Midland™ MEDICAL

# PATIENT INFORMATION SHEET

**LAST NAME** | **FIRST NAME** | **M.I.** | **PREFERRED NAME**

**GENDER** (AS STATED WITH INSURANCE) | **GENDER IDENTITY** | **PREFERRED LANGUAGE**

DATE OF BIRTH | SOCIAL SECURITY NUMBER | **REFERRED TO US BY**

**ETHNICITY:** ☐ Hispanic/Latino ☐ Non-Hispanic Latino **SEXUAL ORIENTATION:** ☐ Heterosexual ☐ Homosexual ☐ Bisexual

**RACE:** ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Middle Eastern ☐ Other: _____

## CONTACT INFORMATION:

**STREET ADDRESS** | **APT/SUITE/UNIT**

**CITY** | **ZIP CODE**

**PRIMARY CONTACT PHONE** ☐ Mobile ☐ Home ☐ Other: _____

**SECONDARY CONTACT PHONE** ☐ Mobile ☐ Home ☐ Office ☐ Other:_____

**EMAIL ADDRESS** (For your Patient Portal setup, securely email your provider, access lab results, request personal health information)

) **EMERGENCY CONTACT INFORMATION:**

NAME | PHONE NUMBER | RELATIONSHIP

**PREFERRED PHARMACY:**

For your convenience, we offer an on-site pharmacy with free delivery and a new patient gift certificate of $25.
For PrEP services, Midland Pharmacy is a key component allowing for same day pick up of medication.

☐ Midland Pharmacy on-site (Please fill only my specialty medications such as PrEP/HIV/Hep-C)

☐ Midland Pharmacy on-site (Please fill all my medications on-site)

☐ Other Pharmacy Offsite (Please fill out the information below):

NAME OF PHARMACY | LOCATION | PHONE NUMBER

Please complete this entire form and sign all pages that require a signature and bring to your appointment.
You may also scan and return this form prior your appointment by sending it to info@midlandmed.com.

# MIDLAND MEDICAL NEW PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| **Name:** *(Last, First, M.I.):* | | **DOB:** |
|---|---|---|
| **Previous/Referring Doctor:** | **Gender at Birth:** | **Gender Identity:** |
| **Reason for Visit:** | | **Date of Last Physical Exam:** |

## PERSONAL HEALTH HISTORY

| Medical Problems Doctors Have Diagnosed | Surgeries/Procedures | Hospitalizations (other than surgeries) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**List *ALL* of the medications you take, <u>including</u> vitamins and supplements**

| Name the Drug | Dose | How often | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies to medications**

| Name the Drug | Reaction You Had |
|---|---|
| | |
| | |
| | |

| **Vaccinations** | **Dose One (Month/Year)** | **Dose Two (Month/Year)** |
|---|---|---|
| COVID-19 | | |
| Diphtheria, Tetanus, Pertussis | | |
| Hepatitis A | | |
| Hepatitis B | | |
| Human Papillomavirus | | |
| Influenza | | |
| Measles, Mumps, Rubella | | |
| Meningococcal | | |
| Pneumococcal | | |
| Polio | | |
| Rotavirus | | |
| Varicella | | |

**Name:** **Date of Birth:**

## HEALTH HABITS AND PERSONAL SAFETY

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL**

**Alcohol**

Do You Drink Alcohol? ☐ Yes ☐ No (skip to next section, Tobacco.)

If yes, how often do you drink? _____per ☐Week ☐ Month ☐ Year

How much do you drink when you drink?

☐ 1-2 Drinks ☐ 3-4 Drinks ☐ 4-5 Drinks ☐ More than Five Drinks

| | | |
|---|---|---|
| Are you concerned about the amount you drink? | ☐ Yes | ☑ No |
| Do you ever drive after drinking? | ☐ Yes | ☑ No |
| Have you had any accidents/falls or fights due to your drinking? | ☐ Yes | ☑ No |

**Tobacco**

Do You use Tobacco? ☐ Yes ☐ I did but Quit_____years ago ☐ No (skip to next section, sex.)

If you are Currently using Tobacco: (Amount per Day)

☐ Cigarettes:___packs/day ☐ Vape: _____ ☐ Other:_____

Interest Level in Quitting:
☐ Very Interested and Motivated ☐ Very Interested ☐ Interested ☐ Not Interested

**Sex**

Do You Have Sex with: ☐ Men ☐ Trans Men ☐ Women ☐ Trans Women ☐ All ☐ _____

Relationship Status:
☐ Relationship - Monogamous ☐ Relationship - Monogamish ☐ Open Relationship ☐ Single

Have You had Sexual activity within the last 12 months? ☐ Yes ☐ No (If no, skip to next section-Exercise.)

Approximate number of partners in past 12 months:
☐ 1 (skip to next section - Exercise) ☐ 2-4 ☐ 5-10 ☐ 11-20 ☐ More Than 20

| Activity | Condom Use? | Activity | Condom Use? | Activity | Condom Use? |
|---|---|---|---|---|---|
| ☐ Perform Oral | ☐ Always ☐ Some of the Time ☐ Close to Never | ☐ Insertive Vaginal | ☐ Always ☐ Some of the Time ☐ Close to Never | ☐ Insertive Anal | ☐ Always ☐ Some of the Time ☐ Close to Never |
| ☐ Receptive Oral | ☐ Always ☐ Some of the Time ☐ Close to Never | ☐ Receptive Vaginal | ☐ Always ☐ Some of the Time ☐ Close to Never | ☐ Receptive Anal | ☐ Always ☐ Some of the Time ☐ Close to Never |

Have you ever been diagnosed with a sexually transmitted infection, such as syphilis, gonorrhea or chlamydia? ☐ Yes ☐ No
If Yes, Describe: _____

Have any of your sexual partners been diagnosed with a sexually transmitted infection? ☐ Yes ☐ No
If Yes, Describe: _____

**Exercise**

☐ Sedentary (No exercise)

☐ Mild Exercise (i.e., Climb Stairs, Walk 3 Blocks, Golf)

☐ Occasional Vigorous Exercise (i.e.- Work or Recreation, Less than 4x/Week for at least 30 min.)

☐ Regular Vigorous Exercise (i.e.- Work or Recreation 4x/Week for at least 30 minutes)

**Occupation**

What Kind of Work do You Do?

**Diet**

| | | |
|---|---|---|
| Are you Dieting? | ☐ Yes | ☐ No |
| If Yes, Describe your Diet: | | |

**Drugs**

| | | |
|---|---|---|
| Do You Currently Use Drugs Recreationally? | ☐ Yes | ☐ No |
| If Yes, Which Drugs Do You Use? | | |
| Do You Feel Like Drug Use is a Problem for You? | ☐ Yes | ☐ No |

**Personal Safety**

| | | |
|---|---|---|
| Physical and/or Emotional Abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue, with your provider? | ☐ Yes | ☐ No |

**Name:** **Date of Birth:**

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## REVIEW OF SYMPTOMS

If you are having any symptoms in the following areas to a significant degree and briefly explain.

☐ Check here if you have none of the symptoms listed below

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| ***Constitutional Symptoms*** | | | ***Cardiovascular*** | | | ***Hematologic/ Lymphatic*** | | |
| Fevers/Chills/Sweats | ☐ | ☐ | Chest pain | ☐ | ☐ | Swollen Glands | ☐ | ☐ |
| Significant Weight Gain | ☐ | ☐ | Irregular Heart Beat | ☐ | ☐ | Frequent Bruising | ☐ | ☐ |
| Unintentional Weight Loss | ☐ | ☐ | Swelling of Feet or Legs | ☐ | ☐ | Bleed Easily | ☐ | ☐ |
| Headaches | ☐ | ☐ | Palpitations | ☐ | ☐ | ***Skin*** | | |
| Fatigue | ☐ | ☐ | ***Respiratory*** | | | Rashes/Sores | ☐ | ☐ |
| ***Eyes*** | | | Wheezing | ☐ | ☐ | Mole Changes | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | Shortness/Difficulty of Breath | ☐ | ☐ | Itching | ☐ | ☐ |
| Double Vision | ☐ | ☐ | Cough | ☐ | ☐ | ***Genital-Urinary*** | | |
| Vision Changes | ☐ | ☐ | Sleep Apnea | ☐ | ☐ | Urine Leakage | ☐ | ☐ |
| ***Allergic/ Immunologic*** | | | ***Musculoskeletal*** | | | Urine Retention | ☐ | ☐ |
| Hay Fever | ☐ | ☐ | Joint Pain | ☐ | ☐ | Burning W/Urination | ☐ | ☐ |
| Medications | ☐ | ☐ | Muscle Weakness Arms/Legs | ☐ | ☐ | Frequent Urination | ☐ | ☐ |
| ***Neurologic*** | | | Muscle Pain | ☐ | ☐ | Urinating at Night | ☐ | ☐ |
| Dizziness | ☐ | ☐ | ***Ear/ Nose/ Throat/ Mouth*** | | | Penile Issues | ☐ | ☐ |
| Seizures | ☐ | ☐ | Sore Throat | ☐ | ☐ | Erectile Dysfunction | ☐ | ☐ |
| Numbness/Tingling | ☐ | ☐ | Sinus Problems | ☐ | ☐ | Testicular Pain | ☐ | ☐ |
| Fainting or Nearly Fainting | ☐ | ☐ | Hearing Problems | ☐ | ☐ | Painful Intercourse | ☐ | ☐ |
| Memory Loss | ☐ | ☐ | Ringing in Ears | ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ |
| ***Gastrointestinal*** | | | Ear Pain | ☐ | ☐ | Infertility | ☐ | ☐ |
| Nausea/Vomiting | ☐ | ☐ | Bleeding of Gums or Nose | ☐ | ☐ | Vaginal Discharge | ☐ | ☐ |
| Constipation/Diarrhea | ☐ | ☐ | Difficulty Swallowing | ☐ | ☐ | Fibroids | ☐ | ☐ |
| Abdominal Pain | ☐ | ☐ | ***Psychiatric*** | | | Abnormal Menses | ☐ | ☐ |
| Heartburn | ☐ | ☐ | Difficulty Concentrating | ☐ | ☐ | Painful Periods | ☐ | ☐ |
| Cramping | ☐ | ☐ | Sadness/Depression/Crying | ☐ | ☐ | ***Breast*** | | |
| Rectal Pain | ☐ | ☐ | Anxiety | ☐ | ☐ | Nipple Discharge | ☐ | ☐ |
| ***Endocrine*** | | | Panic Attacks | ☐ | ☐ | Lumps | ☐ | ☐ |
| Hair Loss | ☐ | ☐ | Thoughts of Suicide | ☐ | ☐ | Breast Tenderness | ☐ | ☐ |
| Heat/Cold Intolerance | ☐ | ☐ | Insomnia | ☐ | ☐ | Skin Changes | ☐ | ☐ |

If yes to any of the above, briefly describe:

_____

_____

_____

_____

_____

**MIDLAND MEDICAL BROWARD, LLC.**

# ASSIGNMENT OF INSURANCE AND RELEASE AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some carriers will pay fixed allowances for certain procedures, others will pay percentages of the charges. It is the patient's ultimate responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance carrier. If we are filing the claim for you, we allow 45 days from the billing date for the carrier to process the claim and make payment accordingly. If payment from your carrier is not received within this time frame, MIDLAND MEDICAL will inform you to pay your balance and seek reimbursement from your carrier. Billing insurance carriers is done as a courtesy to the patient and does not dismiss patient's responsibility for payment in full, unless other written arrangements have been made.

I certify that I have read and understand fully the provider's billing policy and agree to make payment in full, or satisfactory arrangement when asked to do so, as specified to do so, as specified above.

To the extent necessary to determine liability for the payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and other benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, etc. to MIDLAND MEDICAL.

This assignment will remain in effect until revoked by me in writing. A photocopy of this is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by my carrier. Should my account be referred to an attorney and/or collection agency, I shall be responsible for all applicable fees.

## PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize release of any medical information (including HIV status and/or test results) necessary to process any and all medical claims. I also authorize payment to be made for said claims(s) to MIDLAND MEDICAL. I have read and understand and agree with all the information set forth in this document

_____

Patient Signature

_____

Patient Name Date

**MIDLAND MEDICAL BROWARD, LLC**

# HIPAA WAIVER

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), unless directed by the information you provide below, Midland Medical Broward, will not release confidential health information nor discuss appointments, bills, medications or any other affairs pertaining to a patient or any unauthorized individuals or entities either in person or by telephone, email or fax. This includes family members, spouses, and partners. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work). By completing the information below, you are providing us how we may contact you going forward.

I,_____, authorize the physicians and staff of Midland Medical Broward to release confidential medical information pertaining to my care by the following methods and/or individuals listed below. I understand that it is my responsibility to notify Midland Medical Broward, in writing if this authorization information changes.

**Please check each box that applies to how you prefer to be contacted:**

**Cell Number** _____

☐ Ok to send appointment reminders ONLY

☐ Ok to send appointment reminders and leave detailed messages on voicemail

☐ Ok to send appointment reminders but only leave messages with request for call back

**Home Telephone** _____

☐ Do Not Use

☐ Ok to leave detailed message on voicemail ☐ Leave message with call back ONLY

**Work Telephone** _____

☐ Do Not Use

☐ Ok to leave detailed message on voicemail ☐ Leave message with call back ONLY

**Home Fax** _____ ☐ Ok to Fax ☐ Do Not Fax

**Work Fax** _____ ☐ Ok to Fax ☐ Do Not Fax

It is okay to give confidential medical information to my (List specific names):

☐ Spouse/Partner _____

☐ Parent(s) _____

☐ Child(ren) _____

☐ Sibling(s) _____

☐ Other (list relation also) _____

I authorize this information to be disclosed by the preferences I selected above:

Signature: _____ Date: _____

**Midland Medical Broward, LLC.**
1421 East Oakland Park Blvd, Suite 200
Oakland Park, FL 33334
954-565-0875 Office
**954-565-0876 eFax**

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Patient Name:** _____ **Date of Birth:** _____

**Healthcare Facility or Doctor from Which Records are Requested**

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

*Treatment Dates:* **From:** _____ **To:** _____

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Labs** | ☐ | **Operative Reports** | ☐ | **Discharge Summary** |
| ☐ | **History & Physical** | ☐ | **Physical/Occupational Therapy** | ☐ | **STD** |
| ☐ | **EKG's** | ☐ | **Mental Health** | ☐ | **HIV** |
| ☐ | **Radiology Reports** | ☐ | **Alcohol/Drug Dependency** | ☐ | |
| ☐ | **Pathology Reports** | ☐ | **Emergency Department Reports** | ☐ | **All Records** |

**NO PAPER BASED RECORD WILL BE ACCEPTED. PLEASE FAX ALL RECORDS TO 954-565-0876**

I hereby authorize Midland Medical Broward, LLC. to obtain the health information indicated below that is contained in my patient records to the recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and HIV/AIDS test results or diagnoses. I may revoke this authorization at any time, except where information has already been released, by completing Midland Medical Broward, LLC. Revocation of an Authorization Form. This authorization is valid for five years from the date of authorization written below. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. A photocopy or fax of this authorization is as valid as the original.

_____ _____
Signature of Patient or Patient's Personal Representative Print Name

_____ _____
Relationship to Patient Date

**MIDLAND MEDICAL-BROWARD, LLC.**

# ATTENTION PATIENTS:

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical claims for medical malpractice. Your doctor has decided not to carry medical malpractice insurance. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against uninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

I have read and fully understand this statement.

| _____ | _____ | _____ |
|---|---|---|
| Patient's signature | Patient's printed name | Date |

# ATENCIÓN PACIENTES:

Según las leyes de la Florida, se require generalmente que los medicos tengan seguro de mala práctica médica, o a lo contrario demostrar responsabilidad finaciera para cubrir posibles reclamaciones por mala práctica médica. Su doctor ha decidido no tener este seguro. Esto se permite por las leyes de la Florida sujetas a ciertas condiciones. Las leyes de la Florida imponen multas a los médicos no asegurados que no satisfagan juicios adversos derivados de reclamaciones de mala práctica médica. Este aviso ha sido provisto siguiendo las leyes de la Florida.

Yo he leído y entiendo perfectamente este aviso.

| _____ | _____ | _____ |
|---|---|---|
| Firma del paciente | Nombre del paciente en letra de molde | Fecha |

# ATANSYON TOUT PASYAN:

Selon lalwa Florid tout doktè sipoze genyen asirans malpratik medikal oswa montre responsabilite finansye ki pwouve yo ka peye yon reklamasyon pou malpratik medikal. Doktè isit la deside pa genyen asirans malpratik medikal. Lalwa Florid pèmèt sa a avèk kèk kondisyon. Lalwa Florid ap penalize doktè ki pa genyen asirans malpratik medikal e ki pa kapab satisfè yon reklamasyon malpratik. Nou founi notifikasyon sa a dapre lalwa Florid.

Mwen li ak byen komprann notifikasyon sa a.

| _____ | _____ | _____ |
|---|---|---|
| Siyati pasyan | Non pasyan | Dat |

**MIDLAND MEDICAL BROWARD, LLC.**

# NOTICE OF PRIVACY PRACTICES
## (MEDICAL)

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION. PLEASE REVIEW IT CAREFULLY*

The Health insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute, de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatments alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain used and disclosures of protected health information including those related to family member, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. I f we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to inspect and copy your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

By signature I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICE

Patient's signature:_____ Date: _____

**MIDLAND MEDICAL BROWARD, LLC.**

# AUTHORIZATION FOR TREATMENT AND HEALTHCARE INFORMATION CONSENT FORM

I authorize the physician, or the appointed staff, to administer treatment, anesthetics, or perform such operations as deemed necessary or advisable for the diagnosis and treatment of my healthcare. This includes blood draws for laboratory studies which may include HIV/AIDS diagnosis and treatment studies.

I understand as part of my healthcare, MIDLAND MEDICAL originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and health information for billing purposes.
- A means by which a third-party payer can verify that services billed were actually provide.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have received the MIDLAND MEDICAL Notice of Privacy Practices, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting MIDLAND MEDICAL.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations and that this organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting MIDLAND MEDICAL's Privacy Officer and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already made in reliance of my prior consent.

This consent is given freely with the understanding that all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is valid as this original. This consent is valid for 10 years from the date of signing and may be revoked upon written request.

| | |
|---|---|
| Patient's Printed Name | Date |
| Patient's Signature (or Personal Representative) | Patient's Date of Birth |
| Witness's Signature | Witness's Printed name |

**MIDLAND MEDICAL BROWARD, LLC.**

# PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Midland Medical Broward, LLC. as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is responsible for missed appointment charges as outlined in the fee schedule.
- The patient is responsible for charges associated with forms completion as outlined in the fee schedule
- The patient is responsible for any costs associated with collections of patient balances.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)
- If providing an insurance that requires selection of a Primary Care Physician (such as an HMO), it is the patient's responsibility to confirm that a Midland Physician has been selected and assigned as their Primary Care Physician. The patient is responsible for any costs associated with an incorrect PCP selected on their insurance policy.
- The patient is aware that all laboratory charges (other than phlebotomy fees) are billed to your insurance directly by the laboratory and not Midland Medical. If your insurance did not cover certain laboratory charges, the laboratory will bill you directly. We will always use the laboratory your insurance mandates. All billing issues with laboratory charges should be directed to the laboratory and your insurance company.

**Patient Authorizations**

- By my signature below, I hereby authorize assignment of financial benefits directly to Midland Medical Broward, LLC. and associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____

Signature of Patient or Guardian

## Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible of charges and to submit claims to my insurance company at my discretion.

_____

Signature of Patient or Guardian

**MIDLAND MEDICAL BROWARD, LLC**

# FEE SCHEDULE

**Simple forms:**
$5.00

**FMLA and Disability forms**
$15.00

**Medical Records:**
$1.00 per page for the first 25 pages
$0.25 for each additional page

**No Show Fee for Missed Appointments*:**
$60 for Appointments
$150 for Procedures

**Maximum lab fee for insurance covered patients:**
$15

*Cancellations made at the time of a scheduled appointment or after a scheduled appointment will be considered as a missed appointment to which the aforementioned fee will be applied. If a patient incurs three (3) NO SHOWS, within a 12-month period, they will be dismissed from the practice.

Medical records cannot be mailed, faxed, or emailed to patients. There is no charge for medical records being sent to another healthcare provider or healthcare facility.

Self-pay patients will be notified of the cash price prior to their lab draw. **PAYMENT MUST BE RECEIVED IN ADVANCE.**

A copayment/coinsurance is an expense that the provider is expected to collect at time of visit. Providers should collect copayments/coinsurance amounts as defined by the member's contract. **Participating providers are contractually prohibited from waiving a copayment/coinsurance which is considered an unacceptable billing practice for providers.**

PATIENT SIGNATURE DATE

# Consent for Email & Text Communication

As with any form of unencrypted communication, texting and e-mail can create potential risk that individually identifiable health information and other sensitive details contained in such e-mail or text be disclosed to or intercepted by unauthorized third parties. As such, we are seeking to obtain your written consent regarding e-mail and/or text communications. You will not hold Midland Medical Center or any of its affiliated companies liable if others access your e-mail or text messages from your computer, phone or another device.

Below you may consent and sign to receive e-mail and/or text messages from us regarding your treatment notifications and services. We utilize these communication channels for convenient items such as appointment reminders and paperless billing, in addition to other information. E-mail and texts sent to you by Midland Medical or its affiliated companies such as Midland Pharmacy may be included as a part of your medical record. We will use the *minimum necessary* amount of protected health information in any communication.

Please initial next to your choice regarding e-mail or text communication:

_____ I consent to and accept the risk in receiving medical information via e-mail and/or text message. I understand I can withdraw my consent at any time.

_____ I consent *only* to receiving appointment reminders via e-mail and/or text message. I understand I can withdraw my consent at any time.

E-mail address: _____

Mobile phone number: _____

I recognize that I can withdraw consent at any time by sending an email to info@midlandmed.com.

If I send an e-mail message to Midland Medical, Midland Medical will take that as permission to correspond via email and request that you sign this form in the future.

_____

Print Name

_____ _____

Signature Date

**MIDLAND MEDICAL BROWARD, LLC.**

# Our Promise of Privacy and Consent to Patient Records

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate ***security*** for our patient records.
2. Protecting the ***privacy*** of our patients' medical information.
3. Providing our patients with proper ***access*** to their medical records
4. Appropriately maintaining our patient information and bill processes in compliance with national ***standards***.

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Compliance Officer.

# Summary of the HIPAA Rule

1. It sets boundaries on the use and release of health records.
2. It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
3. It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights
4. It strikes a balance when public responsibility requires disclosure of some forms of data – for example, to protect public health.
5. For patients – it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
6. It enables patients to find out how their information may be used and what disclosures of their information have been made.
7. It generally limits release of information to the minimum reasonable need for the purpose of the disclosure.
8. It gives patients the right to examine and obtain a copy of their own health records and request corrections.

Our goal in reviewing and updating our privacy standards center on these components of the final rule. In all that we do in connection with patient records, we should keep in mind the above principles.