Welcome to Orlando Portal MD Internal Medicine

Dear New Patient,

It is a privilege to have chosen Orlando Portal MD Internal Medicine as your partner and primary care provider! Our goal is to provide our patients with the highest quality of care and to keep our patients healthy while managing all pre-existing conditions. **You will need to bring your insurance card, FL ID/Passport, and all medications to each appointment.**

Please let our staff know if you have had any information changes or medical care outside of Orlando Portal MD since your last appointment. All copays and past due balances are expected at the time of service unless prior agreement has been made with our billing department.

We ask that you allow yourself plenty of time to get to the office for your appointment to fill out any paperwork, as we want to do our best to stay on schedule. From time to time a patient emergency may arise, causing a delay to your visit. You will have the option to reschedule or stay and be seen. We will keep you informed of how long the delay will be. We understand that sometimes appointments need to be changed or cancelled, so we ask that you call at least **24 – 48 hours in advance** if you cannot keep your scheduled appointment. Our current office hours for patient care are **Monday – Friday from 8am-12pm and 1pm-5pm Our phone number is (813)-374-8883.**

Whenever our providers believe that there is a medical necessity requiring a follow up with a specialist, you will receive a copy of your referral to which you will call your insurance to see who In-Network with your insurance plan is.

Name:________________________________ DOB: ______________________

PATIENT CONDUCT AGREEMENT

As your primary care provider Orlando Portal seeks to provide the best possible medical care. For this to be achieved, **there must be cooperation between the patient and all medical personnel.** The agreement outlines the expectations of our patients. In return we will make every effort to accommodate you and your needs. **Please review the agreement carefully and initial beside each statement.**

___ **I will take my medication(s) as instructed.** I will not change the way I take them without talking to the Dr first.

___ I understand that after requesting medication refills, I need to allow **24 to 48 hours** for completion.

___ I understand that I am to complete all testing in a timely manner and to follow the treatment regimen prescribed by my PCP.

___ **I WILL ALWAYS TREAT THE OFFICE STAFF WITH RESPECT.** I understand that if I disrespect the staff or disrupt the care of other patients my treatment may be stopped. I understand that if my disruptive behavior persists, I will be discharged from the clinic.

___ **I will attend to all my appointments as scheduled.** In the event I am no longer able to attend my appointment, I must call to **cancel or reschedule** my appointment at least **24-48 hours prior To phone number 813-374-8883.**

___ I understand that it is crucial to keep my PCP informed of any medical needs or concerns that I may have to ensure the best possible quality of care is provided.

___ I understand that I am expected to schedule a follow up visit with my PCP **ASAP** following a hospital visit.

Name: ______________________________ DOB: _____________________

Cancellation Policy

I understand that not adhering to the following statements will result in a **$50 NON-REFUNDABLE CHARGE.**

1. I will cancel or reschedule my appointment at least **24-48 hours in advance.**

2. I will show up to all my scheduled appointments **ON TIME.** In case of any emergency, I will notify the front desk team.

3. If I am late to my scheduled appointment by more than **15 minutes, it will be considered a NO SHOW** unless approved by the Dr for late arrival.

4. I understand that if I do not show up to my scheduled appointment or follow office procedures I will be discharged from the office.

By signing this form, I agree with the above-mentioned statements.

_________________________________ _________________

Patient signature **Date**

Patient Registration Form

Please fill out this form to the best of your knowledge. If you need assistance, please ask a staff member.

Patient name: Last___________________ First_______________________ M_______

Date of birth: ____ /_____ / _______ circle one **Male or Female SSN ______________________**

Marital status circle one **Single / Married / Divorced / Separated**

Email:_____________________________________ Phone Number:______________________________

Emergency contact: ____________________________ Relationship: ____________________________

Emergency contact p#: __________________________

Ethnicity (circle one): - Hispanic or Latino - Black/African American – American Indian/Alaska Native – Native Hawaiian – White – Other: ___________________________

Messages (circle one): **Please call my Home Work Cell**

If unable to reach me: ________You may leave a detailed message or_______leave a message asking for me to return your call. (mark one)

The best times to reach me are: ____

I prefer appointments on: ___________________________ Times: ____________________________

Employment Information:

Company Name:_________________________ Occupation: _______________________

Phone Number: ___________________ If retired, previous occupation: _________________________

Primary Pharmacy:

Name: ____________________________ Phone #: ____________________________________

How did you hear about Orlando Portal MD? ____

Financial Responsibility

Name:________________________________ **DOB:**___________________________

Please initial beside each of the statements listed below.

______**Statement of Financial Responsibility –** I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

______**Notice of "Non-Covered" Services –** I am aware that some services performed by the Practice may be considered "non-covered" by my insurance company, Therefore I will become fully responsible for payment of those services.

______**Waiver of "Usual, Customary and Reasonable" Clauses (for out of network coverage) –** I acknowledge that the fee charged by the Practice for services rendered to me, or to the person whom I assume financial responsibility, may exceed the fees considered "Usual, Customary, and Reasonable", due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill to/Payment Instructions: (initial below)

_______Commercial Insurance _________ Medicare ________Self pay.

I hereby authorize the Practice to bill my insurance company and/or Medicare for services provided to me and request that payments be made to the practice on my behalf.

Financial Agreement – The undersigned agrees whether he/she as a patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Patient (or legal guardian) signature: ___________________________________ **Date:**_______________

If legal guardian, relationship to the patient: ____________________________ **Date:**____________________

Medical Information Release Form – HIPAA Release Form

Name:______________________________ **Date of Birth:** ______/ _______/ _______

Release of Information

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

______ **Spouse:** __________________________ **Phone Number:** _________________________________

_______ **Child(ren):** ________________________ **Phone Number:** _________________________________

________ **Other:** ___________________________ **Phone Number:** _________________________________

_________ **Other:** ____________________________ **Phone Number:** _________________________________

_______ **Information is not to be released to anyone.**

This Release of Information will remain in effect until ended by me in writing. Any desired changes require a new form to be submitted.

Release of Medical Information: I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at Orlando Portal MD including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases. I acknowledge that the "Notice of Privacy Practices" provides information about how this facility may use and/or disclose protected health information about me for treatment, payment, health care operations and as otherwise allowed by law. I understand that Orlando Portal MD cannot be responsible for use or re-disclosure of information by third parties.

Signed: ____ **Date:**________________________

Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information

As required by the Health Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy. Your completion of this form means that you will give permission for the uses and disclosure described below. **Please review and complete this form carefully.** It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

Your Name(print):_________________________ **Date of Birth:**_________________

Address: ___________________________**City:**________**State:** ____**Zip code:** _______

Phone Number: ____________________

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purpose identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law. I understand that any medical record may include information relating to sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS), Human immunodeficiency Virus (HIV), behavioral/mental health services, and treatment for alcohol and/or drug abuse.

Patient (or legal guardian's) signature:____________________ **Date:** ______________

Patient Representative and Relationship: ____________________ **Date:** ______________

(DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY)

I Hereby authorize ______________________________ to release my health information to Orlando Portal MD Internal Medicine 13150 Vail Ridge Dr Riverview, Fl 33579 Phone Number 813-374-8883 Fax Number 813-443-8361 or to 1918 W MLK Jr Blvd Tampa, Fl 33607

CONTINUITY OF CARE

Health Information Questionnaire

Patient Name:____

Specialty	Physician Name / Address	Phone Number	Year
Previous PCP			
Specialist(s)			
Hospital(s)			
OB/GYN			
Mammogram			
Bone Density: DEXA			
Colonoscopy / Stool Cards			
Optometrist / Ophthalmologist			

Health Information Questionnaire

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person unless you have authorized us to do so.

Name: ____ **Date:** ___________________________

DOB: ______________________ **Age:** _______________

What medical/health concerns bring you to our office today? ____

ALLERGIES- Do you have any known allergies to medications or food? _____ YES ______ NO

If yes, please list: ____

MEDICAL HISTORY- Have you ever had or been diagnosed to have (check all that apply)?

____ Alzheimer's disease _____Chicken pox _____Hemorrhoids ____Rheumatic fever _____Anemia

____Colon polyps _____High blood pressure _____Seizures/Epilepsy _____Anxiety ____Depression

____High cholesterol ____Stroke _____Arthritis _____Diabetes/Prediabetes _____IBS _______Syphilis

____Asthma _____Fracture _____Jaundice/Liver disease ______TB/Lung disease _____Atrial fibrillation

_____Glaucoma ____Kidney disease _____Thyroid disease ____Bleeding disorder _____Heart attack

_____Migraines/headaches ____Ulcers _____Blood transfusion ____Heart disease ____Osteopenia

____ Urinary incontinence _______________Cancer: What kind? ______Heart failure ____Osteoporosis

_________________Other conditions ____Heart murmur ____Pneumonia ____Cataracts ____Heartburn

_____Prostate problems

13150 Vail Ridge Dr. Riverview, FL 33579. 1918 W. Martin Luther King Jr. Blvd. Tampa, FL 33607
Phone: 813-374-8883 Fax: 813-443-8361

Health Information Questionnaire

SOCIAL HISTORY

Smoking/Tobacco Use? _____ Current _____ Past _____ Never If you answered yes, answer these additional questions:

Type: ______________ Amount/Day: __________________________ How long(years): _____________________

Alcohol Use? ______ Current ______ Past _____ Never If you answered yes, how many drinks/weeks? ___________

Recreational Drug Use? ______ Current ______ Past ______ Never If you answered yes, type: _________________

Are there any personal problems or concerns at home, work, or school you would like to discuss?

Yes or No If answered yes, type: ____

Health Information

Medication name	Dosage & Frequency

Health Information

Vaccination	Year	Location
INFLUENZA (FLU)		
COVID (Please circle one): Johnson & Johnson Pfizer Moderna Other:		
COVID BOOSTER (Please circle one): Pfizer Moderna Johnson & Johnson		
Shingles		
Pneumonia		
Misc.		

Surgical History – Please list all surgeries that you have had (past & present)

Type	Provider/Hospital	Date

Health Information Questionnaire

Do you have any personal health goals (circle one)? Y / N

If you answered yes, please list: ____

OB/GYN History (females only): Age of menses: ________ Age of menopause: __________

Method of birth control: __________ How many children: ____________ Vaginal/C-section: ___________

Hysterectomy: Y / N Total/Complete: Y / N Doctor/Location: ________________________________

Family History- Please list any health conditions that your blood relative(s) currently have/or have had in the past.

Family Member	Health Problem(s)
Mother (Age____)	
Father (Age ___)	
Brother(s) (Age_____)	
Sister(s) (Age ____)	
Grandparent(s) (Age_____)	

Health Screening Test History- Please fill out chart below.

Screening Test	Y / N (Year)	Provider
EKG		
Prostate specific antigen PSA (males only)		
Spirometry		

Treatment with Opioid Medications: Patient Agreement

I ______________________________ understand and voluntarily agree that **(initial each statement after reviewing):**

_______ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_______ I will participate in all other types of treatment that I am asked to participate in.

_______ I will keep the medicine safe, secure, and out of reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

_______ **I will take my medications as instructed and not change the way I take it without first talking to the Doctor.**

_______ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_______ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team.

_______ **I will always treat the staff at the office with respect. I understand if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped and may be a reason for dismissal or removal from the clinic.**

_______ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_______ I will tell the Doctor all other medicines that I take and let him/her know right away if I have a prescription for a new medicine.

_______ I will use only one pharmacy to get all my opioid medications. ______________________________ (pharmacy name/phone #)

_______ I will not receive any opioid pain medications or other medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamine) without first notifying

Doctor. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekend.

_______ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

Treatment with opioid medications: Patient Agreement

______ I will come in for drug testing and counting my pills within 24 hours of being called. I understand that I make sure the office has current contact information to reach me, and that any missed tests will be considered positive for drug tests.

_______ I will keep up to date with any bills from the office and tell the Doctor immediately if I lose my insurance or am no longer able to pay for treatment.

_______ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement: We here at Orlando Portal MD Internal Medicine are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

- ✓ We will help you schedule regular appointments for medicine refills. If we need to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment. If you are compliant with your routine scheduled appointments.
- ✓ We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having any bad side effects.
- ✓ We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.
- ✓ We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.
- ✓ We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- ✓ We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
- ✓ If you become addicted to these medications, we will help you get treatment and get off the medications that are causing you problems safely, without getting sick.

Patient signature	Patient printed name	Date