University Family Healthcare, PA
6731 Professional Parkway W, Suite 100, Sarasota FL 34240 ph (941)351-2020 fax (941)360-1362

Welcome to University Family Healthcare, PA.

We're delighted that you have chosen us as your primary care providers. We work hard to earn your trust and to see that you have the best healthcare possible. **Good health is the result of a partnership** of providers and patients.

WHAT WE EXPECT OF YOU:

1. **You signed a contract with your insurance provider; should understand what your particular insurance plan covers and how services must be obtained**. What local hospitals participate with your insurance? Can you go to an urgent care? Do you need referrals to see specialists?
2. **We Require that you have a Complete Physical Exam with us each year, and at least one other Wellness visit.** If you have a chronic condition, you may need to see us as many as four or six times per year.
3. **If you are of Medicare age**, the Centers for Medicare Services (CMS) require that we provide preventative care. When we ask you to have a mammogram, a colonoscopy, or a diabetic eye exam, please understand that we are required by Medicare to see that you have these services.
4. **Take the medications we prescribe and follow the care plan we develop with you**. There may be long-term consequences of not managing your health conditions. It is critical to follow your care plan to see its full benefits in your health.
5. **Keep your appointments and arrive a few minutes early**. We have a ten minute grace period for office visits, after which, we have to reschedule your appointment. **Please inform us right away if you are unable to attend an appointment.**

WHAT YOU CAN EXPECT OF US:

1. For emergency services, a provider is available to you via phone, 24/7. You can reach our staff via phone, day or night. (**941-351-2020**) We also have an online portal so you can keep track of your appointments and labs, and ask questions during office hours. We do our best to see sick patients within 24 hours of the first call. Our goal is to see you promptly and give you the best care possible.

2. We will listen to you. No one knows your body like you do. We need your input to get a complete picture of your health and develop the best plan of care for you.

3. **We order and monitor the results of tests and radiology, and will call you if there is cause for concern. You can always call us for results.** Be aware that some results cannot be given over the phone because our providers need to explain them and help you consider treatments.

4. **We continually update our skills and knowledge** to provide you with the best practices in Primary Care Medicine. We regularly update our offerings to reflect state-of-the-art medical treatment, such as joint injections, stem cell treatments, and laser treatments.

5. **We only prescribe medications and treatments that research shows have the best record of improving your condition**. It is important that you follow through with medications that are prescribed. Our diligence and your compliance with treatment are the basis for our mutual trust.

Patient signature_____ Date _____

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Acknowledgement of Receipt of Notice of HIPAA Regulations and Authorization for Release of Medical Records

_____
Printed Name of Patient

I have read the HIPAA regulations posted on the waiting room wall at University Family Healthcare and have been offered a copy to take home with me.

I give the following permissions that University Family Healthcare may:

Send or call appointment reminders to my home:	Y	N
Send or call test results of lab or X-rays to my home:	Y	N
Send or call billing messages to my home:	Y	N
Leave above messages at home or cell:	Y	N
Give my spouse the above information:	Y	N

Give the above information to:

_____, Relationship _____

_____, Relationship _____

I authorize University Family Healthcare to send or receive records to or from the following physicians:

1._____ 2._____

3._____ 4._____

I understand that my records and information may be shared with a specialist to whom I have been referred or in an emergency, to a physician attending me in the hospital.
I understand that my medical records may contain information about but not limited to: alcohol and or drug treatment, mental health or psychiatric care and or HIV / AIDS information.
I understand that if I choose to change this form in any way after it is signed, I must redo the entire form.
I understand that certain records are sent by fax and I relieve University Family Healthcare and its employees or agents from any liability resulting from any mis-transmission of a fax.
I understand that a photocopy of this authorization shall have the same effect as the original.

_____ _____
Signature of Patient Date Signed

_____
Witness

University Family Healthcare, PA

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Patient Name_____

Date of Birth____/____/_____

Medical Information **University Family Healthcare, PA**

Medications: please list medications below or check this box if you do not take any medications ☐

Name	Strength	How do you take this medication/Dosage?

Social History: *Please circle answers*
Tobacco Use: Never smoker Current Smoker: (interested in quitting? Yes No) Former Smoker (approximate quit date:)
Alcohol Use: Never Occasional Daily
Illegal Drug Use: Never Occasional Daily
Caffeine Use: Never Occasional Daily
Occupation:
Are you under a lot of pressure at work? Yes No
Home Environment: Private Home Assisted Living Other (Please describe):
Is anyone hurting you at home? Yes No

Medical History: *Circle all that apply.*		
Cancer: Type:	**Epilepsy**	**Shortness of Breath**
COPD	**Kidney Disease**	**Arthritis**
Diabetes	**Digestive Problems**	**Depression**
Stroke	**Ulcers**	**Glaucoma**
Heart Attack	**Headaches**	**Other:**
Females only: Are you pregnant, planning a pregnancy or nursing a child (circle answer)? Yes No		

Surgeries and Recent Hospitalizations	**Date**

Allergies: *(Environmental, food, and medication)*	**Reaction:**

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Patient Name:_____

Date of Birth____/____/_____

Recent Immunizations	**Date**

Names of last doctor and any current specialists	*Any contact information you have available for these doctors such as phone number, fax number, and/or address:*

Family History: *Please check your answers within the table provided*								
	Father	Mother	Sister	Brother	Aunt	Uncle	Daughter	Son
Deceased								
High Blood Pressure								
Heart Disease								
Stroke								
Kidney Disease								
Obesity								
Genetic Disorder								
Alcoholism								
Depression								
Cancer, Specify Type:								
Other:								

I certify the above information is correct to the best of my knowledge.

Signature:_____

Printed Name:_____

Date:____/_____/_____

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4 TOPICS WE SOMETIMES DO NOT HAVE TIME TO DISCUSS

Mood and Overall Functioning

1. Do you feel "down," depressed, or hopeless? _____
2. Appetite changed? Overeating or not wanting to eat? _____
3. Sleep patterns changed? Too sleepy or unable to sleep? _____
4. Trouble concentrating? Hard to read or watch TV? _____

If you answered yes, we can discuss treatment options that may help you feel better, sleep better, and be more alert.

Exercise

Do you regularly do any form of exercising? _____ *If you do not, we should discuss ways to increase your mobility. If you do, there may be opportunities to safely increase what you are doing.*

Balance and Falls

Have you fallen in the last 12 months? Yes_____ No_____

Do you feel unsafe walking or changing position? Yes_____ No_____

Do you frequently lose your balance or feel dizzy? Yes_____ No_____

If you do, we can discuss things to help you be safe and prevent falls.

Bladder Control

Are you. . .

Going too Frequently? Yes_____ No_____

Unable to control the urge? Yes_____ No_____

Painful urination? Yes_____ No_____

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Patient Name:_____ **Date of Birth**_____

Address: _____

Phone: _____ **Cell:** _____

Screenings and Medical Services in the last year

Please check the boxes for services you have had in the last 12 months.

(Approximate dates will do but we need doctors' names!)

Annual Eye Exam (with Glaucoma Screening): date _____

Colonoscopy: date and doctor_____

Mammogram: date and doctor_____

DEXA Bone Density Scan: date_____

Falls or Fractures in the last year? _____

If you have Diabetes, have you had:

- A Diabetic retinal eye exam? _____
- A Cholesterol test? _____
- A prescription for a blood pressure medication? _____
- An A1C test (blood test)_____
- When and where? _____

What specialists have you seen in the last year?

_____

_____

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APPOINTMENT POLICY

Increases in population and recent legislation have created an increased demand for the services of primary care providers. Further, Medicare and other insurers are placing greater demands on primary care physicians, which require that we see patients more often. Making the best use of our appointment time with patients is increasingly critical. We have a significant waiting list of patients who wish to join our practice and be seen for both preventative care and illnesses.

Our office operates by **APPOINTMENTS ONLY**. Effective January, 2003, any person who fails to keep an appointment, set by this office at a patient's request, may be charged a **$50.00 MISSED APPOINTMENT FEE**. If you are unable to keep your appointment, you must notify this office **PRIOR TO YOUR SCHEDULED APPOINTMENT** and the $50.00 fee will be waived. We will gladly set a new appointment at that time if you desire one. If we are notified in advance, another patient can be scheduled during that appointment time. Please be courteous.

MISSED APPOINTMENTS

We do not charge missed appointment fees for normal fifteen minute appointments unless there have been repeated "no-shows." **WE DO CHARGE no-show fees for all thirty minute appointments, such as Complete Physical Exams (CPEs) surgeries, or other special procedures**. I you do not come for a 30 minute appointment, you have just wasted the time that could have been used by two other patients.

ARRIVING LATE FOR APPOINTMENTS

We make every effort to see our patients at their scheduled appointment time.

It is our policy that if you are more than 10 minutes later for an appointment, you will be asked to reschedule. We understand that there may be good reasons for patients being late, but we cannot ask our other patients to wait for extended times or have our physicians sit idle while waiting to accommodate late patients.

ACKNOWLEDGEMENT

Patient signature _____ Date_____

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MEDICARE PATIENTS

MEDICARE NUMBER: _____

MEDICARE DISCLAIMER

I FULLY UNDERSTAND AND AGREE that if MEDICARE SHOULD DENY PAYMENT for ANY NON-APPROVED SERVICE RENDERED, that I WILL BE FINANCIALLY RESPONSIBLE for ANY REMAINING BALANCE except for that portion that is designated to be "assignment" by Medicare.

*MEDICARE PATIENT'S SIGNATURE*_____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO:

UNIVERSITY FAMILY HEALTHCARE, P.A.

for any and all claims submitted to a third party due to the practice of medicine by Dr. LOREN CARLSON

(*My Physician)* and/ or his employees AND I ALSO REALIZE THAT I WILL BE FINANCIALLY RESPONSIBLE

TO PAY IN FULL FOR ANY CHARGES NOT COVERED BY MY INSURANCE PLAN.

I HEREBY AUTHORIZE THE AUTOMATIC RELEASE OF MEDICAL INFORMATION TO: MY INSURANCE COMPANY, MY PHYSICIAN, AND ANY PHYSICIAN TO WHOM I MAY BE REFERRED by Dr. Carlson and/or his designated employees.

SIGNATURE:_____

ALL PATIENTS or GUARDIANS MUST SIGN HERE

ACKNOWLEDGEMENT AND CONSENT TO TREAT:

I consent to any or all treatment as deemed necessary or desirable for the care of myself, the patient, or my minor child or dependant, named above, including but not restricted to whatever drugs, performance of surgical procedures, laboratory testing, X-rays or other studies or procedures may be used or recommended by Dr. Loren or Brian Carlson, Dr. Workman and/or their Nurse Practitioners, Physician's Assistants, qualified medical assistants, or other designate. (If the patient is a minor or a dependant, Guardian must sign below)

ALL PATIENTS or GUARDIANS

MUST sign here:_____ **DATE:** _____

Circle relationship to PATIENT:

SELF PARENT GUARDIAN

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name	University Family Healthcare P.A			Phone	941-351-2020	
Address	6731 Professional Parkway West, Suite 100					
City/State Zip	City	Sarasota	State	Fl	Zip	34240

RECORDS FROM: (Who is **Releasing** the Records)						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Transcribed Hospital Reports		Laboratory Reports
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until **(Insert Date):** _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

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WEB PORTAL ACCESS

TO OUR PATIENTS:

- Would you like to be able to check on your next appointment date and time?
- Would you like to be able to look up your last A1C or cholesterol level without having to call the office?
- Would you like to be able to print out a copy of your current meds to take with you to another doctor's office or surgery center?

You can do all of that and more when you sign up for access to our Patient Portal!

Our renewed web site, **www.univfamhc.com**, will be functional beginning January 1, 2015, providing information and access to our present and incoming patients. You can learn about our practice and providers, discover the services we provide, and even download new-patient paperwork and educational information. In addition, you'll be able to access our patient portal through the web site. It will help you keep track of your data and learn more about staying healthy.

How do you get access?

The patient portal requires that you have an e-mail address and that you sign up with us for access. Anyone at the front desk can help you create a patient portal account. Then you can access the portal and your health information from your home computer or other electronic device. Just go to our web site, click the link, and put in your user e-mail and the password we give you. You can also go directly to the portal by putting this address into your internet browser: **https://dr-connect.com/UFH/** .

My Name_____

My e-mail address_____

My Initial Password _____