Apopka Medical Center

125 South Park Avenue, Apopka, FL 32703 - (407)-886-1171

Patient Information – Please Print

Last Name: ______________ First: ______________ Middle: ______________

Street Address: ______________ City/State: ______________ Zip: ______________

Are your street address and mailing address the same? Yes ______ No ______ If not, please provide your mailing address:

Mailing Address: ______________ City/State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________

Social Security Number: ______________ Date of Birth: _____/_____/_____ Sex: ______________

E-Mail Address: ______________@______________

Employment Status: Full-Time ________ Part-Time ________ Unemployed ________ Retired ________ Student ________

(If Applicable) Employer: ______________ Occupation: ______________

Work Phone: ______________ Ext: ______ Address of Employment: ______________

City/State of Employment: ______________ Zip at Address of Employment: ______________

Marital Status: Single ________ Married ________ Divorced ________ Widowed ________ Legally Separated ________

(If Applicable) Spouse's Name: ______________ Spouse's Employer: ______________

Spouse's Phone Number: ______________ Work Phone Number: ______________ Ext: ______

Emergency Contact (Other Than A Person With Whom You Reside):

Name: ______________ Relationship: ______________

Address (With City/State): ______________ Phone Number: ______________

Signed: ______________________________ **Date:** ______________

Apopka Medical Center

Authorization To Release Information And Assign Benefits

I authorize Apopka Medical Center to release any of my medical information to insurance companies as needed to secure the payment of benefits. I directly assign all medical/surgical benefits to Apopka Medical Center and understand that I am financially responsible for all charges whether or not paid by insurance.

Financial Policy

In order for us to be able to continue to deliver high quality care, it is necessary to provide a financial policy. Please read all information and acknowledge by signing below.

1. **Insurance Changes:** Please notify the office prior to being seen if there has been any change to your insurance coverage. This includes being issued new insurance cards by your health plan. It is the patient's responsibility to provide the correct information so that we may submit a claim to your insurance company. Failure to do so may make you liable for denied claims.

2. **Due At Time Of Service:** Any deductible, co-payment, or payment for non-covered services, along with any patient balance, is due at the time of your visit. If you are not able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.

3. **Patient Statements:** If there is a balance due after insurance has processed your claim, a statement will be mailed. Payment is due within 30 days. If payment is not received within 45 days, a 1.5% monthly interest may begin to accrue on your account. If payment on your account is not received in a timely manner, your account may be referred to a collection agency and reported to the credit bureau.

4. **Medicare Patients:** We will submit your claims to Medicare for all covered services, and will forward those claims to your supplemental insurance. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the Medicare-allowed amount of your charges until your Medicare deductible is met, if you do not have supplemental insurance, or if the deductible is not covered by your insurance.

5. **Medicaid Patients:** We are not participating providers with Medicaid. We ask that you pay for your services at the time of your visit.

6. **HMO/Medicare Advantage Patients:** If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has Dr. Dean Behner as your PCP. Failure to do so may result in a balance for which the patient is responsible.

7. **Self-Pay Patients:** Self-pay patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements. Special prices may be available.

8. **No-Show or Missed Appointments:** In order to provide our patients with the best possible care and schedule visits in a timely fashion, it is imperative that you notify the office if you do not intend on keeping your scheduled appointment.
   Please call the office to cancel appointments and give a minimum 24-hour notice before your appointment so that we may offer that appointment to another patient. Your account will be charged a no-show fee in the amount of $25 (twenty-five dollars) for any appointment not kept or not canceled outside the 24-hour minimum. This fee will be due and payable prior to being seen in the office again.

I have read and understand the stated Financial Policy of Apopka Medical Center:

Signed: ______________________________ **Date:** ______________

Apopka Medical Center

Dean A. Behner, M.D.

Health History

Patient Name:	Date of Birth:

Active Problems
(List any illnesses for which you are now being treated at any physician's office.)

Past Medical History
(Have you ever had any of these problems? When?)

Problem	Yes	No	Year	Problem	Yes	No	Year
Arthritis/Rheumatism/Gout/Lupus				Tuberculosis			
Asthma (Wheezing)				Blood Clots in Legs or Lungs			
Hay Fever/Sinus Trouble				Diabetes			
Emphysema/Bronchitis/Constant Cough				Anemia			
Pneumonia/Pleurisy				Bleeding Tendency			
Rheumatic Fever/Heart Murmur				Stomach Trouble/Ulcers			
Coronary Artery Disease/Heart Attack/Angina				Bowel Trouble/Colitis/Colon Polyps			
Enlarged Heart/Congestive Heart Failure				Any Type of Cancer/Tumor			
Epilepsy/Seizures				Venereal Disease (Syphilis, Gonorrhea, Chlamydia) or PID			
Stroke/Paralysis				HIV/AIDS			
Thyroid Disorders/Goiter				Jaundice/Hepatitis/Liver Cirrhosis			
High Blood Pressure/Hypertension				Kidney or Bladder Trouble			
Osteoporosis				Migraine Headaches			
High Cholesterol				Mental Illness			
Amputation				Gall Bladder Stones/Removal			
Loss of Vision/Glaucoma				Hearing Trouble			
Appendicitis/Appendix Removal				Skin Disorders/Dermatitis			

Health History Continued

Hospitalizations, Surgeries, or Any Other Major Health Issues (List any hospitalizations, surgeries, or any major issues that are still affecting your health. Start from most recent.)		
Illness/Injury	Onset/Location Date	Hospital/Location/Physician

Lifestyle

Living Arrangements (Select all that apply.)	
Lives alone	
Lives with spouse	
Lives with spouse and children	
Lives with children	
Lives with other relatives	
Lives with non-relatives	
Other: ______________________	

Tobacco Usage (Please answer all.)	Yes	No
Do you smoke?		
- Cigarettes		
- Cigars/Pipes		
- Menthols		
- Chewing Tobacco/Snuff/Dip		
If applicable, number of years smoking:		
If applicable, cigarettes/etc. smoked a day:		
If applicable, year quit smoking:		

Drug Usage (Please answer all.)	Yes	No
Have you ever used illegal drugs?		
- Cocaine		
- Heroin/Opiates		
- Marijuana/Cannabinoids		
- LSD/Mushrooms/MDMA/PCP/ Ecstasy/Ketamine/Salvia/Hallucinogens		
- Methamphetamine/Amphetamines		

Alcohol Usage (Please answer all.)	Yes	No
Do you drink?		
- Beer		
- Wine/Champagne		
- Hard Liquor		
If applicable, number of years drinking:		
If applicable, drinks consumed a day:		
If applicable, year quit drinking:		

Health Maintenance Review

Immunizations (Please answer all.)	Yes	No	Year
Influenza			
Pneumonia			
Tetanus			
Tuberculosis			
Shingles			
Hepatitis B			
Measles/Mumps/Rubella			

Advanced Directives (Please answer all.)	Yes	No
Do you have an advance directive?		
Do you have a living will?		
If so, will you provide this office with a copy for your medical record?		

(If you would like information regarding advance directives, please ask your doctor.)

Health Maintenance Review
(If never performed, please answer "N/A" or leave blank.)

	Date of Last		Date of Last
Physical Examination		Blood Transfusion	
(Females) GYN Exam/PAP test		Eye Exam	
Mammogram		Colonoscopy/Sigmoidoscopy	
Cholesterol Test		Tuberculosis Test	
Blood Stool Test		EKG	
(Males) PSA Test		Stress Test	
(Males) Prostate Exam		Bone Scan	

Allergies

Allergies

	Yes	No
Have you ever experienced an allergic reaction to any medication? (If yes, please list all medications and reactions.)		

Medication	Reaction	Severity	Year

Allergies Continued				
Have you ever experienced an allergic reaction to a substance other than a medication such as pet dander, pollen, dust, peanuts, shellfish, strawberries, or any other allergen? (If yes, please list all allergens and reactions.)			Yes	No
Allergen	Reaction	Severity	Year	

Family History

Family History (Answer all that apply.)					
If a family member has or has had any of the following problems, please check the appropriate box and list the family member. If one or more does not apply, please indicate with "N/A" or leave blank. (Key: M – Mother, F – Father, S – Son, D – Daughter, B – Brother, SI – Sister, GM – Grandmother, GF – Grandfather, A – Aunt, U – Uncle, CO – Cousin)					
Cancer, Breast		Tuberculosis		Heart Attack/Stroke	
Cancer, Prostate		Liver Disease		Anemia/Blood Disorder	
Cancer, Other		Thyroid/Endocrine Problems		Other Heart Problems	
Colon Polyp		Autoimmune Disorders/HIV/AIDS		Diabetes	
Eczema/Psoriasis/Skin Rashes		High Cholesterol		Obesity	
Asthma/Lung Problems		High Blood Pressure		Bladder Problems	
Respiratory Infections		Osteoporosis/Bone Problems		Kidney Problems	
Emphysema/COPD		Seizures		Hepatitis A, B, or C	
Migraine Headaches		Arthritis/Rheumatoid Arthritis		Eye Problems or Blindness	
Bladder Problems		Phlebitis/Thrombosis		Ear Problems or Deafness	
Stomach Problems		Genealogical Problems		Mental Retardation	
Gastrointestinal Problems		Alzheimer's/Dementia		Drug/Alcohol Use	
Neurological Disorders		Allergies		Depression/Mental Illness	

Health Questionnaire

Are You Experiencing… (Are you currently suffering from or noticing any of these symptoms?)					
Problem	Yes	No	Problem	Yes	No
Skin Rashes or Discoloration			Lightheadedness		
Abnormal Lumps or Glands			Night Sweats		
Nausea or Vomiting			Weight Loss		
Abdominal Pain			Weight Gain		
Constipation			Loss of Hearing/Earaches		
Diarrhea			Loss of Sight/Blurred Vision		
Bloody or Tarry Stools			Loss of Consciousness/Fainting		
Excessive or Constant Worrying/Anxiety			Frequent Colds		
Abnormal Tiredness			Headaches or Migraines		
Shortness of Breath			Frequent or Persistent Cough		
Wheezing/Hoarseness			Feeling Lonely or Depressed		
Chest Pain			Inability to Sleep/Insomnia		
Skipped or Irregular Heartbeat			Mood Swings		
Ankle or Leg Swelling			Poor Appetite		
Pain in Legs While Walking/Running			Difficulty Swallowing		
Weakness in Arms or Legs			Hemorrhoids		
Loss of Sensation/Numbness			Trouble Urinating		
Brittle/Dry Hair/Nails			Heart Palpitations		
Change in Bowel Habits			Sinus Problems		
Excessive Thirst			Heartburn		
Frequent Urination			Fatigue		
(Females) Bleeding Between Menstrual Cycles			Morning Stiffness		
Skin Lesions			Fever or Chills		
Arthritis/Joint Pain			Impotence/Sexual Difficulty		

Please give details of any "yes" answers or of other symptoms not listed above: ____________________

____

____

____

Please list any additional problems or special concerns about your health which you would like to discuss with your doctor: ____________________

____

____

____

Other Physicians
(Please list any other doctors you currently see and for what purpose.)

Physician	Phone Number/Location	Illness/Condition

Current Medications

Non-Prescription Medications (OTC) – Please Turn Over For Prescription Medicines
(Please list any non-prescription (OTC) medications currently being taken such as aspirin, Aleve®, ibuprofen, Tylenol®, laxatives, acetaminophens, etc.)

Medication	Dosage	How Often?

Herbal Preparations
(Please list any supplements, vitamins, herbal preparations, or homeopathic treatments currently being taken/performed such as fish oil, garlic powder, tinctures, essential oils, balms, salves, krill oil, rose hips, any sort of vitamins, herbal teas, or herbal supplements.)

Treatment/Supplement	Dosage	How Often?

Prescription Medications (Please list any prescription medications currently being taken.)		
Medication	Dosage	How Often?

Preferred Pharmacy

Please Indicate Your Preferred Pharmacy		
Name	Phone Number	Location

Signed: ______________________________ **Date:** ____________

Apopka Medical Center

Dean A. Behner, M.D.

Authorization for the Disclosure of Protected Health Information

Please think carefully about the names placed on this list. Should any unforeseen medical event occur, we will not be able to discuss your medical condition with anyone, including family, if their name is not listed below.

I, ______________________________, DOB ______________________, **hereby authorize the disclosure of the individually protected health information to the following family members or persons:**

1. ______________________________
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please place your initials next to each item you wish to be disclosed:

________ Lab Results
________ Medical Condition
________ All Diagnostic Test Results
________ All of The Above
________________ Other (Specify)

In addition, place your initials by each specific item for which you are giving authorization for disclosure:

________ Mental Health
________ AIDS Information
________ Drug and/or Alcohol Usage
________ Genetic Testing Information
________ HIV Testing
________ STD/Communicable Disease

I understand that I may revoke this authorization (except to the extent action was already taken in reliance on this signed authorization) at any time by notifying Apopka Medical Center in writing. Otherwise, this authorization will remain in effect until discharged as a patient from Apopka Medical Center.

Signed: ____ **Date:** ______________

Apopka Medical Center

Dean A. Behner, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Apopka Medical Center's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Apopka Medical Center may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Apopka Medical Center's *Notice of Privacy Practices* by requesting in writing a current copy of Apopka Medical Center's *Notice of Privacy Practices*.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our *Notice of Privacy Practices*. You have the right revoke of this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Apopka Medical Center's *Notice of Privacy Practices*:

Printed Name: ____

Signed: ____ **Date:** ______________

If completed by patient's personal representative, please print name and sign below.

Printed Personal Representative Name: ____

Relationship to Patient: ____

Signed: ____ **Date:** ______________

For Apopka Medical Center Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Apopka Medical Center made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

_____ Patient or patient's personal representative refused to sign

_____ Patient or patient's personal representative was unable to sign

_____ Other (Reason: ____)

Employee Printed Name: ____

Signed: ____ **Date:** ______________

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ______________________________

Date of Birth (mm/dd/yyyy): ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: Apopka Medical Center Phone: (407) 886-1171

Address: PO Box 1107, Apopka Florida Fax: (407) 886-8386

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the earlier of: my death or the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X ______________________________
Signature of Patient or Patient's Legal Representative

____
Date Signed (mm/dd/yyyy)

____
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: ______________________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; 42 CFR §59.11 (Family Planning); Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).