WINMED
—HEALTH—

WINMED HEALTH NEW PATIENT REGISTRATION PACKET 2022

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")
PRINT CLEARLY

Patient First/Last Name: _____ Date of Birth/Age: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Sex: ☐Male ☐Female

Social Security #: _____ - _____ - _____ Email address: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Contact Number: _____ Address: _____

INSURANCE

Insurance: _____ MEMBER Number: _____

POLICY HOLDER FULL NAME _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

OFFICE USE ONLY

SCANNED PICTURE ID: _____ SCANNED ID/INSURANCE CARD: _____

ALL FORMS REVIEWED BY: _____

Email to newpatient@windermeremedicalcenter.com or bring into the office. You will be contacted via text message once registration has been completed and insurance verified.

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Marketplace/ObamaCare Insurance Financial Policy

The Affordable Care Act (ACA) created the Advance Premium Tax Credit (APTC) to assist patients in paying their health insurance premiums. This tax credit does not subsidize the entire premium, and as such, you are responsible for paying the remainder portion of your health insurance premium.

If you purchased your health insurance through the ObamaCare website (www.healthcare.gov), you are required to make your monthly premium payments to avoid a 90-day grace period, which puts you at risk of losing your coverage if payment is not made in full at the end of the grace period.

According to federal regulation §156.270, your insurance carrier is required to notify us if you have defaulted on your premium payments. If we receive such notification from your insurance carrier, we will send you a statement for the balance due on your account for services rendered at Windermere Medical Center. Your account will be placed in a self-pay status until your premiums payments are made in full (we will call your insurance carrier for confirmation of payment). If your policy is canceled due to non-payment of premiums, your account with Windermere Medical Center will remain in a self-pay status.

If your balance with Windermere Medical Center is not paid in full after 90 days, your account will be forwarded to a collection agency to collect on your account.

By signing this policy below, the patient/parent confirms that:

I understand and acknowledge that I am personally responsible to pay Windermere Medical Center in full for services that my health insurance payer will not cover due to non-payment of my health insurance premiums. I further understand and acknowledge that my account will be placed in a self-pay status, and I am at risk for my account being forwarded to a collection agency if I do not pay my balance in full.

I confirm that I have **not** purchased insurance through ObamaCare (www.healthcare.gov). I have insurance through my employer or another private/commercial or Medicare plan, or I am a self-pay patient.

_____ _____

Patient Name/Signature Date

I confirm that I **have** purchased insurance through ObamaCare at www.healthcare.gov; I will comply with this policy regarding my account.

_____ _____

Patient Name/Signature Date

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Adult Health History Form

Name _____ DOB _____

Medical History (*Please check here if no past/current medical history:*)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Screening history:

If over 50, last colonoscopy date: _____ Doctor: _____ Phone: _____

If over 21 (female), last PAP smear date: _____ Doctor: _____ Phone: _____

If over 40 (female), last mammogram date: _____ Imaging center: _____

Surgical History (*Please check here if no surgical history:*)

	Abdominal surgery		Coronary bypass		Hip Surgery		Thyroidectomy
	Appendix removal		Coronary Stent		Hysterectomy (partial)		Tonsillectomy
	Back surgery		C-Section		Hysterectomy (total)		Tubal Ilgation
	Biopsy _____		Endoscopy		Knee Surgery		Vasectomy
	Breast Biopsy		Gallbladder Removal		LEEP		Other _____
	Breast surgery		Gastric Bypass		Neck surgery		Other _____
	Broken Bone		Laparoscopic		Ovary Removal		Other _____
	Cataract surgery		Heart Surgery		Sinus Surgery		Other _____

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Adult Health History Form

Please check here if you are not taking any medications:

Medication Name	Dose (mg)	How many times per day?

Social History

1. Occupation _____ Employer: _____
   Retired Homemaker Student Unemployed
2. Who lives with you? Spouse/Partner Children Roommates Parents Other
3. Tobacco use (including cigars): Current every day Current some day Former Smoker Never used
4. Alcohol use (beer/wine/liquor): 1-3 4-6 7+ per Day Week Month Year No alcohol use

Females

Date of last menstruation: _____ Are you breastfeeding or pregnant? Yes _____ No _____

Family History

Father (Living/Deceased): Please circle: High blood pressure / Diabetes /Cancer _____ / Stroke / Other_____

Mother (Living/Deceased): Please circle: High blood pressure / Diabetes /Cancer _____ / Stroke / Other_____

Other significant family history: _____

Medication allergies: _____

Preferred pharmacy: _____ **Address**: _____

If not establishing for primary care, current primary care provider: _____

PRIVIA MEDICAL GROUP

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home.

We invite you to share with us your preferred place and manner of communication. **You may update or change this information at any time; *please do so in writing.***

Patient Name: _____ Date of Birth: _____
(Print Clearly)

I prefer to be contacted in the following manner (check all that apply):

- ☐ Home Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Phone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication: _____
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work/office address
- ☐ Other: _____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. **Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided.** Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

- Name: _____ Telephone: _____ Relationship: _____
- Name: _____ Telephone: _____ Relationship: _____
- Name: _____ Telephone: _____ Relationship: _____

Patient Signature: _____ Date: _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVIA MEDICAL GROUP

AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Name and Relationship of Person Signing, if not Patient: _____

****Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.***

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Acknowledgement of Winmed Health Registration Packet 2022

Patient Name _____ **DOB** _____

- o I have read and agree to the ***"PATIENT FINANCIAL POLICIES"***

  _____ _____
  Patient or legal guardian signature Date

- o I have read and agree to the ***"PATIENT STATUS AND APPOINTMENT POLICIES"***

  _____ _____
  Patient or legal guardian signature Date

- o I have read and agree to *the* ***"PRESCRIPTION REFILL AND CONTROLLED SUBSTANCES POLICIES"***

  _____ _____
  Patient or legal guardian signature Date

**A copy of these policies will accompany your consent in your medical record and can be provided to you for your record as well.

Consent for Protected Health Information via Secure Text Messaging

I state my preference to have my physician, NP or PAs and other staff at Windermere Medical Center communicate with me by standard SMS messaging. This can be in regard to various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that standard SMS messaging is not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

Please note, we have implemented safeguards to ensure protection of your health information with the use of a secure text messaging service that specifically integrates with our electronic medical record. However, under the 2013 HIPAA Omnibus Rule, we must inform you of the risks involved with transmission of unencrypted texts.

I consent to communicate via text message with Windermere Medical Center.

_____ _____
Patient or legal guardian signature Date

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MEDICAL RECORDS REQUEST-ONLY THE X LINES

X_____ Patient Name

X_____ Date of Birth

PLEASE SIGN FOR FUTURE USE:

X_____ Patient or Parent/Guardian Signature

_____ Date

In office use only

_____ Name of Clinic/Physician Releasing Records

_____/_____ Phone Fax

RECORDS REQUESTED BY:

_____ Niral Patel, MD
_____ Nasimul Siddiqui, MD
_____ Stephanie Antepara, APRN
_____ Nicole Colon, APRN
_____ Hector Rocha, APRN
_____ Morgan Pearsell, PA
_____ Tami Llyod, ARPN
_____ Regina Scott, ARNP

Please include the following and fax to our office: 407-347-3950

_____ STAT: PLEASE SEND RECORDS NOW- PATIENT IN OFFICE
_____ ROUTINE: PLEASE SEND RECORDS ASAP
_____ Progress notes/HPI/H&P
_____ Labs only
_____ Radiology exams
_____ Immunization records

Please fax records to our Administrative fax line 407-347-3950. You may reach us at 407-876-2273 if you have any questions.

11600 Lakeside Village Lane, Windermere, FL 34786 Phone: 407-876-2273 Fax: 407-347-3950
www.windermeremedicalcenter.com

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PATIENT FINANCIAL POLICY

Our goal at Windermere Medical Center is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our financial policy allows us to maintain a good flow of communication and run an efficient medical practice.

We verify insurance eligibility for every patient prior to their scheduled appointments and for all walk-in patients. To maintain a strong financial standing while providing excellent medical care, we have implemented a financial policy of collecting all copays, deductibles, and co-insurances **on the day** of your visit. If we find that you have overpaid, we will issue a refund once the Billing Department reviews your Explanation of Benefits (EOB). If you still have patient responsibility left over, we will send you a statement with a balance due.

FOR PATIENTS WITH INSURANCE:

If you are responsible for a deductible or co-insurance, we will collect a fee up front for your visit, if you have further responsibility you will be billed for these services:

- **INSURANCE** – As a courtesy to our patients, we will file claims on all visits and procedures. When we file a claim on your behalf, it is with understanding that benefits will be assigned to Patel Medical Ventures, LLC dba Windermere Medical Center, Health First Medical Group, LLC. You are responsible for all co-payments, deductibles, co-insurance and non-covered services. ***THE ULTIMATE RESPONSIBILITY FOR UNDERSTANDING YOUR INSURANCE BENEFITS REGARDING PAYMENTS, PREVENTATIVE SERVICES, COVERAGE FOR PHYSICIAN AND LAB SERVICES, PATHOLOGY, RADIOLOGY, AND VACCINATION COVERAGE RESTS WITH YOU.***

- **AFTER HOURS** - If you are seen **after 5pm during the week, or on Saturday, it is considered** ***after-hours***. The after-hours reimbursement billing code (99050) will be submitted for such visits. Your insurance plan may or may not cover this, and therefore, you may or may not incur patient responsibility. Once we receive the explanation of benefits (EOB) from your insurance company, our billing department will review your account to determine your responsibility and send you a statement for remittance of payment if necessary.

- **PREVENTATIVE PHYSICALS WITH LAB REVIEW OR OTHER ADDRESSED ISSUES/CONCERNS** – While your physical exam (preventative/wellness exam) may be covered by your insurance plan, the ***lab review*** component of the visit, or other acute complaints or medication refills addressed during the exam are not considered preventative, and will be billed as such. This portion of your visit may or may not be covered by your insurance, and you will be responsible for any remaining balance applied by your insurance company.

- **PAYMENTS:**

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- **CASH PAYMENTS** – Payments of **$25 or less** are cash only. Please note the following:
- We will not accept credit or debit card payments for **$1.00, $2.00, or $5.00** payments.
- ACCEPTED TYPES OF PAYMENT: Cash, Visa, MasterCard, and Discover. **NO PERSONAL** or **BUSINESS CHECKS** will be accepted.

- **LAB FEES (except Medicare)** – If your provider orders labs, you are welcome to visit a LabCorp or Quest lab facility. We do offer you the convenience of having your labs drawn at WMC; a lab draw/convenience fee of $15 (**CASH ONLY**) will be collected for **physical exams, your initial visit, or any follow-up visit. This includes labs drawn during a walk-in visit.** Your lab specimen(s) will be sent to LabCorp or Quest based on your insurance.

- **NEW PATIENTS** – New patients are responsible for co-payments/co-insurances/self-pay fees/deductibles up front. Payment arrangements for first visits are not authorized.

- **ADMINISTRATIVE FEES**

Windermere Medical Center prides itself on providing excellent medical care and customer service to you and your family. We can also provide administrative services to patients upon request. If you require a specific form, paperwork, or letter for your employer or other reasons, we will charge an administrative fee based on the request. Fees must be paid in full before the letter or administrative service is completed. You must allow 7 days for any form(s) to be completed. You will be notified when your letter or paperwork is complete and ready for pick-up at the front desk.

1. Letter typed and printed on company letterhead, and signed by the physician or other provider (example: special travel arrangements, requirements for service, work accommodations, etc.): **$25**
2. Forms or paperwork for work accommodations (not FMLA), handicap parking placards: **$25**
3. Family Medical Leave Act (FMLA): this requires a face-to-face encounter/appointment with a physician. You will be charged your normal office visit fee, and an **additional $50** to complete the FMLA packet.
4. Disability (Short or Long Term): you must be an established patient for at least one year *with* a physical before disability forms are completed: **$50**
5. Requests for admission into a nursing home or assisted living facility: you must be an established patient for ***at least one year*** with a physical: **$50**

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PATIENT STATUS AND APPOINTMENT POLICIES

- **PATIENT EXPECTATIONS**: At Windermere Medical Center, we do regular check-ups, counseling and screenings to prevent illness and disease progression. In addition, you will also be expected to follow age specific screening recommendations such as cervical cancer screening (PAP), colon cancer screening (colonoscopy), breast cancer screening (mammogram) as well as an annual physical. **YOU WILL BE EXPECTED TO HAVE AN ANNUAL PHYSICAL AND AGE-RELATED SCREENING EXAMS TO RETAIN YOUR PATIENT STATUS. If you are unable or unwiling to comply with these expectations, we encourage you to seek care at another practice.**

- **LATE APPOINTMENT & CANCELLATION POLICY/FEES –** We ask all patients to be courteous of the provider and staff's time and attention for your scheduled appointment. If you arrive late (or call to notify of late provider) ***more than 15 minutes***, your appointment will be cancelled/rescheduled and subject to cancellation fee. If you arrive late, but *before* the 15 minutes, you may still be seen, but other patients showing on time for their appointment will be seen first. **See website for cancellation fees.**

- **APPOINTMENTS** – We provide our patients with two forms of appointment reminders: email and text messages. **It is your responsibility to confirm your appointment.**

- **NON-COVERED SERVICES –** Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and medically necessary". If Medicare or another insurance determines that your visit with our physician or nurse practitioner is not "reasonable and medically necessary", they will deny payment for that service. **You will be responsible for anything not covered by Medicare or your insurance company**. All labs are submitted based on **appropriate codes** to a lab based on one's medical condition.

- **PAST DUE ACCOUNTS –** Unpaid balances must be resolved **prior** to being seen in the office. If necessary, you can visit portal.athenahealth.com to pay your balance. If your account is 90 days past due, your account is subject to collections from a third-party collection agency.

- **CARD ON FILE** - Windermere Medical Center will require you to have a card on file in order to schedule an appointment. This will be used to collect outstanding balances. You will receive an email notification 5 days prior to each charge and an email receipt will be automatically sent. You may also use your card on file to pay time-of-service payments.

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PRESCRIPTION REFILL AND CONTROLLED SUBSTANCES POLICY

Our goal at Windermere Medical Center is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our Prescription Refill and Controlled Substances Policy allows us to maintain a good flow of communication and run an efficient medical practice. Please review the policy below:

MEDICATION FOR CHRONIC CONDITIONS

1. All new patients must establish with a Windermere Medical Center provider prior to having a prescription refilled.
2. Additional lab tests may be required to determine exact dosages of prescribed medications; your insurance may or may not cover these tests. It is your responsibility to check with your insurance company to determine what they will cover.
3. Depending on the type of medication you are on, you *must* be seen by a Windermere Medical Center provider **every three to six months** (or more frequent if necessary) to have your prescription refilled. This will be considered a regular office visit and billed accordingly. You will also be required to have bloodwork at least every six months for medications for chronic conditions.

CONTROLLED SUBSTANCES

1. Controlled substances (pain, sleep, muscle relaxants, stimulants, testosterone/hormone replacement) are tracked by the State of Florida Prescription Drug Monitoring Program (PDMP). Pharmacies and physicians can track your usage of controlled substances through obtaining an online report, which annotates physicians who have prescribed, and pharmacies who have dispensed these medications.
2. New patients who request a controlled substance for acute pain may receive **one** prescription of pain medication or controlled substance (at the discretion of the physician) after a PDMP report is obtained.
3. Windermere Medical Center physicians **do not refill narcotic medication prescriptions on an ongoing basis**. If you require such medications, you will be referred to a pain management specialist or other specialist related to your condition.
4. If the physicians at WMC are dispensing a controlled substance (non-narcotic pain medication, sleep medication, muscle relaxant, ADHD medications, testosterone, or hormone replacement), **you are required to have a face-to-face encounter every 3 months for prescription refills.**
5. Failure to comply with this our Prescription Refill and Controlled Substance Policy will result in dismissal from Windermere Medical Center.

PRIOR AUTHORIZATIONS FOR MEDICATIONS

We will make every effort to ensure that you receive the safest, most effective, and reasonably priced prescription drugs that are best suited for your healthcare. We also abide by regulations set by insurance companies and government agencies. Many health insurance companies or plans are requiring Prior Authorization or approval for your medication.

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- This is an additional and labor-intensive service our medical staff completes; we will charge an administrative fee of **$50 per authorization**. This cost is an out-of-pocket expense to you and is **not covered** by insurance. Additionally, there is no guarantee of authorization of the medication.