



WINMED HEALTH NEW PATIENT REGISTRATION PACKET

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

Preferred Locations Windermere Kissimmee Clermont

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 ID Number: _____

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

Secondary Insurance: _____ Policy Number: _____

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

First and Last name of your current Primary Care Doctor: _____

Email to newpatient@windermerehospital.com or bring into the office. Submit with a copy of photo identification and insurance card. Once registered and insurance has been verified, you will be contacted via text message to schedule your first appointment.



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



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 ligation
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 _____



Adult Health History Form

Please check here if you are not taking any medications:

<u>Medication Name</u>	<u>Dose (mg)</u>	<u>How many times per day?</u>

Social History

- Occupation _____ Employer: _____
 Retired Homemaker Student Unemployed
- Who lives with you? Spouse/Partner Children Roommates Parents Other
- Tobacco use (including cigars): Current everyday Current some day Former Smoker Never used
- 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: _____



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.**



Acknowledgment of Winmed Health Registration Packet

Patient Name

DOB

- I have read and agree to the ***“PATIENT FINANCIAL POLICIES”***

Patient or legal guardian signature

Date

- I have read and agree to the ***“PATIENT STATUS AND APPOINTMENT POLICIES”***

Patient or legal guardian signature

Date

- 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 a confidential method 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 the 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 the transmission of unencrypted texts.

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

Patient or legal guardian signature

Date



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: _____

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

Send all communication through my Patient Portal

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)



Medical Records Request

Patient Name _____ Date of Birth _____

PLEASE SIGN FOR FUTURE USE:

Patient or Parent/Guardian Signature _____

→OFFICE USE ONLY

RECORDS REQUESTED BY:

- | | |
|--------------------------------|------------------------------|
| _____ Niral Patel, MD | _____ Morgan Pearsall, PA |
| _____ Nasimul Siddiqui, MD | _____ Hector Rocha, APRN |
| _____ Radha Desai, MD | _____ Tatiana Santander, PA |
| _____ Stephanie Antepara, APRN | _____ Regina Scott, APRN |
| _____ Nicole Colon, APRN | _____ Tamra Lloyd, ARNP |
| _____ Eyad Elfar, MD | _____ Rachelle Mercado, ARNP |

Name of Clinic/Physician Releasing Records

Phone/FAX

_____ / _____

Please include the following and fax 407-347-3950

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

If you have any questions. Please fax records to our Administrative fax line at 407-347-4430. You may reach us at 407-876-2273. 11600 Lakeside Village Ln, Windermere, FL 34786 Phone: 407-876-2273 Fax: 407-347-3950



PATIENT FINANCIAL POLICY

Our goal at WinMed Health is to provide and maintain an excellent physician-patient relationship. Informing you of our financial policy in advance 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 leftover patient responsibility, we will send you a statement with a balance due.

MY FIRST VISIT EXPECTATIONS: - We are committed to providing high-quality healthcare and ensuring that your first visit sets the foundation for a positive and effective care journey. The primary purpose of your first visit is to establish a comprehensive understanding of your health status, medical history, and any immediate health concerns. This visit is subject to applicable copayments or deductibles as determined by your insurance plan. Payment arrangements for first visits will not be authorized. It's important to note that **we do not automatically begin care with a physical examination**. If the provider recommends a physical examination, your copayment and deductible for the first visit will be returned after the completion of the physical examination.

FOR PATIENTS WITH INSURANCE:

If you are responsible for a copay, deductible, or co-insurance, we will collect a fee upfront for your visit, and if you have further responsibility, you will be billed for these services. All monies are due at the time of service.

- **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 the understanding that benefits will be assigned to Patel Medical Ventures, LLC dba WinMed Health, 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.*****
- **PREVENTATIVE PHYSICALS AND BILLING POLICY:** – We want to ensure clarity regarding billing for preventive physical exams. While your insurance plan may cover the preventative/wellness exam portion, **any additional services**, such as lab reviews, addressing acute complaints, or medication refills during the visit, are **not** considered preventative and will be billed separately. The coverage for this portion of the visit may vary, and patients are responsible for any remaining balance applied by their insurance company. We recommend checking with your insurance provider to understand the specifics of your coverage. Our goal is



to provide transparent information on billing practices to avoid any confusion and help you make informed decisions about your healthcare expenses.

- o It will be required to sign a separate waiver for every annual visit before such billing will be applied. You may opt out of these services at your wellness visit, but if you want to discuss these services, an additional separate appointment must be made, which will be subject to your copay, deductible, or coinsurance.
- **NEW PATIENT PHYSICAL SCHEDULING POLICY:** As a new patient, if you request a Physical without a prior history in our records, please be aware that we require an establishment visit to familiarize ourselves with your health concerns and issues. While we cannot guarantee a Physical during the first visit, it is at the provider's discretion. Any out-of-pocket costs associated with the visit must be settled upfront. If the visit leads to a Physical, and you've made an upfront payment, a refund may be issued on the same day. However, since we have no history, it is essential to establish a care plan for you. Physicals are limited to once annually, with a scheduling requirement of 366 days after your last Physical. We urge new patients, especially those self-scheduling, to be aware of these policies when making appointments.
- **PAYMENTS:**
 - o **CASH PAYMENTS** – Payments of **\$15 or less** are preferred cash only. Please note the following:
 - o We will not accept credit or debit card payments for **\$1.00, \$2.00, or \$5.00** payments.
 - o **ACCEPTED TYPES OF PAYMENT:** Cash, Visa, MasterCard, and Discover. **NO PERSONAL or BUSINESS CHECKS** will be accepted.
- **LAB FEES (except Medicare/Medicare Replacement Plans)** – If your provider orders labs, you are welcome to visit a LabCorp or Quest lab facility. We offer you the convenience of having your labs drawn at WMC; a lab draw/convenience fee of \$15 (**CASH PREFERRED**) 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.



- **ADMINISTRATIVE FEES:** - WinMed Health 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 seven 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. Letters 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) 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**



PATIENT STATUS AND APPOINTMENT POLICIES

- **PATIENT EXPECTATIONS:** - At WinMed Health, 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 ANNUAL PHYSICAL AND AGE-RELATED SCREENING EXAMS TO RETAIN YOUR PATIENT STATUS. If you are unable or unwilling 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 their scheduled appointment. If you arrive late (or call to notify us of the late arrival) by *more than 15 minutes*, your appointment will be canceled/rescheduled and subject to a cancellation fee of \$50. If you arrive late but *before* the 15 minutes, you may still be seen, but other patients showing up on time for their appointment will be seen first. If you need to cancel your appointment, please cancel 48 hours before your scheduled time. If not, you will be subject to a late cancellation fee of \$50. If you miss your appointment, you will be charged a no-show fee of \$50. This fee will occur if you schedule an appointment and then reschedule/cancel/no-show within that 48-hour window of that appointment. A fee of \$50 will apply.
- **RESCHEDULING POLICY:** - We recognize that unforeseen circumstances may necessitate appointment rescheduling. To maintain operational efficiency and conserve valuable resources, our existing late reschedule fee is not profit-driven but serves to discourage frequent cancellations. In cases of chronic rescheduling (more than 10 times in one year), we will initially limit schedule access, with continued behavior potentially resulting in dismissal from our practice.
- **APPOINTMENTS** – We have a virtual checkout process, and we utilize automatic scheduling. A text is sent at the time the appointment is made. We provide our patients with two forms of appointment reminders: email and text messages. It is your responsibility to confirm that your number can receive text messages, and the appointment reminder sent to the working text number is the acknowledgment of the appointment. **It is your responsibility to change or cancel your appointment.**
- **PHONE CALLS/PORTAL MESSAGES TEXT:** - Portal messages, text messages, or phone calls requiring more than 5-10 minutes of a provider's time outside a standard visit, insurance typically covers the charge. However, any uncovered portion will be subject to your copay, deductible, or coinsurance. A confirmatory text message will be sent, signifying your consent for insurance billing.



- **NON-COVERED SERVICES** – Medicare and certain other insurance companies will only pay for services they deem “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** - Winmed Health does require you to have a card on file. If you elect to put your card on file, you will be responsible for the charges that are applied.



PRESCRIPTION REFILL AND CONTROLLED SUBSTANCES POLICY

Our goal at WinMed Health 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 WinMed Health provider prior to having a prescription refilled.
2. Additional lab tests may be required to determine the 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 WinMed Health provider **every three to six months** (or more frequently 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 by 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. WinMed Health 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 our Prescription Refill and Controlled Substance Policy will result in dismissal from WinMed Health.



PRIOR AUTHORIZATIONS FOR MEDICATIONS

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

- 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 for the medication.