LABRADOR PRIMARY CARE CENTER

6775 Crosswinds Drive N, St. Petersburg, FL 33710 Ph (727) 381-8006 Fax (727) 381-9629
2191 9th Avenue N, #220, St. Petersburg, FL 33713 Ph (727) 327-9667 Fax (727) 321-1655
2200 56th Street S, Gulfport, FL 33710 Ph (727) 381-8006 Fax (727) 381-9629

ANNUAL UPDATE

_____ _____ ____ _____/_____/_____
Patient Last Name First Name MI Date of Birth

(_____)_____-_____ (_____)_____-_____ _____
Home # Cell # Email

_____ _____ ____ _____
Mailing Address City ST Zip

_____ _____ _____ _____
Physical Address (if different than mailing) City ST Zip

_____-_____-_____ ❑Male ❑Transgender ❑ Single ❑ Married ❑ Divorced
SSN# ❑Female ❑ Widowed ❑ Life Partner

_____ _____
Employer Occupation

INSURANCE INFORMATION

_____ _____
Primary Health Insurance Carrier ID#

_____ _____
Secondary Health Insurance Carrier ID#

Language_____Race_____Ethnicity _____

EMERGENCY CONTACT

_____ _____
Name Relationship

_____ _____ _____ _____
Mailing Address City ST Zip

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home # Cell # Work #

May we share your protected health information with this person? ❑ Yes, you can share information
❑ No, just use as emergency contact

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

LABRADOR PRIMARY CARE CENTER PATIENT NAME_____D.O.B. _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO LABRADOR PRIMARY CARE CENTER

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to Labrador Primary Care Center and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.
I further authorize you to provide to and discuss with Labrador Primary Care staff and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Authorized to release medical records:

Dr. _____

Address: _____

Phone (_____)_____-_____ **Fax (_____)_____-_____**

Release medical records to: LABRADOR PRIMARY CARE CENTER

- ❑ **6775 Crosswinds Dr. N, St. Petersburg, FL 33710** **Ph: 727-381-8006** **Fax: 727-381-9629**
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Which Records? ALL medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports. Include the following **circled** items:

Progress notes	**Case Manager notes**	**Mammogram**	**Echo / Stress test**
Emergency Dept notes	**Discharge Summary**	**Colonoscopy / FOBT**	**EKG**
Operative Reports	**Labs**	**DEXA**	**ALL MEDICAL RECORDS**
Consultation Reports	**Radiology reports**	**Eye exam**	

Purpose of Disclosure: Continuity of care

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release of information may no longer be protected by Federal privacy regulations. I understand that I am not required to sign this Authorization to ensure treatment and I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rule. This authorization shall remain valid for 12 months from the date signed below.
Any re-disclosure of this information by recipient is not protected under this authorization.

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

1st request_____2nd request_____3rd request _____

Consent for Release of Protected Health Information to Personal Representative

I give my written consent for Labrador Primary Care Center to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that Labrador Primary Care Center may share my Protected Health Information with:

Name_____Relationship_____

Name_____Relationship _____

I ***do not*** want my Protected Health Information shared with anyone other than myself at any time. ***Initial here***___

_____**INITIAL** **PATIENT AUTHORIZATIONS**

Authorization to view RX history from External Source

I authorize Labrador Primary Care Center to view any and all available RX history from an external source. I am aware that Labrador Primary Care Center and Staff use a secure connection to SureScripts to send and receive most prescriptions in the office.

HIPAA Privacy Notice / Office Policy Agreement

I have received and read a copy of Notice of Privacy Practices/ Office Policies and agree to comply with Office Policies

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Labrador Primary Care Center for the purpose of diagnosing, providing treatment to me, or obtaining payment for my health care.

Authorization for treatment

I hereby authorize Labrador Primary Care Center staff to render medical services and treatments as deemed necessary.

_____**INITIAL** **FINANCIAL AGREEMENT & PAYMENT POLICY**

You are financially responsible for all services rendered in this office.

We may file your Insurance as a courtesy, however any final balance due is ultimately your responsibility.

All co-pays / deductibles and /or account balances are collected at the time of check-in/out

No samples or non-medically necessary prescriptions will be dispensed or written for patient if account is in overdue or collections status.

Lab draw fees - $20 blood draw fee for all private pay patients. Medicare recipients are excluded.

Late cancellation / No-show - **$35** fee will be assessed for all provider appointments not cancelled with 24 hours' notice

NSF/Return Checks fee – $45 Returned checks will have fees assessed and will be due within 10 days of bank notification.

Form Fee Agreement – **$15** - Disabled Parking Application (forms provided by DMV provided)

$55 - FMLA / School / Educational / Disability / Limitation Forms

Patients covered by Insurance – I hereby agree to allow Labrador Primary Care Services to file any claims to my insurance company or companies for payment of services rendered in this medical practice. I fully understand that any unpaid balances not covered by my insurance company due to insurance cancellation, deductibles, co-insurance, co-payments, or non-covered services, will be deemed due within 30 days from date of service. (Financial agreements will have to be made with management to carry balances over this period of time.)

Self pay patients – Patients seen without insurance coverage will be required to pay the full amount for services rendered on the day of services. Provider visits, lab draws, injections, procedures, and treatments are each priced separately. You will be given all pricing information prior to services being rendered.

Patient accounts with overdue balance or in collection status will have to be paid in full prior to having another appointment. (unless prior arrangements have been made with management)

_____INITIAL **OFFICE POLICY AGREEMENT**

1. Accounts must be kept current in order to continue to receive care.
2. Co-pays, deductibles, and overdue balances are collected prior to appointment.
3. Please arrive 15 minutes before your appointment time
4. Appointments are cancelled if you have not arrived after 15 minutes of appointment time.
5. Provider & Physical Therapy appointments require a 24-hour notice to cancel/re-schedule.
6. All medicine bottles must be brought to each office visit.
7. Medication refills / new requests:
    a. Medications can only be prescribed to patients that have been evaluated in the last year.
    b. Prescriptions only provided during office hours; do not contact the on-call provider for refills.
    c. Request refills when you are near the end of your current supply; we request 24 hours to process refills.
8. Office visits with Providers:
    a. Please do not ask us to address health issues of family members during your appointment.
    b. Respect our schedule and address all questions within your 15 min. appointment time frame.
9. Due to large call volumes, your call may be routed to our answering machine. Please leave a clear message including your name, date of birth, and phone number so that we can return your call promptly.
10. To best answer all your questions we ask that you return to the office to obtain your lab and test results.

_____INITIAL **CANCELLATION / NO SHOW POLICY**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

1. All provider appointments, including physical therapy which are cancelled with less than 24 hours notification may be subject to a **$35 cancellation fee**; this fee will not be billed to your insurance company. This does not apply to Lab or nursing appointments.
2. Patients who do not show up for their appointment without notification will be considered as NO SHOW and will be subject to a **$35 NO SHOW** fee. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.
3. We understand that delays can happen however we cannot delay the next patient's appointment. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.
4. All cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

BEHAVIOR CONTRACT

As a patient in this office, you have a responsibility for conducting yourself in a manner consistent with appropriate behavior. We are establishing expectations as to what is, and is not, considered "appropriate behavior" with respect to what will be tolerated in our office. "Appropriate behavior" is defined, but not specifically limited to, the following:

1. You will neither threaten nor carry out any form of physical abuse to any physician or other staff members involved in your care in this office.
2. You will not touch any physician or other staff members involved in your care.
3. You will not emotionally, psychologically or mentally abuse any physician or other staff member involved in your care. Examples of such activities include, but are not limited to, swearing, bullying, insulting, demeaning, degrading or otherwise using offensive language during the course of office visits, telephone calls, e-mails or other communication with the office staff during the course of your seeking care. Such behavior will not be tolerated at any time and may result in your being transferred from the office's care.
4. You will also conduct yourself appropriately with other patients seeking care in the office. Failure to do so will be considered the equivalent of acting with inappropriate behavior to the staff.
5. You will come to your appointments as scheduled. You will not consistently cancel or “No-show” for appointments. You will have ample opportunity to change appointments when absolutely necessary, but no-call, no-show will not be tolerated. Processes are in place to transfer you from the practice if necessary.

Our Commitment & Responsibilities to You

We are committed to doing all we can to treat your health conditions. We consider our working with you to be a partnership where we will work together cordially and respectfully to help you achieve your best health. As a part of that commitment, we will offer you recommendations as to treatments and/or therapies to help you achieve your best health. Moreover, we will respect your choices and decisions with respect to how you wish to manage and address your health.

Patient Statements

I have been informed that in order to remain a patient of the practice, I need to conduct myself so that my behavior is appropriate within the office setting. Appropriate behavior needs to be exhibited to any physician who practices in the office as well as to the office staff. Appropriate behavior also needs to be exhibited towards other patients on the premises who are seeking care for their own maladies.

I have been informed and understand that, while my physician will make recommendations as to treatments and/or therapies that could improve my health, my physicians will ultimately respect my decisions with regard to management of my health and well-being.

In addition, I authorize Labrador Primary Care Center to provide a copy of this agreement to my pharmacy, other healthcare providers, or insurance carrier upon request. I also authorize and consent to allow my physician/physician assistant and any other office personnel to disclose or share my medical information and treatment received with any other third parties for purposes of treatment and/or payment purposes. In addition, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to authorizing Labrador Primary Care Center and its personnel to cooperate fully with any state or federal law or any state or federal agency (eg. CMS).

I certify that the information provided by me is correct to the best of my knowledge. Labrador Primary Care Center or any staff members will not be responsible for any errors or omissions that occur secondary to incorrect or incomplete data on this form.

By signing I affirm that I have read, understand, and agree to all of the above authorizations and policies

Signature _____ _____/_____/_____

Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

PATIENT CONTRACT FOR PAIN CONTROL

Chronic pain may be helped with the use of narcotic pain medications. A doctor may prescribe appropriate narcotic medications for your specific type of pain. Narcotic pain medications may:

a. Become ineffective with time.
b. Become habit forming or cause addiction.
c. Cause severe constipation that requires frequent use of laxative.
d. Interfere with your ability to operate complex machinery. It is recommended that you not drive an automobile or operate such machinery as power tools while taking narcotic medications.

I understand that a chronic pain problem may require the prescription for narcotic pain medication for relief of pain and to improve my functional ability. The risks, benefits and alternatives of medication have been discussed with me by the physician in detail, including but not limited to, drug dependency, respiratory depression, cardiovascular depression, liver and/or kidney damage, etc.

I will not take any illegal substances.

I will have my prescriptions filled only by my Pain Management doctor and/or my Primary Care Doctor at only one pharmacy and I will notify my Primary Care Physician of the name of the pharmacy if prescribed by Pain Management doctor.

I waive my right to privacy regarding these medication(s). My physician may contact any health care provider, legal authority, other doctors and or pharmacy to obtain or provide information about the patient's care.

I will take the medication(s) only as prescribed and will notify my physician if I do not. If necessary, I agree to random urine and blood tests to assess my compliance.

I understand that the eventual goal is to taper off the narcotic medication(s). I agree to meet regularly with my physician to assess my progress.

Federal and state law regulates dispensing narcotic medications. Forging or altering a narcotics prescription is a crime. Mandatory compliance by both the patient and physician is required. Failure to comply with all the laws regarding narcotic medications may result in criminal action being taken against you. We will notify also your insurance carrier.

Refills will not be given early for any reason. PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS. No narcotics can be given over the telephone. NO AFTER HOURS CALLS WILL BE ACCEPTED FOR THESE MEDICATIONS.

An increase in your pain will NOT necessarily be a reason to increase your pain medication. Contact the doctor for an appointment if you feel a change in your medication is needed.

Eliminating or rescuing the use of your narcotic medications may be a treatment goal, and this may require hospitalization. A psychological evaluation regarding addiction and drug dependency may be necessary for continuation of narcotics more than 3 (three) months.

Failure to follow these instructions may require the doctor to stop prescribing narcotic medications and recommend treatment in a psychiatric, substance abuse, or detoxification program. If this should occur, the doctor may continue to manage your pain in other ways, such as with non-narcotic medications.

If I deviate from the above guidelines or if the medication losses its effectiveness in increasing my function ability, I understand that the narcotic may be tapered off by the physician. My signature at the bottom indicates my understanding and agreement with the above guidelines.

Your signature below indicates that you have read and understand these instructions and that you agree to comply with the terms of this agreement.

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____