TMH PHYSICIAN PARTNERS

TMH PHYSICIAN PARTNERS
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Full Name:_____Patient prefers to be called: _____

Date of Birth: _____ Social Security #:_____-_____-_____Sex: □Male □Female

Mailing Address:_____Apt/Unit#:_____

City:_____State:_____Zip Code: _____

Home Phone: (_____)_____Work Phone: (_____)_____Cell Phone: (_____)_____

Marital Status: □ Single □ Married □Divorced □Widowed □Separated Email: _____

Referring Physician:_____Primary Care Physician: _____

Patient's Employer Name: _____

Employment: □ Full-time □Part-time □Not working □ Self Emp □ Retired □ Military Student: □Full-time □Part-time □N/A

Emergency Contact Name:_____Relationship to Patient: _____

Emergency Contact Phone: (_____)_____Emergency Contact Other Phone:(_____)_____

FOR CHILDREN - guarantor information/responsible for payment:

Guarantor Name:_____Guarantor Relationship:_____

Guarantor Date of Birth:_____Guarantor Address:_____Apt/Unit#:_ City: _____State:_____Zip Code: _____

INSURANCE INFORMATION- <u>PRIMARY PLAN</u> -POLICY INFORMATION

Insurance Company:_____Subscriber name: _____

Cert/Policy #:_____Group Name: _____

Group#:_____Policy Telephone #: _____

Relationship to the insured: □ Self □ Spouse □Child □ Other

If you are not the policy holder, please complete the following:

Policy Holder Name:_____Address:_____City:_____ST:_____Zip: _____

Policy Holder Date of Birth: _____ Policy Holder Sex: □Male □Female

INSURANCE INFORMATION - <u>SECONDARY PLAN</u> - POLICY INFORMATION

Insurance Company:_____Subscriber name: _____

Cert/Policy #:_____Group Name: _____

Group#:_____Policy Telephone #: _____

Relationship to the insured: □ Self □ Spouse □ Child □Other

If you are not the policy holder, please complete the following:

Policy Holder Name:_____Address:_____City:_____ST:_____Zip: _____

Policy Holder Date of Birth: _____ Policy Holder Sex: □Male □Female

EDUCATION: We want to provide education regarding your health conditions and would like to know the following:

My Preferred teaching method is: □ I have no preference □ Writteneducation materials □ Demonstration

Barriers to learning: □ Language barrier □ Poor eyesight □ Poor Hearing □ Other _____
□ No barriers

Would you like someone with you during any education? (Name)_____(Relationship) _____

Primary Language: □English □Spanish □Other: _____

Race: □ Asian □ African American □American Indian □ Caucasian □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □Other: _____

Contact Preference: □ Phone □ Email □Text _____

TMH PHYSICIAN PARTNERS

Tallahassee Memorial HealthCare, Inc.
TMH PHYSICIAN PARTNERS

1. Consent and Acknowledgements Relating to My Care and Treatment:
I hereby consent, for myself or, a minor child or another person for whom I have authority to sign to the rendering of medical care and treatment **(including but not limited to medicinal drugs, diagnostic tests and procedures),** that my attending physician(s) and/or other TMH Medical Staff members consider necessary and advisable to treat while a patient of a provider of Tallahassee Memorial HealthCare (TMH). I acknowledge that my medical care and treatment may be provided by physicians (including residents), physician assistants, nurses, medical and allied health students and other health care providers. In addition, I consent to the appropriate disposal by TMH of any specimens or other bodily materials removed during a technical procedure or for testing purposes.

2. Assignment of Benefits/Consent to Release My Information to TMH: I assign to TMH all my right, title and interest in benefits due from any and all insurance carriers, health care plans, health plan administrators, benefit programs, the Centers for Medicare and Medicaid Services (and their agents and review agencies) and/or other payment sources ("Payers"). I authorize my Payers to make payments directly to TMH of any benefits due for services provided by TMH. I acknowledge that TMH has the right to accept or refuse assignment of medical benefits. If my Payers will not allow direct payment to TMH or if TMH refuses to accept assignment of medical benefits, I agree to pay TMH all payments that I receive for services. I consent to my Payers providing TMH with all pertinent financial information concerning coverage and payments made under my health care plans.

3. Notice of Privacy Practices: I acknowledge that a copy of the TMH Notice of Privacy Practice has been provided to me, and that an electronic version of that document is available at www.tmh.org.
Please Initial_____

4. Patient's Rights and Responsibilities: I acknowledge that the TMH Patient's Rights and Responsibilities, has been provided to me, and that an electronic version of that document is available at www.tmh.org
Please Initial_____

5. Advance Directives. Information about your rights to make advance health care decisions (including but not limited to a Living Will, Healthcare Power of Attorney, and Designation of Healthcare Surrogate), as well as your healthcare providers' policies regarding the same can be found on this document, and electronically at www.tmh.org

☐ YES or ☐ NO

Do you have an Advance Directive?
Policy and Procedure on Advance Directives in The Outpatient Clinic Setting:
Patients will receive screening for advance directives during registration of their first visit to the TMH outpatient clinics. Patients are not required to have an advance directive.
Making Your Wishes Known
Advance directives outline predetermined actions you have indicated you desire for your healthcare if you are no longer able to make decisions for yourself due to incapacity or illness. These legally binding documents outline your wishes regarding life support, resuscitation and other interventions for both your healthcare team and your family members.
Living Will
A living will is a written, legal document that spells out medical treatment you would and would not want to be used to keep you alive if you have a terminal condition and cannot speak for yourself.
Healthcare Decision Maker
Your healthcare decision maker is another adult you appoint to make decisions on your behalf when you are unable to do so. It is usually recommended that you appoint someone who knows your wishes and is willing to carry them out, especially regarding your personal, religious, moral, and cultural beliefs. This can be done by signing a written designation of a healthcare surrogate that complies with Florida law. If you are incapacitated, your healthcare surrogate will have the authority to make all the medical decisions regarding your healthcare, including decisions about when to withhold or withdraw life-prolonging procedures.
Durable Power of Attorney
A durable power of attorney for healthcare is another legal document that can be used to name your healthcare decision maker. Once written, it should be signed dated, witnessed, notarized, and copied, and put into your medical record.

IN THE EVENT THE PATIENTS NEED EMERGENCY CARE IN THE OUTPATIENT CLINIC SETTING, WE WILL PROVIDE BASIC LIFE SUPPORT AND CALL 911 TO SUMMON EMERGENCY LIFE SERVICES, UNLESS A PHYSICIAN WHO IS FAMILIAR WITH THE PATIENT'S WISHES AND MEDICAL HISTORY ORDERS OTHERWISE.

This policy is in place because it may not be possible in an emergency situation in the outpatient clinic to determine your chance of survival or recovery. Once you have reached the Emergency Room or Hospital where a better determination of your condition can be made, your advance directive will be honored if you are not able to express your wishes. If you have an advance directive, please bring us a copy of your advance directive so we can electronically scan it into your medical record.

If you need additional information, you may contact an attorney or the Risk Management Department at TMH- 850-431-5364.

Patient Label

TALLAHASSEE MEMORIAL HEALTHCARE

6. Consent for TMH to Release My Medical Information: I hereby authorize TMH to release my medical information to the following persons/entities (my "medical information" includes but is not limited to information relating to the following: medical, psychological, psychiatric, HIV/AIDS, communicable and sexually transmitted diseases, genetic testing and alcohol/drug abuse):

- My other health care providers for treatment or payment purposes, as well as my primary care provider (if I have provided TMH with the name of such provider);
- Payers for the purpose of processing health care claims; additionally, TMH may share my past, current and future health, treatment and patient records about services received from TMH and other providers for the purpose of managing or coordinating my care and improving the quality of that care;
- Person(s) I designate as my guarantor(s) for handling billing and payment of my account;
- Accrediting and quality organizations, regulatory agencies and/or other persons or entities for health care operations; and
- Persons, entities, agencies, and/or other health care providers as required by law, including but not limited to Section 395.1052, Fla. Stat.

7. Health Information Exchange (HIE): An HIE is designed to provide all your medical providers with quick access to medical records to make treatment more effective and efficient. The HIE may limit the need to repeat tests that have already been done, and provide important information that you may not be able to provide because of confusion, stress other medical emergencies. TMH will follow state and federal laws, including HIPAA, when protecting the release of sensitive information. Sensitive information includes but is not limited to behavioral health, drug/alcohol/substance abuse, abuse treatment, sexual abuse, genetics testing, HIV/STD and adoption records. I understand that my information from my medical records will be exchanged among my health care providers through a HIE network. Participating in the HIE is not a condition to receive health care, and I may opt out of participating in the HIE.

If you wish to Opt-Out of the HIE please check ☐ Opt-Out.

8. Acknowledgment Regarding Billing:
I understand that I will receive one or more bills from TMH for the services provided**.** I understand that I will also receive one or more separate bills from the physicians who provide care while I am at TMH, including but not limited to surgeons, Anesthesiologists, Radiologists, Emergency Physicians, Pathologists and other specialists. Pathologists are responsible for analysis of specimens and assuring test results are clinically valid, reliable, and reported in a timely manner to my doctor. I agree to pay for those pathology services unless the pathologist has entered into an agreement with my insurance company to accept payment in full or unless otherwise provided by law.

9. Acknowledgment of Financial Responsibility: I acknowledge that I am responsible and obligated to pay for all charges for services provided, including but not limited to any amount not paid by my Payers, which includes but is not limited to Medicare, a health maintenance organization, an out-of-state workers' compensation policy, or any other Payer. I consent to TMH obtaining consumer credit reports to determine my eligibility for financial assistance and/or payment options. I agree, whether I sign as the patient or as the parent, guardian, spouse, agent or guarantor of the patient, that I am obligated to pay TMH for the services rendered to the patient; if the account is referred to an attorney or collection agency for collection, I agree to pay the reasonable attorneys' fees and costs of collection.

10. Notice to Medicare Patients: I understand that Medicare will not cover certain drugs. I understand that any tablet, capsule, suspension (including eye drops), ointment, patch or suppository will not be paid by Medicare in an outpatient setting even if my doctor ordered it and I received it. If I am unable to pay, please call the Central Business Office at 850-431-7289.

11. **HMO ELIGIBILITY GUARANTEE**: I hereby certify that if I enrolled in an HMO and/or Medicaid HMO that I am receiving health care services through the Primary Care Physician that I have chosen or has been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a statement/bill from TMH.

12. Consent to Contact Me: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from TMH and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services and goods provided by TMH or its affiliates that may be of interest to me. I understand if this information is provided to a third party, this information will no longer be protected by the person or entity that received the information in accordance with applicable law. TMH may not condition treatment, payment, enrollment or eligibility for benefits on your agreeing to this provision.

13. Consent to Photograph/Video: I consent to TMH physicians and staff taking photographs and/or video to be used in connection with my diagnosis, care and treatment, and such photos and videos are the property of TMH. I acknowledge that I may withdraw my consent at any time and that my medical care is not dependent on my agreement to have photographs and/or video taken.

Patient Label

14. Consent to Search: I acknowledge that I am prohibited from bringing to TMH any weapon, explosive device, illegal substance or drug or any alcoholic beverages. If TMH believes at any time that
I have any of these items with me, I consent to TMH my belongings, confiscating any such items that are found, and disposing of them as appropriate, including but not limited to notification of or delivery to law enforcement.

15. Personal Valuables: I understand that TMH does not accept responsibility for any personal property (monetary or sentimental).

By signing below, I acknowledge and agree that I understand, accept and agree to be bound to the terms of this document. I understand that I have the right to revoke the authorizations in this document at any time by notifying TMH in writing, except to the extent that TMH has already taken action in reliance on them. These authorizations remain valid unless/until I revoke them in writing.

I CERTIFY AND STATE THAT I HAVE RECEIVED NO PROMISES, ASSURANCES, OR GUARANTEES FROM ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED BY ANY MEDICAL TREATMENT OR SERVICES.

- If the patient is 18 years of age or older, the patient must sign and date this form.
- If the patient is 18 years of age or older and incapable of signing, a legally authorized person may sign and date the form; please indicate your legal authority and include documentation of that authority:
  ☐ **Legal Guardian** ☐ **Health Care Surrogate/Power of Attorney** ☐ **Spouse/Proxy**
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law; please indicate your authority:
  ☐ **Parent** ☐ **Legal Guardian**

PRINT PATIENT NAME	**PATIENT DATE OF BIRTH**
PRINT LEGAL REPRESENTATIVE NAME	**DATE**
SIGNATURE PATIENT/LEGAL REPRESENTATIVE	**RELATIONSHIP TO PATIENT**

Patient Label

TMH PHYSICIAN PARTNERS

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION Date(s) of Service Requested: **___/___/__to** **___/___/__**	NAME:_____ DATE OF BIRTH:_____/_____/ LAST 4 NUMBERS OF SSN:_____DAY PHONE:_____ ADDRESS:_____ CITY:_____STATE:_____ZIP CODE:_____
RELEASING PARTY (***Who*** has the information you want released?)	NAME:_____ ADDRESS:_____DAY PHONE:_____ CITY:_____STATE:_____ZIP CODE:_____ FAX NUMBER:_____ **(URGENT CARE PATIENT ONLY)**
RECEIVING PARTY (***Where*** do you want the information sent? ***Who*** may have the information?)	NAME:_____ ADDRESS:_____DAY PHONE:_____ CITY:_____ STATE:_____ZIP CODE:_____ FAX NUMBER:_____**(URGENT CARE PATIENT ONLY)**

HOSPITAL (check all that apply):	**OFFICE/CLINIC (check all that apply):**	**BEHAVIORAL HEALTH/SUBSTANCE ABUSE (check all that apply):**
□ Hospital Summary □ Discharge Summary □ History and Physical □ Consultation Reports □ Operative Reports □ Laboratory Reports □ Radiology Reports/ X-Ray Reports □ Pathology Reports □ Entire Record (not including psychotherapy notes)	□ Office Visits □ Immunizations □ Physical Exam □ Laboratory Reports □ Radiology Reports □ Other_____ □ Entire Record (not including psychotherapy notes)	□ Hospital Summary □ Discharge Summary □ Assessments □ Progress Notes □ Laboratory Reports □ Medications □ Entire Record (not including psychotherapy notes)
□ Emergency Record □ Cardiac Reports/ EKG □ Other_____ _____ _____ _____		

FORMAT: □ USB/ CD □ Paper □ Other_____ **DELIVERY METHOD:** □ Mail □ Pick-up □ Fax, where permitted

PATIENT'S RIGHTS- I understand that: 1) I can cancel this permission at anytime. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above; **2)** Any cancellation will apply only to information not yet released by facility or practice; **3)** Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations; **4)** Refusing to sign this form will not prevent my ability to get treatment; **5)** TMH will not share or use my health information without my permission other than by ways listed in TMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at tmh.org; **6)** A fee may be charged for providing the protected health information; **7)** I have a right to receive a copy of this form upon my request.

I DO NOT WANT TO RELEASE (check all that apply):
□ HIV/AIDS □ GENETIC INFORMATION □ SEXUALLY TRANSMITTED DISEASE (STD) □ DRUG/ALCOHOL □ MENTAL HEALTH

This permission expires one year after the date of my signature unless another date or event is written here:_____

Signature:_____ **Print Name:**_____ **Date:**_____

Witness Signature:_____ **Print Name:**_____ **Date:**_____

Note: If a minor consented for their outpatient treatment for pregnancy, STD or behavioral/ mental health without parental consent, the minor must sign this authorization.

Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form.
Check the box below to indicate the relationship/ authority (Written Proof May be Requested):

□ Healthcare Agent/ POA □ Guardian □ Executor/Administrator/Attorney in Fact □ Spouse
□ Parent □ Adult Child □ Affidavit Next of Kin □ Other_____

TMH PHYSICIAN PARTNERS

Consent to Medical Treatment for Minor Accompanied by Persons other than Legal Guardian or Unaccompanied Adolescent Minor TMH Physician Partners

Name of Child: _____ **DOB:** _____

Name of Parent(s) or Legal Guardian: _____

I hereby grant permission to any person named below who is caring for the above-named minor during my unavailability to seek medical care for the above-named minor when he/she finds it necessary.

Babysitters: _____
Friends: _____
Other Family Members: _____
Neighbors: _____
School Officials: _____

I understand, that should the above-named minor be brought to a Tallahassee Memorial Healthcare Physician Partners (TMHPP) clinic for non-routine medical treatment, an attempt will be made to notify me by telephone. I hereby give my consent to TMHPP to the rendering of medical care and treatment (including but not limited to medicinal drugs, diagnostic tests and procedures), that the minor's physician(s) and/or other TMH Medical Staff members consider necessary and advisable to treat. This consent does not include consent for surgery/ invasive procedures, general anesthesia, or provision of psychotropic medications.

This permission shall include any circumstance when I am not present, including, but not limited to, when the above-named minor is unaccompanied or when the above-named minor is accompanied by a person other than me, such as my baby-sitter, friend, other family member, neighbor, or school official designated above.

I certify and warrant that I am the above-named minor's parent or legal guardian, and I have the authority to sign this form without the approval or additional signature of any other person or entity, or (ii) that I have the authority designated by statute and/or court order to consent for any and all forms of healthcare for the above-named minor.

I understand that this authorization shall be in effect until revoked in writing by me. I agree to be financially responsible for payment of all charges that are not paid by any insurance agency for all medical care and treatment services furnished by Tallahassee Memorial Healthcare. I authorize Tallahassee Memorial Healthcare to bill my insurance on file.

Unaccompanied Adolescent Minor's Affirmation

I, the minor named above am an unaccompanied adolescent minor seeking routine medical treatment from a TMHPP clinic. I understand that if I am required to receive treatment that is not routine medical treatment, TMHPP will have to contact my parent(s), legal guardian(s), or legal custodian(s) to obtain consent for such treatment.

Parent(s)/ Legal Guardian(s):

Signature: _____
Print Name: _____
Date: ____/____/____

Adolescent Minor (if minor will be unaccompanied):

Signature: _____
Print Name _____
Date: ____/____/____

Witness Signature: _____ **Print Name:** _____ **Date:** ____/____/____
Witness Signature: _____ **Print Name:** _____ **Date:** ____/____/____

Patient Label

TALLAHASSEE MEMORIAL HEALTHCARE
Ambulatory Care Services

To Our Patients:

Under the Patient Self-Determination Act it is your right under law to accept or refuse medical care. Advance Directives can protect this right if you ever become mentally or physically unable to choose or communicate your wishes due to an accident or an illness.

An Advance Directive is any instruction you give relating to the provision of healthcare in the event you become unable to make your own decisions. Examples of Advance Directives include: Living Will; Durable Power of Attorney; Appointment of a Healthcare Surrogate. When using Advance Directives, you protect your right to make medical choices that can affect your life; your family can avoid the responsibility and stress of making difficult decisions; and your physicians will have guidelines for providing your care.

Living Wills are written instructions that explain your wishes regarding healthcare should you have a terminal condition such as cancer, Alzheimer's disease, etc. They are called Living Wills because they take effect while the patient is still alive.

A Durable Power of Attorney for Healthcare allows you to name a person (called a surrogate/proxy) to make decisions for you if you become unable to do so. Also, in the Power of Attorney, you may list the healthcare decision that you desire concerning life-prolonging care, treatment, services and procedures, as well as special provisions and limitations. These life-prolonging measures may include cardiopulmonary resuscitation, intravenous therapy, feeding tubes, respirators, dialysis, pain relief, Do Not Resuscitate orders, and organ donation.

A Healthcare Surrogate (proxy) is a person you choose to make healthcare decisions for you if you are not able to do so for yourself. This person should be someone who knows your wishes and who will make decisions on what he/she believes you would want.

Once you have completed your Advance Directive, please discuss the details of the directive with your physician, family members, minister, surrogate and/or close friends. Make sure your surrogate has a copy of your Advance Directives, place a copy in the glove compartment of your car and give copies to those whom you feel should know.

If an emergency takes place in our office your Advance Directive would not immediately be honored because it is not possible in an emergency situation to determine your chance of survival or recovery. We would call 911 and begin our emergency procedures unless a physician is present who knows your medical history and Advanced Directive, and gives the order to stop. Otherwise, once you have reached the ER or hospital where a better determination of your condition can be made, your Advance Directive will be honored if you are not able to express your wishes.

If you need help in preparing Advance Directives or if you would like more information you may contact a lawyer, your State Attorney General's office, Hospitals, Hospices and Long-Term Care Facilities. You may also seek information and assistance from the Risk Management Department at Tallahassee Memorial HealthCare by calling (850) 431-5364.