Welcome
to Lake Howell Health Center

Today's Date_____ Email_____

Name Last_____ First_____ Middle Initial____

Street Address_____

City _____State____ Zip Code_____

Home Phone_____ Cell Phone_____

Date of Birth _____ Age_____ Marital Status_____

Gender_____ Race (circle one): Black White Asian Hispanic American other

Employer_____ Occupation _____

Employer address_____

Employer phone number_____

Emergency Contact

Name_____ Relationship_____

Cell phone_____

Pharmacy

Name_____ Address_____

Family Member	Living or Deceased	Present Age or Age of Death	Major Illness and/or cause of death
Father			
Mother			
Siblings (Name) Circle M F			
M F			
M F			
M F			
M F			
M F			
M F			
M F			
Children (Name) Circle M F			
M F			
M F			
M F			
M F			

Spouse/ partner's name (if applicable):_____

Who referred you to us, or how did you hear about our practice? _____

Do you smoke cigarettes/ use tobacco? _____ How many years? _____ #per day _____

If applicable, when did you quit smoking? _____

How much alcohol do you drink on an average daily, weekly, or monthly basis? _____

List all surgeries you have had and there approximate dates: _____

List all medications you are allergic to or have had reactions to: _____

List all medications you are currently taking with dosages: _____

_____

_____

What major medical problems have you had in your lifetime? (I.e. cancer, diabetes, high blood pressure)

_____

_____

Name_____ Signature _____date _____

Lake Howell Health Center
Kent S. Hoffman D.O., P.A.
406 Lake Howell Road • Maitland, FL 32751
407-691-3960 Fax: 407-691-3961

Lab Draw Convenience Agreement

For patients who desire LHHC to draw blood at the office, there will be a charge of twenty five dollars ($25.00) convenience fee each time they have blood drawn in our office.

It is understood that this convenience fee is not considered a "covered service" by your insurance company. Therefore, this fee is not reimbursable by your insurance company.

You are free at anytime to request a written prescription to have your labs drawn at a lab draw station or elsewhere.

By signing this you are aware of this policy:

I have read and agree to abide by the office policy as stated above.

_____ _____

Patient Signature Date

Lake Howell Health Center
Consent/HIPPA Form

Financial Policy/Authorization to release inform to insurance company
I, Undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to LLHC understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Lake Howell Health Center (LHHC) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

Signature X_____Date:_____

Are you the Guarantor? Yes____No____ If not please see the receptionist.

Consent for Treatment & Release Information to pharmacy/consulting physician/hospitals
Having voluntarily presented myself (or my dependent) LHHC I acknowledge recognition of the fact that the evaluation and treatment received, I also give LHHC permission to discuss RX history, advised or deemed necessary, to be the judgment of the physician.

Signature X_____Date:_____

Acknowledgement of receipt of privacy notice (HIPPA)
Health Insurance Portability and Accountability Act
By signing this form, you acknowledge that LHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in a various situations. We must attempt to have you sign this form on you first date of service with us after April 2003. This includes the situation where your first date of service occurred electronically. If our first date of service with us was an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

- ☐ I have received a copy of the Privacy Notice of LHHC
- ☐ LHHC has offered me a copy of the Privacy Notice with I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature X_____Date:_____

Additional Person(s) Authorized to make the use or disclosure of my PHI
We at LHHC value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant other with our written consent). If you want anyone other than your referring physician to have access to your medical information please list their name(s), and relationship(s) below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name_____Relationship_____

Name_____Relationship_____

Signature X_____Date:_____

Witness Signature

The Staff of LHHC complete this section of Acknowledgement Form is not signed by the Patient:

1. Does the Patient have a copy of the Privacy Notice? Y or N
2. Please explain why the patient was unable to sign an acknowledgment form and our efforts in trying to obtain the Patient signature:_____

Employee Signature:_____Date_____

FINANCIAL POLICY

The doctors and staff at Lake Howell Health Center would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current—accordingly, all self pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard or Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for you original appointment.
- A returned check will result in a $40 service charge and all future payment being required in the form of cash or credit card.

If you have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your healthcare benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibilities from the date of services are rendered.
- Cancellations within 24 hours and missed appointments will result in a fee of $25.00 for office visits and $50.00 for physicals.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. IF you have any questions about the above information please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	X_____	_____
Patient Name (please print)	Patient Signature	Date
_____	X_____	_____
Patient Name (please print) (if other than patient)	Responsible Signature	Date

Lake Howell Health Center
406 Lake Howell Road
Maitland, FL 32751
Phone: (407)691-3960
Fax: (407) 691-3961
www.lakehowellhealthcenter.com

Controlled Substance Agreement

The doctors are being held accountable by the DEA for prescribing controlled substances. Patient non-compliance can no longer be tolerated. It is the patient's responsibility to manage their appointments and medication refills in a timely manner. Responsibility is a part of recovery. We are here to help you with your recovery.

I understand that I have the following responsibilities/guidelines for treatment under Lake Howell Health Center. Please read and initial each line and sign at the bottom of the page.

☐ 1. I will take medication at the dose and frequency prescribed and will not increase or change how I take my medications without the approval of my doctor.

☐ 2. I will schedule my doctor appointments in a timely manner prescribed by my doctor during regular office hours preferably with a 2 week notice. I will not ask for refills or partial refills earlier then agreed, after hours or on holidays and weekends.

☐ 3. I will not request any other medications for my diagnosis from any other health care providers and will inform all physicians what I am taking and who is monitoring medication.

☐ 4. I will protect my prescriptions and medications. I understand that lost, stolen or misplaced prescriptions will not be replaced. If I go into withdrawal I will not hold my physician responsible.

☐ 5. I will keep all follow-up appointments.

☐ 6. I understand that my doctor may stop prescribing the medications if:
   a. If I do not show any improvement in my diagnosis.
   b. I develop rapid tolerance or loss of improvement from the treatment.
   c. I develop significant side effects.
   d. My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from the practice.

Signature-

Date-

PRIOR AUTHORIZATION AGREEMENT

Name _____ **Date**_____

Your provider has been put in a difficult situation, due to the overwhelming burden it takes to get a prior authorization from insurance companies. They now have to ask you to call your insurance company and find out what is covered without a prior authorization or we can go through the process of getting a prior authorization for you. There will be a charge of $25.00 for each prior authorization.

We understand the inconvenience and cost it comes to you. However, we do not have a relationship with your insurance company. It can take up to 15days and hours of staff/provider time to get just one authorization completed. We do not condone the fact the insurance company is dictating what medication is prescribed for you. We feel you and your provider should make that decision.

Please keep in mind this does not guarantee the insurance company will approve/authorize the medication your provider prescribed.

Please initial_____

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: Lake Howell Health Center Phone: (407) 691-3960

Address: 406 Lake Howell Road, Maitland, FL 32751 Fax: (407) 691-3961

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: _____)