2026 Updated Patient Demographic

Clearwater * St. Petersburg * Brandon * Tampa

CONTACT INFORMATION

FULL LEGL NAME____

DATE OF BIRTH: ______________________________ SOCIAL SECURITY # ______________

PHYSICAL ADDRESS: ____

CITY: ____________________ STATE: ____________ ZIP CODE: __________

CELL PHONE: ________________________ HOME PHONE: ______________

EMAIL: ____

EMERGENCY CONTACT: ____________________ RELATIONSHIP: ______________

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.

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Authorization to Administer Treatment:

(Initial)______I hereby give permission to the providers and staff at Total Vitality Medical Group to administer treatment, prescribe testing procedures as indicated by the provider, he/she may deem necessary to diagnose and/or treat my condition.

Patient Communication Consent:

(Initial)________I authorize Total Vitality Medical Group, LLC to contact me regarding my care (appointments, treatment, billing) via phone, voicemail, text (SMS), email, and fax (if applicable). I understand these communications may include protected health information (PHI), and that email/text may carry some security risk. Standard messaging rates may apply. I may opt out of any communication method at any time by notifying the practice in writing. I am responsible for keeping my contact information current. This consent does not replace the need for direct medical care or emergency services.

Authorization to Release Medical Information:

(Initial)______This authorization or photocopy hereof will authorize Total Vitality Medical Group, to furnish all information on record regarding my condition 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.

Treatment Disclaimer:

(Initial)______We are not Urgent Care. We are Primary Care. 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, screening for diabetes and occult 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, 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 to render treatment to my minor child .

This authorization is extended to all affiliated doctors and staff members and is intended for the performance of diagnostic tests, chiropractic adjustments, radiographic examination (at the doctor's discretion) as well as other treatment 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 the care of my child should be revoked or modified in any way, I will notify this office immediately.

Signature: ____________________________ ____________________________ Date: ___________

Parent or Guardian - Print Signature

Witness: ____________________________ ____________________________ Date: ___________

Print Signature

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Office/Financial Policy

Thank you for choosing **Total Vitality Medical Group (TVMG)** for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhering 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 Care Credit cards. Personal checks are not accepted.

OFFICE HOURS (By Appointment Only):
Each location has different hours, please contact the office to verify the specific days/hours of operation.
The office is closed from 12:00 pm to 2:00 pm every Monday through Friday.
As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. We do not have after-hours or weekend providers available.

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 service 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 when 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. Any patient not willing to pay for their financial responsibility may not be seen/treated.

Claim submission: We will submit your insurance claims. 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. Broken appointments represent not only a cost to us, but also an inability to provide medical 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. 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 will be charged **$75** for any additional refills issued without seeing the Provider or to replace a lost prescription if it is 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.

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 plan what “alternative medications” are covered 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 **$45** fee if completed.

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, TVMG 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 car 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 medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, or services provided by Total Vitality Medical Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the 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

PATIENT CODE OF CONDUCT

Total Vitality Medical Group is a healing environment. To accomplish our mission to improve the lives of our patients, we will need to work together to provide a safe and healthy environment for our patients, staff, and visitors. Total Vitality Medical Group expects all visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of others.

As a patient visiting our practice, we expect the following:

- If you need to cancel or reschedule an appointment, please contact the office at least 24 hours prior to your appointment to avoid a $95 cancellation fee. Please understand that if you cancel without notice, not only do you not receive care, but your late notice prevents someone else from receiving care as well. A text reminder is sent to every patient prior to their scheduled appointment.
- We have a zero-tolerance policy for any aggressive behavior directed toward our staff. We encourage you and all members of your support team to be respectful of your healthcare team.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away or silence the ringer / notification sounds.
- Please supervise any underage children accompanying you to your appointments.
- End every visit with a clear understanding of your provider's expectations and treatment goals.
- Follow recommended treatment plans, consultations, and other follow up care from your provider.

•**The following behaviors are prohibited:**

- Possessing firearm or any weapon in this office.
- Intimidating, harassing, physically assaulting, or threatening the staff or other patients or visitors including profanity or aggressive language.
- Making threats of violence through phone calls, letters, voicemail, e-mail, or other forms of written, verbal, or electronic communication.
- Damaging business equipment or property.
- Making menacing or derogatory gestures.
- Making racial, cultural, sexual slurs or other derogatory remarks.
- Refusing to follow any practice of public health and safety policies or regulations including wearing a face mask when required.
- Videotaping, audio taping or recording Total Vitality Medical Group providers, staff members, patients, or visitors by any other means without prior authorization from management.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report it to any staff member.

Violators are subject to immediate removal from the facility and constitute grounds for discharge from the practice.

Patient Name (Print) Signature Date