TRI COUNTY HEALTH LLC

Welcome Letter

We are honored that you have chosen us as your health care provider. We have exciting news regarding your health management with our practice.

As we continue our efforts to provide our patients with the highest quality of care, we are constantly looking for methods together with our patients to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the World Wide Web to track the most important aspects of your health care through our office. Our Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely via the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Patient Portal to view their personal and private documents, including labs and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- Ask questions to doctors, nurses, and staff members
- Request refills and referrals
- Schedule appointments
- View your personal health records
- Examine your current and past billing statements

. . . all from the comfort of your home, whenever it is convenient for you!

By using the Patient Portal, you no longer have to call the office, leave a message and wait for the return call to get the results of your test; those results will be available to you through the Patient Portal. You can also send a message to the office through the portal and get a prompt reply.

To learn more or to sign up, contact our office today at:

(352) 268 - 0003

Locations: Freedom Plaza 4056 E SR 44 Wildwood, Fl 34485
Summit Plaza: 753 HWY 466 Lady Lake, FL 32159
Office Number: (352) 268-0003 Fax: (855) 642-1129

TRI COUNTY HEALTH LLC

Patient Registration Form

Please Print Clearly and Answer ALL Questions

Today's Date: _____

Last Name: _____ **First Name:** _____ MI: _____

Primary Address: _____

Secondary Address: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Age:** _____ **Date of Birth**: _____

Gender: _____ **Marital Status:** S / M / D / W/ Other **Social Security:** _____

Employee Status: **Full Time/ Part Time/ Retired/ Unemployment** **Military:** **Active/ Non-Active**

Employer Name: _____ **Work Number:** _____

Emergency Contact: _____ Relationship: _____ (P): _____

Primary Care Physician: _____ **Office Location:** _____ (P) _____

Referring Physician: _____ **Phone:** _____

(ALL Prescriptions Are Forwarded Electronically to your Pharmacy and Verified also with E Force)

Preferred Pharmacy: _____ Location: _____ (P): _____

Preferred Pharmacy: _____ Location: _____ (P): _____

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Do you have an Advance Directive? ☐ **Yes** ☐ **No**

Do you give consent for TriCounty Health to have permission to view your medication history from external sources? ☐ **Yes** ☐ **No**

Can we share your prescription information with other medical providers? ☐ **Yes** ☐ **No**

Can we release medical record information to the insurance company to process the claim? ☐ **Yes** ☐ **No**

Can we release medical record information to providers listed in your chard? ☐ **Yes** ☐ **No**

Can we electronically send and received medical records through the Integrated Data Exchange? ☐ **Yes** ☐ **No**

TRI COUNTY HEALTH LLC

Patient Registration Form

Please Answer ALL the Questions: The below questions are required to be asked by State Law for Census

Language Preference: English/ Spanish/ Portuguese/Other: _____

Race: Black/ White/ Asian/ Hispanic/ American Indian or Alaska Native/ Refuse to report/ Other:

Ethnicity: Hispanic/ Not Hispanic/ Refuse to Report

Residence Type: Private Home/ Residential Home/ Skilled Nursing Home/ Nursing Home/ Homeless Your

Birth Order: 1 2 3 4 5 6 7 8 9 10 **VFC Eligibility:** YES/ NO If Yes, what eligibility do you have? _____

RESPONSIBLE PARTY OR PRIMARY INSURANCE SUBSRIBER

Relationship to patient: Self/ Spouse/ Child/ Other: _____

If not self:

Last Name: _____ First Name: _____ MI: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION:

(Please Present All Insurance I.D Cards to the Receptionist)

Primary Insurance Company Name:_____ Address: _____

Phone:_____ Insured Name:_____

Employer:_____ Policy Number:_____ Group Number: _____

Secondary Insurance Company Name: _____Address: _____

Phone: _____Insured Name: _____ Employer: _____

Policy Number: _____ Group Number: _____

_____ _____ _____ _____

Patient/ Legal Representative Signature Date Witness Signature Date

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TRI COUNTY HEALTH LLC

Patient Medical Information Form

Date: _____

Name:_____ **DOB :**_____

Allergies:_____

List ALL medications you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please contact your pharmacist

Personal Medical History: Please circle ALL that apply

ADHD
Alcoholism
Allergies Seasonal
Anemia
Anxiety
Arthritis
Arrhythmia (Irregular Heartbeat)
Asthma
Bipolar
Bleeding Problems
Bladder Problems/ Incontinence
Chron's Disease
Cancer: _____
COPD/Emphysema
Dementia
Depression
Diabetes 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflex)
Glaucoma
Heart Disease
Headaches
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
HIV
High Cholesterol
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia
Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Pulmonary Embolism (PE)Psoriasis
Rheumatoid Arthritis
Sleep Apnea
Seizure Disorder
Stroke
Thyroid Disorder
Ulcerative Colitis

Surgical History: (Please list ALL prior surgeries and approximate dates performed)

_____

_____

SOCIAL/ CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal? ☐ Yes ☐ No

Tri County Health

Patient Medical Information Form

Current Living Situation (Check ALL that apply):

☐ Skilled Nursing Facility ☐ Single Family Household ☐ Multi-Generational Household
☐ Homeless ____ Shelter ☐ Other: _____

Smoking/ Tobacco Use:	☐ Current	☐ Past	☐ Never	☐ Type: _____
Alcohol:	☐ Current	☐ Past	☐ Never	Drinks/week: _____
Recreational Drug Use:	☐ Current	☐ Past	☐ Never	Type: _____
Are you sexually active?	☐ Yes	☐ No		

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No
Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No
Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No
How often do you get the social and emotional support you need? ☐ Always ☐ Usually ☐ Sometimes
Comments: (Please feel free to comment on any answers marked "yes" above)

_____

FAMILY HISTORY:

Father:	Living Age _____	Deceased Age _____		
Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	Other: _____

Mother:	Living Age: _____	Deceased Age: _____		
Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	Other: _____

_____ _____ _____ _____
Patient/ Legal Representative Signature Date Witness Signature Date

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TRI COUNTY HEALTH LLC

Authorization to Release Medical Information

Date: _____

I, _____ (Provider) of Tri County Health LLC, to disclose protected health information (PHI) regarding:

Patient Name: _____ DOB:_____

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I authorize the PHI to be disclosed at my individual request to Tri County Health LLC at the following location:

____ Freedom Plaza 4056 E SR 44 Wildwood,Fl 34785 Ph: (352) 268-0003 Fax: (855) 642-1129

____ Summit Plaza 753 HWY 466 Lady Lake, FL 32159. Ph: (352) 268-0003 Fax: (855) 642-1129

Check One: I authorize the following PHI to be released by paper, electronically shared, integrated Data Exchange:

__ All health information about the patient in the possession of Provider, including, but not limited to psychiatric; mental health treatment information excluding psychotherapy notes, HIV test results, generic testing information or alcohol or drug treatment information good for one year of the data signed.

__ For a limited time period beginning (date) _____ and ending _____ all health information about the patient in the possession of Provider, including but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, generic testing information or alcohol or drug treatment information.

___ Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed: _____

___ Other, as described here:_____

Release PHI (To) or (Obtain PHI) from see below

Name of Organization/ Person:	
Address of Organization	
Phone Number:	Fax Number:

(i) Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.

(ii) The provider is authorized by law to use or disclose PHI for a variety of reasons without the patient's authorization. Please see the Provider's Notice of Privacy Practice for details.

This Authorization was developed to comply with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) Act, the American Recovery and Reinvestment Act (ARRA) of 2009 and associated regulations.

_____ _____ _____ _____

Patient/ Legal Representative Signature Date Witness Signature Date

TRI COUNTY HEALTH LLC

Authorization for Treatment / Release of Information

Consent to Treatment: The patient and/or authorized representative d hereby consent to any and all treatments which may deem advisable by the physician or Tri County Health LLC., Inc. Patient consent to Rx verification Electronic Data Health Exchange (eEHX Interoperability). Each procedure and diagnostic study will be discussed in detail with patient before procedure is performed. Additional consent will be required at the time of procedure.

Assignment of Insurance Benefits: I assign payment directly to Tri County Health LLC, Inc. Insurance Benefits otherwise payable to me, I understand that I am financially responsible got charges paid by this assignment. I will assist in the collection of my insurance payment got any claims unpaid after 30 days. If after 45 days the claim remains unpaid, I understand the balance will be due from me.

Medicare Patients: I certify that the information given by me in applying for payment under the XVIII of the Social Security is correct. I authorize Tri County Health LLC, to release to the Health Care Financing Administration of its intermediaries any information needed for this related Medicare claim, I hereby authorize payment directly to Tri County Health LLC., Inc for medical benefits otherwise payable to me as beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to routine testing may be covered by Medicare unless the physician provides medical necessity.

Patient/ Guarantor Agreement: I understand that Tri County Health LLC, is not in business expanding credit. Therefore, it is the policy of Tri County Health LLC. To require payment in full at the time of service. If unable to pay due balance in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my/ the patient's account with Tri County Health LLC. Regardless of my insurance benefits, I authorize copies of this form to be valid as the original.

Print Patient/ Responsible Party's Name: _____

_____	_____	_____	_____
Patient/ Legal Representative Signature	Date	Witness Signature	Date

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TRI COUNTY HEALTH LLC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Tri County Health LLC to use ad disclose PHI about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tri County Health LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tri County Health LLC.

With this consent, Tri County Health LLC may call y home or other alternative location and leave a message o voice mail or e-mail/text me, publish my records to patient portal in reference to any items that assist the practice in carrying out TPO. This may include appointment reminders, insurance issued, and concerns with my clinical care, such as laboratory test results, diagnostic imaging, Integrated Data records Exchange (eEHX), Marketing, etc.

With this consent, Tri County Health LLC, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked “Personal and Confidential”.

With this consent, Tri County Health LLC, may text or e-mail to my home or alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, and medical records. I have the right to request that Tri County Health LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Tri County Health LLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, Tri County Health LLC, may decline to provide treatment to me.

_____	_____	_____	_____
Patient/ Legal Representative Signature	Date	Witness Signature	Date

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TRI COUNTY HEALTH LLC

Notice of Privacy and Authorization Form

I acknowledge that if a copy of my personal information is needed for reasons other than immediate treatment, I hereby authorize the release of information to the following: family member, providers, or friends acting on my behalf:

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Please choose one of the following options below:

- ☐ I understand that I may amend this authorization at any time, until then this form will be kept on file until further changes are made. I also understand that any other request for personal health information by another other than those listed will require additional authorization by me in writing.
- ☐ I refuse to have any information be release to anyone, this include: Family members, Providers, or friends, acting on my behalf.

_____ _____ _____ _____

Patient/ Legal Representative Signature Date Witness Signature Date

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TRI COUNTY HEALTH LLC

Communication Form

I, _____ would like to be contacted by Tri County Health LLC by the following communications indicated below:

	Appointment Confirmation/Reminders	Test Results
Telephone Communication	☐ Accept	☐ Reject
Written Communication (Mail)	☐ Accept	☐ Reject
Text Messaging	☐ Accept	☐ Reject
Email	☐ Accept	☐ Reject
Patient Portal	☐ Accept	☐ Reject

☐ I refuse ALL the above communications. I understand that this means the office will not be able to communicate with me in any way and I understand the risks involved. Should an emergent test result or situation arise the office/physician will not be able to contact me in any way.

Please be aware that due to HIPAA compliance this form will be adhered to and not deviated from. You may change your designations above by filling out a new form and submitting it to the office. The form is in effect for one year, unless written notification is given otherwise.

_____ _____ _____ _____

Patient/ Legal Representative Signature Date Witness Signature Date

Advanced Directives

(For Compliance with the Patient Self-Determination Act)

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TRI COUNTY HEALTH LLC

Patient Name:_____ DOB: _____

Have you executed an Advanced Directive? ☐ **Yes** ☐ **No**

If yes, is this directive in the form of:

☐ **A Living Will**

☐ **A Durable Power of Attorney**

☐ **A Health Care Surrogate (Someone to make decisions for you)**

☐ **DNR (Do Not Resuscitate)**

Have you provided this office with a copy of Advanced Directive?

☐ **Yes** ☐ **No**

(If you would like more information regarding advanced directives, please ask the nurse or receptionist)

_____ _____ _____ _____

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TRI COUNTY HEALTH LLC

New Patient Survey

Thank you for taking the time to answer a few questions about how you heard about our office. The information that you share will be kept confidential and will be used to better understand how to reach our patients.

How did you hear about our office? _____

Have you seen any of our ads in the following: (Please check ALL that apply)

- ☐ Daily Sun
- ☐ Daily Commercial
- ☐ Healthy Living Magazine
- ☐ Style Magazine
- ☐ Word-of-mouth
- ☐ Television
- ☐ Internet
- ☐ Doc-Talk's or Hospitals
- ☐ Referral: _____
- ☐ Other/comments (please fill in): _____

Thank you for taking the time to fill out this brief survey. If you would like for someone to contact you regarding our services, please let an administrative assistant at our front desk know.

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TRI COUNTY HEALTH LLC

Please answer all the questions:

The below questions are required to be asked by State Law for Census

Sexual Orientation

Check Mark	Name	
	Lesbian, gay or homosexual	38628009
	Straight or heterosexual	20430005
	Bisexual	42035005
	Do not know	UNK
	Choose not to disclose	ASKU
	Something else, please describe:	OTH

Gender Identity

Check Mark	Name	
	Male	446151000124109
	Female	446141000124107
	Female-to-Male (FTM) / Transgender Male/Trans Man	407377005
	Male-to-Female (MTF) / Transgender Female/Trans Woman	407376001
	Genderqueer, neither exclusively male nor female	446131000124102
	Choose not to disclose	ASKU
	Additional gender category or other, please specify	OTH

☐ Transgender

Patient Signature: _____ **Date**: _____

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