Lake View Medical Park
7400 Docs Grove Circle
Orlando, FL 32819

SOUTHWEST ORLANDO FAMILY MEDICINE, P.L.

MEDPLEX B
7350 Sandlake Commons Blvd, Ste. 3322
Orlando, FL 32819

www.swofm.com
(407) 352- 9717 PHONE (407) 354-5425 FAX

MEDICAL HISTORY FORM

DEMOGRAPHICS

NAME (Last, First)	**BIRTHDATE** (MM/DD/YY) / /

DIAGNOSED CONDITIONS/ MEDICAL DISEASES *(Mark an "X" on conditions that apply to you.)*

- ☐ Anemia
- ☐ Aneurysm
- ☐ Birth Defects
- ☐ Bleeding Disorder
- ☐ Cancer (Pls. indicate type) _____
- ☐ Epilepsy/Neurological
- ☐ Arthritis
- ☐ Eye Problems
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney/ Bladder
- ☐ Liver disease/ Hepatitis
- ☐ Lung/Respiratory Disease
- ☐ Osteoporosis
- ☐ Rheumatic fever
- ☐ Stomach/Gastric Disease
- ☐ Stroke/CVA Brain
- ☐ Thyroid Disease
- ☐ Mental Health (Pls. indicate type) _____

OTHERS: _____

MEDICAL DISEASES: FAMILY HISTORY *(Please indicate which conditions each member has and if Alive or Deceased)*

FATHER: ALIVE/ DECEASED *(Circle One)*	**SISTER:** **Number of sisters:** ___ ALIVE/ DECEASED
MOTHER: ALIVE/ DECEASED	**FAMILY HISTORY OF:**
BROTHER: **Number of brothers:** ___ ALIVE/ DECEASED	

HISTORY OF HOSPITALIZATIONS / SURGERIES *(Please indicates date, hospital and reason for the hospitalization.)*

_____

_____

PRESCRIPTION ALLERGIES *(Please indicate medication and reaction type, and/ or seasonal allergies.)*

_____

SOCIAL HISTORY

Children: # of sons: _____ # of daughters: _____	Military Experience: YES / NO What branch?	Exercise: SEDENTARY / MODERATE / VIGIROUS

TOBACCO HISTORY

Tobacco Use: (current, former, never)	Type: *(i.e. cigars, cigarettes …)*	Amount Per Day:	Years Used: _____ Year Quit: _____	Ever Tried to Quit? (Y/N) _____ Which Method? _____

ALCOHOL HISTORY

Alcohol Usage: *YES / NO / FORMERLY*	Type:	Frequency:	Amount:	Year Quit:

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CAFFEINE

Caffeine Use: *YES / NO*	Type: *(i.e. coffee, tea, soda, energy drinks…)*	Cups Per Day:

DRUG HISTORY

Drug Usage: *(yes, no, former)*	Type:	Number of Years Used:	Year Quit:

HEALTH MAINTENANCE *(Please indicate the dates [month/year], if applicable)*

Last Complete Physical Exam	Last Cholesterol Blood Test	Last EKG	Last Stool Test for Blood
Last Chest X-ray	Last Eye Exam	Last Foot Exam	WOMEN: Last Menstrual Period
WOMEN: Last GYN Exam (PAP/Pelvic). Please indicate result.			WOMEN: Last Mammogram
Last DEXA (Bone Density Exam)	MEN: Last Prostate Exam	Last Colonoscopy	

MEDICATIONS *(Please list all current medications that you are taking including supplements and OTC meds.)*

Medication Name	What is the medication for?	Dosage	Times Daily
Example: Tylenol	Fever	500 mg	Once daily

(Please list additional medications on a separate sheet)

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HIPAA UPDATE 2018

NAME (Last, First, Middle)	BIRTHDAY (MM/DD/YYYY) / /

PATIENT RECORD OF DISCLOSURES

In general, the **HIPAA privacy rule** gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that all communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

PARENTS:
If parents of the underaged patient (Under the age of 18) are divorced, please check the box and indicate if the other parent will have access to the patient's chart below and write their name down in the blanks provided.

Are Parents Divorced? →	☐ Yes, Parents are divorced	☐ Parents listed below have the right to participate in child's healthcare
Yes, allowed access or No one is allowed access? →	☐ **YES**, others can access my information *(if yes, please list person(s) below)*	☐ **No one** is allowed to access patient's chart

****CONFIDENTIALITY CLAUSE**
I authorize the VERBAL and/or WRITTEN release of my information and test results to my specified person(s) in the event that I am not available:

	Full Name	Relationship
1.)	_____	_____
2.)	_____	_____
3.)	_____	_____

EMERGENCY CONTACT INFORMATION

Name	Relationship	Home Phone ( ) -	Cell Phone ( ) -

Signature: _____ Date: _____

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NEW PATIENT PACKET

PATIENT INFORMATION – PLEASE PRINT			
NAME (Last, First, Middle)	BIRTHDATE (MM/DD/YYYY) / /	SSN	GENDER
LOCAL ADDRESS	CITY, STATE, ZIP		
RACE:	LANGUAGE:	EHNICITY ☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER	PHARMACY NAME: PHONE: ( ) -
EMPLOYER'S NAME / EMPLOYER'S ADDRESS / OCCUPATION		REFERRED BY:	

*I allow **Southwest Orlando Family Medicine** to **CALL OR TEXT** me on the specified number(s).*

HOME PHONE ( ) - CELL PHONE ( ) - WORK PHONE ( ) -

Email Address: _____ @ _____.com

☐ YES *I allow Southwest Orlando Family Medicine to **EMAIL** me through **eClinicalWorks Patient Portal**.*
☐ NO *I do not allow Southwest Orlando Family Medicine to **EMAIL** me through **eClinicalWorks Patient Portal**.*

Southwest Orlando Family Medicine encourages the use of the patient portal as we go green by minimizing the printing of paper. The patient portal is a secured system operated by a password-protected login and allows patients on-line access to their medical records.

ASSIGNMENT OF BENEFITS

It is therefore **my sole responsibility as the patient to know my insurance company coverage**, including which laboratory, medical provider or facilities my insurance company is contracted with. I will not hold Southwest Orlando Family Medicine and its management responsible for any bills incurred regarding any expenses or errors pertaining to me going to a non-covered laboratory, medical provider or facilities.

A photocopy of the Assignment shall be considered as effective and valid as the original. **I** also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Ins. Card holder (if not patient): _____ DOB: _____ SSN_____ Relationship_____

By signing, I hereby acknowledge that all the information provided above is accurate and true. I have also read and understood the **Notice of Privacy Practice**, **Patient Policies** and **Financial Policies**, which states that I am fully responsible for any services, balances, and/or no-show fees incurred.

_____ _____/_____/_____

PATIENT / RESPONSIBLE PARTY (SIGNATURE) **DATE**

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SOUTHWEST ORLANDO FAMILY MEDICINE, P.L. FINANCIAL POLICY

STAFF TO SCAN AND **GIVE BACK TO PATIENT** *(Patient's Copy)*

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits.

- **Payment is due at the time service is rendered**. For those patients with insurance coverage, it will be necessary for you to pay your deductible, co-insurance, or co-payment at the time service is rendered.

- You should be aware that your insurance is a contract between you and the insurance company. We file insurance claims as a courtesy to you. However, you will be responsible for all unpaid balances. Insurance plans differ, depending on the contract your employer has negotiated. It is **your responsibility** as a patient to become an **active participant in your own health care** and **know your insurance benefits**.

- For any insurances plans that we do not participate with and are considered **out-of-network providers, including all forms of Medicaid**, **services rendered will not be billed**. By selecting our practice as your Primary Care Physicians, **you assume financial responsibility** for any balance due after your primary insurance has processed your claim. Any co-payments, deductibles, and non-covered service charges left by the primary insurance will be the patient's responsibility.

- By, law, your insurance carrier must remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier, as we feel it is necessary to work together to resolve any insurance problem. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge.

- We accept cash, check, MasterCard, Visa, Discover & American Express. Our fee for a returned check is $25.00-$30.00. **We are unable to honor postdated checks**.

- If you are unable to keep your appointment, kindly give our office a minimum 24 hours' notice, otherwise a **$50 no-show fee** will be charged if you miss a *New Patient, Complete Physical Exam, Well Woman Exam, Blood Pressure or Holter Monitor appointment*.
- If you miss a diagnostic procedure (*e.g. Dexa Scan, Ultrasound, Nerve Conduction Study, VNG Testing, Urodynamics Testing, etc.*), a **$75 no-show fee** will be charged.
- All other missed appointments will be charged a **$25 no-show or same-day cancellation fee**. Regretfully, we had to implement this policy in order to give other patients the opportunity to be cared for in a timely manner. This will also ensure that our provider's times are efficiently utilized.
- We request that you call at least 24-hours prior to your appointed time either to cancel and/or reschedule your appointment.

- All payments are due upon receipt of a statement from our office. Balances over sixty days (60) old from the date of service will be sent to an outside collection agency, unless prior arrangements have been made with our billing office.

We understand that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us for assistance in the management of your account.

_____ _____/_____/_____ _____/_____/_____

PATIENT / RESPONSIBLE PARTY (SIGNATURE) **DATE OF BIRTH** **DATE**

_____

PRINT NAME

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SOUTHWEST ORLANDO FAMILY MEDICINE, P.L. PATIENT POLCIES

(Patient's Copy)

Appointments

Office visits are by appointment only. However, in the event that you or one of your family members develop a sudden illness and need to be seen the same day, we will do our best to accommodate you. Do understand that you may be seen by a different provider for that particular visit to be able to care for you in a timely manner, we do our utmost best to work you in with your preferred provider depending on availability.
Please inform our reception staff beforehand about the nature of your problem so that sufficient time will be allotted for your visit.

Cancellation Policy

In the event you need to cancel or reschedule an appointment, a 24-hour notice is required prior to your appointed time or a no show fee will be charged to your account. If you are more than 10 minutes late for your appointment, you will be considered a walk-in.

- **$25 no show fee** = Acute Visits
- **$50 no show fee** = Chronic Visits, Preventive Wellness Exams, New Patient Visits
- **$75+ no show fee** = Procedures (i.e. BP Monitor, Ultrasound)

After Hours

If you need to reach our office after hours for an emergency, please call **407-352-9717** and the answering service will contact our on call provider immediately. Please take note that this service is for medical advice to assist you in urgent situations that require decision making. Prescriptions, refill requests, referral requests and test results will not be entertained after hours. However, if you have a **MEDICAL EMERGENCY please call 911** instead of our office.

Surgical Clearance

If you are an established patient scheduling an appointment for surgical clearance the following information is required before we can set up your appointment:

- Surgeon's name
- Surgeon's office phone and fax number
- Type of procedure or surgery
- Date of surgery
- Surgical clearance form

Hospital Admissions

If you are admitted to the Emergency Room and/or the hospital, please make sure to inform hospital admission staff that we are your Primary Care Provider (PCP) so that we can follow up your care after your hospitalization. Studies show that **follow-up with your PCP within 3 days** after hospitalization minimizes re-admissions and complications.

Preventive Care

Complete / Annual Physical Exams (CPE/APE) and Well Woman Exams (WWE) are considered wellness visits. Complete physical exams are preventative visits that screen patients for common health conditions and include a head to toe assessment.

Complete/Annual Physical Exams include the following:

- A baseline reading of your blood pressure, temperature, pulse and respirations, weight, height, vision, hearing and other vital functions depending on your age, gender and level of activity.
- Recommendations for wellness services and healthy lifestyle changes are done during this visit.
- This annual physical will help us help you identify and reduce potential and future health risks.

Your insurance may cover an annual physical exam once every 12 months. Please inquire from your insurance company regarding coverage.
Once again, please be reminded that CPE/APE cannot be scheduled on the same visit as consults, sick visits or other requested appointments. This is to ensure that we can focus on prevention and well visit discussions or counseling.

Referral/Authorization for Specialists and/or Pharmacies

For referrals/authorizations to specialists, allow our referral coordinators **48-72 hours** to process the referral. For authorizations for procedures and/or pharmacies, approval is contingent on how your insurance processes the request.

Forms

For any documents that needs to be completed by a medical provider, we encourage that you schedule an appointment specifically for the completion of this document. This is to ensure that the document is completed accurately and appropriately. These documents include: Physical Examination Forms, FMLA, Attending Physician Statements, Short Term Disability Forms, and Parking Permit forms.
If you are not able to schedule an appointment, there is a $50-75 charge, depending in the extent of the document. Allow us seven (7) business days to get this completed for you. Also note, that not all documents can be completed in our office. Please inquire with our staff before scheduling an appointment or dropping off the document.

Prescription Refill Requests

- *For local pharmacy refills* – Please call your pharmacy directly when requesting a refill and ask them to fax your request to our office.
- *Mail order pharmacy refills* – Please call our office with the fax number of the mail order pharmacy along with your request.

Prescription refill request may take up to 72 hours to be approved. Therefore, we ask that you call our office at least one week before your prescription runs out.
We do not prescribe antibiotics without an office visit. We do not prescribe controlled substances on the first visit.
Our office has a strict policy on controlled substance medications and tranquilizers. Due to increasing regulations, you may be referred to a pain management provider or a psychiatrist to manage these medications.

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NEW PATIENT CHECK LIST

The following items are REQUIRED for your first office visit

- O Completed New Patient Packet
- O Read and Understood FINANCIAL POLICY and No-Show policy of the office
- O Medical Records from Previous Primary Care Physician / Specialist(s)
  (This includes Previous Procedures / Surgeries/ Notes/Medications/Immunizations)
- O Photo Identification
  (*We will not see you for your first visit without proper identification*)
- O Active Insurance Card(s)
- O Medication Bottles or a specific list of medications with dosages, frequency and quantities
- O Email Address for the Patient Portal to receive test results
  *(Mandatory, otherwise, records have to be picked up from the office or a **$2** fee to mail results will apply)*
- O Patient Portal Medical Questionnaire Intake
  - ➔ Website: https://www.health.healow.com/swofm
  - ➔ User name and password will be provided for you when you make your initial visit
  - ➔ Complete intake before arriving at your first appointment

Please arrive **20 minutes** earlier for your appointment. Arrive **30 minutes** if you're a new patient. Thank you.

FOR NEW PATIENTS: WE DO NOT PRESCRIBE NARCOTICS OR CONTROLLED SUBSTANCES ON THE FIRST VISIT.