



Dear Patient,

We are pleased to welcome you to Lake Howell Health Center. We strive to provide the very best in medical care in a friendly environment. It is our goal that this letter will provide you with helpful information regarding your upcoming visit.

For your convenience we have included New Patient Forms. Please complete and return these forms with a photo picture of the front and back of your insurance card either by email lhhc@lakehowellhealthcenter.com, USPS mail or hand deliver to our office before your scheduled appointment to expedite your initial visit with us. If you are unable to complete and return these forms before your appointment, please arrive 20 minutes prior to your scheduled appointment.

Please notify us at least 24 hours in advance if you are not able to keep this appointment.

Please bring the following:

- These completed forms if not already sent to the office
- List of current medications
- Insurance card(s)
- Photo ID
- Payment (copay, deductible, co-insurance, etc.)

Sincerely,

Lake Howell Health Center

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 (Select):

Married Single Partnered Divorced Separated Widowed

Spouse/Partner's name (if applicable) _____

Gender (Select):

Male Female Transgender Other _____

Race (Select):

White

Black

Native American/Alaska Native

Asian

Native Hawaiian/Other Pacific Islander

Other _____

Employment Information

Employer _____

Occupation _____

Employer Address _____

Employer Phone Number _____

Emergency Contact

Name _____ Relationship _____

Cell phone _____

Pharmacy

Name _____ Phone Number _____

Address _____

Referred by: _____

Family History

Family Members		Living or Deceased?	Present age or age at death.	Major Illness and/or Cause of Death
Father				
Mother				
Siblings (Name) & Gender				
	M F			
	M F			
	M F			
	M F			
Children (Name) & Gender				
	M F			
	M F			
	M F			
	M F			
	M F			

Is there a family history of anything NOT listed here? (Please explain)

Have you ever had surgery or been hospitalized? (Please explain)

Please list all current prescribed medications and dosages.(include herbal medications or vitamins)

List any allergies you have. (Sulfa, Penicillin, Bees, Peanuts.)

What major medical problems have you had in your lifetime? (*Cancer, Diabetes, High Blood Pressure, etc.*)

Social History

Years Married/Long-Term Relationship_____

Times Married_____

Times Divorced_____

Who are you currently living with? (Select one)

By Yourself

Spouse/Partner

Family Members

Friends

Homeless

Other_____

Do You Have Children?

Yes

No

If Yes, List Current ages of Children_____

Do Your Children Live With You?

Yes

No

If no, Where? _____

Do you have family nearby?

Yes

No

Education (Select most recent):

Graduate School

College

Professional or Vocational School

High School

Other _____

Are You Currently employed?

Yes

No

Have you been arrested or convicted of a crime?

Yes

No

If yes, For What? _____

Have you ever been abused?

Yes

No

If Yes, what type of abuse have you experienced?

Physical

Sexual (including rape or attempted rape)

Verbal

Emotional

Other _____

Have you ever been in counseling or therapy?

Yes

No

Substance Use:

Have you had treatment for alcohol or drug abuse?

Yes

No

If Yes, Which substance? _____



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 LHHHC 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 (LHHHC) 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

I acknowledge recognition of the fact that the evaluation and treatment received, may be discussed with a designated pharmacy/consulting physician. I also give LHHHC permission to discuss RX history, advised or deemed necessary, to be at 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 LHHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must attempt to have you sign this form on your first date of service with us after April 2003. This includes the situation where your first date of service occurred electronically. If your 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 LHHHC

LHHHC has offered me a copy of the Privacy Notice which 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 LHHHC 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 out 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 LHHHC complete this section of Acknowledgement Form if 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:** _____



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: X_____

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 your 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

Kent S. Hoffman D.O., P.A.
Board Certified Addiction Medicine
Board Certified Family Practice
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