



4449 Meandering Way
Tallahassee, FL 32308
Phone: 850.644.1543
Fax: 850.645.0577

WELCOME!

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

Attached is your registration packet; please complete this packet in its entirety. We ask that you call 850.644.1543 to schedule your appointment. If you have not selected the physician of your choice, attached is a pamphlet to assist you or you can schedule the first available appointment.

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

- **All medications and supplements/ name of your preferred pharmacy**
- **Insurance card(s)**
- **A photo ID**
- **Your email address (or your authorized representative email address)**

*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.*

We are located at 4449 Meandering Way, Tallahassee, FL 32308 in the Lower Level within the Parry Center Building. Once on the campus, feel free to park at one of the 'FSU SeniorHealth' parking spots or visitors parking. If you have any questions or need to reschedule your appointment, please call 850.644.1543.

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

Sincerely,

Lynn Dorvil

Lynn Dorvil, MHA
Medical Practice Manager
850.644.1543

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

Florida State University College of Medicine | Florida Medical Practice Plan, Inc.

FSU SENIORHEALTH

(Please Print)

Today's date:				Primary Doctor:			
PATIENT INFORMATION							
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):			Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):				Relationship to patient:			
Home phone# () -				Other phone# () -			
Other family members seen here:							
PREFERRED PHARMACY							
Name of Preferred Pharmacy:				Phone# () -			
Address of Preferred Pharmacy:							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Primary Insurance Name: Policy #							
Secondary Insurance Name: Policy#							
Notice of Privacy Practices Acknowledgment							
<p>I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.</p>							
_____ Patient Name or Legal Guardian (print)				_____ Date			
_____ Signature							
Reassignment of Benefits							
<p>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.</p>							
_____ Patient Name or Legal Guardian (print)				_____ Date			
_____ Signature				<i>(please complete other side also)</i>			

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



New Patient Questionnaire

(please complete all pages)

Full legal name: _____ Todays' date: _____

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

Date of birth: _____ Gender: M F Social Security #: _____

Address: _____

Street Address

Apt. Number

City/State: _____ Zip code: _____

Preferred pharmacy: _____ 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 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 PROBLEMS	LUNG PROBLEMS
<input type="radio"/> cataracts	<input type="radio"/> heart attack: year _____	<input type="radio"/> asthma
<input type="radio"/> glaucoma	<input type="radio"/> heart failure	<input type="radio"/> bronchitis
<input type="radio"/> macular degeneration	<input type="radio"/> high blood pressure	<input type="radio"/> emphysema
<input type="radio"/> hearing loss/hearing aid	<input type="radio"/> irregular heartbeats (arrhythmias)	<input type="radio"/> other, specify:
<input type="radio"/> other, specify:	<input type="radio"/> other, specify:	

BONE/JOINT PROBLEMS	GLAND PROBLEMS	KIDNEY & URINARY TRACT PROBLEMS
<input type="radio"/> arthritis	<input type="radio"/> diabetes	<input type="radio"/> kidney disease
<input type="radio"/> osteoporosis	<input type="radio"/> overactive thyroid - high	<input type="radio"/> prostate disease
<input type="radio"/> fractured hip, wrist or spine (circle)	<input type="radio"/> underactive thyroid - low	<input type="radio"/> bladder/kidney infections
<input type="radio"/> gout	<input type="radio"/> other, specify:	<input type="radio"/> urinary incontinence
<input type="radio"/> other, specify:		<input type="radio"/> other, specify:

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)
<input type="radio"/> alone	<input type="radio"/> single-family house
<input type="radio"/> spouse or partner	<input type="radio"/> condo or apartment
<input type="radio"/> child or other family member	<input type="radio"/> live with other in their home, condo or apartment
<input type="radio"/> other, specify:	<input type="radio"/> other, specify:

Are you currently...(check one)	How many children do you have? _____
<input type="radio"/> married	Are you in regular contact with your children?
<input type="radio"/> divorced/separated (circle one)	<input type="radio"/> yes <input type="radio"/> no
<input type="radio"/> widowed	
<input type="radio"/> single (never married)	
<input type="radio"/> living with significant other	

How much school did you complete? (check one)	What has been your principal occupation?
<input type="radio"/> less than 6 th grade	_____
<input type="radio"/> less than high school	Are you currently...(check one)
<input type="radio"/> high school graduate	<input type="radio"/> retired, not working
<input type="radio"/> some college	<input type="radio"/> working part-time
<input type="radio"/> college - undergraduate	<input type="radio"/> working full-time
<input type="radio"/> college – graduate/doctorate	<input type="radio"/> unemployed (but not retired)

Do you employ someone to provide care or help in your home? <input type="radio"/> yes <input type="radio"/> no	Do you get help from a family member or friend in your home? <input type="radio"/> yes <input type="radio"/> 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? <input type="radio"/> yes <input type="radio"/> no	Is this sufficient to meet your needs? <input type="radio"/> yes <input type="radio"/> no
Who would you call if you were sick and needed help? _____	Do you provide care for a family member? <input type="radio"/> yes <input type="radio"/> no

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

Have you <u>ever</u> smoked cigarettes? <input type="radio"/> yes <input type="radio"/> no	
If yes, do you currently smoke? <input type="radio"/> yes <input type="radio"/> no	If you quit smoking...
How many years have you smoked? _____	How many years ago did you quit? _____
How many packs a day do you smoke? _____	For how many years did you smoke? _____
	How many packs per day did you smoke? _____

C. 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 disease						
cancer, specify:						
heart disease or stroke						
diabetes						
depression						
other, specify:						

D. 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	<input type="radio"/> yes	<input type="radio"/> no	
getting from bed to chair	<input type="radio"/> yes	<input type="radio"/> no	
getting to the toilet	<input type="radio"/> yes	<input type="radio"/> no	
getting dressed	<input type="radio"/> yes	<input type="radio"/> no	
bathing	<input type="radio"/> yes	<input type="radio"/> no	
walking safely	<input type="radio"/> yes	<input type="radio"/> no	
using the telephone	<input type="radio"/> yes	<input type="radio"/> no	
taking medicines	<input type="radio"/> yes	<input type="radio"/> no	
preparing meals	<input type="radio"/> yes	<input type="radio"/> no	
managing money/financial affairs (checkbook)	<input type="radio"/> yes	<input type="radio"/> no	
doing laundry	<input type="radio"/> yes	<input type="radio"/> no	
doing house work	<input type="radio"/> yes	<input type="radio"/> no	
shopping for groceries	<input type="radio"/> yes	<input type="radio"/> no	
driving	<input type="radio"/> yes	<input type="radio"/> no	
doing 'handyman' work	<input type="radio"/> yes	<input type="radio"/> no	
climbing stairs	<input type="radio"/> yes	<input type="radio"/> no	
getting to places beyond walking distance	<input type="radio"/> yes	<input type="radio"/> no	

E. REVIEW OF SYSTEMS

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

GENERAL PROBLEMS & MISCELLANEOUS	GYNECOLOGY PROBLEMS
<input type="radio"/> weight loss	<input type="radio"/> vaginal bleeding
<input type="radio"/> weight gain	<input type="radio"/> vaginal discharge
<input type="radio"/> fevers	<input type="radio"/> breast lumps or discomfort
<input type="radio"/> chills	
<input type="radio"/> sweats	DIGESTIVE PROBLEMS
<input type="radio"/> cold or flu	<input type="radio"/> difficulty swallowing
<input type="radio"/> change of appetite	<input type="radio"/> frequent indigestion or stomach ache, heartburn
<input type="radio"/> excessive thirst	<input type="radio"/> frequent nausea or vomiting
<input type="radio"/> feel too hot or too cold	<input type="radio"/> change in bowel habits
<input type="radio"/> problems with sexual function	<input type="radio"/> black bowel movement or bleeding from rectum
<input type="radio"/> problems with sexual function	<input type="radio"/> frequent diarrhea
	<input type="radio"/> persistent constipation
EYES	
<input type="radio"/> trouble seeing	BONE AND JOINT PROBLEMS
<input type="radio"/> eye pain	<input type="radio"/> leg pain on walking
<input type="radio"/> dry eyes	<input type="radio"/> back or neck pain
	<input type="radio"/> joint pain or stiffness
EAR, NOSE, MOUTH, THROAT	<input type="radio"/> foot problems
<input type="radio"/> trouble hearing	<input type="radio"/> falls
<input type="radio"/> ear pain or itching	
<input type="radio"/> sinus problems	BRAIN AND NERVOUS SYSTEM PROBLEMS
<input type="radio"/> nose bleeds	<input type="radio"/> frequent headaches
<input type="radio"/> sore throat	<input type="radio"/> frequent dizzy spells
<input type="radio"/> teeth problems	<input type="radio"/> passing out or fainting
<input type="radio"/> hoarseness	<input type="radio"/> falls
<input type="radio"/> mouth sores	<input type="radio"/> paralysis, leg or arm weakness
<input type="radio"/> allergies	<input type="radio"/> numbness or loss of feeling
	<input type="radio"/> serious problem with memory or difficulty thinking
HEART PROBLEMS	<input type="radio"/> tremor or shaking
<input type="radio"/> chest pain or tightness	<input type="radio"/> problems with sleep
<input type="radio"/> rapid or irregular heart beat	
<input type="radio"/> swelling of feet	KIDNEY AND URINARY TRACT PROBLEMS
	<input type="radio"/> urination at night (how many times _____)
LUNG PROBLEMS	<input type="radio"/> frequent urination
<input type="radio"/> persistent cough	<input type="radio"/> painful urination
<input type="radio"/> difficulty breathing or shortness of breath	<input type="radio"/> loss of urine or getting wet
<input type="radio"/> coughing up blood	
<input type="radio"/> wheezing	SKIN PROBLEMS
	<input type="radio"/> rash
MOOD/SADNESS PROBLEMS	<input type="radio"/> sores
<input type="radio"/> depression	<input type="radio"/> itching
<input type="radio"/> anxiety	

F. HEALTH MAINTENANCE

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 (three cards at home)? yes no

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 the Pneumovax vaccine (a shot to prevent pneumonia)? yes no

If YES, in what year? _____

Have you ever had the Shingles vaccine? 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

_____ jogging

_____ bicycling or stationary bike

_____ tennis or pickle ball

_____ golf or croquet

_____ bowling or boccie

_____ none of the above

_____ other, specify: _____

How many minutes a week do you exercise? _____

G. FALLS AND MOBILITY

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 H or I 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:

Do you use a walking or mobility aid? yes no

If YES, check all that apply: cane walker wheelchair other, specify _____

Men proceed to section H. Women proceed to section I.

H. 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? _____

I. 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 ____/____

J. 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 _____	<input type="radio"/> yes <input type="radio"/> no
Do you have a Living Will?	<input type="radio"/> yes <input type="radio"/> no
Do you have a 'Do Not Resuscitate Order Form' at your home or residence?	<input type="radio"/> yes <input type="radio"/> no

K. 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 family) have concerns about your driving? yes no

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

Have you ever gotten lost driving? yes no

Do you have any other health problems that you would like your doctor to know about before your visit?

May we contact you about research projects conducted by FSU faculty? yes no

Print Name:

Address:

Phone: _____

Signature _____ Date _____

Form must be signed by the patient. No proxy signatures please.



THE FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

FSU SeniorHealth

HIPAA Notice of Privacy Practices

Florida Medical Practice Plan, Inc.
4449 Meandering Way
Tallahassee, FL 32308-5740
(850) 878-1136

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.



March 1st, 2017

FSU SeniorHealth Patient:

Thank you for the opportunity for us to provide your healthcare at *FSU SeniorHealth* at Westminster Oaks. 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 us, we have activated a Patient Portal with e-mail capability for you. You'll soon receive an e-mail at the e-mail address you provided to us that will contain a link for setting up a unique password for the e-mail 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 to take to your lab appointment, physician appointment reminders, health education materials and other communications to help you manage your healthcare better.

To make Patient Portal access and use easier, we are including *FSU SeniorHealth* Patient Portal - Patient Access and Use Instructions. If you have any questions about this new service or the instructions on access and use, please give us a call at 850-644-1543.

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,

Lynn Dorvil, MHA
Medical Practice Manager

Attachment

FSU SeniorHealth
Patient Portal
Patient Access and Use Instructions

We believe it's important for you, and those you designate, to be fully informed about your health status. To improve communications between us, a Patient Portal with e-mail capability is now available for your use. Below are instructions on how to access and use your new Patient Portal.

STEP 1 – ACCESS

Provide a valid e-mail address to the receptionist at *FSU SeniorHealth* either for yourself or your Designated Personal Representative (per HIPAA). The e-mail address provided will be your user name for the patient portal.

Upon receipt of an e-mail from *FSU SeniorHealth*, click the first link in **blue** to "access your new account".

Verify your account by entering your date of birth and click "Verify". If this does not work, return to the e-mail from *FSU SeniorHealth* and make note of the password provided. Click the second link in **blue**, <http://fsuseniorhealthatwok.myupdox.com> to access your patient portal.

On the "Home" page, beside "Have an ID and password?", click "Click here to sign in".

The first time you sign in, you will need to update your password. Following the instructions on the screen for selecting a password, choose a password that will be easy for you to remember but difficult for anyone else to guess. Reenter the password where indicated and click "Continue Signing In". You may be asked to Verify your Account at this point. If so, enter your date of birth and click "Verify".

Every time you sign-in in the future, you will be asked to enter your user name (the email address you gave us), the new password you've chosen and click "Sign In".

STEP 2 - USE

Once you have successfully signed in, you will see your name, date of birth and your medical record number in the top right corner of the "Home" page. You will also see the office hours for *FSU SeniorHealth*.

From the Home page you can navigate to messages, records, forms and your personal profile.

Messages

Click "Messages". You will see a list of e-mail messages in your inbox. Click each to review the message. When you open a message, you can view it, reply to it, forward it, print it, or open it as a PDF document.

Reply – Click "Reply" and compose your response to the message. Click "Send Reply". There is no need to include an e-mail address for the recipient. It will automatically go to the person who sent you the original message.

Forward – Click "Forward". A "Forward" window will open. Please note that you must have the "Direct" e-mail address for the person to whom you are forwarding the message. A Direct e-mail address is a secure, encrypted e-mail address that physicians and other providers must use to send or receive protected health information by e-mail. You can get the Direct e-mail address for any provider by calling their office. Once you have the Direct e-mail address, compose the message as you would any other e-mail and click "Send".

Print – to print the message, click "Print" and select the printer you normally use for your computer.

Open as PDF – to print the message in PDF format, click "Open as PDF" and follow the instructions provided.

When you finish with the message, you can keep it in your inbox or delete it by clicking "Delete".

Records

If there are records for you to review, you will see them listed on this screen. To access in a readable format, click "View" or "Download Text". If you wish to send them to another physician for review, click "Transmit". You must have the secure Direct e-mail address of the physician to whom you wish to share the documents.

Forms

If there are forms the practice needs you to complete, you will receive an e-mail in your patient portal telling you which form to select. Click "Forms" and find the form named in the e-mail. Click the correct form and complete it. Once done, click "Submit Form". If you need more time to complete it, click "Finish Later".

Send Message (upper right corner under name)

If you want to send a message to someone in the practice, click "Send Message". Using the dropdown arrow, select the person to whom you want to send the message. Enter the subject of your question or comment and compose your message. If there are attachments you wish to include, click "Add Attachments" and select the document from your computer files. When done, click "Send".

My Profile (upper right corner under name)

Click "My Profile".

"My Information" will appear (**Patient Information**). This is the information *FSU SeniorHealth* currently has on file for you. If changes are needed, scroll to the bottom and click "Edit". You will be able to enter the updated information in text boxes that appear. When done, click "Update". A message will appear that your changes will not be effective until the practice reviews them and has a chance to question any that are not clear.

Click **Patient Profile** (menu at left) and "My Profile" will appear. This is where you can change your Patient Portal user name, e-mail address, or password. Once changes are made, click "Update" at the bottom.

Click **Family Access** (menu at left) and "Access to my Portal" will appear. This is where you can create new users to have access to your Patient Portal. You can also give access to someone who currently has their own *FSU SeniorHealth* Patient Portal. *If you choose to give access to others, please be aware that they will receive the same e-mails and health information about you that you receive.*

Signing Out

When you have finished your Patient Portal activity, it is important to sign out. In the upper right corner, click "Sign Out". That will ensure your health information remains protected and confidential.