Ocala Family Medical Center, Inc.

How did you hear about us?	☐ Family ☐ Friend ☐ Phone Book ☐ Signs ☐ Internet ☐ Other:

PATIENT INFORMATION FORM

Last Name:	First Name:	Initial:	PT#
Primary Mailing Address:			
Alternate Mailing Address:			
Reside here **FROM** (Month)	**TO** (Month)		
Gender: / Gender Identity:	Sexual Orientation	Date of Birth:	
Employer or School:	Employment Status:	Mobile#:	
SSN#	Marital:	Home#:	
Race:	Ethnicity:	Work#:	
Language:	Email:		

CONTACT INFORMATION – MUST BE COMPLETED

☐ Consent to leave message with detailed information

☐ Consent to leave message with call back number, extension and name only

I wish to be contacted in the following manner:
(apply number 1-4 indicating preferred number and indicate preferred method of contact)

____ Home: ☐	____ Work: ☐	____ Mobile: ☐	____ ☐ Patient Portal
☐ Voice	☐ E-Mail	☐ Text	☐ Don't Contact

HIPAA consent to release Protected Health Information (PHI) to the following person(s)
THIS FORM REPLACES ALL PRIOR FORMS
(i.e. pick up your prescriptions, release medical records, discuss billing/clinical information)

Name: Relationship:

Name: Relationship:

HIPAA consent to release Protected Health Information (PHI) to Patient Registries
(i.e. Specialists, Hospitals, Insurance Carrier Registries, Immunization Registries, Cancer Registries)

Consent to submit PHI to patient registries ☐ Yes ☐ No

Emergency Contact Information / Living Will

Name of Emergency Contact: Phone: Relationship:

Do you have a living will? YES ☐ NO ☐ If yes, copy provided: YES ☐ NO ☐

Primary Insurance

Name: Member ID: Effective Date:

Secondary Insurance

Name: Member ID: Effective Date:

Preferred Pharmacies

Name: Address: Phone:

Name: Address: Phone:

I understand and agree: *I authorize treatment and will be responsible for the payment of all charges incurred on behalf of myself or family member.*

Please be prepared to pay the copay/deductible for today's visit

I authorize payment of medical benefits to: OCALA FAMILY MEDICAL CENTER, INC.

Signature: _____ Date: _____

Revised: 09/01/2023

OFMC
OCALA FAMILY MEDICAL CENTER

NAME: _____ **DOB:** _____ **SHOE SIZE**_____

PRIMARY COMPLAINT: _____

RIGHT FOOT (PLEASE CIRCLE IF IT APPLIES)

WHOLE FOOT	BALL OF FOOT	TOP OF FOOT	ARCH	HEEL
GREAT TOE	SECOND TOE	THIRD TOE	FOURTH TOE	LESSER TOE
ANKLE	LEG	NAIL FUNGUS	INGROWN	

LEFT FOOT (PLEASE CIRCLE IF IT APPLIES)

WHOLE FOOT	BALL OF FOOT	TOP OF FOOT	ARCH	HEEL
GREAT TOE	SECOND TOE	THIRD TOE	FOURTH TOE	LESSER TOE
ANKLE	LEG	NAIL FUNGUS	INGROWN	

NATURE OF THE PAIN

SHARP DULL ACHING BURNING RADIATING STABBING ITCHING OTHER_____

Pain Scale: 1-10 (1=LOW/10=HIGH) 1 2 3 4 5 6 7 8 9 10

IS YOUR PROBLEM: OCCASIONAL FREQUENT INTERMITTENT CONSTANT

SWELLING? NONE MILD MODERATE SEVERE

HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM? WHEN? TREATMENT? DR'S NAME

_____

WHAT HOME TREATMENTS HAVE YOU ATTEMPTED, IF ANY?

ORAL/TOPICAL MEDICATIONS ICE NEW SHOES INSERTS REDUCED ACTIVITY

WHEN DID THE PROBLEM START? DAYS_____ WEEKS____ MONTHS_____ YEARS_____

IS THE PROBLEM INJURY RELATED? IF YES PLEASE, EXPLAIN IN DETAIL_____

WHAT MAKES THE PROBLEM WORSE?

STANDING WALKING RUNNING EXERCISE SHOES DAILY ACTIVITIES

WHAT MAKES THE PROBLEM BETTER?

_____

NAME _____ **DOB**_____

DO YOU EXERCISE REGULARLY? NO YES/HOW OFTEN _____

DO YOU DRINK ALCOHOL? YES, HOW MANY PER DAY? NO YES_____

DO YOU USE RECREATIONAL DRUGS? YES, IF SO PLEASE LIST: NO YES_____

TOBACOO USE?

NEVER FORMER, NUMBER OF YEARS_____ CURRENT___PACKS PER DAY/YEARS_____

OTHER TOBACCO: PIPE E-CIGARETTE SNUFF CHEW

DO YOU HAVE ANY OF THE FOLLOWING?

ITCHING	LEG CRAMPING	MUSCLE/JOINT PAIN	DIZZINESS/FAINTING
RASH	LEG WEAKNESS	STIFFNESS	TREMORS
DEFORMED NAILS	CLOTS IN LEGS	BACK PAIN	SEIZURES
PSORIASIS	COLD FEET	REDNESS OF JOINTS	WEAKNESS
SKIN CANCER	VARICOSE VEINS	SWELLING OF JOINTS	NUMBNESS
ECZEMA		TRAUMA	TINGLING

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF YES, PLEASE LIST...

_____

NEW PATIENTS ONLY: MEDICATION LIST

_____

_____

_____

_____

_____

OFMC Podiatry Clinic
2131 SW 20th Place
Ocala, FL 34471
(352) 368-1370

Dear Patient:

Welcome to Ocala Family Medical Center. Our goal is to improve your quality of life.

It is our policy to charge for missed appointments at the rate of:

New Patient Appointment: $100.00 dollars

Follow Up Appointment: $75.00 dollars

Missed Procedures: $100.00 dollars

Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep this appointment, please call (352) 368-1370 to reschedule your appointment at least 24-hours in advance.

Sincerely,
The Staff of Ocala Family Medical Center

I have read and understand the above no show policy for OFMC Podiatry clinic.

Print Name	Witness
Signature	Date

Effective: 02/01/2024

MISSED APPOINTMENTS

UNLESS CANCELED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT THE RATE OF A NORMAL OFFICE VISIT. PLEASE HELP US TO SERVE YOU BETTER BY KEEPING YOUR SCHEDULED APPOINTMENTS.

MINOR PATIENTS

THE ADULT ACCOMPANYING A MINOR AND THE PARENTS (OR GUARDIANS) OF THE MINOR ARE RESPONSIBLE FOR FULL PAYMENT OF SERVICES RENDERED. NON-EMERGENCY TREATMENT WILL BE DENIED TO UNACCOMPANIED MINORS UNLESS CHARGES HAVE BEEN PRE-AUTHORIZED TO AN APPROVED CREDIT PLAN, VISA / MASTERCARD, OR PAYMENT BY CASH OR CHECK AT TIME OF SERVICE.

CONSENT TO TREAT / AUTHORIZATION

I UNDERSTAND THAT COVID-19 IS PREVALENT IN THE COMMUNITY AND IS A RISK WITH ANY MEDICAL VISIT OR PROCEDURE. I HEREBY GIVE OCALA FAMILY MEDICAL CENTER, INC. CONSENT TO PROVIDE WHATEVER TREATMENT DEEMED NECESSARY TO THE PATIENT FOR WHOM I AM RESPONSIBLE. I UNDERSTAND THAT MY REFUSAL OF SUCH TREATMENT MUST BE VERIFIED BY MY SIGNATURE.

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS AND OTHER INFORMATION, AS REQUIRED FOR PAYMENT OF BENEFITS PAYABLE BY INSURANCE, OR THIRD PARTY SOURCES, IN CONNECTION WITH TREATMENT OF _____ (PATIENT'S NAME). I FURTHER AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO OCALA FAMILY MEDICAL CENTER, INC. OF ANY BENEFITS PAYABLE WHICH ARE OTHERWISE PAYABLE TO ME.

GUARDIAN OF A MINOR COMPLETE BOX BELOW

I, _____, BEING THE LEGAL GUARDIAN OF _____ (PATIENT'S NAME) HEREBY AUTHORIZE THE MEDICAL TREATMENT OF SAID PATIENT BY THE STAFF OF OCALA FAMILY MEDICAL CENTER, INC.

IN THE EVENT THAT I AM NOT AVAILABLE, I AUTHORIZE THE RELEASE OF MEDICAL AND / OR FINANCIAL RECORDS FOR INFORMATION TO: _____

I HAVE READ AND FULLY UNDERSTAND THE CONTENT OF ALL PAGES OF THIS PATIENT INFORMATION AND MEDICAL RELEASE FORM. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO IT.

_____	_____	_____
SIGNATURE OF PATIENT	SIGNATURE OF RESPONSIBLE PERSON (WHERE APPLICABLE)	DATE
_____	_____	
PRINT NAME OF PATIENT	PRINT NAME OF RESPONSIBLE PERSON	

METHOD OF PAYMENT: CASH ☐ CHECK ☐ CREDIT CARD ☐ INSURANCE ☐

OFMC
OCALA FAMILY
MEDICAL CLINIC

2230 SW 19th Avenue Road
Ocala, FL 34471
Phone: (352) 237-4133
Fax: (352) 873-4581

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I, _____, understand that as part of my healthcare, Ocala Family Medical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations.
- If I elect to not allow an Ocala Family Medical Center staff member to have access to my records I must notify Ocala Family Medical Center in writing. The request will be addressed by a member of the management team and/or the privacy officer. I will be contacted if additional information is required.

I understand that Ocala Family Medical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164-506 of the Code of Federal Regulations.

I further understand that Ocala Family Medical Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164-520 of the Code of Federal Regulations. Should Ocala Family Medical Center change their notice, they will send a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information (PHI) to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I authorize my health care provider to use an automated telephone system and/or email and to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information (PHI) regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine.

I fully understand and accept the terms of this consent.

_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date

NOTIFICATION OF ALTERNATE SUPPLIERS OF DIAGNOSTIC IMAGING SERVICES

Dear Valued Patient:

During your office visit your provider may recommend that you seek certain diagnostic imaging services (i.e., CT or MRI) as part of your course of treatment.

Pursuant to Section 6003 of the Patient Protection and Affordable Care Act, Ocala Family Medical Center is hereby providing notice to you that you may obtain diagnostic imaging services from another provider other than Ocala Family Medical Center if you so choose.

The Following is a list of suppliers that provide such diagnostic imaging services within a twenty-five-mile (25mile) radius of this location:

- AdventHealth Ocala, 1500 S.W. 1st Avenue, Ocala, Fl 34471
  352.351.7200
- Ocala Regional Medical Center, 1431 SW 1st Avenue, Ocala, Fl 34471
  352.401.1000
- West Marion Community Hospital, 4600 SW 46th Court, Ocala, Fl 34474
  352.291.3000
- Timberridge Imaging Center, 9521 SW HWY 200, Ocala, Fl 34481
  352.671.4300
- Advanced Imaging, 8150 SW HWY 200, Ocala, Fl 34481
  352.854.2020

If you elect not to use one of the aforementioned alternate suppliers, Ocala Family Medical Center will be pleased to provide your diagnostic imaging services here at this location.

Please acknowledge your receipt of this notification by signing below.

_____
Signature

_____
Printed Name

_____
Date