

Patient Registration

	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient:
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone:
Work Phone:	Emergency Contact Information
Mobile Phone	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone:
Patient email:	
Required by government mandate [although you may refuse]:	Employer information
Language:	Employer:
Race:	Address
Ethnicity:	Phone:
Marital Status:	
Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:
Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Member ID: Group #:	Member ID: Group #:
Last Name	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name :
Address:	Address:
City: State	City: State:
Zip:	Zip:
Date of Birth: Sex (please circle): M or F	Date of Birth: Sex (please circle): M or F
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY

Name: _____ Address: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date: _____	Meningococcus	Date: _____
Flu Shot	Date: _____	MMR (<i>Measles, Mumps, Rubella</i>)	Date: _____
Gardasil/HPV	Date: _____	Pneumonia	Date: _____
Hepatitis A	Date: _____	Tdap (<i>Tetanus and pertussis</i>)	Date: _____
Hepatitis B	Date: _____	Tetanus	Date: _____
		Zostavax (<i>Shingles</i>)	Date: _____

Date of last colonoscopy: _____

Results of colonoscopy: _____

Date of last physical exam: _____

Last vision screening: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal Last Mammogram Date _____ Abnormal Age of first menstrual period: _____ Date of last menstrual period or age of menopause: _____ Number of pregnancies: _____ births: _____ miscarriages: _____ abortions: _____ Cesarean sections If yes, then number: _____	Bleeding between periods Heavy periods Extreme menstrual pain Vaginal itching, burning, or discharge Wake in the night to go to the bathroom Hot flashes Breast lump or nipple discharge Painful intercourse Sexually active Current sexual partner is Female Male Do you use condoms Yes No Other Birth control method used: _____ Interested in being screened for STD's _____
--	--

PAST MEDICAL HISTORY

Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes – Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes – Non-Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other |

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS					
Grandmother (maternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic disease
			Heart disease	Hypertension	Osteoporosis	Stroke		
Grandfather (maternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic disease
			Heart disease	Hypertension	Osteoporosis	Stroke		
Grandmother (paternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic disease
			Heart disease	Hypertension	Osteoporosis	Stroke		
Grandfather (paternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic disease
			Heart disease	Hypertension	Osteoporosis	Stroke		

Financial Responsibility

I understand and accept that I will be financially responsible for all deductibles, co-payments, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment at least 24 hours prior to my appointment a \$25 dollar fee will be charged. If my insurance requires a referral to receive medical care, I understand it is my responsibility to provide such a referral. If my referral is determined to be invalid by my insurance carrier, I understand I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to Palm Beach Family Medicine, LLC all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the physician and/or representative(s) to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions when manual or electronic.

Patient signature _____ Date: _____

I have received a copy of Florida's Patient's Bill of Rights and Responsibilities.

Print Name

Signature

Date

Florida Patient's Bill of Rights and Responsibilities

Florida Statute 381.026

(1) **SHORT TITLE.**--This section may be cited as the "Florida Patient's Bill of Rights and Responsibilities."

(2) **DEFINITIONS.**--As used in this section and s. 381.0261, the term:

- a) "Department" means the Department of Health.
- b) "Health care facility" means a facility licensed under chapter 395.
- c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.
- d) "Responsible provider" means a health care provider who is primarily responsible for patient care in a health care facility or provider's office.

(3) **PURPOSE.**--It is the purpose of this section to promote the interests and well-being of the patients of health care providers and health care facilities and to promote better communication between the patient and the health care provider. It is the intent of the Legislature that health care providers understand their responsibility to give their patients a general understanding of the procedures to be performed on them and to provide information pertaining to their health care so that they may make decisions in an informed manner after considering the information relating to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments. It is the intent of the Legislature that patients have a general understanding of their responsibilities toward health care providers and health care facilities. It is the intent of the Legislature that the provision of such information to a patient eliminate potential misunderstandings between patients and health care providers. It is a public policy of the state that the interests of patients be recognized in a patient's bill of rights and responsibilities and that a health care facility or health care provider may not require a patient to waive his or her rights as a condition of treatment. This section shall not be used for any purpose in any civil or administrative action and neither expands nor limits any rights or remedies provided under any other law.

(4) **RIGHTS OF PATIENTS.**--Each health care facility or provider shall observe the following standards:

(a) *Individual dignity.*--

1. The individual dignity of a patient must be respected at all times and upon all occasions.
2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his or her care. The patient's rights to privacy must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider's office. However, this subparagraph does not preclude necessary and discreet discussion of a patient's case or examination by appropriate medical personnel.

3. A patient has the right to a prompt and reasonable response to a question or request. A health care facility shall respond in a reasonable manner to the request of a patient's health care provider for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent such services do not require the approval of the patient's health care provider or are not inconsistent with the patient's treatment.

4. A patient in a health care facility has the right to retain and use personal clothing or possessions as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons.

(b) Information.--

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

(c) Financial information and disclosure.--

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A health care provider or a health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. Such reasonable estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

4. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

(d) Access to health care.--

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.

(e) Experimental research.—

In addition to the provisions of s. 766.103, a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

(f) Patient's knowledge of rights and responsibilities.—

In receiving health care, patients have the right to know their rights and responsibilities.

(5) RESPONSIBILITIES OF PATIENTS.--Each patient of a health care provider or health care facility shall respect the health care provider's and health care facility's right to expect behavior on the part of patients which, considering the nature of their illness, is reasonable and responsible. Each patient shall observe the responsibilities described in the following summary.

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

History.--s. 1, ch. 91-127; s. 65, ch. 92-289; s. 656, ch. 95-148; s. 21, ch. 98-89; s. 178, ch. 98-166; s. 64, ch. 99-397; s. 7, ch. 2001-53; s. 2, ch. 2001-116.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name

Date of Birth

Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with **Florida** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Palm Beach Family Medicine, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Palm Beach Family Medicine, LLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Palm Beach Family Medicine, LLC.
3. I have the right to revoke this authorization at any time by writing to Palm Beach Family Medicine, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. **THIS AUTHORIZATION DOES NOT AUTHORIZE PALM BEACH FAMILY MEDICINE, LCC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.**

Signature of patient or representative authorized by law

Date

Relationship to Patient

Interpreter, if utilized

Witness Signature

HIPAA Privacy and Release of Information Authorization

Patient Name: _____
Patient DOB: _____

I, _____ hereby authorize Palm Beach Family Medicine, LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient Printed Name Date

Patient Signature

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:

Relationship: _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify): _____

Name of the Individual Giving this Authorization

Date of birth

Signature of the Individual Giving this Authorization

Date

Patient Consent of Receive text and/or phone messages

Do we have permission to leave the following information on your home answering machine or voice mail?

Medical information; i.e. Lab results _____ Yes _____ No

Do we have permission to text you the following information?

Medical information; i.e. Lab results _____ Yes _____ No

Do we have permission to leave the following information on your cell voice mail?

Medical information; i.e. Lab results _____ Yes _____ No

Patient Printed Name

Date

Patient Signature

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

- a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
- b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
- c. E-mail senders can easily type in the wrong email address.
- d. E-mail is easier to falsify handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
- f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
- g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into the computer system.
- i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

- a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
- b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
- c. The patient is responsible for protecting his/her password or other means of access to e-

E-mail Consent Form

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

- d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

- a. Limit or avoid using his/her employer's computer.
- b. Inform Provider of changes in his/her e-mail address.
- c. Confirm that he/she has received and read the e-mail from the Provider.
- d. Put the patient's name in the body of the e-mail.
- e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).
- f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____

Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____

Date _____

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's
Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of _____ at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

- _____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- _____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- _____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- _____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- _____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- _____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- _____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- _____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- _____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- _____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- _____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- _____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between _____ and staff and _____
(Healthcare provider's name) *(Patient's name)*

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative *(circle one)* fully understands what I have explained.

Healthcare Provider Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial

Palm Beach Family Medicine

Emily Harrison, MD

1447 Medical Park Blvd, Ste 405

Wellington, FL 33414

(P) 561-377-7131

(F) 866-219-0330

Transfer of Patient Medical Records

Dear Doctor: _____

Medical Center Name and Address: _____

Phone/Fax: _____

Re: (Patient Name): _____

Date of Birth: _____

Patient's Address: _____

The above patient is now a patient of Emily Harrison, MD and requires that **all** his/ her medical records are forwarded to the above address. If you are able to send the records electronically please do so. Thank you.

I understand the information in my health record may include information relating to sexually transmitted disease and other reportable disease, AIDS/HIV. It may also include psychiatric or mental health services, and treatment for alcohol and drug abuse. I have the right to revoke this authorization at any time by contacting Emily Harrison, MD in writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment. I understand I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand this authorization will expire one year from the date below.

Signature: _____ Date: _____