FLORIDA MOBILE PHYSICIANS, LLC

Welcome to Florida Mobile Physicians.

A Next Generation Physician Housecalls Practice.

We are appreciative that you have chosen our team to care for your medical needs.

Our team consists of qualified, caring healthcare professionals who consistently work together to bring you the highest quality of care with compassion, confidentiality and respect. We encourage you to ask our supportive staff any questions that will make your visit more enjoyable and comfortable. Our office hours are Monday – Friday, 9:00am – 4:00pm. However, one of our physicians is always available. If you need to contact us for an emergent need after the business office hours, the answering service will forward you to the physician on call at that time. Your call will be returned at the earliest opportunity. If you are experiencing an emergency, please call 911 immediately.

Next Generation Physician Housecalls

Florida Mobile Physicians brings primary care, preventative healthcare services and support to the homes of those patients that are homebound due to chronic conditions, therefore making it challenging for them to seek medical care outside of their home, in Manatee and Sarasota Counties. Our highly professional, approachable and competent medical team will offer you services such as medication management, psychological assessments, transitional care and medical care coordination, all with legal and medical compliance and financial stewardship. Should your home be with one of our assisted living facility partner communities, we provide you with confidence in your continuity of care. Should you be experiencing a transitional stay with a skilled nursing facility after surgery, our healthcare providers may be providing interim medical care for your chosen primary care physician until you are able to commute to their office again. Understanding that each patient deserves individualized medical care, upon your request we meet with caregivers, family members, community staff and any other healthcare professional involved in your care. Your care and comfort is always our team's top priority.

Florida Mobile Physicians, LLC
7313 International Place, Suite 80
Lakewood Ranch, FL 34240
Phone: (941)907-1190 | Fax: (941)907-0305
www.FloridaMobilePhysicians.com

What To Expect At Your Appointment

We strive to offer our patients medical care in a timely and efficient manner by appointment. Our medical visits will be one-on-one and will be confirmed within a two hour timeframe. On occasion, emergencies may cause delays. Whenever possible and with respect for your time, our staff will notify you of any delays. You can expect compassionate care with a healthcare professional during your appointment with a full review of your medications, disease processes and symptom management.

Communication With Our Team

All patients are encouraged to call with any questions about the care we provide. We try to minimize physician interruptions during office hours. Our staff has been trained to answer many questions. They will timely relay information to your physician if necessary, and your call will be returned at the earliest opportunity.

Prescriptions And Renewals

All prescriptions and authorizations for renewals should be requested during business office hours. Please allow the office staff 24-48 hours to process all medication requests. Also, please note that controlled drugs will not be refilled on Saturday or Sunday. Most prescriptions can be refilled by telephone as medically needed.

Hospital Admissions

Our practice is proud to be affiliated with Werther Marciales, MD, Waguih El Masry, MD, and Jorge Hernandez, MD in association with both Manatee Memorial Hospital and Blake Medical Center. For our patients in Sarasota County we are affiliated with Tracy Vasile, DO who is the covering physician at Sarasota Memorial Hospital and Doctors Hospital. These physicians extend excellent hospital care as an extension of the care you will receive from your Florida Mobile Physician healthcare provider. Should you have an experience that results in hospitalization, please call as soon as possible to notify our office staff.

Medicare And Managed Care

We participate with most insurance plans as primary and secondary providers. Our business office team will submit claims and verify benefits routinely. For complete coverage of your medical needs by our healthcare provider team, it is critical that you update our business office immediately of any changes to your insurance coverage, address, telephone number or employer.

For more information on how the billing process works or an estimate of your portion of services charged or for a copy of our billed fees, please contact our office at (941) 907-1190.

Medicaid Fraud Hotline: (866) 762-2237
Agency for Health Care Administration Complaint Line: 1 (888) 419-3456
Abuse/Negligence/Exploitation Hotline: 1 (800) 962-2873

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Last Name: _____ First Name: _____ Middle Initial_____
Sex: ☐ Male ☐ Female | Date of Birth: _____ | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address: _____ City:_____ State: ____ Zip:_____
Facility: _____ Room #: _____ Email Address: _____
Home Phone: _____ Mobile Phone: _____ Social Security# _____

Is the above patient homebound? ☐ Yes ☐ No | Homebound Reason: _____
Pharmacy Name: _____ Phone: _____
Referral Source: _____ Phone: _____
Previous Primary Care Physician: _____ Phone: _____
Preferred Home Health Agency: _____ Preferred Hospital: _____

Primary Insurance Name: _____ Member ID# _____
Secondary Insurance Name: _____ Member ID# _____

Nearest Relative or POA we may contact in case of an Emergency (Outside your Home)

Name: _____ Relationship:_____
Address: _____ City: _____ State: _____ Zip: _____
Telephone #: _____ Email Address: _____@_____

Assignment of Benefits Authorization for Treatment:
I hereby authorize treatment and authorize direct payment of medical benefits to Florida Mobile Physicians, LLC for services rendered by Sherri Jonas-Lazin, M.D., Dipti Patil, M.D., Bridget Ratner, ARNP, or Ronald T. Droz, Psy.D., in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

PRINT PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

PLEASE ATTACH A COPY OF IDENTIFICATION AND INSURANCE CARDS FOR BOTH PRIMARY AND SECONDARY INSURANCES. IF APPLICABLE PLEASE ATTACH A COPY OF POWER OF ATTORNEY DOCUMENTS OR GUARDIANSHIP DOCUMENTS.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____

(PRINT NAME)

_____ **Date**_____

(SIGNATURE)

Florida Mobile Physicians, LLC

Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), Protected Health Information, under a federal health privacy law, as described below.

I, _____, authorize Florida Mobile Physicians, LLC to release and obtain my private health information to/from (check all that applies):

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on PHI to be disclosed: ☐ Yes ☐ No | If yes: _____

☐ No one other than myself may have access to my medical records

May our office leave a message on your machine: ☐ Yes ☐ No

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient of Florida Mobile Physicians, LLC I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at 42627 Garfield, Suite 218, Clinton Twp, MI 48038. I understand that my revocation will not affect any actions taken Florida Mobile Physicians, LLC prior to receiving my revocation. 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 understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed, or until revoked in writing. At which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative and Relationship Date

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone Number: _____

I authorize the following physician/facility to disclose information from my health record:

FOR FLORIDA MOBILE PHYSICIANS, LLC USE ONLY:	Physician Name Address City State Zip		Facility Phone Number Fax Number
DATE OF SERVICE REQUESTED:	From: _____ To: _____		
INFORMATION REQUESTED:	☐ History & Physical ☐ Office Visit Note(s) ☐ Laboratory Results ☐ Radiology Report(s)	☐ Discharge Summary ☐ ER Note ☐ Consultation Note(s) ☐ Medication List	☐ Billing Record ☐ Other:
INFORMATION TO BE SENT TO:	Florida Mobile Physicians, LLC 7313 International Place Suite 80 Lakewood Ranch, FL 34240	Phone Number: (941)907-1190 **Fax Number: (941)907-0305**	

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drugs abuse; my signature authorizes release of any such information.
I may refuse to sign this authorization form. I understand that the practice will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.
I understand that, if this information disclosed to a third party, information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release the practice, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Patient Signature or Authorized Representative and Relationship Date

For Florida Mobile Physicians, LLC Use Only:

Date Sent: _____ Date Received: _____ Processor Initials: _____

Payment Policy

Insurance: We participate in several insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Upon request a schedule of our fees will be provided. We will make every effort to verify your coverage prior to your first appointment, however, the more information we can get from you, the less likely you are to receive a bill from us in error.

Co-payments and deductibles: All co-payments and deductibles must be paid no later than 30 days after a statement was received. To make sure all bills are sent to the correct address and the person responsible for the account, please make sure to let us know of any changes.

This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by informing us in a timely manner of changes in financial responsibility.

Non-covered services: Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. If this happens, we will make every effort to communicate this to you prior to services being rendered. However, services that are not covered by your insurance are responsibility of the patient.

Services by other Providers: We rely on a network of other providers to provide complete patient care, this may include labs, radiology facilities and other specialists. In cases where we either do not participate with your insurance or accept Self Pay status for a patient, referrals to other providers are not covered, either. If a referral or order is deemed necessary, we will make every effort to communicate this to you ahead of time so you may contact your insurance to find out what possible covered alternatives exist. However, we are not responsible for balances resulting from referrals to other providers.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments: Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

"Why Every Practice Needs a Payment Policy." Ciletti MV. *Family Practice Management*. April 2004:17-20, http://www.aafp.org/fpm/20040400/17whye.html.

Patient History

Patient Name: _____ **Date:** _____

Please mark if you have ever had the following?

☐Hypertension	☐Chest Pain	☐Heart Attack	☐Irregular Heartbeat
☐Pacemaker	☐Cardiac Defibrillator	☐Asthma	☐COPD/Emphysema
☐Sleep Apnea	☐Kidney Disease	☐Hepatitis	☐Diabetes
☐Anemia	☐Gout	☐Thyroid Disease	☐Phlebitis
☐Stroke	☐Cancer	☐High Cholesterol	

Please mark if you are experiencing the following:

☐Chills	☐Fever	☐Shortness of Breath	☐Chest Pain
☐Numbness	☐Extremity Weakness	☐Resting Pain	☐Pain when walking
☐Temporary Blindness	☐Slurred speech		

Florida Mobile Physicians, LLC in order to comply with "meaningful use", we are asking our patients to fill out the following questionnaire.

Race: ☐American Indian ☐African American ☐Alaskan Native ☐Native Hawaiian/Pacific Islander ☐Asian ☐White ☐Decline to report/Unreported

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Decline to report/Unreported

Nationality: _____ ☐Decline to report/Unreported

Primary Language: _____ ☐Decline to report/Unreported

Social History:

Alcohol: ☐Current ☐Past How Much? _____

Illegal Drug Use: ☐Current ☐Past How Much? _____

Tobacco: ☐Every Day ☐Some Days ☐Former ☐Never

☐Other: _____

Past Surgeries:

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Allergies: _____

Current Medications:

Name: _____ Strength: _____ Frequency: _____

Name: _____ Strength: _____ Frequency: _____

Name: _____ Strength: _____ Frequency: _____

Name: _____ Strength: _____ Frequency: _____

Name: _____ Strength: _____ Frequency: _____

Name: _____ Strength: _____ Frequency: _____

Current Physicians:

Name: _____ Specialty: _____ Number: _____

Name: _____ Specialty: _____ Number: _____

Name: _____ Specialty: _____ Number: _____