ACCESS FAMILY CARE, LLC
712 W 25th Street, Sanford, FL 32771 (Ph) 407.402.2303, (F) 407.322.6341,
www.accessfamilycarefl.com, Email: accessfamilycarefl@gmail.com

New Patient Information

Complete ALL Sections and bring this packet to your appointment on: _____________@________

Patient Information

Last Name: ____________________First:__________________ MI: _______

Preferred Name: ______________________ DOB: _________ Sex: M/F :_________

Race: ___________ Ethnicity: ____________ Marital Status: ____________________

Address: ____

City: ____________________________ State: ___________ Zip: _________________

Home Phone: _____________ Cell Phone: _____________ Preferred: Home/Cell/Work

Email Address: ____

Employment: __________________________ Phone Number: ____________________

Pharmacy: ____________________ City: _____________ Phone #:______________

Preferred Lab: Quest LabCorp Other: ______________

How did you hear about our office? Internet Insurance Website

Dr. Reference: ____________ Another Patient: _____________

Emergency Contact:1 ____

Relationship to patient: _________________________

Mailing Address: ____

Phone: ____________________

 initials______

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MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

☐ **NONE**

☐ Allergies
☐ Asthma
☐ Cancer (type)_______________
☐ Reflux
☐ Gout
☐ Hepatitis
☐ HIV
☐ Hypertension
☐ Kidney Disease
☐ Thyroid disease
☐ Lupus
☐ Psychiatric Disorder
☐ Anemia
☐ COPD/Emphysema
☐ Hypothyroidism
☐ Migraine Headaches
☐ Seizure Disorder
☐ Stroke/TIA (History of)
☐ Arthritis
☐ Diabetes
☐ Heart disease
☐ High Cholesterol
☐ Liver Disease
☐ Testosterone (Low)

☐ **Other** ______________________________

FAMILY HISTORY List any family members who have the following conditions.
(Parent(s), Grandparent(s), Uncle(s), Aunt(s), Sibling(s), and/or Children)

❑ Y ❑ N Cancer if yes Type(s) _______________ *Relationship* ____________________
(Alive / Deceased)

❑ Y ❑ N Diabetes if yes *Relationship* ____

❑ Y ❑ N Heart disease if yes *Relationship* _____________________________________

❑ Y ❑ N High blood pressure if yes *Relationship*_________________________________

❑ Y ❑ N High cholesterol if yes *Relationship* ____________________________________

❑ Y ❑ N Kidney disease if yes *Relationship* _____________________________________

❑ Y ❑ N Thyroid disease if yes *Relationship* _____________________________________

❑ Y ❑ N Other if yes *Relationship* ____

PREVIOUS SURGERIES Have you undergone any of these surgical procedures?

❑Appendectomy ❑Breast Surgery ❑Hysterectomy ❑Joint Surgery ❑Thyroid Surgery
❑Tonsillectomy ❑Gallbladder ❑Other: ____________________

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IMMUNIZATIONS Have you received any of the following vaccines? If yes, please list the approximate date they were received.

Influenza (Flu Vaccine): _______________
Pneumonia: __________________
Tetanus: _____________________
Other: _____________________
Shingles: __________________
HPV: _____________________
Covid:_____________________

OB/GYN HISTORY

Number of pregnancies: ___ Number of children: ___Number of miscarriages/abortions: ___
Birth Control? ___________________ LMP: ________
Age of first menses: _____ Age of menopause: ____

ALLERGIES Please list any allergies/intolerances you may have, write N/A if none:

Medicines: ____________________________ Type of Reaction: _____________
Foods: _______________________________ Type of Reaction: _____________
Other: _______________________________ Type of Reaction: _____________

SCREENINGS/ PREVENTIVE HEALTH Please list the date of your last screening exam, if applicable:

Colonoscopy: _________________
Pap smear: ___________________
Bone Density: __________________
Mammogram: _________________
Prostate Exam: ________________
Other: ________________

Do you smoke? Yes/No Former
When did you quit? __________
How many a day? _____
Do you drink alcohol? Yes/No
How often? Daily/Weekly/Monthly
Have you done/do any illicit drugs? Yes/No

PATIENT HEALTH QUESTIONNAIRE

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	*NOT AT ALL*	*SEVERAL DAYS*	*MORE THAN ONE-HALF THE DAYS*	*NEARLY EVERY DAY*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

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PRESCRIPTION HISTORY CONSENT

I hereby grant permission to Access Family Care, LLC to view my prescription history from external sources.

Signature: ____ Date: ____________________

MEDICATIONS

Please list any medications and/or supplements that you take

Name	Dosage	Reason
For Additional Medications Please Attach A Separate List		

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BIOGRAPHY

Race/Ethnicity questions below comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity, dated October 30, 1997

Please select the category or categories that best describes your background:

ETHNICITY *(Mark one):* _____ Hispanic or Latino _____ NOT Hispanic or Latino _____ Decline to State *(if checked, provide initials):* _____	**RACE** *(Mark as many as apply):* _____ American Indian or Alaska Native _____ Asian _____ Black or African American _____ White _____ Hispanic _____ Native Hawaiian _____ Other Pacific Islander _____ Other Race: _______________ _____ Decline to State *(if checked, provide initials):* _____
LANGUAGE *(Mark primary language):* _____ English _____ Spanish _____ Russian _____ Hindi/ Urdu _____ Arabic _____ Other: ______________	

FINANCIAL POLICY FOR ACCESS FAMILY CARE, LLC

We require all patients to pay at time of service by cash, check, debit, or credit card. Credit card or health saving account debit card are the preferred method of payment. You will be charged at the time of visit for any outstanding deductible, co-insurance, or co-payment due, as well as any fees for services not covered by your insurance plan.

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EXAMPLES

Your Plan	What You Do	What We Do
Medicare	Pay your deductible ($203 for 2021) and co-insurance (20% of the allowable). If you request any services that Medicare does not cover, you agree in writing to pay our regular fee for those services.	We will file Medicare for you.
Medicare + Secondary Insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you. For secondary insurance that we do not contract with see "Insurance we are not contracted with".
Cigna **Aetna** **Freedom** **United Healthcare** **BlueCross/BlueShield** **Florida Healthcare Plans** **Advent Health** **Bright Health**	Pay your deductible, co-insurance, or co-pay at time of service.	We will file your Insurance for you.
Insurance we're not contracted with	Pay the visit in full at time of service.	We will submit the claim as a courtesy and you will receive direct payment from your insurance plan.
Worker's Compensation, Automobile Accident, Disability Evaluation	Please contact respective agencies.	

Additional Charges:

- No Show $25 fee for scheduled appointments cancelled without 24 hour prior notice. The Completion of Forms fee is $35. Please allow up to 3 business days for forms to be completed. Please sign below stating that you understand the above Additional Charges.

Signature: ______________________________________ Date: ________________

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of Access Family Care, LLC's financial policy and agree to the terms of payment due.

 initials______

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Access Family Care, LLC any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare and all other insurance benefits be made on my behalf to Access Family Care, LLC for any services provided to me and/ or my dependents. I authorize any holder of medical information about me and/ or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with Access Family Care, LLC, I am not responsible for amounts it has agreed to write-off. If my insurance does not have a contract with Access Family Care, LLC, I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. If balance of payment needs to be forwarded to a collection agency, I understand that I will be dismissed from the practice.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Access Family Care, LLC.

I hereby acknowledge that I have received and reviewed the Financial Policies of Access Family Care, LLC.

Signature: ____ Date: ________________

PATIENT CONTACT PREFERANCES/ RELEASE OF PATIENT INFORMATION

People whom we may share information regarding your care:

Name/Relationship/Contact Number

____

____

____

I hereby grant permission to Access Family Care, LLC to share information regarding my care to the people listed above.

Signature: ____ Date: ________________

____

INSURANCE AUTHORIZATION CONSENT

Patient Name (Last, First): _________________________________ DOB: _______

Primary Insurance: ________________________ Insured's Name: _________________

Relationship: ______________ DOB: ______ Secondary Insurance: ______________

I hereby authorize my insurance benefits to be paid directly to Access Family Care, LLC and authorize my physician to release any information requested by my insurance carrier.

Signature: ____ Date: ______________

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GENERAL OFFICE POLICIES

APPOINTMENTS

Please plan on allocating at least one hour for a new patient visit and between 15 minutes to 45 minutes for a follow up visit depending on the complexity. We strive to keep to our schedule. If you are unexpectedly late to your appointment please notify us as soon as possible. If you are over 15 minutes late to an appointment it will likely need to be rescheduled.

CANCELLATION / NO SHOW

It is a requirement that cancellations be made at least 24 hours before the scheduled appointment. A no-show fee of $25 will be billed in the event an appointment is missed without prior notice. Emergency cancellations will be addressed on an individual basis.
Multiple cancellations or failure to show for repeated appointments could result in discharge from the practice. If this occurs the doctor will continue to be available for treatment for a period of 30 days only from the time of discharge.
In general, client discharge is a measure of last resort. However if the patient/provider relationship can no longer be carried out effectively due to non- adherence to recommendations or other issues, discharge from the practice may occur.

PRESCRIPTION and MEDICATION RENEWAL

With rare exceptions, prescriptions will be written or renewed during your scheduled office visit. Prescriptions for antibiotics or narcotic pain medication will require a medical visit. If requesting medication renewals outside of the time of visit please allow a minimum of 3 business days to process.

MEDICAL RECORDS

You as a patient are entitled to review or request a copy of your medical record for personal use. Requests for medical records must be made in writing. Per Florida statues you will be charged $1.00 a page for the first 25 and $0.25 per page for remaining pages. This fee must be paid before the medical record is released. Please allow 7 business days for processing.

RESULTS OF DIAGNOSTIC TESTS

The results of all diagnostic tests ordered by the practice will be reviewed with you at the time of a scheduled office visit. If a test requires immediate attention you will be contacted directly by Access Family Care, LLC with the treatment plan. You will not be contacted for laboratory results that are normal and require no further changes in management. These results will be saved in your medical records and will be available for your review by contacting the office.

I hereby acknowledge that I have reviewed the above General Office Policies.Signature:

____ Date: _______________