Pain ___ Joint Pain ___ Muscle ___ Pain/ Weakness	**Ears, Nose, Throat** ___ Hearing Changes ___ Sinus Problems ___ Neck Pain/Mass ___ Difficulty Swallowing	**Psychological** ___ Feel Depressed ___ Feel Anxious ___ Feel Safe ___ Memory Problems **Gastrointestinal** ___ Diarrhea ___ Constipation ___ Nausea/Vomiting ___ Abdominal Pain	**Neurological** ___ Tremor ___ Dizziness ___ Numbness/ Tingling **Eyes** ___ Vision Change ___ Glasses Respiratory ___ Cough ___ Wheeze	**Genitourinary** ___ Problems Urinating ___ Urination at Night ___ Change in Sex Drive ___ Erectile Problems	**Blood** ___ Blood Clot ___ Bleeding Problems ___ Swollen Gland or node **Cardiovascular** ___ Chest Pain ___ Palpitation ___ Irregular Heart beat

Preventive Health Screening

TEST	DATE / YEAR	IMMUNIZATIONS	DATE / YEAR
Mammogram (Female)		Tetanus	
Pap Smear (Female)		Hepatitis	
Colon/Sigmoid Screening/FIT		TB Skin Test	
Eye Screening		Flu Shot	
Bloodwork		Pneumonia/Zoster	
		MMR	

Medications: (Name, Dose, Frequency) ***example Lisinopril 20mg, once a day***

Name	Dose	Frequency

PHQ-2 (Please answer if you are experiencing the following)

1) Little interest or pleasure in doing things YES NO
2) Feeling down, depressed, or hopeless YES NO

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AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION/MEDICAL RECORDS

Patients Name: _____ DOB:_____
Telephone No. _____ SS#:_____

I hereby authorize AFM HEALTHCARE to:

o Request Information from o Release Information to

NAME/ORGANIZATION: _____ TEL. _____
ADDRESS: _____ FAX: _____

PLEASE RELEASE THE FOLLOWING:

___ All records in the past 2 years of treatment
___ Lab Results/Pathology Reports
___ Radiology Reports
___ Drug abuse
___ Alcohol abuse
___ Mental health
___ Others: _____
___ HIV test results
___ Immunization Records
___ Pharmacy/Prescription Records

*NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, Ca DX, Drug/Alcohol abuse, or sexually transmitted disease, you are hereby authoring disclosure of this information.

REASON FOR RELEASE:

___ Continuation of patient care ___ Personal Use ___ Attorney/Legal
___ Specialist Consult ____ Other: _____

RELEASE BY:

___ FAX
___ EMAIL: _____ ENCRYPTED [ ] YES [ ] NO
___ PRINT

Consent:

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization at any time in writing. I have the right to receive a copy of this information. I understand that I may be charged for copies provided, for personal use ($1/page for the first 25pgs and $0.25 per page thereafter). This authorization is valid for one year from the date it was signed.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient or Legal Representative

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Patients Name: _____ DOB:_____

I. Acknowledgement of Practice's HIPAA Privacy Notice:
<u>This Authorization will expire one year from the date signed.</u>

I acknowledge that AFM Healthcare has provided me a copy of the HIPAA Privacy Notice and that I understand my rights and I have agreed to its terms.

- ❑ I agree
- ❑ I do not Agree

II. Designation of Caregivers as my Personal representative:

I give permission for the following person(s) to pick up prescriptions, schedule and receive any of my personal health information on my behalf. I understand that no prescriptions or health information will be released other than to the person(s) listed below.

- ★ Person's listed below will be required to present a driver's license or other state/ federally issued photo ID when picking up prescriptions, billing information, and /or any personal health information.

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

- ❑ I agree
- ❑ I do not Agree

III. Messages: We use multiple messaging systems for our patients. Please read below and check what's best for you.

I consent to ***<u>receive phone calls</u>*** for (Appointments, RX confirmation and general notification and other reminders)

- ❑ I agree
- ❑ I do not Agree

If you agree please choose:
[ ]English [ ] Spanish
[ ]Home Phone [ ] Cellphone

I consent to ***<u>receive text message</u>*** ***(***Appointments, RX confirmation and general notification and other reminders)

- ❑ I agree
- ❑ I do not Agree

If you agree please choose:
[ ]English [ ] Spanish
[ ]Home Phone [ ] Cellphone [ ] Both

I consent to receive ***<u>email</u>*** *(Healow messaging,* Appointments, RX confirmation and general notification and other reminders)

- ❑ I agree
- ❑ I do not Agree

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PAYMENT POLICY

Name: _____ DOB: _____

Please read and initial each item contained in our payment policy.

Insurance. We participate in most insurance plans including Medicare. Unfortunately do not accept Medicaid and Medicare/Medicaid Advantage plans.

_____ 1. For **MEDICARE ONLY**: Alilin Family Medicine is a Medicare Participating Provider, which means Medicare tells us the amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay 80% and you (or your supplemental insurance) will pay 20%. Your out-of-pocket expense is limited to the yearly deductible that you need to pay before Medicare pays and the 20 percent do-payment mandated by Medicare. The 20% may be covered by another secondary insurance if you have one.

If you have a secondary insurance policy, we will file with that secondary insurer after we receive a response from Medicare. You will receive a bill from us the month following Medicare's response. We allow 60 days from the date Medicare responds for your supplemental policy to pay. After 60 days, the balance becomes your responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

_____ **2. Co-payments and Deductibles**. All co-payments and deductibles must be paid on time. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying your co-payment.

_____ **3. Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a ***copy of your driver's license and current valid insurance to provide proof of insurance***. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

_____ **4. Claims**. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

_____ **5. Non-payment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may discharge you from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

_____ **6. Payment plan**. We offer a monthly payment plan if you meet the criteria. If you are interested just call our office and we will be glad to assist you through the process and explain the options available.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Legal Representative **Date**

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CONSENT FOR MEDICAL TREATMENT

Patients Name: _____ DOB:_____

I voluntarily present to AFM Healthcare and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include but not limited to the administration of medications considered advisable to my diagnosis, treatment, pelvic exams, biopsy, injections and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risk.

_____ _____

Signature of Patient or Legal Representative **Date**

Do you want to sign any of the following forms we have in our office: If you check one of these boxes. Our front office staff will provide you the form.

- ❑ Living Will
- ❑ Do not Resuscitate Form

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(A)NOTIFIER(S):
(B)PATIENT NAME:
(C)IDENTIFICATION NUMBER:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for *(D)* _____ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the *(D)* _____ below.

(D) _____	*(E)* **Reason Medicare May Not Pay:**	*(F)* **Estimated cost:**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive (D)_____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1**. I want the *(D)* _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund and payments I made for you, less co-pays or deductibles.
☐ **OPTION 2**. I want the *(D)* _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.**I don't want the *(D)* _____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay**.

(H) **Additional Information:**
This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

(I) **Signature:**	*(J)* **Date:**

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(A)NOTIFIER(S):
(B)PATIENT NAME:
(C)IDENTIFICATION NUMBER:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If your insurance doesn't pay for *(D)* _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the *(D)* _____ below.

(D) _____	*(E)* **Reason Your Insurance May Not Pay:**	*(F)* **Estimated cost:**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive (D)_____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance you might have, but your insurance cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1**. I want the *(D)* _____ listed above. You may ask to be paid now, but I also want your insurance billed for an official decision on payment, which is sent to me on an EOB (EXPLANATION OF BENEFIT). I understand that if your insurance doesn't pay, I am responsible for payment, but **I can appeal to your insurance** by following the directions on the EOB . If your insurance does pay, you will refund and payments I made for you, less copays or deductibles.
☐ **OPTION 2**. I want the *(D)* _____ listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if your insurance is not billed**.
☐ **OPTION 3.**I don't want the *(D)* _____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if your insurance would pay**.

Signing below means that you have received and understand this notice. **You also receive a copy.**

(I) **Signature:**	*(J)* **Date:**

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Statement of Patient's Rights

- You have the right to be treated with dignity and respect
- You have the right to fair treatment
- You have the right to have your treatment and other information kept private
- You have the right to privacy. Only with consent, or if required by law, can records be released
- You have the right to have an easy to understand explanation of your condition and treatment
- You have the right to information about providers' professional backgrounds
- You have the right to know your rights and responsibilities in the treatment process

Statement of Patient's Responsibilities

- The patient has the responsibility to give providers information they need. For the purpose of delivering the best possible care
- The patient has the responsibility to follow their medication and treatment plan. They must tell their provider about medication changes, including medications given to them by other providers.
- The patient has the responsibility to treat those providing them with care, dignity and respect.
- The patient should not take actions that could harm the lives of AFM Healthcare employees, providers or other patients.
- The patient has the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits. Patients will be billed for missed or late cancelled appointments.
- The patient has the responsibility to follow the plan and instructions for their care.
- The patient have the responsibility to plan medication visits or refill in advance so as to not precipitate emergency calls
- The patient has the responsibility to inform their providers of any change in insurance coverage as soon as it is known in order to avoid the non –payment by insurances, thus we can implement self-pay charges. .
- For HMO, the patient has the responsibility to call our office for updates regarding visits to other doctors.

I, _____, have had full opportunity to read and consider the contents of

- AFM Healthcare *Notice of HIPAA Privacy Practices* containing a description of the uses and disclosures of my health information
- AFM Healthcare *Office Policy*
- AFM Healthcare *Payment Policy*
- AFM Healthcare *Patient's Rights and Responsibilities*
- *AFM Healthcare Consent of Medical Treatment*
- AFM Healthcare *ABN (Advance Beneficiary Notice of Non Coverage)*

Patient Name: _____ Signature: _____
Date:_____

Thank you for choosing AFM Healthcare.
We look forward to giving you a LIFETIME of CARE.

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AFM Healthcare Office Protocol

1) Patient's Right and Responsibilities - A copy of our "Patient's Rights and Responsibilities" is included with this package and is available at our website www.afmhealthcare.com. Please read over these as they address our responsibilities to you as a patient and your responsibilities as a recipient of AFM Healthcare services.

2) Communication

2.1 Telephone Calls- We are very committed in providing you fast and easy communication; however, we need your assistance to make it possible. Always say your "name, telephone numbers where you can be reached, the reason for the call and convenient times to reach you". **Please be reminded that we will return your phone call within 24-48 hours.**

2.2 Healow- We are using Healow as the fastest way to communicate with us. Using this portal, you can send us a message, ask for a refill, check your appointment times and view your progress notes. Please sign up for secure messaging via patient portal. Check with our office staff for detailed information for this service.

3) Emergencies

Office Hours: If there is an emergency during normal working hours (8:30-5:00pm), please contact the office and tell the staff member the nature of the emergency. You will be assisted in obtaining the services you needed.

After Hours: If you need emergency assistance after hours, please call our office and follow the prompts. Phone calls to the main office will be forwarded to our answering service. The on-call physician will be paged for calls requiring immediate attention. All other calls will be directed to our office during regular office hours.

Life threatening emergencies: If the situation is life threatening, please call 911 or go to the nearest ER.

4) Cancellation of appointments- We send you reminders 48 hours before your appointment, via text, call and Healow patient portal. We have reserved the time for you and will not be able to offer that time slot to another patient. For this reason, you are asked to contact us **24 hours in advance if you need to cancel a scheduled appointment, to avoid the late cancellation charges of $25.00. A fee of $25.00 will be charged if you miss the appointment.**

5) Prescription Refills

Please make every effort to make and keep timely appointments with your provider.

For routine medication please be reminded to call our office 1 week before your medication is completely gone.

Please do not go to the pharmacy and wait for your prescription. Please allow 24-48 hours for your request to be processed.

Medications such as **Antibiotics or Narcotics** will not be refilled by phone and **require an office visit unless stated by your provider.**

In accordance with our pain policy AFM Healthcare will not prescribe or manage chronic pain with narcotics or opioids until you've been seen by your primary care provider. In addition, no narcotics will be maintained on the clinic premises. In accordance with recommendations by the Federation of State Medical Boards, we will direct those patients in need of the use of controlled substances to pain specialists and experts for further evaluation, treatment, and monitoring.

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6) Fees - Please make sure that every time you visit our office you are aware about your insurance benefit and patient due responsibilities. It will be important for us to have that information as well as any changes, so we may assist you in using your benefits appropriately.

Please give your insurance information and changes to office staff as soon as it is available. Failure to provide updated insurance information may result in non-payment by insurance payors and you will be responsible for the full amount of charges.

Co-payment and co-insurance fees are due and payable in full before seeing the provider. We accept cash, credit cards and checks. Make checks payable to "AFM Healthcare". We will submit claims to your insurance companies for processing. However, if we do not work with your insurance carrier you can opt for self-pay. **We charge a $35 service fee for returned checks.**

7) Confidentiality- We comply strictly with your Healthcare records and we by HIPAA rules. No records of your treatment will be released outside AFM Healthcare, without written permission from you. You should know that there are some unusual circumstances under which your clinician may release treatment information without your authorization. These situations are (1) an emergency involving imminent danger or harm to self or another.

(2) court order (3) physical or sexual abuse of a minor, and (4) if a crime is threatened or committed at one of our sites against any of our staff. Our patient care coordinator will discuss these conditions with you if you have any concerns.

8) Referrals- If other specialty care is required your family doctor will:

Refer to another specialist, if it is medically appropriate.

If you are a member of a managed care health plan (or HMO), you are responsible for following the rules of your plan. Generally, an HMO requires that you call our office for a referral before seeing a specialist. Each plan has its own regulations. so be sure you understand your responsibilities.

Please allow at least five (5) business days to process a referral. A written referral will be completed for you by the referral coordinator.

9) Forms: We charge the following fees for forms:

1) Animal Support Letter- $25.00 (if first copy is displaced and pt need new copy)
2) Sport Physical - $25.00 (if first copy is displaced and pt need new copy)
3) Medical Records - Retrieval Fee $25 + (First 25 pages $1.00, $0.25 for the subsequent pages)

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AFM Healthcare is required by law to keep the privacy of your health information and to provide individuals with notice of its legal duties and privacy practices with respect to health information. AFM Healthcare must abide by the terms of the Notice currently in effect. AFM Healthcare reserves the right to change the terms of its notice and to make the new notice provisions effective for all PHI (Protected Health Information) that it supports. This Notice of Privacy Practices and Policies outlines our practices, policies and legal duties to maintain confidentiality and protect against prohibited disclosure of protected health information ("PHI") under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").PHI includes your demographic information such as name, address, telephone number, and family; past, present, or future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information may be used to identify you. Your PHI may be kept by us electronically and/or on paper. We may amend this Notice of Privacy Practices and Policies periodically. The new notice will be effective for all PHI that we keep at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices or you may obtain a copy by accessing our website at www.afmhealthcare.com, by calling the office, 407-657-2111 and asking that a revised copy will be sent to you in the mail or asking for one at the time of your next appointment.
We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI.
If a representative is a court appointed legal guardian, a copy of court documents must be supplied and kept in medical records.
Your health records may be released to the following:

- ***To other health- care professionals within the organization for the purpose of providing you with quality health care.***
- ***To your insurance provider for the purpose of the organization receiving payment for providing you with needed health care services.***
- ***To public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.***
- ***To other health care providers in the event, you need emergency care.***
- ***To a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication)***

Your confidential health-care information may be released only after receiving written authorization from you.
The following are your rights:

- ***You may revoke your permission to release confidential health care information anytime.***
- ***You may restrict the disclosure of your protected health information for any services provided whereby you or somebody else pays "out of pocket", in full, for the services.***
- ***You may be contacted by AFM Healthcare to remind you of any appointments.***
- ***You have the right to opt out of any notifications about healthcare treatment options and marketing that are offered to you.***
- ***Right to receive confidential communication about your health status.***
- ***Right to review and photocopy any/all portions of your healthcare information***
- ***Right to make changes to your health care information***
- ***Right to know who has accessed your health care information and to know what purpose.***
- ***Right to own a copy of this privacy notice upon request.***
- ***Right to complain to AFM Health care if you believe your rights to privacy have been violated. Please mail your complaint to***

AFM Healthcare
7221 Aloma Ave, Suite 200-400 B
Winter Park , FL 32792

For further information about this HIPAA Privacy notice please call 407-657-2111 and www.afmhealthcare.com
This notice is effective. 02/18/2020.