MAIN STREET MEDICAL CENTER

369 N. Main Street Crestview, FL, 32536 · Office (850) 398-6963 · Fax (850) 398-8277

PATIENT INFORMATION

Name _____ Date of Birth _____

Mailing Address _____

Social Security # _____ Home # _____

Email Address _____ Cell # _____

Work Place_____ Work # _____

Emergency contact _____ Emergency #_____

Relationship _____

Race _____ Hispanic? YES or NO Primary Language _____

Which phone number would you like to have reminder calls, lab results, test results, etc sent to? (Circle one)

HOME or CELL or NONE

Would you like to receive emails or texts from our office regarding reminder calls, lab results or test results?

EMAIL or TEXTS or BOTH

Do you have an advanced directive or living will? YES or NO

BILLING INFORMATION

Primary Insurance Name _____ Secondary Ins. _____

Responsible Party Name _____ Date of Birth _____

Relationship_____ Mailing Address (if different) _____

*** Please give all copies of insurance cards to check in desk.

CLINICAL INFORMATION

****Refills are only given at appointments or through our patient portal ONLY. No phone calls accepted. ****

Pharmacy _____ Mail Order Pharmacy? YES or NO

Mail Order Member ID _____

Preferred Lab: QUEST LABCORP HOSPITAL MED ARTS BLDG (four story bldg)

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CURRENT MEDICATIONS

Name	Dose/Strength	Quantity		How many times per day?

Do we have permission to call your pharmacy to verify dosage and quantities of your medication?

Yes or No

ALLERGIES

Please list all drug, food and seasonal allergies

☐ No Known Allergies.

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for health care benefits or may affect my healthcare.

Patient Signature _____ Date _____

Printed Name _____

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Patient Financial Responsibility & No Show/Late Arrival Policy

Patient Name: _____ Date of Birth: _____

Name of responsible party/Policy Holder: _____

Relationship to patient: _____ Date of Birth: _____

Contact Number: _____ SSN#: _____

Address Responsible Party: _____

If you have health insurance, a copy of your insurance will be kept on file. It is the patient's responsibility to notify our office of any changes to the policy. **All patient co-payments are due on the day of patient appointment. We can only estimate your co-payment, which will be $20 unless specified on your insurance card. We do note receive any guarantees, from the insurance company, of payment until after claims are reviewed.**

No Show/Late Arrival Policy: Effective August 1, 2008 - We understand that situations arise and you may not be able to make your appointment or that you are unexpectedly running late to your appointment. Courtesy calls of 24 hours in advance for cancellations and notice that you are unexpectedly running late, will help us eliminate increased wait times and costs. We strive hard to keep our patients costs and wait times low, but increased no shows and late arrivals will lead to overbooking of physician schedules.

Charges:

1st No Show: $25

2nd No Show: $50

3rd No Show: $75

4th No Show: Discharge from Practice

I have read and that I understand the above information to the best of my knowledge. I understand that providing incorrect information could result in non-coverage by my health insurance company. I agree to be responsible for the payment of all services rendered on my behalf or dependants. I understand that payment is due at the time of service and in case of default; patient may be dismissed by practice, and will be responsible for reasonable attorney's fees and all costs of collections. Payment options are available should assistance be required. There will be a $30 charge for all returned checks. I understand the No Show Policy and charges that are associated with not showing up for my appointment without a courtesy call of cancellation.

I, the patient, have been informed of my financial responsibilities and agree to comply with this policy.

_____ _____

Patient Name (printed) Date

_____

Signature of Responsible Party

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Privacy Consent

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this practice may use your personal health information for the purposes of treatment, payment, or health care operations only. The specific uses and disclosures that we intend to make are described in our privacy policy. You have the right to review our privacy policy prior to signing this consent form. You may request that certain restrictions on the uses and disclosures described in the privacy policy. If you request any restrictions, please list them in the appropriate section below:

Consent Section:

I, _____, hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the *Privacy Policy of Main Street Medical Center*, which is located in the lobby or available in paper format.

Restriction Request:

I hereby request the following restrictions to the use and disclosure of my health information:
Please describe in detail anyone who ***IS NOT*** allowed information.

_____

_____

_____

Please list below the individuals who will be allowed permission to discuss your health information:

NAME	RELATIONSHIP

_____ _____

Patient Printed Name Date

_____

Patient Signature

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Electronic Health Record Consent

Main Street Medical Center utilizes electronic health records (EHR's) or electronic medical record (EMR). This allows our healthcare providers to record patient information electronically instead of using paper records. The government has initiated EHR Programs which asks providers to use the capabilities of their EHRs to achieve benchmarks that can lead to improved patient care.electronic medical records keeping and transmission in accordance with CMS (Center for Medicare & Medicaid Services) meaningful use guidelines. As a service to you, and as required by the government, we offer a website and patient portal which grants YOU secured access to your medical record; which will include: visit summaries, appointment reminders, refill requests, etc.

With your permission, providers and staff members of Main Street Medical Center will be given access to all available electronic records documenting any medical care you receive at our clinic.
You are being asked to agree to this disclosure, exchange, and use of clinical information because your providers believe timely access of your medical records and exchanging those medical records electronically with other physicians will increase your quality of care. Clinical information that may be shared with other physicians include items such as lab test results, operative reports, office visit notes, x-ray reports, hospital discharge summaries, and other clinical information relating to you and the care you receive. **This confidential information may also include some or all of the following: diagnostic or treatment information relating to mental health or psychiatric conditions; information relating to referrals for, or the diagnosis or treatment of, drug or alcohol abuse; genetic testing information or results; information relating to being a victim of, or counseling about, domestic abuse, neglect, or violence; and/or HIV/AIDS test results or treatment.** The shared information will be used only for the purposes of facilitating your medical treatment, payment for that treatment, or certain limited health care operations uses permitted under HIPAA - the federal Privacy Rule.

Main Street Medical Center is committed to respecting and protecting the confidentiality of your clinical information and have policies and procedures in place to protect your health information. Access to your electronic medical records is tracked and this access may be audited to assure that it is appropriate. (For more on Main Street Medical's patient privacy policies go to **http://www.crestviewmsmc.com**.

By signing below you are indicating that you are aware of Main Street Medical Center's use of Electronic Medical Records (EMR) and patient portal and that you give consent for such disclosure, electronic exchange, and electronic use of your protected health information.

Patient E-mail Address: _____

_____ _____

Patient Printed Name Date

_____

Patient Signature