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PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below

PATIENT'S PERSONAL INFORMATION Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Sex: Male ☐ Female ☐

Name: _____ _____ _____
(last name) (first name) (middle initial)

Date of Birth: _____/_____/_____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code:_____

PATIENT'S RESPONSIBLE PARTY INFORMATION Relationship To Patient: Self ☐ Spouse ☐ Parent ☐ Other: _____

Name: _____ _____ _____
(last name) (first name) (middle initial)

Date of Birth: _____/_____/_____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Address: _____ Apt. #_____ City:_____ State: _____ Zip Code: _____

PATIENT'S PERSONAL INFORMATION Please present insurance card(s) to the receptionist.

Primary Insurance Name: _____

Address: _____ Apt. #_____ City: _____ State: _____ Zip Code: _____

Name of Insured: _____ Date of Birth: _____/_____/_____ Relationship to Insured: _____

Policy #: _____ Group #: _____ Copay: $_____

NOTIFY STAFF IF YOU HAVE A SECONDARY INSURANCE

REFERRING PARTY INFORMATION

Name: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

Address: _____ Apt.#: _____ City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address:_____ Apt. #_____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Assignment of Benefits / Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to JMJ Family Practice Inc., and any assisting physicians for service rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____ Date:_____

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PATIENT PHARMACY INFORMATION REQUEST

In order to provide you with the best service possible, we ask that you provide the information requested below. Pharmacy information is needed in order to process prescriptions electronically.

Your Full Name: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

LABORATORY TESTING ACKNOWLEDGEMENT

We are a functional medicine practice and prioritize finding the root cause of illness and disease. The labs we order **may not** be covered by insurance. *We ask you to verify with your insurance which labs may or may not be covered prior to getting your labs done.* **We do not change coding or billing as it applies to the labs after mitigation.**

I acknowledge that it is my responsibility to contact my insurance to become aware of what my insurance covers.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

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GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and its relevant recommended surgical, medical or diagnostic procedure to be used so that you may make an informed decision about whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that

(1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended;

(2) you consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient Name (Print)

_____ _____

Patient Signature Date

_____

Patient Representative Name (Print, if applicable)

_____ _____

Patient Representative Signature (if applicable) Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

We maintain the privacy of medical and health information of any individual for whom we provide services and endeavor to comply with all relevant state, national, and international laws and regulations including the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996. We abide by the terms of this Notice, as amended from time to time. The Moscati Center reserves the right to modify the privacy practices as outlined in the notice.

I have received a copy of the Notice of Privacy Practices for JMJ Family Practice, Inc.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

_____
Patient Representative Name (Print, if applicable)

_____ _____
Patient Representative Signature (if applicable) Date

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FINANCIAL POLICY

We are committed to providing you the best care possible and keeping you informed about the charges for your services and obligations.

1. Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; if you agree to have your insurance company pay the doctor directly. In the event that the insurance company does not pay JMJ Family Practice Inc within a reasonable time, you will be billed for the services given. If a payment from the insurance company is received after you have paid for services, we will refund any overpayment to you.
2. Prior arrangements have been made with many insurance companies and health care plans to accept assignment of benefits. They will be billed directly and you will be required to pay a copayment at the time of service.
3. If we do not have a prior arrangement with your insurance plan, we will prepare and send the claim for you on an unassigned basis. The insurance company will send the payment to you and you will be responsible for payment at the time of service
4. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be “not covered,” you will be responsible for payment of service. Payment is due upon receipt of a statement from JMJ Family Practice.
5. Your insurance company will be billed for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the financial policy; I agree to be bound by the terms. I also understand that such terms may be amended by JMJ Family Practice.

_____

Patient Name (Print)

_____ _____

Patient Signature (or responsible party) Date

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MISSED APPOINTMENT POLICY

Our practice is committed to providing the best treatment to our patients, please help us better serve you by keeping your regularly scheduled appointments.

All appointments must be canceled 24 hours prior to your scheduled appointment; failure to do so may result in a $50.00 charge, which will not be billed to the insurance company. All missed appointment fees will be billed directly to the patient.

Feel free to contact us if you have any questions or concerns.

I have read and understand the missed appointment policy and agree to abide by the guidelines.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

NO SHOW POLICY

At our office we define a “No-Show” as the following: an appointment where 1) the time of the appointment has passed, 2) no communication has been received by our office in regards to the appointment and 3) the patient has not arrived. In order to maintain a fair and honest schedule for both patients and providers, no show fees ($50) will be directly assessed to the patient balance.

I have read and understand the no show policy and agree to abide by the guidelines.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

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PATIENT CODE OF CONDUCT POLICY

At JMJ Family Practice we hold the care and treatment of our patients in the highest regard.

In return, we have high expectations of our patients to conduct themselves kindly in return. The following behaviors are prohibited and/or may be grounds for discharge from the practice without warning.

- Possessing firearms or any weapons
- Abuse of the patient portal as outlined in the consent for portal guidelines
- Intimidating, harassing, physically assaulting, or threatening staff or other patients
- Making threats of violence through phone calls, letters, portal messages, voicemails, or other forms of written, verbal, or electronic communication
- Damaging business equipment or property
- Making menacing or derogatory gestures
- Making racial, cultural, or sexual slurs or other derogatory remarks
- Repeatedly missing your scheduled appointments. More than 3 no-shows will result in discharge from the practice
- Refusing to follow the Provider's treatment plan or instructions for a high-risk diagnosis
- Fraudulent behavior
- Repeated failure to observe office policies, i.e. prescription refills, refusal to adhere to mandated infection-control precautions
- Repeatedly failure to pay copayments, coinsurance, or deductibles required under the plan
- Repeated disregard of patient's rights and responsibilities outlined in Florida statute 381.026

Violators are subject to removal from the facility and/or discharge from the practice.

_____ _____

Patient or Guardian Signature Date

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ACCESS AGREEMENT

JMJ Family Practice Inc provides portal access for the exclusive use of its patients.

It is the mutual responsibility of both the health care provider and the patient to ensure that all information in a patient's records is correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately.

This patient portal is not designed to provide healthcare services. You should always contact our office for healthcare questions and needs. Please note the following additional limitations regarding the use of this patient portal:

- No internet-based triage and treatment requests. Diagnosis can only be made and treatment rendered after the Provider sees the patient.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, or calling 911 should the emergency be life threatening.
- No request for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 48 hours to receive a response to a message sent through the Patient Portal. If you do not receive a response within 48 hours, please contact the office at 321-425-2233 or 407-935-9012.
- If you lose your password or username, you may request a new one through the Patient Portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information.

<u>We do encourage using the portal for</u>

- Prescription refills request
- View laboratory results
- Appointment requests for non-urgent concerns
- Review of continuity of care document including your medication list, problem list, immunizations & allergies

This patient portal is provided as a courtesy to our valued patients. If you abuse the patient portal, or we suspect such abuse, JMJ Family Practice reserves the right at our own discretion to modify, suspend or terminate your access and use of the patient portal system.

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Patient Acknowledgement and Agreement

Please select one option.

_____ Accept Access: I acknowledge that I have read and fully understand this consent form. I have been provided with the risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between my physician and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is voluntary and will not influence the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the guidelines set forth herein, as well as any other instruction that my physician may impose for online communications. I have been offered an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction.

_____ Decline Access: I do not agree to the terms and conditions of this agreement, therefore I do not wish to participate in the Patient Portal offered by the Stockbridge Munsee Community (partnered with AthenaHealth) nor want an invitation sent to me to do so.

_____ _____

Patient Name Print Date of Birth

_____ _____

Patient/Guardian Signature Date

Private Email: _____

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PREVIOUS/CURRENT MEDICAL HISTORY

Full Name: _____ **Today's Date:** _____

Date of Birth: _____ **Gender:** Male ☐ Female ☐

Preferred Pharmacy Name: _____

Insurance In-Network Lab: Quest ☐ LabCorp ☐ HealthFirst ☐ Other: _____

Allergies: Food, Pollen, Odors, Medicines, Pets, etc… No Known Drug Allergies ☐

_____

Current medications, strength and dosage:

_____

_____

_____

Current herbs/vitamins/homeopathy/supplements and dosage:

_____

_____

_____

Does the patient have any history of STD's? Yes ☐ No ☐

If yes, please explain. _____

Does the patient have a history of mental health? Yes ☐ No ☐ If yes, please explain below.

_____

Does the patient have current mental health issues? Yes ☐ No ☐ If yes, please explain below.

_____

Work/Living Situation (Check all that apply)

a natural family practice

Occupation: Employed ☐ as _____ Retired ☐ Homemaker ☐ Student ☐ Other ☐ _____

Do you live alone, with a roommate, with family, or with a significant other? _____

Preventative Screening (List the date)

Last Mammogram: _____ or Never ☐ Last Pap Smear: _____ or Never ☐

Last Bone Density scan (DEXA): _____ or Never ☐

Last Physical exam: _____ or Never ☐ Last Colonoscopy: _____ or Never ☐

Obstetric History

Total number of pregnancies? _____

Do you have children and if so, how many? _____ Age(s)?_____

Family past medical history: (Check all that apply)

	Mom/Dad			Mom/Dad			Mom/Dad	
Allergies	☐	☐	Arthritis	☐	☐	Asthma	☐	☐
Bleeding Disorder	☐	☐	Cancer	☐	☐	Diabetes	☐	☐
Heart Disease	☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐
Liver Disease	☐	☐	Mental Illness	☐	☐	Seizures	☐	☐
Stroke	☐	☐	Thyroid Disorder	☐	☐	Tuberculosis	☐	☐
Other:	☐	☐	Other:	☐	☐	Other:	☐	☐

_____ _____ _____

Has the patient had any surgeries? Yes ☐ No ☐ **If yes, when and for what:** _____

_____

_____

Physical Traumas? Yes ☐ No ☐ **If yes, when and what happened?**

_____

_____

Lifestyle, Self-care, and Social (Answer each question)

Do you have a smoker in your house? Yes ☐ No ☐

Do you smoke cigarettes? Yes ☐ No ☐ If yes, how many per day: _____ Number of years: _____

Have you ever smoked? Yes ☐ No ☐ If yes, when did you quit: _____

Do you drink alcohol? Yes ☐ No ☐ If yes, at what frequency: Occasional ☐ Moderate ☐ Heavy ☐

Do you drink caffeinated beverages? Yes ☐ No ☐ If yes, which type and at what frequency?
Coffee ☐ Tea ☐ Energy Drinks ☐ Other ☐ : _____ usage is Occasional ☐ Moderate ☐ Heavy ☐

Do you use recreational drugs? Yes ☐ No ☐ If yes, which type and at what frequency?
Type(s): _____ **Frequency?** Occasional ☐ Moderate ☐ Heavy ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Is blood transfusion acceptable in an emergency? Yes ☐ No ☐

What type of diet are you following? Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Dairy-free ☐ Specific ☐ Cardiac ☐ Diabetic ☐ Carbohydrate ☐

Do you exercise regularly? Yes ☐ No ☐ **Frequency?** Occasional ☐ Moderate ☐ Heavy ☐

Patient's Current Medical History: (Check all that apply)

Allergies ☐	Arthritis ☐	Asthma ☐
Bleeding Disorder ☐	Cancer ☐	Diabetes ☐
Heart Disease ☐	Headaches ☐	High Blood Pressure ☐
Liver Disease ☐	Mental Illness ☐	Seizures ☐
Stroke ☐	Thyroid Disorder ☐	Tuberculosis ☐
Other: ☐	Other: ☐	Other: ☐

_____ _____ _____

Any significant past medical history?

_____

_____

_____