CHECK THIS LIST PRIOR TO STARTING YOUR PAPERWORK

The following is a list of payment options we offer, and insurance carriers that we are in network with:

- Cash & all major credit cards accepted
- If you do not have insurance or are underinsured, this practice offers a Sliding Fee Discount Schedule for essential services based on family size and income. Check with our front desk for more information.
- Payment Plans through Care Credit & Reliant Acute Care if eligible.
- Medicare Part B (Medicare Advantage plans only if listed below)
- Straight Medicaid (additional managed care plans as listed below)
- WellCare Medicare Advantage
- Staywell Medicaid & Florida Healthy Kids
- Molina: Medicaid, Florida KidCare, Medicare (Medicare Advantage, Medicare Options & Molina Medicare Options Plus)
- Cigna (PPO, HMO, Open Access)
- Tricare (Humana Military)
- Evolutions Healthcare Prime, Select, Choice, and International Networks
- Liberty Healthshare
- MultiPlan Network, PHCS, PHCS Savility (If the MultiPlan Savings Program logo appears on your card, you will be eligible to receive discounts when seeing us out of network).
- Out of network patients welcome. Because out of network coverage typically has a large deductible, you will be expected to pay 50% of your charges at time of service. The remaining balance will be billed to you after being processed by your insurance company.

Reliant Acute Care, LLC Date: ____________________

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS			
CITY	STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	SEX ❑ Male ❑ Female		MARITAL STATUS ❑ Single ❑ Married ❑ Other ______	

INSURED/RESPONSIBLE PARTY INFORMATION — RELATION TO PATIENT: ❑ Spouse ❑ Parent ❑ Guardian ❑ Self

NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS (if different from patient)	
HOME PHONE	EMAIL	BIRTH DATE

OTHER INFORMATION

PRIMARY DOCTOR	PRIMARY DOCTOR PHONE #	
IN CASE OF EMERGENCY CONTACT – FIRST AND LAST NAME	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the practitioner and I am financially responsible for non-covered services. I also authorize the practitioner to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to (optional):

NAME(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:
❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Reliant Acute Care, LLC Date: ______________________

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	DOB:
REASON FOR VISIT:	
*** Preferred Pharmacy (Please be specific):	

Allergies

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast Dye ❑ Latex ❑ Morphine ❑ Penicillin
❑ Sulfa Drugs ❑ Wheat

OTHER:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ______________________________ ☐ Retired ☐ Disabled (reason ______________________)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations you have had in the past year.

Medical History: Do you have any of the following? Check all that apply.

❑ environmental allergies
❑ pancreatitis
❑ asthma
❑ COPD
❑ cancer
❑ heart attack
❑ arterial fibrillation
❑ stroke
❑ CAD coronary artery disease
❑ hypertension
❑ liver disease

❑ CHF congestive heart failure
❑ stomach ulcers
❑ Type 2 diabetes mellitus
❑ Type 1 Diabetes, insulin dependent
❑ kidney problems
❑ drug abuse
❑ alcohol abuse
❑ kidney stones
❑ A-fib
❑ hypothyroidism
❑ heart murmur

❑ osteo arthritis conditions
❑ bleeding problems: **(If so, what is the name of the problem):** ______________________
❑ auto immune disease. (**if so, what is the name of the disorder**): ______________________
❑ None of the problems listed

Other Conditions/additional information:

FEMALES ONLY (CIRCLE ONE): **ARE YOU PREGNANT?** YES/NO **ARE YOU BREAST FEEDING?** YES/NO

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Please ***initial and sign*** to select your current method of coverage, and to complete the acknowledgement and consent for Medical Treatment and Payment Policy.

___Self-Pay (FFS) Patient Visit

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by Reliant Acute Care, LLC. I understand that these costs must be paid prior to the provision of such services through its authorized representatives. I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Reliant Acute Care, LLC to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Reliant Acute Care, LLC is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Reliant Acute Care, LLC.

___Health Insured Patient Visit

I request that payment of authorized insurance benefits, including Medicaid or Medicare, be made on my behalf for any professional services or supplies provided to me by Reliant Acute Care, LLC. I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Reliant Acute Care, LLC to my insurance company or other entity upon request to secure payment of my benefits. I understand that I am financially responsible to Reliant Acute Care, LLC for any charges not covered by health care benefits. It is my responsibility to notify Reliant Acute Care, LLC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Reliant Acute Care, LLC and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

___CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to my Reliant Acute Care, LLC provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care. I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Reliant Acute Care, LLC.

___OFFICE POLICY ON PAYMENT

It is our policy to require all co-payments to be made at the time of service. All accounts over 60 days, after processed by the provided insurance, will be charged an interest rate of 2% a month or a $5.00 minimum. In the event any balance is not paid as agreed, the undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee. I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by Reliant Acute Care, LLC and does not expire unless written notice is provided by me.

Name of person signing below (print): ______________________________

Today's (Visit) Date: ______________________

Signature of Patient or Guardian: ______________________________

Relationship to Insured
☐Self ☐Spouse ☐Dependent ☐Other
Relationship to Patient
☐Self ☐Spouse ☐Guardian ☐Other

Reliant Acute Care

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact our privacy officer.

During your treatment at Reliant Acute Care, our employees may gather information about your medical history and current health. This *Notice of Privacy Practices* describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your privacy rights, and rights to access and control your protected health information.

We are required to abide by the terms of this notice of Privacy Practices. We may change the terms of our notice as required. The new notice will be effective for all protected health information that we maintain at that time. A revised copy will be available to you at the time of your next appointment or anytime upon request.

1. USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION

Reliant Acute Care may use your protected health information to carry out treatment, payment, and health care operations. This list is meant to be example, not exhaustive:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

Health Care Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your provider's practice.

Business Associates: We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. You have the right to be notified in the even you are affected following a breach of PHI.

We may use or disclose your protected health information in certain situations without your authorization or providing you the opportunity to agree or object:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. This includes Law Enforcement, court order, grand jury subpoena, FDA, Research, Public health, Health Oversight Legal proceedings or Workers Compensation.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described above. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization. Any uses and disclosures for marketing purposes, sale of PHI or fundraising communications will not be made without individual authorization. You have the right to opt-out by notifying the Privacy officer.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object: We may use and disclose your protected health information in the following instances. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.

2. YOUR RIGHTS

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your provider and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You may restrict disclosure of PHI to health plans if you have paid for services out of pocket in full.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. Please make this request in writing to our Privacy Officer.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in the Notice of Privacy Practices. It excludes disclosures we may have made to you as provided in the privacy rule and described in the Notice of Privacy Practices.

You have the right obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at 239-265-9760 for further information about privacy concerns, practices, requests regarding your information, or the complaint process.

This notice was published and becomes effective on 08/01/2017

Reliant Acute Care

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been informed that Reliant Acute Care maintains a privacy policy that states how they may disclose PHI about me for the following:

- We may disclose PHI to provide treatment.
- We may disclose PHI to obtain payment.
- We may disclose PHI for Healthcare operations.
- Any disclosure of PHI for purposes other than those listed within the complete notice will require my prior written authorization.

I have been given a copy of Reliant Acute Care's privacy practices to review and acknowledge by signing below.

<u>YES/NO</u> (circle one) *I give permission to leave detailed messages on my answering machine or voicemail.*

<u>YES/NO</u> (circle one) *I authorize Reliant Acute Care employees to speak with the following people regarding my medical care/treatment.*

1. ______________________________. Relationship to you:____________________.
2. ______________________________. Relationship to you:____________________.
3. ______________________________. Relationship to you:____________________.

____

Patient Signature   Date

PATIENTS REQUESTING A SLIDING FEE SCALE DISCOUNT MUST FILL OUT & SIGN THE FOLLOWING

FINANCIAL CLASSIFICATION WORKSHEET

We need to gather your household income and dependent information to determine if your family is eligible for discounted fees.

SOURCE	AMOUNT	WEEKLY	BI-WEEKLY	ANNUAL
Gross wages & salaries (self)		☐	☐	☐
Gross wages & salaries (spouse)		☐	☐	☐
Social Security (self/spouse/children)		☐	☐	☐
Alimony, Child Support		☐	☐	☐
Supplemental Social Security		☐	☐	☐
Unemployment Compensation		☐	☐	☐
Public Assistance/Food Stamps		☐	☐	☐
Pension, Retirement, Veteran's Benefits, Etc.		☐	☐	☐
Disability, Workers Compensation		☐	☐	☐
Other Income (Interest, Dividends, Rent, Etc.)		☐	☐	☐
Total Income:**		*Household includes guarantor, spouse, children or stepchildren 18 yrs. & under, and handicapped children		
TOTAL NUMBER IN HOUSEHOLD*:				

**Tax return and/or wage statement will be required upon second visit to confirm stated income. If not provided, you will be expected to pay the full fee at time of next service.

I hereby certify that the above income and family information is true and correct to the best of my knowledge. I understand that if I have knowingly given false information, I am liable for prosecution under State and/or Federal Law.

Name (Print): ______________________ Date: ____________

Signature:

I understand that if I do not supply proof of income at my next visit, I will not be eligible for discounted fees and will be required to pay the full fee at time of service.

Name (Print): ______________________ Date: ____________

Signature: