Drs. Elias & Oakley, PA
63 East 3rd Street
Apopka, FL 32703
www.apopkafamilydoctors.com

Adult Patient Packet Contents:

We appreciate you having these forms completed to the best of your ability prior to your office visit.

1. Pages 1-2 are General Patient Demographic Forms.
2. Page 3 is an Adult Medical History Form.
3. Pages 4-6 are forms on our Practice Policy and Procedures which must be signed.
4. Page 7 is a form to list your current medications. Please include Name, Strength, and frequency. For example:

   Made up Diabetes pill 500mg 3 pills by mouth morning and night.

5. Page 8 is a Medicare Signature on file authorization.
6. Pages 9 and 10 are our Privacy and procedure Policies.
7. Page 11 is Authorization to allow us to share you information with another individual including spouse, close friend, caregiver, etc. **This is OPTIONAL.**

Dr. George Elias, DO & Dr. Theresa Oakley, DO
63 East Third Street Apopka, FL 32703
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ADULT PATIENT INFORMATION: Please write clearly.

Last Name: _____ First Name: _____MI:_____

Mailing Address: _____City:_____

State_____ Zip_____ Sex: M or F Date of Birth: _____ Age:_____

Home Phone #:_____Cell #:_____ Work/other # _____

Which is the best phone number to reach you and/or leave a message? ☐ Home ☐ Cell ☐ Work

SSN: _____ - _____ - _____ Marital Status : M S W D

Home Address (if different from mailing address) _____City: _____

State _____ Zip _____ Email address: _____

Can we email you information from our office?_____ including appointment reminders?_____including general newsletters?_____

Occupation: _____ Employer Name: _____

Employer Address:_____City:_____ State:_____Zip:_____

Spouse Name: _____Spouse Employer: _____

Please check the appropriate box:

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ decline to answer

Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ decline to answer

Primary Language: ☐ English ☐ Spanish ☐ Other:_____

Please provide insurance card and drivers license to receptionist. Please notify us of any changes in your insurance information. COPAY AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

Policy Holder's Name :_____ Relationship to Patient _____

Policy Holder's SS# _____ - _____ - _____ Policy Holder's Date of Birth _____

Policy Holder's Employee Address: _____

Policy Holder's Home Phone Number _____ Policy Holder's Work Phone Number_____

Please provide contact information for nearest living relative, not in your household, that we may contact in case of emergency.

Name: _____ Relationship:_____ _____

Phone: _____ Alternate Phone Number:_____

Address: _____ City: _____ State _____ Zip _____

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Page 2 Adult Information

How did you hear about us?

_____

Advanced Directive: All adults in health care settings have the right in the state of Florida to an "advanced directive". This is a written or oral statement made and witnessed in case of a serious illness or injury, stating how medical decisions will be made for you. An advanced directive enables you to state your decisions, or may name someone to make decisions for you, if you should become unable to make decisions about your own medical treatment. In signing this statement, you understand that information is available to you on advanced directives. Please ask us for more information or go to www.floridahealthfinder.gov.

SIGNATURE: _____DATE:_____

At times, we may need to view your previous prescriptions so that we may care for you to the best of our abilities. By signing this, you grant Drs. Elias & Oakley, permission to view prescription history from external sources.

SIGNATURE: _____DATE:_____

I authorize the release of any medical information necessary to obtain payment of medical benefits from my health insurance company. I authorize my insurance company to pay Drs Elias & Oakley, PA any medical benefits due for their services. I understand that I am responsible to pay deductibles, copays and any other charges not paid by my insurance company.

Our policy is that payment is expected in full at time of service, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company, initially, for services rendered. You are responsible for repeated filings of insurance or filing to secondary insurance. **Co-payments and deductibles are due at time of your office visit**. There is a $30.00 return check fee. If your account becomes delinquent, you are responsible for your bill plus all collection costs. Please read our additional office policy form for further information regarding payment policies.

You are responsible for notifying us of any changes in your insurance information, billing address, phone numbers.

You may request a copy of our Notice of Privacy Practices in accordance with HIPPA law. If you would like significant others to receive personal medical information about you, it is necessary to complete a Disclosure Form.

To the best of my knowledge the above information is correct. I understand and agree to comply with Drs. Elias & Oakley, PA financial policies.

SIGNATURE: _____ **DATE**: _____

PRINT NAME: _____

MEDICAL HISTORY: Please circle if you have now (or have had) any of the following:

Seizures	Bowel Trouble	Bleeding Disorders	Thyroid Disease	Gout
Migraines	Angina	Hemorrhoids	Anemia	Gallbladder Disease
Stroke	Bypass Surgery	Hepatitis	Arthritis	Circulatory Problems
Allergies	Heart Trouble	Liver Disease	HIV/AIDS	Asthma
Glaucoma	Heart Murmur	Stomach Ulcers	Cancer _____	Tuberculosis
Cataracts	Palpitations	Kidney Infections	Depression	Emphysema/COPD
Hearing Trouble	Pacemaker	Kidney Stones	Suicide	Osteoporosis
Blood Clots	High Blood Pressure	Prostate Trouble	Drug Abuse	Other:_____
Skin Cancer	High Cholesterol	Diabetes	Alcohol Abuse	_____

REVIEW OF SYSTEMS: Please circle if you are ***currently*** having any of the following symptoms:

Weight loss/gain	Swallowing Difficulties	Chest Pain	Excessive Urination
Unusual weakness	Ear Pain	Abdominal Pain	Painful Urination
Bleeding	Allergies	Nausea	Blood in Urine
Fever	Neck Pain	Vomiting	Joint Pain
Vision Changes	Cough	Diarrhea	Back Pain
Hearing Changes	Shortness of Breath	Constipation	Memory loss
Nose Bleeds	Wheezing	Rectal Bleeding	Dizziness
Leg Swelling	Palpitations	Heart Burn	Headaches
Muscle Cramps	Rashes	Erection Problems	Other

ALLERGIES: Are you allergic to anything?

_____

Last Physical: _____

Colonscopy: _____

Pneumonia vaccine: _____

SOCIAL HISTORY: Do you now or have you consumed:

Cigarettes ___ yes ___ no _____Packs/Day ____# of years _____quit

Alcohol/beer ___yes ___ no _____ drinks/week

Street Drugs ____ yes ____ no _____ type

Caffeine _____yes _____ no _____ cups/day

PREVIOUS SURGERIES: _____

NAMES OF SPECIALISTS YOU SEE: _____

_____

FAMILY HISTORY: Circle the following health problems that occur in your family:

Asthma	Bleeding Disorder	Emphysema	High Blood Pressure	Other:
Anemia	Colon Cancer	Seizures	High Cholesterol	
Osteoporosis	Diabetes	Depression	Heart Attacks	
Heart Trouble	Breast Cancer	Strokes	Prostate Cancer	

RELATION	AGE	DECEASED AGE	HEALTH PROBLEMS	CAUSE OF DEATH
Father				
Mother				
Sister				
Brother				

FEMALES ONLY: Could you be pregnant now?_____ Birth Control Method _____

How many times have you been pregnant?_____ How many children do you have? _____

Date of last pap smear _____ last mammogram _____ last bone density _____

Please circle if you have now (or have had in the past) any of the following:

Breast Surgery		Sexually Transmitted Disease	Menstrual Difficulties	Abnormal pap smear
D&C	HPV	Hysterectomy	Abnormal Mammogram	Ovarian Cysts	Tubal Ligation

PLEASE GIVE A LIST OF YOUR CURRENT MEDICATIONS TO OUR MEDICAL ASSISTANT.

Name:_____Date of Birth:_____ Age:_____

FOR OFFICE USE ONLY:
Reviewed by: **Date:**

Drs. Elias & Oakley, PA
63 E 3rd St
Apopka, Fl 32703
Phone: 407-889-9800
WWW.ApopkaFamilyDoctors.com

Thank you for choosing us as your primary care providers. We are committed to providing you with quality care and creating a long-lasting relationship. Every physician office that you go to may operate differently; therefore we have created this information sheet so that you may be aware of our office policies. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Prescription Refills: **Please bring all medications to ALL office visits**. Many patients see multiple physicians and medications can change frequently. Medication errors and drug interactions may be serious. If all medication bottles are reviewed at time of the office visit, and all necessary refills made, safety is improved. Follow up appointments are schedule to correlate with medication refills. Antibiotics, pain medications, or controlled drugs will not be refilled without the patient being seen. Prescription refills are not given over the phone after hours.

Physicals: These appointments are to focus on wellness and preventative care. In most cases, because of your insurer's payment policy, we may have to complete your wellness care and your illness care on separate visits. If you have a health problem you want to discuss with your doctor during your well visit, the doctor may decide to treat that problem and ask you to schedule another appointment for your well visit. Please be aware not all insurance companies cover physicals.

After Hours: Currently our normal operating business hours are Monday through Friday from 7am to 4pm Eastern Time. We are available after hours by phone for emergency advice only. The after- hours doctor will not call in medications over the phone, this includes pain medications and antibiotics. If you need emergent or urgent medical attention we recommend that you go to the nearest emergency department or walk in center. We take pride in usually being available for same day appointments and can usually provide care by evaluating a non-emergent problem in person the next business day. Same day appointments do fill up quickly, please call early to be worked in. If you need to report an urgent condition to the doctor on call, please call 407-889-9800 and follow the instructions.

No Shows/Cancellation: We understand that circumstances occur where it may be necessary to cancel an appointment. We request that you notify us 24 hours in advance. This way we are able to take care of another patient in that appointment slot. We reserve the right to dismiss a patient from our practice for frequent short notice cancellations and/or "no-shows". Please note that we expect you to reschedule all missed/cancelled appointments so that continuity of care and follow-up of previous problems or test results are not missed. We make sure that all patients have enough refills to last until the next follow-up appointment by asking if you need refills at each and every visit. If an appointment is missed and not rescheduled, then it is likely that you will run out of medications.

Test Results: We call you with all test results, whether normal or not. We may request that you make an appointment to discuss test results in person. This way we can spend time making treatment recommendations with you and make decisions together regarding your plan of care. If you do not hear from our office within 1 week of doing the prescribed test, please contact our office immediately!

Labs/Referrals: All patients are required to know which laboratory, medical provider, or facilities their insurance company is contracted with. We will not be responsible for any expenses incurred by a patient if they end up being referred to the wrong lab or non-covered facility/provider.

Payment Policy:

1. Insurance. We participate in most insurance plans, including Medicare. If you have a plan we do not accept, payment is due at time of service. If you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your State or Federal Government Issued Identification; and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims as a courtesy to our patients and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. Please be aware that the balance of your bill is your responsibility. Your insurance benefits are a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In addition to the amount owed, you also will be responsible for the fees chaged by the collection agency for costs of collections, attorneys fees, and court costs.

We understand that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us for assistance in the management of your account. We accept cash, check, Visa, Mastercard, American Express, and Discover card. There is a $30.00 return check fee .

Thank you for understanding our office policies. Please let us know if you have questions or concerns.

Our practice is committed to providing the best treatment to our patients. If you have any questions please notify the office staff.

I have read and understand these policies and agree to abide by their guidelines:

_____ _____

Printed Name of Patient and Guardian **Date**

_____

Signature of Responsible Party/Person/Gaurdian

Drs. Elias & Oakley, PA

63 East Third Street Apopka, Fl 32703

MEDICATION LIST

DATE:	MEDICATION:	STOP DATE	REASON/REACTION

ALLERGIES: _____ **Pharmacy Name/Number/Address:**

PATIENT NAME: _____

Drs. Elias & Oakley, PA
63 East Third Street Apopka, Fl 32703

Medicare Signature on File Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Drs. Elias & Oakley, PA/ Theresa M. Oakley, DO/George M. Elias, DO* for any services furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services. I also request that payment for authorized Medigap benefits to be made on my behalf to *Drs. Elias & Oakley, PA/ Theresa M. Oakley, DO/George M. Elias, DO* for services provided. I authorize the holder of medical information about me to release to the Medigap insurer listed, any information needed to determine these benefits. I understand that I do not need to provide my supplemental insurer with information concerning this because my signing this authorization will cause Medicare payment information to cross over automatically.

_____ _____

Beneficiary Signature **Date**

_____

Print Name

Drs. Elias & Oakley, PA

63 East Third Street Apopka, Fl 32703

PRIVACY PRACTICES POLICY: **EFFECTIVE DATE: 04/14/03**

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will--

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices.
- ☞ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- ☞ Use and disclose PHI to remind patients of their appointments unless they instruct us not to. Request a phone number in which the patient will permit us to leave a message.
- ☞ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
    - ➢ Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- ☞ Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
    - ➢ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - ➢ Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or law otherwise authorizes the release.
- ☞ Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a **copy** of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--
    - ➢ Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
    - ➢ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- ☞ All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes **other than** TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- ☞ All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- ☞ All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- ☞ Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

PRIVACY PROCEDURES:

- The Privacy Officer will provide the front office staff with an original form for patients to complete when the patient desires to inspect and copy his/her PHI.
- The front office staff will photocopy and make available to patients the form to Inspect and Copy PHI.
- The front office staff will respond to patients' requests and questions concerning inspecting and copying their PHI. In addition, the front office staff will distribute the form to the patients upon their request.
- Once the patient completes the form, the front office staff should forward the form to the Privacy Officer/Physician for review.
- Once the patient has submitted his/her request in writing (using the practice's form is optional), the front office staff must verify that the patient's signature matches his/her signature on file.
- The Privacy Officer must review the patient's request and respond to the patient within 30 days from the date of the request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the patient in writing with the reason for the delay clearly explained.
- The Privacy Officer should agree to all reasonable requests. If access is denied, the Privacy Officer must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.
- When the patient has requested to inspect their PHI and his/her request has been accepted, the Privacy Officer or other authorized practice representative should accompany the patient to a private area to inspect his/her records and remain with the patient during inspection. After the patient inspects the record, the Privacy Officer will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or changes to the record.
- When the patient's request to copy his/her PHI has been accepted, the front office staff should copy his/her record within ten business days at a charge of $1.00 per page.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

By signing this authorization, I authorize Dr. Elias & Oakley, PA to use and/or disclose certain protected health information (PHI) about me to:

_____.

This authorization permits Dr. Elias & Oakley, PA to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information)._____

_____

The information will be used or disclosed for the following purpose:_____

_____.

The purpose is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Drs. Elias & Oakley, PA. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and my no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Drs. Elias & Oakley, PA
63 E 3rd Street
Apopka, FL 32703

_____ _____

Signature of Patient/Legal Guardian Date

_____

Patient's Name

The original form is to be kept in the patient's medical record. The patient/guardian can be provided with copy of signed copy, if requested.