WELCOME

Please complete in its entirety

Name _____ **Middle Name** _____ **Last Name** _____
Date of Birth _____/_____/_____ **Telephone** _____
Email _____ **Language** _____
Address _____
Gender ☐ Female ☐ Male **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widow

Ethnicity ☐ American Indian/Alaska Native ☐ Asian ☐ African American
☐ Hispano o Latino ☐ Native Hawaiian ☐ Caucasian

Occupation _____
Emergency Contact:

Full name _____ Phone Number _____
Relation to you ☐ Spouse ☐ Child ☐ Sibling ☐ POA ☐ Other_____
Pharmacy: _____ Phone Number _____
Address _____

How did you hear about us?

☐ Return patient ☐ Walk-in ☐ post-Mail ☐ Insurance Plan ☐ Internet Search ☐ Flyer
☐ Friend_____ ☐ Social Media_____

Primary Insurance
Insurance name _____
Primary insured name_____
Relationship to Patient ☐ Self ☐ Spouse ☐ Child
Member ID _____
Group # _____

Additional Insurance
Insurance name _____
Primary insured name _____
Relationship to Patient ☐ Self ☐ Spouse ☐ Child
Member ID _____
Group # _____

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to RPS Primary Medical Center (RPS) and/or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify RPS of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by RPS and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

_____ _____ _____
PATIENT/LEGAL REPRESENTATIVE NAME *SIGNATURE* *DATE*

GENERAL CONSENT FOR CARE

The Florida Medical Consent Law, Chapter 766.103 of the Florida Statutes, requires any person undergoing procedures and treatment shall be informed in general terms of the following:

1. A general understanding of the procedure(s) and or course of treatment or care provided in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained
2. Medically acceptable alternative procedures or treatments, including no treatment; and
3. Risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; and Accordingly, you have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, there may not be a specific treatment plan recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at your residence or other mutually acceptable location that is conducive to the proposed treatment and/or procedures. *The consent will remain fully effective until it is revoked in writing.* You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your other physician or health care providers about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (e.g., Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, Medical Social Worker, etc.), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care from RPS Primary Medical Center. I understand that if additional testing or procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment and that I am responsible for all reasonable charges, if any, in connection with the care and treatment rendered.

_____	_____	_____
PATIENT/LEGAL REPRESENTATIVE NAME	*SIGNATURE*	*DATE*

FINANCIAL POLICY

We accept Visa, MasterCard, Discovery, American Express, as well as cash.

Upon registration, you will be asked to provided your picture ID and Insurance Card, failure to provide such information will result in rescheduling of your appointment. Based on your current health plan coverage you may be assigned a deductible, copay, or coinsurance that will be collected **prior** to services being rendered. Additional services may be rendered once you are in the room with the provider, additional payment for those services will be collected upon check out.

We reserve the right to refuse checks at the office at any time as copayments, deductibles and coinsurances are required. RPS holds the right not to bill a patient for upfront collectable copays, and deductibles. If after billing your health plan there remains a balance, RPS will send a statement for the balance due via mail and will expect payment upon next visit with the provider. Payment can be mailed, in office, or via phone call to the office.

Please be as specific as possible with your insurance information as it will help facilitate a clean claim for your health plan for services rendered.

Medicare Patients: RPS hold the right to bill Medicare and any secondary insurance you may provide. If payment for services rendered are not received after 2 attempts to health plan, RPS may contact you as the patient for further assistance in retrieving payment. If payment is not rendered, RPS will bill the patient for those services rendered.

Uninsured Patients: Payment for medical services rendered is expected on the day of service.

Balances and statements: RPS will provide and send a statement for any additional balances you may incur after health plan benefits are exhausted. Whereas payment is expected upon statement reviewed and received.

_____ _____ _____

PATIENT/LEGAL REPRESENTATIVE NAME *SIGNATURE* *DATE*

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PERSONAL MEDICAL HISTORY

Any present health concerns?

_____

Have you been diagnosed with High Blood Pressure? Yes, or no? When? If you are taking medications for high blood pressure, how long have you been taking them?

_____

Have you been diagnosed with high cholesterol? Yes, or no? When? If you are taking medications for cholesterol, how long have you been taking them?

_____

Medications: Prescribed or over the counter medications, such as vitamins, herbs, etc.:

Medication, Supplement, Vitamin, etc.	Dose	Repetitions per day, for how many days of use

Allergies: Please include all kinds of allergies be it food, medications, etc.

Medication, food, etc.	Reaction or effect

Surgical History:

Surgery Type	Date	Where

Please indicate if you have or have had any of the following:

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight loss

Cardiovascular
- ☐ Chest Pain
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Cardio Rheumatic
- ☐ Diseases
- ☐ Claudication
- ☐ Shortness of breath
- ☐ Edema, Where?

  _____
- ☐ Palpitations
- ☐ Short night breathing
- ☐ Congestive Heart Failure
- ☐ Cyanosis
- ☐ Varicose Vein
- ☐ Open Heart Surgery

Ears /Nose/Throat:
- ☐ Earache
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Running Nose
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Bleeding gums
- ☐ Pain in the teeth
- ☐ Nosebleeds

Endocrine or Sexual
- ☐ Diabetes
- ☐ Menopause
- ☐ Sexually transmitted diseases
- ☐ Hyperthyroidism
- ☐ Swelling in feet and hands
- ☐ Hair Loss
- ☐ Heat/cold intolerance
- ☐ Infertility
- ☐ Excessive sweating

Eyes:
- ☐ Glasses/ Contacts
- ☐ Blurred Vision
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ Dryness
- ☐ Glaucoma

Gastrointestinal or urinary
- ☐ Abdominal Pain
- ☐ Anorexia
- ☐ Difficulty swallowing
- ☐ Constipation/Diarrhea
- ☐ Heart Burn/Gastric Reflux
- ☐ Vomiting blood
- ☐ Hemorrhoids
- ☐ Pancreatitis

Hematological /Lymphatic
- ☐ Bruises with ease
- ☐ Excessive bleeding
- ☐ Lin adenomatous
- ☐ Blood Transfusion

Integumentary
- ☐ Jaundice
- ☐ Itchy skin
- ☐ Eruptions
- ☐ Dry Skin
- ☐ Acne
- ☐ Fungal infections
- ☐ Warts

Muscular
- ☐ Arthritis
- ☐ Joint Stiffness
- ☐ Pain in the extremities
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Osteoporosis

Neurological
- ☐ Alzheimer
- ☐ Migraines/Headache
- ☐ Dizziness/Vertigo
- ☐ Seizures
- ☐ Parkinson
- ☐ Cerebrovascular Diseases
- ☐ Depression
- ☐ Anxiety
- ☐ Mental Illness
- ☐ Ataxia
- ☐ Fainting
- ☐ Memory Loss
- ☐ Tremors
- ☐ Bipolarity
- ☐ Feeling Stressed
- ☐ Suicidal Thoughts
- ☐ Discomfort when sleeping
- ☐ Personality Changes
- ☐ Mood swings

Respiratory
- ☐ Coughing
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Wheezing
- ☐ Bronchitis
- ☐ COPD (Chronic Obstructive
- ☐ Pulmonary Disease)
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Nasal Problem
- ☐ Tuberculosis
- ☐ (exposure)
- ☐ Shortness of breath

Other
- ☐ Seasonal Allergies
- ☐ HIV
- ☐ AIDS
- ☐ Anemia
- ☐ Obesity
- ☐ Cancer _____

  _____

Women Only

When was your last menstruation?

_____

Are You Sexually Active? Yes or no

Do you use any type of contraceptive?

_____

Have you been or are you pregnant? Yes or No

How many times? _____

When was your last Pap smear?

_____

Are you postmenopausal? Yes or no

Have you had a history of hysterectomy? Yes or No

Social History

Do you drink alcohol? Yes or No

Frequency? Daily / Occasional / Socially / Never

Do you use tobacco? Yes or No

Frequency? ____ Daily boxes ___ Daily cigarettes __ Pipe ____

Do you drink Coffee? Yes or No

Caffeinated Soda? Yes or no

Do you exercise regularly? Yes or No What Type?

_____

Do you use any illicit/controlled drugs? Yes or No What type?

_____

Specialist List

Specialist Type	Doctor Name	Address	Phone Number	Fax Number
Previous PCP				
Cardiologist				
Dermatologist				
Endocrinologist				
Gastroenterologist				
Ophthalmologist				
Otolarnyngologist				
Podiatrist				
Rheumatologist				
Other:				
Other:				

AUTHORIZATION TO SHARE MEDICAL INFORMATION
(Request/Issue)

Patient Name: _____

Date of Birth: _____ Phone _____

Address: _____

City, State, Postal code: _____ Pharmacy: _____

Purpose of this order:

☐ Health Care ☐ Other _____

☐ Personal ☐ Primary Care Transfer

Type of Medical History:

All medical records related to an illness or lesson.

_____

History of care (including physical history, laboratories, x-rays, operations, illnesses)

Specific information (select as many as necessary)

☐ Procedures Report ☐ Physical therapy

☐ X-rays ☐ Laboratory results

☐ Physical histories ☐ Other _____

This authorization is valid for:

This requirement for the medical history of any future treatment of the type described above until: _____

I wish to accept the following authorization boxes to allow exchange of information on the following topics:

☐ AIDS/VIH

☐ Alcohol and/or drugs

☐ Mental Health Treatments

In this authorization I understand that:

My rights to receive medical treatment are not conditioned by whether I sign this authorization or not. I may cancel the validity of this authorization at any time, with only a written letter to the address that is in the header of this authorization. If I request to receive information related to my personal medical record, a fee may be charged for the required medical history.

Medical Records are faxed only to another provider if necessary.

_____ _____ _____

PATIENT/LEGAL REPRESENTATIVE NAME *SIGNATURE* *DATE*

NOTICE OF PRIVATE PRACTICE (HIPPA)

Patient Consent Form for HIPPA Compliance our notice of privacy practices provides information about how we may use or disclose protected health information. The notice contains a patient rights section that describes their rights under the law.

You assure that with your signature you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or health care operations. We are not obligated to accept this restriction, but if we do, we will abide by this agreement. The *Health Insurance Portability and Accountability Act* of 1996 (HIPPA) allows the use of information for treatment, payment, or health care operations.

You have the right to revoke this consent in writing, signed by you. However, such revocation shall not be retroactive. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or health care operations.

1. The practice reserves the right to change the privacy policy as permitted by law.
2. The practice has the right to restrict the use of information, but the practice does not have to agree with those restrictions.
3. The patient has the right to revoke this written consent at any time and then all full disclosures will cease.
4. The practice may condition the receipt of the treatment to the execution of this consent.
    - Can we phone you, email you, or text you to confirm appointments?
      Yes or No
    - Can we leave a message on your home answering machine or cell phone?
      Yes or No
    - Can we can discuss your medical condition with any member of your family
      Yes or No

If yes, name the permitted members:

1. _____
2. _____

_____ _____ _____

PATIENT/LEGAL REPRESENTATIVE NAME *SIGNATURE* *DATE*

CONSENT TO DISCUSS MEDICAL INFORMATION

I, _____, consent to RPS Primary Medical Center to discuss

_____ (DoB _____) medical information with the
PATIENT'S FULL NAME

individuals or entities enrolled below.

Full name _____ Phone Number _____
Relation to you ☐ Spouse ☐ Child ☐ Sibling ☐ POA ☐ Other_____

Full name _____ Phone Number _____
Relation to you ☐ Spouse ☐ Child ☐ Sibling ☐ POA ☐ Other_____

Full name _____ Phone Number _____
Relation to you ☐ Spouse ☐ Child ☐ Sibling ☐ POA ☐ Other_____

I wish to accept the following authorization boxes to allow exchange of information on the following topics:

- ☐ ALL RECORDS
- ☐ AIDS/VIH
- ☐ Alcohol and/or drugs
- ☐ Mental Health Treatments
- ☐ Prescriptions
- ☐ Lab/Imaging orders
- ☐ Lab/Imaging results
- ☐ Other: _____

When I decide, I can cancel or suspend this request.

☐ I do not wish to allow RPS to discuss with anyone.

_____ _____ _____
PATIENT/LEGAL REPRESENTATIVE NAME *SIGNATURE* *DATE*

PATIENT APPOINTMENT CANCELLATION POLICY

A cancellation/re-schedule made with **less than a 48 hour notice** significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our mission, serving our patient with compassion, RPS has instituted the following policy:

1) A "No-Show," "No-Call" or missed appointment, without proper 48-hour notification, **fee of $50** will be assessed. This Fee is NOT billable to your insurance/health plan.
2) Please provide our office a **48-hour notice** if you need to cancel or reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service, voicemail box, or sent through the online patient portal to avoid a fee being charged.
3) If you are **15 minutes or more late** for your appointment, the appointment may be cancelled and rescheduled and a **$50 fee** sited.
4) As a courtesy, our system sends out a text and e-mail message the day your appointment is made to let you know and have it added to your calendar, then 5 days prior to your appointment asking you to *confirm or cancel* and complete a pre-check-in questionnaire. If no answer is received, another message is sent out 3 days prior to your appointment, and finally the day of your appointment a reminder message is sent 60 minutes before the appointment. If no response is made a reminder call one to two days in advance may be made. Please note, if reminder calls or messages are not received, the cancellation policy remains in effect.
5) Repeated missed appointments may result in termination of the physician/patient relationship.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by RPS Primary Medical Center.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.

_____	_____	_____
PATIENT/LEGAL REPRESENTATIVE NAME	*SIGNATURE*	*DATE*

RECEIVING NOTICE FROM PRIVATE PRACTICE

Note to the patient who signed:

RPS Primary Medical Center ("private practice") is required to provide the patient with a copy of the notice of private practices (and privacy), which states how the private practice may use and/or disclose the patient's health information.

Please sign this form as an acknowledgement of receiving this notification.
The patient may refuse to sign this notice, if it is the patient's wish.

I acknowledge that I have received a copy of the notice of private practices:

OFFICE REPRESENTATIVE NAME	*PATIENT/LEGAL REPRESENTATIVE NAME*
SIGNATURE	*SIGNATURE*
_____ DATE	_____ DATE

PATIENT RIGHTS & RESPONSIBILITIES PATIENT RIGHTS

1. A patient has the right to respectful care given by competent workers.
2. A patient has the right to know the names and the jobs of his or her caregivers.
3. A patient has the right to privacy with respect to his or her medical condition. A patient's care and treatment will be discussed only with those who need to know.
4. A patient has the right to have his or her medical records treated as confidential and read only by people with a need to know. Information about a patient will be released only with permission from the patient or as required by law.
5. A patient has the right to request amendments to and obtain information on disclosures of his or her health information, in accordance with law and regulation.
6. A patient has the right to know what facility rules and regulations apply to his or her conduct as a patient.
7. A patient has the right to have emergency procedures done without unnecessary delay.
8. A patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
9. A patient has the right to make informed decisions regarding his or her care and has the right to include family members in those decisions.
10. A patient has the right to information from his or her doctor in order to make informed decisions about his or her care. This means that patients will be given information about their diagnosis, prognosis, and different treatment choices. This information will be given in terms that the patient can understand. This may not be possible in an emergency.
11. A patient given the option to participate in research studies has the right to complete information and may refuse to participate in the program. A patient who chooses to participate has the right to stop at any time. Any refusal to participate in a research program will not affect the patient's access to care.
12. A patient has the right to refuse any drugs, treatment or procedures to the extent permitted by law after hearing the medical consequences of refusing the drug, treatment or procedure.
13. A patient has the right to have help getting another doctor's opinion at his or her request and expense.
14. A patient has the right to care without regard to race, color, religion, disability, sex, sexual orientation, national origin, or source of payment.
15. A patient has the right to be given information in a manner that he or she can understand. A patient who does not speak English, or is hearing or speech impaired, has the right to an interpreter, when possible.
16. Upon request, a patient has the right to access all information contained in the patient's medical records within a reasonable timeframe. This access may be restricted by the patient's doctor only for sound medical reasons. A patient has the right to have information in the medical record explained to him or her.
17. A patient has the right not to be awakened by staff unless it is medically necessary.
18. A patient has the right to be free from needless duplication of medical and nursing procedures.
19. A patient has the right to treatment that avoids unnecessary discomfort.
20. A patient has the right to be transferred to another facility only after care and arrangements have been made and the patient has been given complete information about the hospital's obligations under law.
21. A patient has the right to a copy of his or her bills. A patient also has the right to have the bill explained.
22. A patient has the right to request help in finding ways to pay his or her medical bills.
23. A patient has the right to help in planning for his or her discharge so that he or she will know about continuing health care needs after discharge and how to meet them.
24. A patient has the right to access people or agencies to act on the patient's behalf or to protect the patient's right under law. A patient has the right to have protective services contacted when he or she or the patient's family members are concerned about safety.
25. A patient has the right to be informed of his or her rights at the earliest possible time in the course of his or her treatment.
26. A patient has the right to make advance directives (such as a living will, health care power of attorney and advance instruction for mental health treatment) and to have those directives followed to the extent permitted by law.
27. A patient has the right to personal privacy and to receive care in a safe and secure setting.
28. A Medicare patient has the right to appeal decisions about his or her care to a local Medicare Review Board. The Facility will provide the name, address, and phone number of the local Medicare Review Board and information about filing an appeal.
29. A patient has the right to be free from all forms of abuse or harassment.
30. A patient has the right to be free from the use of seclusion and restraint, unless medically authorized by the physician. Restraints and seclusion will be used only as a last resort and in the least restrictive manner possible to protect the patient or others from harm and will be removed or ended at the earliest possible time.
31. A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient.
32. A patient has the right to pastoral care and other spiritual services.
33. A patient has the right to be involved in resolving dilemmas about care decisions.
34. A patient has the right to have his or her complaints about care resolved.
35. The patient has the right to appropriate pain management.
36. A patient has the right to be free from financial exploitation by the health care facility.

Patient Responsibilities

37. Patients are responsible for providing correct and complete information about their health and past medical history.
38. Patients are responsible for reporting changes in their general health condition, symptoms, or allergies to the responsible caregiver.
39. Patients are responsible for reporting if they do not understand the planned treatment or their part in the plan.
40. Patients are responsible for following the recommended treatment plan they have agreed to, including instruction from nurses and other health personnel.
41. Patients are responsible for keeping appointments.
42. Patients are responsible for proper rescheduling/cancelation notifications with more than 48-hour notice in order to avoid a fee.
43. Patients are responsible for treating others with respect.
44. Patients are responsible for following facility rules regarding smoking, noise, and use of electrical equipment.
45. Patients are responsible for what happens if they refuse the planned treatment.
46. Patients are responsible for paying for their care.
47. Patients are responsible for respecting the property and rights of others.
48. Patients are responsible for assisting in the control of noise and the number of visitors in their rooms.

To report a Patient's Rights Concern or file a grievance, please contact:

RPS Primary Medical Center
2900 Loopdale Lane
Kissimmee, FL 34741
P: (407) 900-0232 F: (407) 675-3558
office.manager@rpsmed.net

FL Department of Health and Human Services Division of Health Services Regulation

By Phone:
Complaints against licensed practitioners or facilities cannot be filed over the phone. Florida law requires the complaint be signed. However, you may file an unlicensed activity complaint over the phone by calling 1-877-HALT-ULA (1-877-425-8852).

By Fax:
850-488-0796

By Web:
https://www.flhealthcomplaint.gov/home

By Mail:
Department of Health
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-326

U.S. Department of Health and Human Services, Office for Civil Rights
Electronically through the Office of Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

By Mail:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

By Email:
OCRComplaint@hhs.gov
Complaint forms for mailing are available at: https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

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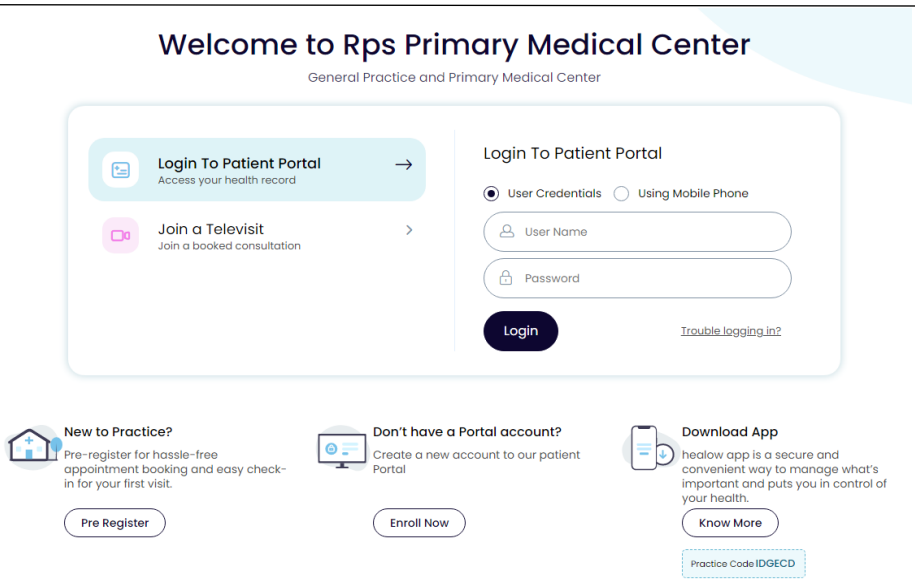

To create an online Patient Portal register online at https://mycw156.ecwcloud.com/portal21691/jsp/100mp/login_otp.jsp or scan QR code