



Date:

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Dear \_\_\_\_\_:

Thank you for choosing our practice. Attached, please find our “New Patient Application” for your completion. After you complete the enclosed paperwork, please return it to our office for the physician to review. Our office will be calling you within the next few days to schedule your appointment.

Your new patient physical must be confirmed in advance, as we allow extended time to meet you and gather your history. Our office staff will be calling to confirm your appointment 2 days in advance, if we are unable to reach you, we ask that you return the call to let us know you will be keeping the appointment as originally scheduled.

We would like to make your visit to our office as efficient as possible. In order to do so, we require a 24 hours notice should you need to cancel your appointment. There is a charge for “no show” appointments. We have reserved a specific time for you, please be courteous and advise us as quickly as possible so we may see a patient who urgently needs an appointment.

We are looking forward to meeting you.

**David L. Oliver, D.O.**

1805 SE 16th Avenue • Suite 1201 • Ocala, Florida 34471 • Phone: (352) 351-4634 • Fax: (352) 351-1900

# NEW PATIENT INFORMATION FORM

Current date: \_\_\_\_\_

## PATIENT INFORMATION:

By what name do you like to be called? \_\_\_\_\_

Patient's Last Name	First	Middle	Mr. ___ Miss ___	<u>MARITAL STATUS</u>
			Mrs. ___ Ms ___	Single ___ Married ___
				Div. ___ Widowed ___

Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone # \_\_\_\_\_

P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Best phone # to contact you \_\_\_\_\_

E-mail address: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work #: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's SS#: \_\_\_\_\_

## INSURANCE INFORMATION (Please provide your insurance card to our receptionist)

Primary Insurance: \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ Co Payment \_\_\_\_\_ Patient's relationship to subscriber \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Person responsible for bill \_\_\_\_\_ Birth Date \_\_\_\_\_ Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

**IN CASE OF EMERGENCY:**

**Name of friend or relative (not living at the same address)**

**Relationship to Patient**

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<b>Phone #</b>	<b>Work #</b>	<b>Cell #</b>
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**Whom may we thank for referring you?  family  friend  yellow pages  other**

I hereby give consent for treatment and hereby authorize any physician, hospital, or medical facility to release any information concerning my medical history and treatment.

I hereby authorize release of medical information including positive exposure to HIV infection, ARC, AIDS, alcohol or drug dependency, mental and nervous disorders to other physicians, hospitals, or medical facilities that may be included in my care.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize American Family Medical or my insurance company to release any information required to process my claims.

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PATIENT SIGNATURE

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DATE

**YOUR INSURANCE:**

We have made prior arrangements with many insurers and health plans. We will bill those plans with whom we have an agreement and will collect any required copayment, coinsurance, or deductible at the time of service. Copayment, coinsurance, and/or deductible will be collected upon sign in for your appointment time without exception. Payment may be made via cash, check, credit or debit. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. **We do not file secondary unless there is an automatic cross over from Medicare. We do not file Medicare HMO plans. Please inform us when your insurance plans change.**

**MINOR PATIENTS:**

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment in full at the time of service, regardless of who is legally responsible. All minors must be accompanied by a parent or legal guardian unless prior arrangement for another party to be present or children older than 12 to be seen alone has been made in writing by a parent or legal guardian.

**MISSED APPOINTMENTS:**

In order to provide the best possible service and availability to all our patients, it is our policy to charge a \$45.00 fee for any “brief” appointments not cancelled 24 hours in advance, and \$80.00 for physicals. Please call us as early as possible if you know you will need to reschedule your appointment.

**MEDICAL RECORDS:**

Medical records may be released with a signed consent from the patient only and may be charged \$1.50 per copy, up to \$35.00 and .50 cents for each copy thereafter. There is also a \$30.00 charge for the completion of medical forms (i.e. FMLA, Medication Authorization, Forms for Supplies).

**COMPLIANCE:**

In an effort to maintain optimal health, each patient is expected to comply with the physician’s advice regarding their health care needs. Failure to do so may result in our inability to continue providing your health care. In order to maintain continuity of care, we request that you schedule an annual physical exam.

**FINANCIAL AGREEMENT:**

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that will not be covered (e.g., yearly physicals, pap smears, mammograms, urinalysis, hemoccult, blood work). It is your responsibility to be familiar with your health insurance plan.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** For your convenience, we accept VISA, MASTERCARD, PERSONAL CHECKS, and DEBIT CARDS. There will be a \$30.00 charge on all returned checks. All past due accounts over 60 days will be charged a late fee of 5% of the unpaid monthly balance. On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. If it becomes necessary to collect any sum due through an attorney, then the patient/guarantor agrees to pay all reasonable costs of collection, including attorney’s fees, whether suit is filed or not. If you have any questions, about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us, we are here to assist you.

**I have read and understand the policies of the practice. I understand and agree that such terms may be amended from time-to-time by the practice.**

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Signature of Patient/Parent

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Date

**American Family Medical, LLC**

**David L. Oliver, D.O.**

1805 SE 16th Ave • Suite 1201 • Ocala, FL 34471

**MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse \_\_\_\_\_ Date of Birth \_\_\_\_\_

Children: 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_ 4: \_\_\_\_\_

Ages: \_\_\_\_\_

**Medical Problems**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Presently Taken (what dosage & how often)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies**

**Type of Reaction**

_____	_____
_____	_____
_____	_____

**Food Allergies**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries**

**Date (approximate)**

**Reason**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Hospitalizations (other than for surgery)**

**Reasons**

**Place & Date**

_____	_____
_____	_____
_____	_____

**Serious Accidents or Fractures**

**Date**

**Lasting Complications (if any)**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family Medical History**

<u>Relative</u>	<u>Living</u>	<u>Deceased</u>	<u>Age</u>	<u>Medical Problems</u>
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

**List Anyone in The Family With:**

High Blood Pressure \_\_\_\_\_ Cancer \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Diabetes \_\_\_\_\_  
Kidney Disease \_\_\_\_\_ Lung Diseases \_\_\_\_\_  
Tuberculosis \_\_\_\_\_ Other Diseases \_\_\_\_\_  
Premature Death (before age 60) \_\_\_\_\_ Addictions \_\_\_\_\_ Mental Illness \_\_\_\_\_

**Social History**

What is your current or previous major occupation? \_\_\_\_\_

Are you or have you been a smoker? Yes \_\_\_\_\_ No \_\_\_\_\_ Oral tobacco? \_\_\_\_\_

If "Yes", Please List; the amount, \_\_\_\_\_ pks. per day, the duration, \_\_\_\_\_ years, and the year that you quit \_\_\_\_\_ (if applicable).

Do you drink any alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes", how much \_\_\_\_\_ and how often \_\_\_\_\_

Religious Preference \_\_\_\_\_

Are you using or have you ever used illicit substances (i.e. marijuana, cocaine) If so, what? \_\_\_\_\_

**Review of Systems**

Would you describe your general health as: Excellent Good Fair Poor (circle one)

Have you experienced any unexpected weight loss or weight gain? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes", how much \_\_\_\_\_

**Have you ever had or been treated for any of the following? (If so, give details)**

Ear Problems \_\_\_\_\_ Eye Problems \_\_\_\_\_  
Hay Fever \_\_\_\_\_ Thyroid Disease \_\_\_\_\_  
Asthma \_\_\_\_\_ Lung Disease \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Chest Pain \_\_\_\_\_  
Dark Tarry Stools \_\_\_\_\_ Ulcers \_\_\_\_\_ Hemorrhoids \_\_\_\_\_  
Rectal Bleeding \_\_\_\_\_ Other Bowel Diseases \_\_\_\_\_  
Gallbladder Disease \_\_\_\_\_ Urinary Tract Infections \_\_\_\_\_  
Kidney Stones \_\_\_\_\_ Sexual Dysfunction \_\_\_\_\_  
Decreased Urinary Flow \_\_\_\_\_ Frequent Nighttime Urination \_\_\_\_\_  
Arthritis \_\_\_\_\_ Chronic Back Pain \_\_\_\_\_  
Anemia \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_  
Chronic Skin Conditions \_\_\_\_\_ Psychiatric Problems \_\_\_\_\_  
Other Medical Problems \_\_\_\_\_  
Addictions \_\_\_\_\_

When was your; last EKG \_\_\_\_\_ , last chest x-ray \_\_\_\_\_ , last tetanus shot \_\_\_\_\_

**Females Only**

Total number of; Pregnancies \_\_\_\_\_ , Births \_\_\_\_\_ , Miscarriages \_\_\_\_\_

Complications of pregnancy and labor, if any \_\_\_\_\_

Menstrual Cycle: How Often \_\_\_\_\_ Duration \_\_\_\_\_ , Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_

When was your; last pap smear \_\_\_\_\_ , last mammogram \_\_\_\_\_

Type of birth control used \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW AMERICAN FAMILY MEDICAL MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

American Family Medical is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by American Family Medical or received by American Family Medical from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. American Family Medical will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

American Family Medical reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

### Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

American Family Medical may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare options. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

#### Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare provider's concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, American Family Medical may determine that you require the services of a specialist. In referring you to another doctor, American Family Medical may share or transfer your healthcare information to that doctor.

#### Payment activities may include:

- Activities undertaken by American Family Medical to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, American Family Medical will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

#### Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, American Family Medical may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

American Family Medical may contact you, by telephone or mail or email, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when American Family Medical is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.  
In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wounds occurred as a result of a crime.  
Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities.  
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.  
We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and Administrative Proceedings.  
Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death.  
We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research.  
Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety.  
We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers' compensation.  
We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

American Family Medical will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that American Family Medical has taken action in reliance thereon. Any revocation must be in writing.

#### Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by American Family Medical to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. American Family Medical may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that American Family Medical send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that American Family Medical not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that American Family Medical amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by American Family Medical for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with American Family Medical and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with American Family Medical, please contact the Privacy Officer at the following:

Privacy Officer  
American Family Medical  
1805 SE 16th Avenue  
Suite 1201  
Ocala, FL 34471

It is the policy of American Family Medical that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

**AMERICAN FAMILY MEDICAL, LLC**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

I \_\_\_\_\_ acknowledge that I have received a copy of American Family Medical Notice of Privacy Practices. This Notice describes how American Family Medical may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

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Signature of Patient or Personal Representative

Date

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Relationship to Patient

Dear Patient:

In an effort to make our office as efficient as possible, and to reduce waiting time for you the patient, please review the following suggestions. We have found that when patients' follow these simple steps we are able to provide better care in a more timely and efficient manner.

**KNOW YOUR MEDICATIONS:** The name of the medication, what the medication is being taken for, and also the strength and dose. Keep an updated list of your medications with you for quick reference.

**REFILLS:** Advise the medical assistant of any refills you need and whether you or your insurance prefers 30, 60, or 90 day refills. Also, provide her with the name and phone number of your pharmacy, we now send most prescriptions electronically. When calling in for prescription refills, please provide this information as well.

Check the number of refills on your prescription prior to calling us to avoid additional calls.

**INSURANCE FORMULARY:** Become familiar with your insurance formulary plan for prescriptions, provide the office with a copy of the formulary to be placed in your chart for future reference. If we prescribe a medication for you that is not on your formulary and you don't inform us, there will be a need for you to schedule another appointment with the provider to select another medication that is best suited for you with your medical condition.

**OFFICE VISITS:** Our office tries, if possible, to evaluate only one-two medical problems per patient, per visit. This allows our appointment schedule to run at a manageable rate and has proven to be the fairest to all concerned. Emergencies and exceptions do arise and some problems take longer to evaluate than others. We make every effort to minimize our patients waiting time.

**SCHEDULING APPOINTMENTS:** Allow yourself sufficient time when scheduling office appointments; realizing that due to the nature of our office we do handle medical emergencies when they arise, this may cause our schedule to run behind.

Thank you so much for your attention to these important matters. If you have any further questions or comments, please bring them to the attention of the receptionist. Thank you again for choosing our office, and we look forward to treating you.

By signing this document, I acknowledge reading and understanding the above. I have received a copy for my records. The original will be placed in my chart.

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Patient Name

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Date