Patient Demographic Update

FULL/LEGAL NAME: _____
(First) (MI) (Last)

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT INFORMATION

HOME#: _____ CELL#: _____ WORK#: _____

EMAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS & PHONE#: _____

_____

INSURANCE INFORMATION

INSURANCE: _____

POLICY NUMBER: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SECONDARY/SUPPLEMENT INSURANCE: _____

POLICY NUMBER: _____ MEMBER ID: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

IF YOU ARE TREATING AT OUR OFFICE DUE TO AN INJURY
(EXAMPLE: AUTO ACCIDENT, SLIP & FALL, WORK COMP OR ANY OTHER TYPE OF ACCIDENT)

ATTORNEY NAME: _____ PHONE#: _____

PATIENT SIGNATURE: _____ **DATE:** _____

By Signing, I attest that all information provided is true/accurate to my knowledge.

Authorization to Administer Treatment:
(Initial)_____I hereby give permission to the Providers and staff of Total Vitality Medical Group, LLC to administer treatment, prescribe testing procedures indicated by the Provider that he/she may deem necessary to diagnose and/or treat me.

Authorization to Release Medical Information:
(Initial)_____This authorization or photocopy hereof will authorize Total Vitality Medical Group, LLC to furnish all information on record regarding my care while under observation or treatment, including the obtained history, x-rays, physical findings, diagnosis, and prognosis.
This authorization also allows all records to be released to Total Vitality Medical Group, LLC.

Treatment Disclaimer:
(Initial)_____This office provides care for semi-urgent medical needs and or care on a walk-in basis. It is recommended to all patients to have routine preventative medical examinations that include, but are not limited to, colon cancer screening, lipid screening, pap smears, breast examinations and mammography, and screening for diabetes and heart disease.

Signature: _____ Date: _____
Policy holder/Responsible Party

Pregnancy Release for X-rays:

I,_____, hereby state to the best of my knowledge that I am not pregnant and give my full consent to Total Vitality Medical Group, LLC, their associates, and x-ray technicians to x-ray me.
My last menstruation cycle began on_____/_____/_____

Signature:_____Date: _____
Policy holder/Responsible Party

Minor Consent (if applicable)**:**

I hereby request and authorize Total Vitality Medical Group, LLC to render treatment to my minor child _____. This authorization is extended to all affiliated Providers and staff members and is intended for the performance of diagnostic tests, chiropractic adjustments, radiographic examination (at the doctor's discretion) as well as any other treatment deemed necessary for the minor child's care.

As of this date,_____, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable), under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize care to my child should be revoked or modified in any way, I will notify this office immediately.

Signature: _____ _____ Date: _____
Parent or Guardian Print Name

Witness: _____ _____ Date: _____

Office/Financial Policy

Thank you for choosing **Total Vitality Medical Group, LLC** for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Except as indicated below, payment is required at the time services are provided unless other arrangements have been made in advance. We accept cash, VISA, MasterCard, Discover, American Express and CareCredit cards. There is a $40.00 service charge for returned checks paid on account balances.

OFFICE HOURS (By Appointment Only):

Each location has different hours, please contact the office to verify the specific days/hours of operation.
We do not schedule appointment between 12:00 pm and 2:00 pm.
As a courtesy to other patients, we request you arrive on 15 minutes before your appointment. If you arrive 15 minutes late, you may be asked to reschedule. We do not have after-hours or weekend appointments, or Providers available at these times.

INSURANCE:

We participate in many insurance networks and will bill your insurance plan accordingly. If we do not participate with your insurance network, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan.

• **Proof of Insurance**: All patients must complete and/or update our Patient Information Form at the beginning of each year, and at any time you change personal information. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

• **Co-payments and deductibles**: All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible, and non-covered services.

• **Claim submission**: We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Florida insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether your insurance company has paid. Referrals: If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to referral. We require a 72-hour notice to facilitate a referral request and cannot issue retroactive referrals.

OUT-OF-NETWORK CARE / SELF PAY: Please be aware that you have an option to seek care from Providers even though they are not participating in your network. In this situation, it is your responsibility to seek reimbursement through your insurance company. We will only send your claims for out-of-network care to your insurance if requested in advance. We will charge a self-pay rate.

Please contact the front office for current Self-Pay Pricing.

ADMINISTRATIVE SERVICES, CHARGES AND PATIENT RESPONSIBILITIES: Due to the continued decline in reimbursements from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

• **Missed appointments.** Missed appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. **We require a 24-hour notice of cancellation to avoid a $95 cancellation fee** for all appointments. We have automated reminder systems in place however it is your responsibility to remember your appointment.

• **Prescription refills**. New prescriptions will not be issued without first seeing your Provider. Prescriptions for acute care or chronic conditions are written with an appropriate number of refills to complete the course of treatment or to last until your next scheduled appointment. You may be charged $75 for any additional refills issued without seeing the Provider or to replace a lost prescription, as long as it's a medication in which we are able to do so. All prescription requests are taken only during regular office hours and filled within 48 hours. The law requires a face-to-face visit for all controlled substance prescriptions and refills.

• Prescription Prior- authorizations. We will honor prior authorization requests from the patient, but the patient is responsible for contacting their insurance company to have them forward the prior authorization form to our office. A $25 fee may be assessed for time to complete the prior authorization form. Any request for a forced change in your medication by your insurance company will require an office visit. The patient will need to ask their insurance company what "alternative medications" are covered in their plan and provide a list to their Provider.

• Letters / Form completion. At the discretion of the Provider, letters and forms requiring medical review and Provider signature are subject to a $25 fee if completed without an appointment.

• Telephone Consultations: Telephone consultations calls for medical advice/treatment may be subject to a $150 fee that is billed directly to you.

• Requests for medical records. In accordance with Florida law, Total Vitality Medical Group, LLC requires written requests for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on current Florida law and is dependent on the number of pages requested. Please take this into consideration when requesting copies of your medical records.

Personal Injury Cases

• This office will bill for any auto accident or other liability or lawsuit related cases as a courtesy to you. It is your responsibility to provide us with the auto insurance carrier name, claim number and any corresponding information prior to your visit to obtain proper authorization.

Workers Compensation

• If your injury is work related, it is your responsibility to provide us with the case number and carrier name prior to your visit to obtain proper authorization. We will be happy to bill your worker's compensation insurance company as a courtesy to you.

Assignment of Insurance Benefits (Health Insurance)

Patients with insurance please read and sign below that you understand and agree with the following statement.

I hereby assign all major medical benefits to which I am entitled, private insurance, and any other health plans, or services provided by Total Vitality Medical Group, LLC to Total Vitality Medical Group, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges which remain unpaid by insurance. I hereby authorize said assignee to release information necessary to secure payment.

I have read, understand, and agree to comply with the terms of this Office / Financial Policy for payment of services rendered and applicable fees.

_____	_____	_____
Printed Name	Signature	Date

_____ **By Initialing here, I attest that I have received the Notice of HIPAA rights/responsibilities.**