South Lake Medical Center

Shazia Nasir, MD ● Jessica Bean, ARNP ● Teresa Karcsmar, ARNP ● Lindsay Wood, APRN
1950 Hospital View Way
Clermont, FL 34711
P: 352.243.3443 F: 352.243.3044

DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	M.I.	GENDER □MALE □FEMALE	DATE OF BIRTH

PRIMARY ADDRESS	CITY	STATE	ZIP
ALTERNATIVE ADDRESS (IF APPLICABLE)	**CITY**	**STATE**	**ZIP**

MARITAL STATUS	WORK STATUS	SOCIAL SECURITY #:
□ SINGLE □ MARRIED □ DIVORCED □ OTHER	□ EMPLOYED □ RETIRED □ UNEMPLOYED □ STUDENT	

HOME PHONE #	CELL PHONE #	EMAIL ADDRESS

PLACE OF EMPLOYMENT	WORK PHONE	EXT	REFERRED BY

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NUMBER

RACE	ETHNICITY
□ DECLINE TO PROVIDE INFORMATION □ WHITE □ AFRICAN AMERICAN □ HISPANIC □ NATIVE HAWAIIAN/PACIFIC ISLANDER □ ASIAN □ AMERICAN INDIAN OR ALASKA NATIVE	□ DECLINE TO PROVIDE INFORMATION □ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO **PREFERRED LANGUAGE:**

PRIMARY INSURANCE (CARD WILL BE SCANNED)	SECONDARY INSURANCE (CARD WILL BE SCANNED)
NAME OF POLICY HOLDER	**NAME OF POLICY HOLDER**

DATE OF BIRTH	SOCIAL SECURITY #	DATE OF BIRTH	SOCIAL SECURITY #

RELATIONSHIP TO POLICY HOLDER	RELATIONSHIP TO POLICY HOLDER
□ SELF □ SPOUSE □ CHILD □ OTHER:_____	□ SELF □ SPOUSE □ CHILD □ OTHER:_____

AUTHORIZATION

I AUTHORIZE THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY INSURANCE CHANGES OR PLAN UPDATES AND TO SUBMIT TO THEM MY INSURANCE CARDS FOR COPYING. I UNDERSTAND IT IS ALSO MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY NAME CHANGES AND ADDRESS CHANGES OR UPDATES.

_____ _____
SIGNATURE OF __PATIENT__PERSONAL REPRESENTATIVE* DATE

_____ _____
PRINTED NAME *IF PERSONAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

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OFFICE AND FINANCIAL POLICIES

PLEASE READ AND INITIAL OUR OFFICE AND FINANCIAL POLICIES AND SIGN BELOW.

- IT IS OUR MISSION TO PROVIDE EXCEPTIONAL PATIENT CARE AND CREATE A SAFE ENVIRONMENT BUILT ON COMPASSION AND RESPECT. AS SUCH, WE EXPECT MUTUAL RESPECT FROM OUR PATIENTS IN ORDER TO BUILD LASTING AND TRUSTING DOCTOR-PATIENT RELATIONSHIP. SOUTH LAKE MEDICAL CENTER RESERVES THE RIGHT TO TERMINATE PATIENT CARE IN THE EVENT OF PATIENT MISCONDUCT INCLUDING BUT NOT LIMITED TO:
    - REPEATED FAILURE TO KEEP SCHEDULED APPOINTMENTS OR ADHERE TO AN AGREED-UPON TREATMENT PLAN
    - REPEATED FAILURE TO PAY BALANCES
    - RUDE, DISRUPTIVE OR ENDANGERING BEHAVIOR

    _____**INITIAL**

- ANY FORMS THAT NEED TO BE COMPLETED REQUIRING THE DOCTOR'S SIGNATURE(S) AND EXTENSIVE REVIEW OF THE MEDICAL RECORD WILL RESULT IN A $35.00 CHARGE (**EXAMPLES: FMLA PAPERWORK & DISABILITY FORMS**). _____**INITIAL**

- IF YOU NEED **PRINTED** COPIES OF YOUR MEDICAL RECORDS FOR YOUR **PERSONAL USE**, WE WILL NEED A TWO-WEEK NOTICE. THERE WILL BE A CHARGE OF $1.00 PER PAGE FOR THE FIRST 25 PAGES AND $0.25 PER PAGE THEREAFTER. THERE WILL BE NO CHARGE FOR MEDICAL RECORDS IF ANOTHER PHYSICIAN OR MEDICAL FACILITY IS REQUESTING THEM. _____**INITIAL**

- THERE WILL BE A $25.00 CHARGE FOR ALL RETURNED, INSUFFICIENT FUND CHECKS OR STOP PAYMENT CHECKS AND YOU WILL BE REQUIRED TO PAY CASH OR CREDIT CARD ON ALL FUTURE VISITS. _____**INITIAL**

- ALL PATIENTS REQUIRING NON-EMERGENCY APPOINTMENTS WILL BE GIVEN AN APPOINTMENT WITHIN 2 WEEKS OF THEIR REQUEST. EMERGENCY APPOINTMENTS WILL BE WORKED IN THE SAME DAY. _____**INITIAL**

- ALL SELF-PAY PATIENTS WILL BE EXPECTED TO PAY THE FULL PAYMENT ON THE DATE OF SERVICE. THE CURRENT SELF PAY PRICE IS $100 FOR A FOLLOW UP VISIT. _____**INITIAL**

- YOUR INSURANCE COMPANY REQUIRES US TO COLLECT CO-PAYMENTS AT THE TIME OF SERVICE. WAIVER OF CO-PAYMENTS MAY CONSTITUTE FRAUD UNDER STATE AND FEDERAL LAW. TO REMAIN COMPLIANT, WE COLLECT YOUR CO-PAYMENT AT EACH VISIT. _____**INITIAL**

- ALL PATIENTS WHO DO NOT CONTACT THE OFFICE TO CANCEL OR RESCHEDULE THEIR APPOINTMENT 24 HOURS PRIOR TO THEIR APPOINTMENT TIME WILL BE CHARGED A $50.00 FEE. _____**INITIAL**

- WE USE DIAGNOSIS CODES ON YOUR LAB REQUEST TO THE BEST OF OUR KNOWLEDGE AND ACCURACY, HOWEVER, OUR OFFICE ***WILL NOT*** BE RESPONSIBLE FOR ANY BILL THAT MAY BE INCURRED BY THE INSURANCE OR LAB COMPANY. _____**INITIAL**

- IF YOU HAVE NOT HAD A VISIT WITH ANY OF OUR PROVIDERS IN OVER 2 YEARS, YOUR ACCOUNT WILL BECOME INACTIVE. IF YOU REQUEST TO RE-ESTABLISH WITH OUR PRACTICE, YOU WILL BE CONSIDERED A NEW PATIENT AND THE CURRENT POLICY FOR NEW PATIENT ACCEPTANCE WILL APPLY. _____**INITIAL**

- WE ***DO NOT*** ALLOW THE RE-ESTABLISHMENT OF A PATIENT ONCE THEY HAVE TRANSFERRED CARE TO ANOTHER PRIMARY CARE PHYSICIAN FOR ANY REASON OTHER THAN CHANGE OF INSURANCE OR DUE TO RELOCATION. _____**INITIAL**

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE **OFFICE AND FINANCIAL POLICIES.** I RECOGNIZE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. BY SIGNING THIS FORM, I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED FEES.

_____ _____

PATIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE) DATE

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CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU READ AND UNDERSTAND THE FOLLOWING:

I AUTHORIZE SHAZIA NASIR, M.D. AND THEIR PROVIDERS TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA RXHUB PRESCRIPTION SERVICE. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE OTHER UNAFFILIATED MEDICAL PROVIDERS, INSURANCE COMPANIES, AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY MY PROVIDERS AND OFFICE STAFF, AND IT MAY INCLUDE PAST PRESCRIPTIONS FROM SEVERAL YEARS AGO. I UNDERSTAND THIS WILL ALLOW MY PROVIDERS TO BETTER COORDINATE MY CARE AND MEDICATION HISTORY TO MAXIMIZE THE EFFECTIVENESS AND SAFETY OF MY TREATMENT PLAN.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTAND AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

_____

SIGNATURE OF __PATIENT__AUTHORIZED REPRESENTATIVE* DATE

_____

PRINTED NAME *IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT

PREFERRED PHARMACY:

NAME: _____

LOCATION: _____

PHONE #: _____

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES

THE PATIENT HEREBY CONSENTS TO THE USE OR DISCLOSURE OF HIS/HER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("PROTECTED HEALTH INFORMATION") AND PATIENT MEDICAL RECORD INFORMATION BY **SHAZIA NASIR, M.D.** IN ORDER TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PATIENT SHOULD REVIEW THE PRACTICE'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF THE POTENTIAL USES AND DISCLOSURES OF SUCH INFORMATION, AND THE PATIENT HAS THE RIGHT TO REVIEW SUCH NOTICE PRIOR TO SIGNING THIS CONSENT FORM.

THE PRACTICE RESERVES FOR ITSELF THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. IF THE PRACTICE DOES CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES, PATIENT MAY OBTAIN A COPY OF THE REVISED NOTICE IN THE OFFICE OR BY SENDING A WRITTEN REQUEST TO **SOUTH LAKE MEDICAL CENTER, 1950 HOSPITAL VIEW WAY, CLERMONT, FL 34711.**

PATIENT RETAINS THE RIGHT TO REQUEST THAT THE PRACTICE FURTHER RESTRICT HOW HIS/HER PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PRACTICE IS NOT REQUIRED TO AGREE TO SUCH REQUESTED RESTRICTIONS; HOWEVER, IF THE PRACTICE DOES AGREE TO PATIENT'S REQUESTED RESTRICTION(S), SUCH RESTRICTIONS ARE THEN BINDING ON THE PRACTICE.

PATIENT ACKNOWLEDGES AND AGREES THAT THE PRACTICE MAY DISCLOSE PATIENT'S PROTECTED HEALTH INFORMATION AND PATIENT MEDICAL RECORD INFORMATION TO THE FOLLOWING INDIVIDUALS WHO ARE EITHER THE PATIENT'S FAMILY MEMBERS, LEGAL REPRESENTATIVES, GUARDIANS, HEALTH CARE SURROGATES, OR HAVE POWER OF ATTORNEY ON BEHALF OF THE PATIENT:

WITH THIS CONSENT, SHAZIA NASIR, M.D. MAY DISCUSS MY MEDICAL INFORMATION WITH:

NAME:_____ RELATIONSHIP:_____PHONE #:_____
NAME:_____ RELATIONSHIP:_____PHONE #:_____
NAME:_____ RELATIONSHIP:_____PHONE #:_____

THE PATIENT AGREES THAT THE PRACTICE MAY DISCLOSE THE FOLLOWING TYPES OF INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORDS (PLEASE **INITIAL** THE APPROPRIATE CATEGORIES LISTED BELOW):

_____ HIV/AIDS INFORMATION
_____ MENTAL HEALTH INFORMATION
_____ SUBSTANCE ABUSE INFORMATION
_____ SEXUALLY TRANSMITTED DISEASE INFORMATION

PATIENT AGREES AND CONSENTS TO THE PRACTICE RELEASING INFORMATION TO PATIENT IN THE FOLLOWING ALTERNATIVE MANNERS (PLEASE **INITIAL** THE APPROPRIATE SPACES BELOW):

_____ VIA E-MAIL TO THE PATIENT'S DESIGNATED E-MAIL ADDRESS WHICH IS: _____.

_____ VIA REGULAR MAIL WITH ANY ENVELOPES BEING MARKED PERSONAL AND CONFIDENTIAL AND ADDRESSED TO PATIENT.

_____ VIA TELEPHONE, IF PATIENT CONTACTS THE PRACTICE AND PROVIDES THE APPROPRIATE INFORMATION (INCLUDING THE PATIENT'S NAME, SOCIAL SECURITY NUMBER AND UNIQUE PERSONAL IDENTIFIER).

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

AT ALL TIMES, PATIENT RETAINS THE RIGHT TO REVOKE THIS CONSENT. SUCH REVOCATION MUST BE SUBMITTED TO THE PRACTICE IN WRITING. THE REVOCATION SHALL BE EFFECTIVE *EXCEPT* TO THE EXTENT THAT THE PRACTICE HAS ALREADY TAKEN ACTION IN RELIANCE ON THE CONSENT.

THE PRACTICE MAY REFUSE TO TREAT PATIENT IF HE/SHE (OR AN AUTHORIZED REPRESENTATIVE) DOES NOT SIGN THIS CONSENT FORM. IF PATIENT (OR AUTHORIZED REPRESENTATIVE) SIGNS THIS CONSENT AND THEN REVOKES IT, THE PRACTICE HAS THE RIGHT TO REFUSE TO PROVIDE FURTHER TREATMENT TO PATIENT AS OF THE TIME OF REVOCATION (EXCEPT TO THE EXTENT THAT THE PRACTICE IS REQUIRED BY LAW TO TREAT INDIVIDUALS).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE, *IF REQUESTED*, RECEIVED A PAPER COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____
SIGNATURE OF __PATIENT__AUTHORIZED REPRESENTATIVE* DATE

_____ _____
PRINTED NAME *IF AUTHORIZED REPRESENTATIVE, RELATIONSHIP TO PATIENT

*PLEASE EXPLAIN REPRESENTATIVE'S RELATIONSHIP TO PATIENT AND INCLUDE A DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT: _____

_____

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Text Message Consent

South Lake Medical Center would like to contact you via text messaging using your personal phone. Some limited personal information may be included however no medical or test results will be specified. Initial below if you wish to be contacted via text messaging or not.

_____ (Initial) Yes, I want South Lake Medical Center to use my cell phone listed below to send text messages.

_____ (Initial) **No, I do NOT** want South Lake Medical Center to use my cell phone to send text messages.

Cell/Text Message Number: (_____) _____-_____

Please contact our office immediately with any change in your phone number.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Office use only: ____ (Initials) Consent updated in patients chart.