FLORIDA STATE UNIVERSITY
College of Medicine

Phone: 850.644.1543, opt 1
Fax: 855.230.7402
Website:
www.FsuSeniorHealth.org

WELCOME!

Thank you for the opportunity for us to provide your healthcare with *FSU SeniorHealth*.

Attached is your registration packet; please complete this packet in its entirety. We ask that you call 850.644.1543, option 1 to schedule your appointment. Please note, you will be scheduled with the first available physician.

Please send your completed packet to us by fax to: 855-230-7402. You can also mail or hand deliver your packet. Please see below for more information.

- If scheduled with: **Dr. Paul Katz** or **Dr. Lisa Granville**
  - 4449 Meandering Way, Tallahassee, FL 32308 *(Lower Lobby of the Parry Center Building)*
- If scheduled with: **Dr. John Agens** or **Dr. Casey Rust**
  - 2911 Roberts Avenue, Tallahassee, FL 32310 *(location of FSU PrimaryHealth™ Clinic)*

In addition to this registration packet, we ask that you provide the following at your appointment:

- **All medications and supplements**
- **Name of your preferred pharmacy**
- **Insurance card(s)**
- **A photo ID**

*So that our physicians can get to know you more quickly; we will ask to take a photo of you. *This is a onetime request that will be directly uploaded to your patient medical record.*

If you have any questions please call your personal new patient scheduler at 850.644.1543, option 1.

We look forward to seeing you at your first visit! And don't forget to tell your friends and family about us!

Sincerely,

FSU SeniorHealth™ Team

FSU SeniorHealth is focused on helping patients live an active and healthy lifestyle.

New Patient Questionnaire

(please complete all pages)

Full legal name:_____ Todays' date: _____

Name you wish to be called *(if different)*:_____

Date of birth:_____ Social Security #: _____

Gender: ◯ Male ◯ Female ◯ Other_____

Primary Insurance / Member ID: _____

Secondary Insurance / Member ID: _____

Billing Address: _____

Street Address *Apt. Number*

City/State:_____ Zip code: _____

Mailing Address: _____

Street Address *Apt. Number*

City/State:_____ Zip code: _____

Preferred pharmacy:_____ Location:_____

Preferred laboratory:_____ Location:_____

Home phone #:_____ Cell phone #: _____

Work phone # *(if applicable)*:_____ Email address: _____

Contact preference *(check all that apply)*: ◯ home phone ◯ cell phone ◯ work phone ◯ email ◯ mail Race: _____

_____ Ethnicity:_____ Language preference:_____

Who is completing this form? _____

*Relationship, if other than patient:_____ Phone #: _____

Name of previous primary doctor: _____

Address:_____

City/State:_____ Zip code: _____

Phone #:_____ Fax #: _____

A. PAST MEDICAL HISTORY

Which medical conditions do you have or have you had in the past? *(check all that apply)*

EYE & EAR PROBLEMS	HEART / VASCULAR PROBLEMS	LUNG PROBLEMS
◯ cataracts	◯ high blood pressure	◯ asthma
◯ glaucoma	◯ irregular heartbeats (arrhythmias)	◯ bronchitis
◯ macular degeneration	◯ heart failure	◯ emphysema
◯ hearing loss/hearing aid	◯ heart attack: year _____	◯ sleep apnea
◯ other, specify:	◯ hyperlipidemia	◯ other, specify:
	◯ other, specify:	

BONE/JOINT PROBLEMS	GLAND PROBLEMS	KIDNEY & URINARY TRACT PROBLEMS
◯ arthritis	◯ diabetes	◯ kidney disease
◯ osteoporosis	◯ overactive thyroid - high	◯ prostate disease
◯ fracture of hip, wrist or spine *(circle)*	◯ underactive thyroid - low	◯ bladder/kidney infections
◯ gout	◯ other, specify:	◯ urinary incontinence
◯ other, specify:		◯ other, specify:

GASTROENTESTINAL PROBLEMS	NERVOUS SYSTEM PROBLEMS	OTHER HEALTH PROBLEMS *(circle all that apply)*
◯ ulcers	◯ stroke	◯ allergies, specify:
◯ reflux / hiatal hernia	◯ dementia or Alzheimer's disease	◯ anemia
◯ diverticulosis	◯ Parkinson's disease	◯ hernia
◯ liver disease/cirrhosis	◯ epilepsy or seizures	◯ thrombosis (blood clots)
◯ hepatitis	◯ tremor	◯ depression
◯ polyps	◯ neuropathy	◯ sexual dysfunction
◯ gallbladder disease	◯ other, specify:	◯ cancer, specify:
◯ irritable bowel		
◯ other, specify:		
		◯ other, specify:

Surgeries – inpatient and outpatient *(use additional pages, if needed)*

DATE	SURGERY

Other Hospitalizations *(use additional pages, if needed)*

DATE	REASON FOR HOSPITALIZATION

Do you have any drug or other allergies? ◯ yes *(specify below)* ◯ no

NAME OF DRUG	REACTION

List all medicines that you currently use *(Prescriptions, Non-Prescriptions, Natural Products)*

Medications used regularly	**What dose OR strength?**	**How do you use it? (*How much OR how many tablets? How many times a day?*)**
Example: Tylenol	*500 mg*	*1 pill 3 times a day*

B. SOCIAL HISTORY

With whom do you live? *(check one)*	**Which of the following best describes your residence?** *(check one)*
◯ alone	◯ single-family house
◯ spouse or partner	◯ condo or apartment
◯ child or other family member	◯ live with other in their house, condo or apartment
◯ friend	◯ other, specify:
◯ other, specify:	**Are there stairs in your home?** ◯ yes ◯ no

Are you currently…*(check one)*	**How many children do you have?** _____
◯ married	**Are you in regular contact with your children?**
◯ divorced/separated *(circle one)*	◯ yes ◯ no
◯ widowed	
◯ single *(never married)*	
◯ living with significant other	**Are you in regular contact with relatives?**
◯ other, specify:	◯ yes ◯ no

How much school did you complete? *(check one)*	**What has been your principal occupation?**
◯ less than 6th grade	_____
◯ less than high school	**Are you currently…***(check one)*
◯ high school graduate	◯ retired, not working
◯ some college	◯ working part-time
◯ college - undergraduate	◯ working full-time
◯ college – graduate/doctorate	◯ unemployed *(but not retired)*

Do you employ someone to provide care or help in your home? ◯ yes ◯ no	**Do you get help from a family member or friend in your home?** ◯ yes ◯ no
If yes, how many hours a day and how many days a week is the person available for you? _____hours/day_____days/week	**If yes, how many hours a day and how many days a week is the person available for you?** _____hours/day_____days/week
Is this sufficient to meet your needs? ◯ yes ◯ no	**Is this sufficient to meet your needs?** ◯ yes ◯ no

Who would you call if you were sick and needed help? _	**Do you provide care for a family member?** ◯ yes ◯ no

How often do you drink alcohol? *(including beer, wine, other)*	**If you drink alcohol, has anyone ever been concerned about your drinking?** ◯ yes ◯ no
◯ never	
◯ less than 1 time a week	
◯ 1 to 3 times a week	
◯ almost daily *(4-6 times a week)*	
◯ daily	

Have you <u>ever</u> used tobacco? ◯ yes ◯ no	
If yes, do you currently use tobacco? ◯ yes ◯ no	**If you quit using tobacco…**
How many years have you used tobacco? _____	How many years ago did you quit? _____
How much tobacco do you use daily? _____	For how many years did you use tobacco? _____

Have you <u>ever</u> used other drugs? ◯ yes ◯ no	
If yes, do you currently use other drugs? ◯ yes ◯ no	**If you quit using other drugs…**
How many years have you used other drugs? _____	How many years ago did you quit? _____
What other drugs are you using? _____ _____	What other drugs have you used? _____ _____

C. DAILY FUNCTIONING

Do you require help with the following? If yes, who helps you?

TASK	NEED HELP	WHO HELPS YOU? *(name and relationship)*
feeding yourself	◯ yes ◯ no	
getting from bed to chair	◯ yes ◯ no	
getting to the toilet	◯ yes ◯ no	
getting dressed	◯ yes ◯ no	
bathing	◯ yes ◯ no	
walking safely	◯ yes ◯ no	
using the telephone	◯ yes ◯ no	
taking medicines	◯ yes ◯ no	
preparing meals	◯ yes ◯ no	
managing money/financial affairs (checkbook)	◯ yes ◯ no	
doing laundry	◯ yes ◯ no	
doing house work	◯ yes ◯ no	
shopping for groceries	◯ yes ◯ no	
driving	◯ yes ◯ no	
doing 'handyman' work	◯ yes ◯ no	
climbing stairs	◯ yes ◯ no	
getting to places beyond walking distance	◯ yes ◯ no	

D. FAMILY MEDICAL HISTORY

Have any members of your family had any of the following conditions?						
	Father	Mother	Brother/Sister *(indicate which)*	Brother/Sister *(indicate which)*	Brother/Sister *(indicate which)*	Brother/Sister *(indicate which)*
dementia or Alzheimer's						
cancer, specify:						
heart disease or stroke						
diabetes						
depression						
other, specify:						

E. REVIEW OF SYSTEMS

During the last three months, have you had any of the following symptoms or problems? *(check all that apply)*

GENERAL	**MUSCULOSKELETAL PROBLEMS**
◯ weight loss	◯ back or neck pain
◯ weight gain	◯ arm or leg pain
◯ fevers	◯ joint pain or stiffness
◯ chills	◯ foot problems
◯ fatigue	**SKIN AND BREAST PROBLEMS**
EYES	◯ rash
◯ trouble seeing	◯ sores
◯ eye pain	◯ dry skin
◯ dry eyes	◯ breast tenderness
EAR, NOSE, MOUTH, THROAT	◯ breast lump or discharge
◯ trouble hearing	**BRAIN AND NERVOUS SYSTEM PROBLEMS**
◯ ear pain or itching	◯ frequent headaches
◯ sinus problems / runny nose	◯ frequent dizzy spells
◯ nose bleeds	◯ passing out or fainting
◯ sore throat	◯ falls
◯ hoarseness	◯ leg or arm weakness
◯ teeth problems	◯ numbness or loss of feeling
◯ mouth sores	◯ tremor or shaking
HEART PROBLEMS	**MENTAL HEALTH**
◯ chest pain or tightness	◯ depression
◯ rapid or irregular heart beat	◯ anxiety
◯ swelling of feet	◯ problems with sleep
LUNG PROBLEMS	◯ problems with memory or difficulty thinking
◯ persistent cough	**ALLERGIC / IMMUNOLOGIC**
◯ coughing up blood	◯ hives
◯ difficulty breathing or shortness of breath	◯ seasonal allergies
◯ wheezing	◯ frequent infections
GASTROINTESTINAL PROBLEMS	**BLOOD / LYMPH**
◯ difficulty swallowing	◯ easy bruising
◯ frequent indigestion or stomach ache, heartburn	◯ bleeding
◯ frequent nausea or vomiting	◯ blood clots
◯ change in bowel habits	◯ swollen lymph nodes

◯ black bowel movement or bleeding from rectum	**ENDOCRINE**
◯ diarrhea	◯ excessive thirst
◯ constipation	◯ feel too hot or too cold
GENITOURINARY PROBLEMS	◯ problems with sexual function
◯ urination at night (how many times_____)	◯ Men: problems with erection
◯ frequent urination	◯ Men: problems with prostate
◯ painful urination	◯ Women: vaginal dryness
◯ loss of urine or getting wet	◯ Women: vaginal discharge or bleeding

F. FALLS AND MOBILITY

Do you use a walking or mobility aid? ◯ yes ◯ no

If YES, check all that apply**:** ◯ cane ◯ walker / rollator ◯ wheelchair ◯ other, specify _____

Are you afraid of falling? ◯ yes ◯ no

Have you had a fall in the past year? ◯ yes *(Please continue to next question)*
◯ no *(STOP – proceed to section G below)*

Please tell us about your last two falls

If you have had less than two falls, just tell us about the one you have had. To describe the circumstances of each fall, please tell us: *what you were doing when you fell, what you think caused the fall, whether you experienced light-headedness or palpitations, how you landed (front/back/side), if there was loss of consciousness, what treatment (if any) you received for the fall, and anything else you think is important.*

Most Recent Fall

Date *(as best you can recall)*: Month:_____Year: _____

How did this fall happen *(briefly describe circumstances)*:

_____

_____

Did you need to see a doctor or other professional for treatment after this fall? ◯ yes ◯ no
If YES, describe the treatment you received:

_____

_____

Prior Fall ____Check here if not applicable *(if you have had only one fall)*

Date *(as best you can recall)*: Month:_____Year: _____

How did this fall happen *(briefly describe circumstances)*:

_____

_____

Did you need to see a doctor or other professional for treatment after this fall? ◯ yes ◯ no
If YES, describe the treatment you received:

_____

_____

G. DRIVING

Do you currently drive? ◯ yes ◯ no

If you do not drive, how do you get around town? *(Check all that apply)*

◯ Family/Friend drives ◯ Cab ◯ Dial-a-Ride ◯ Public Bus

Do you (or your friends / family) have concerns about your driving? ◯ yes ◯ no

Have you had (in the past year) any: ◯ Accidents / Crashes ◯ Tickets ◯ Near Misses

Have you ever gotten lost driving? ◯ yes ◯ no

H. HEALTH MAINTENANCE

Have you ever had the Pneumovax vaccine (a shot to prevent pneumonia)?

◯ yes ◯ no If YES, in what year? _____

Have you ever had the Prevnar 13 vaccine (a shot to prevent pneumonia)?

◯ yes ◯ no If YES, in what year? _____

Have you ever had a Shingles vaccine? Zostavax ◯ yes ◯ no If YES, in what year? _

Shingrix (2 shots) ◯ yes ◯ no If YES, in what year? _

Have you ever had a tetanus shot? ◯ yes ◯ no

If YES, in what year did you have your last tetanus booster? _____

Did you get a flu shot during the most recent season (October-February)? ◯ yes ◯ no

Do you always wear a seatbelt when you drive or ride in a car? ◯ yes ◯ no

Do you currently participate in any regular activity to improve or maintain your physical fitness?

(either on your own or in a formal class) ◯ yes ◯ no

If YES, check all current activities

_____walking _____swimming

_____aerobics or exercise classes _____dancing

_____bicycling or stationary bike _____jogging

_____tennis or pickle ball _____golf or croquet

_____bowling or bocce _____other, specify: _____

How many minutes a week do you exercise? _____

Have you had a hearing test within the last two years? ◯ yes ◯ no

Have you had an eye exam within the past year? ◯ yes ◯ no

Have you seen a dentist in the last year? ◯ yes ◯ no

Have you ever had an examination of your bowel with a scope? ◯ yes ◯ no

(*Circle which one:* sigmoidoscopy or colonoscopy)?

If YES, in what year did you have your most recent sigmoidoscopy or colonoscopy? _____

In the past 12 months, have you had a test for blood in your stool? ◯ yes ◯ no

Men proceed to section I. Women proceed to section J.

I. QUESTIONS FOR MEN ONLY *(After completing this section, proceed to section K)*

Have you ever had a prostate exam (rectal exam)? ◯ yes ◯ no

If YES, in what year did you have your last prostate exam? _____

Have you ever had a blood test to look for cancer of the prostate (PSA)? ◯ yes ◯ no

If YES, in what year did you have your last PSA? _____

J. QUESTIONS FOR WOMEN ONLY

Do you perform breast self-exams (BSE) once a month? ◯ yes ◯ no

Have you ever had a mammogram? ◯ yes ◯ no

If YES, have you had a mammogram within the last year? ◯ yes ◯ no

If YES, when was your last mammogram? month/year_____/_____

Have you had a hysterectomy (surgical removal of the uterus)? ◯ yes ◯ no

If NO, have you ever had a Pap smear/pelvic examination? ◯ yes ◯ no

If YES, when was your last Pap smear? month/year _____/_____

***K.* PLANNING for FUTURE HEALTHCARE** *(please bring a copy of each document marked 'YES' below)*

Do you have a medical Durable Power of Attorney or Health Care Surrogate? Surrogate's name/relationship _____	◯ yes ◯ no
Do you have a Living Will?	◯ yes ◯ no
Do you have a 'Do Not Resuscitate Order Form' at your home or residence?	◯ yes ◯ no

Do you have any other health concerns that you would like your doctor to know about?

_____

_____

_____

***For purposes of this Consent and Authorization, Florida Medical Practice Plan, LLC (FMPP) describes a collaboration of the Florida StateBoard of Trustees for the benefit of the Florida State University College of Medicine, FSU SeniorHealth™ , FSU PrimaryHealth™ ,** FSU TeleHealth and FSU Health Neuromodulation™ **and Florida Medical Practice Plan, LLC**
Collectively, these entities are referred to as FMPP in this form.

Consent and Authorization for Routine Treatment – I consent to and authorize FMPP, my physicians and health care providers (collectively "my providers") to provide or order the routine medical care, diagnostic and laboratory procedures, which my providers believe to be necessary. I understand FMPP is affiliated with a teaching institution, and that residents, interns, students, and other individuals may observeor participate in my care,treatment,and services ("Care"). I consent to FMPP taking photographs and/or video/audio recordings of me in the course of and related to my Care, and to their use of suchphotographs or videos and my medical data for educational purposes within FMPP. I authorize FMPP to retain, preserve, use for educational purposes, or to otherwise dispose of, any specimens, tissues, medical devices, or implants removed from my body during my Care. **Telemedicine:** I understand and agree that my providers may utilize telemedicine (the electroniccommunication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, andremote monitoring of vital signs as part of my Care. Except in emergency circumstances, my providers will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek Care elsewhere in lieu of atelemedicine encounter.

Valuables Release – I understand and acknowledge that FMPP has no responsibility for the loss of any valuables or personal belongings ("property") unless those items are deposited with FMPP Security, and I release FMPP from all liability for loss of any property which I do not deposit with FMPP Security. All items deposited with FMPP Security that remain unclaimed for ninety (90) days will be considered abandoned and may be disposed of by FMPP.

Safety and Security – In order to protect the health and safety of patients, visitors and staff, I understand FMPP does not permit contraband on its premises (including guns, knives, other weapons, illicit drugs, or alcohol). I consent to a search of my person and belongings to identify and remove contraband should FMPP reasonably suspect the presence or use ofcontraband on its premises. If my providers reasonably suspect the use of contraband substances, I consent to an alcohol and/ordrug test as necessary to provide me appropriate patient Care. I understand and acknowledge that FMPP has zero tolerance for harassing, aggressive or violent behavior by its visitors, staff, and patients. I agree that neither I nor my visitors willphotograph, film, or record any provider without that provider's express consent.

Disclosure of Patient Information – I authorize FMPP and my providers to release my health information (including information relating to mental health/psychiatric care, alcohol and/or substance abuse, genetic testing, and HIV tests) and any other information for treatment purposes and/or to obtain payment for charges incurred by me or on my behalf to: my providersor any affiliated provider; my referring or treating providers; any third party engaged in the collection or dissemination of my medication information; the guarantor on my accounts; any third party payors (defined as including, but not limited to, Medicare, Medicaid, Tri-care or governmental programs; health, accident, automobile or other insurance; workers' compensation payors, agents or administrators; HMOs; self-insured employers; and any sponsors who may contribute payment for medical services) or their agents; regional or national health information networks; and other providers of medical services and products related to or connected with this admission or course of Care.

I authorize FMPP to disclose my patient information to: business associates, public health and oversight agencies, regulatory entities, other health care providers or organizations who have provided me with Care to facilitate health care operations of any of these parties; residents, interns, students, and others in furtherance of educational purposes; disaster relief agencies as necessary to assist in their endeavors; law enforcement to correctly identify me or to report a crime; affiliated charitable foundations in connection with fundraising programs; and FMPP to send health promoting or informational materials to me. If my admission or treatment is due to a motor vehicle accident, I authorize FMPP or my providers to obtain a copy of my "crash report" required by Florida Statutes, in order to facilitate third party payment.

I understand that my patient information is protected by the right to privacy guaranteed by Article 1, Section 23 of the Florida Constitution. I do not authorize the release of my patient information, including the release of information with my name or identifying information redacted, if requested by other patients or their representatives.

Medicare Request for Payment/Assignment of Benefits – I request payment of authorized Medicare benefits due to me or on my behalf for any services furnished to me by FMPP and my providers. I hereby assign to FMPP and my providers payment from Medicare, Medicaid and all third party payors with whom I have coverage or from whom benefits areor may become payable to me, for the charges I receive for, related to, or connected with Care (past, present, or future) I receive from FMPP and my providers. I agree to be personally responsible for payment for all Care that is not covered by my third party payors, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/orco-payments.

Guarantor Agreement – I agree to the following: 1) I am responsible for FMPP's and providers' charges for this Care and past and future Care if related to the same accident or illness; 2) the charges are due and payable at the time ofdischarge or discontinuation of Care; 3) I agree to pay the charges in effect at the time Care is provided; 4) unless otherwise precluded by contract or law, if FMPP or providers bill third party payors, they do so as a courtesy,and FMPP and providers may demand payment in full of any balance due at any time; 5) if I have not paid a final bill within one hundred and twenty days (120) days, I may be declared in default, and the overdue account may be referred toa collection agency. I consent to FMPP or any third party contacting me by telephone, including my cellular phone, for purposes of collecting any amounts owed by me.

Lien on Third Party Liability Proceeds – If my Care is due to an accident or injury, FMPP shall have a lien uponthe proceeds of any cause of action, suit, or settlement I receive related to such accident or injury, in order to recover payment for all charges

(continued on next page)

Patient Name:

Date:

(continued)

for Care I receive related to such accident or injury (past, present, or future), effective as of the date Care was first provided.

Florida State University and Other Independent Providers – I acknowledge that I will receive Care from Independent Providers (including, but not limited to, radiologists, anesthesiologists, pathologists, emergency physicians, surgeons, obstetricians, and perfusionists) who are NOT employees or agents of EITHER the Florida State University Board of Trustees OR any of the following Florida Medical Practice Plan Inc, FSU PrimaryHealth™, FSU SeniorHealth™, FSU College of Medicine (collectively referred to as the "FMPP Entities"): I further acknowledge that I will receive care from health Care providers who areemployees and/or agents of the Florida State University Board of Trustees ("FSU Providers). To the extent that the law imposes any duty upon any FMPP to provide certain services, I HEREBY: consent to the delegation of that duty to FSU Providers and/or Independent Providers participating in my Care; discharge FMPP from any duties the Health Center may have with regard such services; and give up my right to hold a FMPP Center liable for any injury suffered as a result of a negligent act or omission based on any FSU Provider or Independent Provider.

Risk Management and Dispute Resolution – I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my Care) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of FMPP, for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both entities.

Agreement to Mediate – In accepting Care at a FMPP facility, I agree that before I file any lawsuit against FMPP or any of its facilities, employees or agents arising out of the Care provided to me by providers, I will first attempt to resolve myclaim through confidential mediation. Mediation is a process through which a neutral third person who has been certified to be a mediator tries to help settle claims. FMPP will pay the cost of the mediator. I further agree that any mediation must takeplace in the State of Florida and in the county where my Care was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right tofile a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

By signature below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me and/or my minor child(ren), if provided Care by or on behalf of FMPP, or if born during this admission or Care by FMPP. Asigned copy shall be as valid as the original.

PATIENT/GUARDIAN	DATE	INSURED (If other than the above for assignment of benefits, e.g., step-parent)	DATE
AUTHORIZED REPRESENTATIVE (Patient unable to sign)	DATE	WITNESS (Print Name)	DATE
GUARANTOR (Spouse, Partner, etc.)	DATE	WITNESS (Signature)	DATE

NOTICE OF LIMITED LIABILITY

PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD, HEREBY ACKNOWLEDGE THAT:

THE MEDICAL CARE AND TREATMENT I, MY CHILD AND/OR MY WARD RECEIVE AT FSU TEACHING HEALTH CENTER, WILL BE PROVIDED BY EMPLOYEES AND/OR AGENTS OF THE FLORIDA STATE UNIVERSITY BOARD OF TRUSTEES (FSUBOT);

THE FSUBOT EMPLOYEES AND/OR AGENTS PROVIDING THIS MEDICAL CARE AND TREATMENT INCLUDE BUT ARE NOT LIMITED TO: PHYSICIANS; PHYSICIAN ASSISTANTS; HEALTHCARE RESIDENTS, FELLOWS, AND STUDENTS IN TRAINING; ADVANCED REGISTERED NURSE PRACTITIONERS; NURSES; PERFUSIONISTS; AND TECHNICIANS, WHO WILL AT ALL TIMES BE UNDER THE EXCLUSIVE SUPERVISION AND CONTROL OF THE FSUBOT; AND

THE LIABILITY FOR THE NEGLIGENT ACTS AND OMISSION OF THESE FSUBOT EMPLOYEES AND/OR AGENTS IS LIMITED BY LAW TO $200,000 PER CLAIM OR JUDGMENT BY ANY ONE PERSON AND TO $300,000 FOR ALL CLAIMS OR JUDGMENTS ARISING OUT OF THE SAME INCIDENT OR OCCURRENCE (SEE SECTION 768.28(5), FLORIDA STATUTES).

I FURTHER ACKNOWLEDGE, ON BEHALF OF MYSELF, MY CHILD AND/OR MY WARD, THAT THE FSUBOT EMPLOYEES AND AGENTS PROVIDING MEDICAL CARE AND TREATMENT AT A FSU HEALTH CENTER, INC., (collectively "FSU HEALTH") OTHER FACILITIES ARE NEITHER EMPLOYEES NOR AGENTS OF FSU HEALTH.

Printed Patient Name

Patient/Parent/Guardian Date

Patient Name:

Date:

Medical Record Number:

Patient Rights and Responsibilities

You have the right to:

- Be treated with courtesy and respect, with appreciation of individual dignity, and with protection of privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for your care.
- Know what patient support services are available (including help with a hearing impairment, or an interpreter in your language if you do not speak English, at no charge to you).
- Know what rules and regulations apply to your conduct.
- Be provided with written information about advance directives and available health care decision-making options in Florida.*
- Formulate advance directives and to have the medical staff and Health Center personnel caring for you implement and comply with your advance directives.
- Receive a "Notice of Beneficiary Discharge Rights," "Notice of Non-Coverage Rights," and "Notice of the Beneficiary Right to Appeal Premature Discharge," if you are a Medicare patient.
- Participate in decisions involving your health care, including consideration of ethical issues. You have the right to participate in the development, including any revisions, and implementation of your inpatient treatment/care plan, your outpatient treatment care plan, your discharge plan, and your pain management plan.
- Make informed decisions regarding your care, including the right to receive information from the health care provider about diagnosis, planned course of treatment, including surgical interventions, alternatives, risks, and prognosis and outcomes of care that may impact your decisions regarding treatment.
- Accept or refuse treatment, except as otherwise provided by law.
- Have a family member or representative of your choice and your own physician notified promptly of your admission to the Clinic upon request.
- Be given, upon request, full information and necessary counseling on the availability of financial resources for your care.
- Know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request prior to treatment, a reasonable estimate of charges for medical care. Such reasonable estimate shall not preclude the health care provider or the health care facility from exceeding the estimate or making additional charges based on changes in your condition or treatment needs.
- Receive a copy of a clear and understandable itemized bill upon request and to have the charges explained.
- Impartial access to medical treatment or accommodations regardless of race, national origin, religion, sexual orientation, physical handicap, source of payment, age, color, marital status, or gender.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for experimental research purposes and to consent or refuse to participate in such experimental research knowing that refusal will not compromise access to any other services.
- Know the health care facility's procedure for expressing a grievance. You have the right to express grievances regarding any violation of your rights, through the grievance procedure of the health care provider or health care facility, which served you, and to the appropriate state agency**
- Personal privacy, except as limited for the delivery of appropriate care.
- Receive care in a safe setting.
- Be free from all forms of abuse, neglect, and harassment whether from staff, other patients, or visitors.
- The confidentiality of your clinical records, except as provided by law.
- Except under limited circumstances, access information contained in your clinical records within a reasonable time frame.
- Access individuals outside the Health Center by means of visitors and by written or verbal communication. When it becomes necessary to restrict communication, the therapeutic effectiveness of the restriction will be periodically evaluated.
- Retain and use personal clothing or possessions if space permits and it does not interfere with another patient or medical care.
- Be free from restraints or seclusion used as means of coercion, discipline, convenience, or retaliation.
- Appropriate assessment and management of pain.
- Access any mode of treatment, including complementary or alternative healthcare treatments, that is, in your own judgment and the judgment of your physician(s), in your best interest, to the extent that such mode of treatment is offered by the Health Center.

It is your responsibility to:

- Provide to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, medications, and other matters relating to your health.
- Report unexpected changes in your condition to the health care provider.
- Report to the health care provider whether you understand a planned course of action and what is expected of you.
- Understand that contraband is not permitted on Health Center premises (including guns, knives, or other weapons, illegal or unauthorized drugs or alcohol), and to not possess or use such contraband at FMPP.
- Follow the treatment plan recommended by the health care provider.
- Keep appointments and, when unable to do so for any reason, notify the health care provider or health care facility.
- Be responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
- Assure the financial obligations of your health care are fulfilled as promptly as possible.
- Ensure that your behavior while on FMPP premises does not harass, intimidate, or physically harm FMPPvisitors, staff, and/or patients.
- Notify the health care provider of any advance directive(s) you may have executed.
- Be respectful of the property of other persons and of the Health Center.

** It is the policy of FMPP to honor all appropriately completed Advance Directives.*

*** Agency for Health Care Administration / 2727 Mahan Drive / Tallahassee, FL 32308 / (888) 419-3456 or Joint Commission on Accreditation of Healthcare Organizations / Office of Quality Monitoring / One Renaissance Boulevard / Oakbrook Terrace, IL 60181 / 800.994.6610*

THE FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

FSU SeniorHealth™

HIPAA Notice of Privacy Practices

Florida Medical Practice Plan, Inc.
4449 Meandering Way
Tallahassee, FL 32308
(850) 644-1543

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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 a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Patient Name: _____Patient or Guarantor Signature:_____

FLORIDA MEDICAL PRACTICE PLAN'

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Florida Medical Practice Plan™

FSU Clinical Practices Financial Policies

MRN:_____ PATIENT NAME:_____ VISIT DATE: _____

1. Payment is expected at time of service. This includes co-pays, co-insurances and deductibles.

2. At check out, our staff will ask you for payment for any past due balances as well as your portion of the payment for today's service. Failure to meet your financial obligations could result in being discharged from the practice.

3. If you are unable to keep your appointment, it is important to notify us 24 hours prior to your appointment. This will allow us to free your appointment time for other patients. You may be charged a $25 cancellation or no show fee if you fail to notify us.

4. Adult patients who do not show up for a scheduled appointment 3 times within a 12 month period and fail to notify us prior to the appointment, may be discharged as a patient. Patients under the age of 18 may be discharged for the same.

5. If you are scheduled for an elective non-covered procedure, an estimate of your portion of the payment will be given to you. Payment will be expected at least 10 days prior to this procedure. If you have any outstanding balance, we will also expect payment 10 days prior to the procedure. Failure to make the required payments will result in the service being rescheduled. When you receive your estimate, you will also receive a payment voucher to send back with your payment. Please remember to include the voucher along with your payment.

6. Some insurances require that your labs be performed in a different location other than your doctor's office. If you choose to have the test performed at your physician's office, you will be expected to pay the fee for this service. Your insurance cannot be billed in those instances.

7. Similarly, if your insurance does not authorize a procedure or test and you choose to have the procedure or test done anyway, you will need to pay for the service up front. Your insurance cannot be billed in those instances.

If you have any questions, please call our Patient Relations department at (850) 644-1543, and select option 4, Monday thru Friday, 8:30 AM to 4:30 PM.

Patient or Guarantor Signature_____Date_____

Authorization for Release of Medical Records

Patient Name:_____ DOB: _____

From: _____
(Health Care facility releasing information)

To: _____
(Name of institution or individual receiving information)

_____
(Street Address)

_____
(City) (State) (Zip)

Information to be disclosed:

From (Date)_____ To (Date) _____

- ◯ Discharge Summary
- ◯ History and Physical Examination
- ◯ Operative Report
- ◯ Pathology Report
- ◯ Laboratory Results/
- ◯ X-ray Reports
- ◯ EKG/EEG Reports
- ◯ Emergency Room Record
- ◯ Clinic Notes
- ◯ Behavioral Health Information
- ◯ Physical/ Occupational Therapy Notes
- ◯ Prenatal (Pregnancy) Records
- ◯ Radiology Images
- ◯ Other (please specify)_____

Purpose of Release: ◯ Medical Care ◯ Transferring Care ◯ Personal Records ◯ Attorney

◯ Other _____

This Statement of Consent can be revoked at any time before disclosure of information, and expires on_____.
If no expiration date or identifiable event is listed, then authorization expires 12 months after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Revoking the authorization will not have any effect on actions taken prior to revocation. I understand that the individual/ institution that receives the information described above, may not be covered by federal privacy regulations, and that the information may be disclosed publicly and no longer be protected by those regulations.

_____ _____
(Signature of Patient) (Signature of Parent, Guardian, or Authorized Representative)

_____ _____
(Date) (Print Name)

_____
(Relationship to patient)

Note:
Please fax all records to: (855) 230-7402
Or mail: *FSU SeniorHealth™*
4449 Meandering Way
Tallahassee, Florida 32308
ATTN: FSU SeniorHealth

FLORIDA MEDICAL PRACTICE PLAN
FLORIDA STATE UNIVERSITY College of Medicine

Reassignment of Benefits

I authorize the release of any medical or other information necessary to process my claims. I also request payment of all benefits including government benefits to the physician or supplier for services rendered under Florida Medical Practice Plan, Inc.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Authorization to Disclose Medical Information

I authorize the release of any medical or other information necessary to provide care for myself to the individual(s) listed below.

_____

Name

_____

_____

Name

Medical History Information

I authorize *FSU SeniorHealth*™ to access all of my prior medical records in order to provide consultation(s).

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Vaccination Records

I agree to allow *FSU SeniorHealth*™ to upload any vaccine information to Florida Shots for tracking vaccination records.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

THE FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE
Department of Geriatrics

Research Involvement (Optional)

Faculty members in the Department of Geriatrics at the Florida State University College of Medicine conduct research studies on topics such as healthy aging, healthcare access, and dementia. These studies recruit individuals and/or caregivers to take part in activities such as interviews and surveys. Taking part in research is your choice. Your choice to take part or not take part will have no impact on your current or future relations with Florida State University, the College of Medicine, FSU SeniorHealth™, or Westminster Communities of Florida.

With your permission, researchers in the Department of Geriatrics would like to contact you about potential research projects. You will only be contacted if the study has received approval from the Florida State University Institutional Review Board (FSU's central office that oversees research involving human subjects so you and your rights are protected).

May we contact you about research projects conducted by Department of Geriatrics faculty? ◯ Yes ◯ No

Print Name:	
Mailing Address:	
Phone:	
Email:	
Signature:	
Date:	

FSU SeniorHealth Patient:

Thank you for the opportunity for us to provide your healthcare at *FSU SeniorHealth*. Our goal is to make sure you experience the highest quality of care in an environment that is comfortable, safe and positive.

We believe it's important for you, and those you designate, to be fully informed about your health status. To improve communications between you and your doctor, we will activate a Patient Portal with email capability for you *(Please provide your email address below)*.

Email: _____

You'll soon receive a link at the email address you provided that will contain instructions for setting up a unique password to your account in the Patient Portal. Once you've done that, you'll begin receiving electronic messages from us.

Messages you might receive include summaries of your physician visits, lab orders, physician appointment reminders, health education materials and other communications to help you manage your healthcare better.

If you have any questions about this service, please give us a call at 850-644-1543, option 1.

We hope that you find the Patient Portal helpful. Your feedback and satisfaction are important to us and we look forward to hearing from you.

Sincerely,

FSU SeniorHealth™ Team