ARDENT
Family Care, P.A.

84 Pinnacles Drive Suite 200
Palm Coast, FL. 32164-2324

Ph: (386) 439-9777 | Fax: (386) 206-0017

NEW PATIENTS

The attached paperwork will start the new patient process for you at Ardent Family Care, P.A.

Please be advised that each paper **MUST** be signed and completed before an appointment can be scheduled. If something does not apply, please put **N/A**.

Our process will be to review your paperwork and your insurance information, and you will be contacted within 5 business days to let you know if we are able to accommodate your request. Be aware that ***verification of coverage is not a guarantee of payment of benefits.***

Please arrive 15 minutes early to allow time for registration prior to your visit. It is mandatory that you bring your insurance card and a government-issued photo ID.

We reserve the right to cancel or change an appointment if our office policy is not followed.

Thank you for your understanding and thank you for choosing Ardent Family Care, P.A. for your primary care needs.

To Our Valued Patients:

The Ardent Family Care, P.A. family would like to express our gratitude for helping our practice grow. However, our growth and HIPPA regulations have required us to implement the following changes to ensure that you continue to receive the highest level of quality of medical care.

Due to HIPPA regulations we can no longer discuss your personal medical information in public. If you have any questions or requests regarding your medical information, please call (386) 439-9777 and use our automated telephone system:

- Appointments Opt. 1
- Clinical Team Opt. 2
- Prescription Opt. 3
- Authorizations Opt. 4
- Billing Department Opt. 5
- Medical Records Opt. 6

If you have an appointment and are unable to keep it, please give us 24-hour notice prior to your cancellation to avoid the $25.00 no- show fee as this will allow us to accommodate other patients who might want to be seen. Without advance notice, we will be forced to implement the charge for the missed office visit. Three (3) no shows without advanced notice will cause the patient's dismissal from the practice.

All insurance co-payments, deductibles and/or ANY patient balance is expected to be paid in full upon check-in. This will help speed up your office visit and eliminate a bill being sent to your home. We reserve the right to cancel or change an appointment if payment is not provided.

Thank you for your understanding and cooperation.

Ardent Family Care, P.A.
84 Pinnacles Drive Suite 200 Palm Coast, FL. 32164-2324

HIPAA PRIVACY NOTICE

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

We may contact you via phone or text message to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment that it is in your best interest to make such disclosures.

Other Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement ♦ About a death we believe may be the result of a criminal conduct
- About criminal conduct on our premises
- In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:

- Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record

♦ Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
♦ Protected health information involving laboratory tests when your access is required by law
♦ If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you
♦ If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research ♦ Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law
♦ If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information

We may also deny a request for access to protected health information if:

♦ A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person
♦ The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person
♦ The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:

♦ Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment
♦ Is not part of your medical or billing records
♦ Is not available for inspection as set forth above
♦ Is not accurate and complete

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:

♦ To carry out treatment, payment and health care operations as provided above
♦ To persons involved in your care or for other notification purposes as provided by law
♦ For national security or intelligence purposes as provided by law
♦ To correctional institutions or law enforcement officials as provided by law
♦ That occurred prior to April 14, 2003
♦ That are otherwise not required by law to be included in the accounting

6. You have the right to request and receive a paper copy of this notice from us.

7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us. Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice at (386) 439-9777 x 100 Mon – Thurs from 8 a.m. – 4 p.m. and on Fri. from 8 a.m. – 1:30 p.m or our Privacy Officer. All complaints must be submitted in writing to: 84 Pinnacles Drive Suite 200 Palm Coast, FL. 32164-2324. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Ardent Family Care, P.A.

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www.ardentfamilycare.com

PATIENT DEMOGRAPHIC INFORMATION

First Name: _____ MI _____ Last Name: _____

Gender: M / F Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Occupation: [ ] Employed [ ] Retired [ ] Unemployed [ ] Student [ ] Unknown

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Widowed [ ] Divorced

Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Undefined [ ] Decline to Specify

Race: [ ] Caucasian [ ] American Indian/Alaskan Native [ ] Asian [ ] Black or African American
[ ] More than one race [ ] Other _____ [ ] Decline to Specify

EMERGENCY CONTACT INFORMATION

Emergency Contact #1: _____ Ph# _____

Relationship: _____

Emergency Contact #2: _____Ph#: _____

Relationship: _____

CONSENTS

May we leave a confidential message on your voicemail: Y / N If yes, what number: _____

May we speak with someone else regarding your health: Y / N If yes, who: _____

INSURANCE INFORMATION

Primary Ins: _____ **Secondary Ins.** _____

Policy/ID#: _____ Policy/ID#: _____

Group/Plan#: _____ Group/Plan#: _____

Policy Holder Name: _____ Policy Holder Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Medicare Lifetime Signature on File: I request that payment of authorize Medicare benefits be made on my behalf to Ardent Family Care, P.A. for any services furnished me by the physicians. I authorize any holder of medical information about me to release to CMS and its agents any information to determine these benefits payable for related services.

_____ _____

Patient/Parent or Guardian Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Ardent Family Care, P.A. for any services furnished me by the physicians, and I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient/Parent or Guardian Signature Date

ARDEN
Family Care PA

Financial Policy

Please initial each line to consent to the following:

——Please carefully read each statement and sign below. This policy has been implemented to ensure that payments are paid on time when due, and that we may continue to provide quality medical care for our patients. It is important that we work together to ensure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

——I understand that if I do not have my insurance card, referral, and/or my appointment may be rescheduled until I can provide the required documents or payments.

——I understand that reminder appointment calls from the office are for courtesy only, and that I am responsible for keeping track of my appointment and being on time.

——I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefit payments. I understand I will be responsible for the portion not covered by my insurance.

——I understand that if I am unable to make a scheduled appointment, I need to contact the office at least 24 hours prior to my scheduled appointment. **A $25 FEE MAY BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST A 24-HOUR NOTICE.**

——I understand there is a $35 charge for a Non-Sufficient Funds (NSF) check.

——I understand there may be a $25.00 charge for all forms deemed appropriate, filled out by the Physician (e.g. Disability, FMLA, etc.). When dropping forms off, I must allow 5-7 days for completion.

——I understand if my account is not paid in full within 90 days, I may be turned over to a collection agency for further processing and incur additional fees. The legal action fee will be 50%.

I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____
Signature of the Patient or the Patient's Legal Representative

Date _____

_____
Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient. _____

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HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

_____ _____

_____ _____

Contact information: _____
_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

[ ] A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

[ ] B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
- [ ] Mental health records
- [ ] Communicable diseases (including HIV and AIDS)
- [ ] Alcohol/drug abuse treatment
- [ ] Other (please specify):

_____
_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
- [ ] An electronic record or access through an online portal
- [ ] Hard copy

This authorization shall be effective until (Check one):
- [ ] All past, present, and future periods, **OR**
- [ ] Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying Ardent Family Care, P.A., preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R.

NOTICE TO PATIENTS REGARDING PHYSICALS/WELL EXAMS

Ardent Family Care, P.A.

If you have scheduled an Annual Wellness Visit (AWV), PAP, or physical exam , your insurance company may call this visit "preventative", "yearly" or "annual". Please take a moment to read the remainder of this letter:

Your insurance should cover a wellness /physical/preventive visit once every 12 months, if you don't remember when your last a wellness /physical/preventive exam was, and you request one, you will receive a bill If your insurance denies stating that you already had one done within 12 months.

If during your visit you have additional concerns that require diagnosis and treatment, or chronic conditions that need to be managed, you may incur additional office or lab charges- including a copay and/or deductible. Additionally, if your Physician finds a medical issue that needs immediate care, they are required to address the concern, which may result in an office visit charge. These additional charges will be submitted to your insurance company, as well as the preventative visit. If your insurance company does not cover some or all of the charges, you will be billed for the balance your insurance company indicates as patient responsibility. Please do not ask us to re-bill by changing a procedure code or diagnostic code. By asking this of your physician, you are asking them to commit insurance fraud. You may also schedule a separate follow up appointment with the doctor to address your additional concerns.

Thank you for your understanding in this matter. Your cooperation is greatly appreciated.

Print Name_____ Date of birth _____

Signature _____ Date _____

MEDICATIONS

(Please list ALL medications including vitamins)

Medication Name	Dosage	Frequency

Name of Preferred Pharmacy: _____ **Ph#:** _____

PLEASE BE SURE TO BRING YOUR MEDICATION BOTTLES WITH YOU AT EACH VISIT. THIS ALLOWS US TO KEEP OUR RECORDS CURRENT AND IS ESPECIALLY IMPORTANT WHEN PHYSICIANS FROM OTHER OFFICES ARE PROVIDING MEDICATIONS FOR YOU.

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY:

Chronic headaches/Migraines	[ ] Y / [ ]N	High Blood Pressure	[ ] Y / [ ]N
Epilepsy/Seizures	[ ]Y / [ ]N	High Cholesterol	[ ]Y / [ ]N
Asthma	[ ]Y / [ ]N	Thyroid Disease	[ ]Y / [ ]N
COPD	[ ]Y / [ ]N	Glaucoma	[ ]Y / [ ]N
Heart Disease	[ ] Y / [ ]N	Hernia	[ ] Y / [ ]N
Anemia	[ ]Y / [ ]N	Blood/Plasma Transfusion	[ ]Y / [ ]N
Venereal Disease	[ ]Y / [ ]N	Hemorrhoids	[ ]Y / [ ]N
Tuberculosis	[ ]Y / [ ]N	AIDS / HIV	[ ]Y / [ ]N
Ulcer	[ ] Y / [ ]N	Stroke	[ ] Y / [ ]N
Hepatitis	[ ]Y / [ ]N	Atrial Fibrillation	[ ]Y / [ ]N
Kidney Disease	[ ]Y / [ ]N	CHF	[ ]Y / [ ]N
Cancer	[ ]Y / [ ]N	Infectious Mono	[ ]Y / [ ]N
Eczema	[ ] Y / [ ]N	Bleeding/Bruising Tendency	[ ] Y / [ ]N
Back Pain	[ ]Y / [ ]N	Kidney Stones	[ ]Y / [ ]N
Arthritis	[ ]Y / [ ]N	Cerebral Palsy	[ ]Y / [ ]N
Fibromyalgia	[ ]Y / [ ]N	Neuropathy	[ ]Y / [ ]N
Anxiety	[ ] Y / [ ]N	Depression	[ ] Y / [ ]N
Insomnia	[ ]Y / [ ]N	Other Mental Illness	[ ]Y / [ ]N
Dementia	[ ]Y / [ ]N	Parkinson's Disease	[ ]Y / [ ]N
ADD/ADHD	[ ]Y / [ ]N	Anorexia/Bulimia	[ ]Y / [ ]N
Incontinence	[ ] Y / [ ]N	Kidney Stones	[ ] Y / [ ]N
Osteopenia	[ ] Y / [ ]N	Osteoporosis	[ ] Y / [ ]N
Type 1 Diabetes	[ ]Y / [ ]N	Type 2 Diabetes	[ ]Y / [ ]N
Gestational Diabetes	[ ]Y / [ ]N	Polio	[ ]Y / [ ]N
Blindness	[ ]Y / [ ]N	Hard of Hearing	[ ]Y / [ ]N

Other Health Issues/Diseases

_____

_____

Date of your last annual exam:_____

Female

Date of Last Pap smear: _____ Date of Last Mammogram (if applicable): _____

Date of Last DEXA/Bone Density (if applicable): _____

OB/GYN: _____ Ph#: _____

Are you currently pregnant: [ ] Y / [ ] N

SURGICAL HISTORY: *Please list all surgeries and when they were performed if applicable.*

_____

_____

_____

[ ] Y / [ ] N Have you had a colonoscopy within the past 10 years. If yes, what date or year: _____

DRUG/FOOD ALLERGIES: *Please list all current allergies*

_____

_____

FAMILY HISTORY

	Age	Present/Past Diseases	Deceased
Father			[ ] Y / [ ]N
Mother			[ ]Y / [ ]N
Siblings			[ ]Y / [ ]N
			[ ]Y / [ ]N
			[ ] Y / [ ]N
			[ ]Y / [ ]N
			[ ]Y / [ ]N
Spouse			[ ]Y / [ ]N
Children			[ ] Y / [ ]N
			[ ]Y / [ ]N
			[ ]Y / [ ]N
			[ ]Y / [ ]N

SOCIAL HISTORY

Use of Alcohol: [ ] Never [ ] Rarely [ ] Moderate [ ] Daily [ ] Former use

Use of Tobacco: [ ] Never [ ] Former Use [ ] Current/Every day Smoker
Packs/day: _____

Use of Recreational Drugs: [ ] Y / [ ] N If so, type/frequency: _____

Excessive Exposure to:
[ ] Fumes [ ] Dust [ ] Solvents [ ] Noise [ ] Airborne Particles [ ] Second Hand Smoke

RELEASE OF INFORMATION
ARDENT FAMILY CARE, P.A.

I hereby authorize _____ to release information including, if any, psychiatric or psychological information, infection, or contagious disease information, to include but not limited to HIV/AIDS and other disabilities, and/or information regarding alcohol and other drug abuse or treatment of same from the health record(s) of:

Patient Name: _____ Phone Number: _____
Date of Birth: _____ SSN: _____
Patient Mailing Address: _____
_____
Physical Address: _____
_____

Covering the period of treatment from: _____to _____

Information to be released: [ ]Complete Record [ ]Other: _____

Information to be released from:
Name of provider and/or facility: _____
Phone: _____ Fax No.: _____

Information is to be released to:

ARDENT FAMILY CARE, PA
84 PINNACLES DR STE 200
PALM COAST, FL. 32164-2324
TEL: (386) 439-9777
FAX: (386) 206-0017

I HEREBY RELEASE Ardent Family Care P.A. and it's employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this Consent of Release of Medical Information.
I understand that this Consent of Release of Medical Information is subject to revocation by the undersigned at any time, except to the extent that action has already been taken by ARDENT FAMILY CARE P.A. in reliance upon this consent, Unless otherwise stated below, this consent shall automatically expire ninety (90) days from the date set forth below, or upon the following date, event, or condition.

I _____have read and understand the Consent of Release of information and have voluntarily and knowingly signed such consent.

_____ _____
Patient/Parent or Guardian Signature Date

ARDENT FAMILY CARE, P.A.

84 PINNACLES DR STE 200
PALM COAST, FL. 32164-2324

LABORATORY SPECIMENS

It is the patient's responsibility to know what lab a Pap smear, culture, or biopsy is sent to. If the pathology is sent to the incorrect lab, the bill is the patient's responsibility:

Name of Lab: _____

I have read and understand and agree to the above policy.

_____ _____

Patient/Parent or Guardian Signature Date

ARDENT FAMILY CARE, P.A.
84 PINNACLES DR. STE 200
PALM COAST, FL. 32164-2324

Referrals and other procedures Notice

It is the patient's responsibility to know his or her insurance plan.

Should your insurance plan require a referral to see a specialist, you must first make an appointment with your primary care physician to determine the course of treatment.

Absolutely no referrals will be backdated. If the patient makes an appointment with a specialist without the written authorization from this office, he/she will be responsible for the specialist's fees if the insurance denies the claim.

All insurance plans have different benefits; therefore, it is the patient's responsibility to know what procedures, labs, x-rays, or immunizations, are covered by your carrier. The patient also needs to know what facility the insurance company requires you to utilize for labs or other outpatient procedures.

Ardent Family Care, P.A.

_____
Patient/Parent or Guardian Signature Date

Acknowledgement of Privacy Practices

I have received notice of the Privacy Practices of Ardent Family Care, P.A. and I have been provided an opportunity to review these practices.

_____ _____
Patient/Parent or Guardian Signature Date

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PRESCRIPTION REFILL POLICY

Prescription refills may be obtained by contacting your local pharmacy. They will contact our office with the information about your prescription. You may also leave a message on our prescription line for all refill requests.

Please avoid leaving multiple messages on the prescription line so that it does not delay the process of your prescription being filled.

All medication refills may be electronically prescribed to the pharmacy of your choice.

Prescription phone-in / pick-up: Monday – Thursday during normal business hours ONLY (8:00am – 4:00pm) and Friday (8:00 am – 1:30pm)

Please allow **24-48 hours** to process prescriptions, renewals, and/or pick-up requests.

Please note that no prescriptions will be filled on weekends or holidays.

All controlled substance prescriptions require a follow-up appointment every 3 months, unless otherwise stated by care provider.

Failure to keep appointments will result in the denial of your refill request.

No early refills will be permitted if a medication is being overused, abused, and/or misused.

Please contact our office if your medication has been lost, stolen, or misplaced, so that the appropriate action can be taken.

I understand and accept the protocols listed above.

_____ _____

Patient/Parent or Guardian Signature Date

ARDENT FAMILY CARE, P.A.
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PALM COAST, FL. 32164-2324

AGREEMENT FOR CONTROLLED SUBSTANCES

This agreement is to prevent any misunderstanding about certain medications that you will be taking for pain management.

I have agreed to use narcotics as part of my treatment for chronic pain. This decision was made because my condition is serious and/or other treatments have failed in controlling my pain.

I understand that these drugs are very useful, but have a high potential for misuse and addiction and are closely regulated by local, state, and federal government.

I understand that the goal of using these medications is to relieve/decrease pain, to improve my function and ability to work/care for myself and my family.

Because my physician is prescribing such medication to help manage my pain, I agree to following conditions and am aware that failure to abide by any of these conditions will be considered a breach of contract and, at the sole discretion of my physician, may result in the termination of our physician/patient relationship and will no longer obtain the medications.

Please initial each line to consent to the following:

____1. I agree to take the medication exactly as prescribed and not change the medication dosage and/or frequency without the approval of Ardent Family Care, P.A.

____2. The side effects, risks, and benefits of the medication will be explained to me as well as the estimated time for the medication to offer noticeable relief.

_____3. The use of controlled substances may cause decreased levels of alertness or the feelings of drowsiness. If you are to experience any of these symptoms, please refrain from driving or operating machinery.

____4. I agree to contact my healthcare provider or go to the emergency room if I am to experience any major side effects towards my medication(s).

___5. I agree that my medication(s) is for my use alone. I will not share, sell, trade, or give my medication to anyone else, as the federal law prohibits the transfer of this drug to any person other than the person for whom it is being prescribed for.

____6. I will not use any other illegal substances including cocaine, heroin, etc., and I understand that I should not consume alcoholic beverages while taking this medication(s).

____7. I will safeguard my medication and prescriptions from loss or theft.

____8. I understand that my medication(s) will be adjusted and refilled at my physician's discretion.

____9. I will not attempt to obtain pain medications or other narcotics such as Xanax, Valium, Tramadol, etc., from any other physicians before discussing this with my provider at Ardent Family Care, P.A.

____10. I agree to communicate all medications and supplements I am taking to each physician I see.

____11. I agree to have the recommended laboratory studies required to keep the regimen as safe as possible, submit to blood or urine test and/or random medication count if requested by my doctor to determine my compliance with my regimen of pain control.

____12. I agree that I will communicate fully with my physician about the character and intensity of my pain, how the pain affects my daily life, and how the medication is helping me relieve pain and improve my functional status and quality of life.

____13. I agree to use only one pharmacy for all my medications. If I change my pharmacy for any reason, I agree to notify my doctor and to also advise my new pharmacist of my prior pharmacy address and phone number. I agree to allow my physician to receive information from my pharmacy about my medication use.

____14. I agree that my physician has given me information about pain medication usage and I also have the opportunity to ask questions and review this information.

____15. I agree to waive any applicable privileges or rights of privacy or confidentiality with the respect of the prescribing of my pain management. I authorize the doctor and my pharmacist to cooperate fully with any city, state, or federal law enforcement agency and also authorize the doctor to provide a copy of this agreement to my pharmacy.

____16. I agree that this agreement is essential to the doctor's ability to treat my pain effectively and the failure for me to abide by the terms of this agreement will result in the withdrawal of all prescribed medications by the doctor, and the termination of the doctor-patient relationship.

Due to FDA regulations, narcotics, as well as other prescribed sedatives, **will not** be dispensed early by this office. This is to prevent and decrease the risk of potential abuse of these medications as they can pose harmful if not taken properly.

This agreement has been entered on the _____day of _____, 20____.

_____ _____

Patient/Parent or Guardian Signature Physician Signature

ARDENT FAMILY CARE, P.A.
84 PINNACLES DR STE 200
PALM COAST, FL. 32164-2324

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003listed standards that have been included in an ePrescribe program. These include:

- **Formulary and benefit transactions**- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Ardent Family Care P.A. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Ardent Family Care P.A. to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____	_____	_____
Patient/Parent or Guardian Signature	Date of Birth	Date

ARDENT FAMILY CARE, P.A.

84 PINNACLES DR STE 200
PALM COAST, FL. 32164-2324

TERMS AND CONDITIONS OF REGISTRATION

THE PRACTICE
Ardent Family care, P.A. and/or physicians, employees, agents, or assignees will hereafter be referred to as the Practice.

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of medical treatment, diagnosis and/or therapeutic procedures as required by the physician rendering care. The procedures may include, but are not limited to, laboratory and x-ray procedures.

HIV/HEPATITIS B/HEPATITIS C TESTING NOTIFICATION
The patient shall have the right to informed consent or refusal for HIV/Hepatitis C testing. The practice does not randomly test for HIV.

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize the Practice to apply for benefits in exchange for the services rendered to myself/us under any health insurance policies/programs providing such benefits. I do hereby assign and authorize payments of benefits from my insurance company to the Practice including benefits payable under Title XVIII of the Social Security Act and/or any other government agency. Furthermore, I irrevocably authorize such payments to the practice.

RELEASE OF INFORMATION
I authorize the Practice to release any and all of my medical records, as well as any other information required by my/our insurance or the designated review agent who provide insurance benefits in my/our behalf including if applicable, my employer and/or workman's compensation insurance company, the Social Security Administration. Such medical records and information may be needed to determine benefits, process insurance claims and secure payment of benefits to either the insured or to the Practice. I also authorize any hospital, laboratory, physician, healthcare provider and/or its staff to release my/our records and any information about myself/us to the Practice. I agree to pay the applicable charges arising from the copying of such medical records which shall not exceed $1.00 per page for the 1st 25 pages and $0.25 per page thereafter, in addition to the $10.00 regular postage/handling fee.

REFERRALS AND PRECERTIFICATIONS
I understand that I must have the appropriate document(s) for referrals, authorizations or pre-certifications prior to seeing a specialists/healthcare provider, or before going to a healthcare facility. I also understand that the practice does not provide retroactive referrals (referrals generated after a visit, authorizations or pre-certifications) in accordance with my insurance policy guidelines. I further understand that if I must go to the emergency room/urgent care facility, I must notify the Practice prior to going, if possible, or within the specified number of hours (usually 48 hours) required by my insurance company. If any of the

aforementioned procedures are not done, I am fully aware that such may cause reduced or rejected coverage for which I may be held responsible. I authorize the Practice to contact my employer or insurance company regarding the existence and coverage of my/our benefits.

COPY OF SIGNATURE

I permit that a copy of this authorization be used in lieu of the original on all insurance claims, as well as for the release of my medical records and/or any other information as stated herein, whether manual, electronic, or by telephone.

CERTIFICATION

I certify that the information I have reported with regard to my/our insurance coverage is true and correct and that the above mentioned Terms and Conditions of Registration be honored carrier(s). This certification will also apply to the application for benefits under the Title XVIII of the Social Security Act and/or any other government agency. I further certify that I have read the forgoing and that as a patient/guarantor, I fully understand and accept the terms and conditions therein.

_____ _____

Name of Patient/Guarantor Date