Ocala Family Medical Center, Inc.

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

PATIENT INFORMATION FORM

Patient Name Last:	First Name:		Initial:	PT#
Mailing Address:		Apt #:	Age:	Gender:
City, State, Zip:			Date of birth:	
Employer or School:	Employment Status:		Mobile#:	
SSN#	Marital:		Home#:	
Race:	Ethnicity:		Work#:	
Language:	Email:			

****** Patient Contact Information ******

☐ 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)
(i.e. pick up your prescriptions, release medical records, discuss billing/clinical information)

Name:	Relationship:
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

Emergency Name: Phone: Relationship:

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

Primary Insurance

Plan/Policy Name:	Effective Date:
Member ID:	

Secondary Insurance

Plan/Policy Name:	Effective Date:
Member ID:	

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.*

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

Signature: _____ Date: _____

Revised: 06/04/2020

Name: _____ DOB: _____

Primary Complaint: _____

Height:_____ Weight:_____ Shoe Size:_____

Location:

RIGHT

☐ Whole Foot ☐ Ball of Foot ☐ Top of Foot ☐ Arch ☐ Heel
☐ Great Toe ☐ Second Toe ☐ Third Toe ☐ Fourth Toe ☐ Lesser Toe
☐ Ankle ☐ Leg

LEFT

☐ Whole Foot ☐ Ball of Foot ☐ Top of Foot ☐ Arch ☐ Heel
☐ Great Toe ☐ Second Toe ☐ Third Toe ☐ Fourth Toe ☐ Lesser Toe
☐ Ankle ☐ Leg

Nature of the Pain: (Please answer all that apply)

☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Radiating ☐ Stabbing ☐ Itching ☐ Other _____

Pain Scale:

	1	2	3	4	5	6	7	8	9	10	
LOW	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	HIGH

Is your Problem: ☐ Occasional ☐ Frequent ☐ Intermittent ☐ Constant

Swelling:

☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you ever had previous medical treatment for this problem? ☐ Yes ☐ No
If yes, what treatments? Please list doctor's name.

What home treatments have you attempted if any?

☐ Oral or Topical Medication ☐ Ice ☐ New Shoes ☐ Inserts ☐ Reduced Activity
☐ Other_____

Do you have any other complaints or problems? ☐ Yes ☐ No
If yes, please list:

When did the problem start? ☐ Suddenly ☐ Gradually
Duration: Days:_____ Weeks:_____ Months:_____ Years:_____

Is this problem related to an injury? ☐ Yes ☐ No
If yes, please provide the date and details of the injury:

What makes your problem worse?

☐ Standing ☐ Walking ☐ Running ☐ Exercise
☐ Work ☐ Shoes ☐ Daily Activities

What makes your problem better?

Revised: 3/17/2020

Name: _____ DOB: _____

Medical History

Please indicate with a (✓) any of the medical conditions below that pertain to you

☐ Arthritis	☐ Osteoporosis
☐ Back Pain	☐ Phlebitis
☐ Bleeding Disorders	☐ Pulmonary Embolus
☐ Circulatory Problems	☐ Rheumatic Fever
☐ Deep Venous Thrombosis (DVT)	☐ Rheumatoid Arthritis
☐ Diabetes, Type II	☐ Ulcers
☐ Edema	☐ Varicose Veins
☐ Fracture	☐ Other: _____
☐ Gout	

Surgical History

Please indicate with a (✓) any of the surgical conditions below that pertain to you, and circle which anatomical side

☐ Amputation of Foot Right/Left	☐ Hip Replacement Right /Left
☐ Amputation of Toes Right /Left	☐ Knee Replacement Right /Left
☐ Ankle Surgery Right /Left	☐ Open Heart Surgery
☐ Bunion Surgery Right /Left	☐ Organ Transplant
☐ Colon Surgery	☐ Pacemaker/Defibrillator
☐ Foot Surgery Right /Left	☐ Vein Surgery/Artery Surgery
☐ Fracture Repair, Ankle Right/Left	☐ Other _____
☐ Fracture Repair, Foot Right/Left	
☐ Hammertoe Surgery Right /Left	

Family History

Please indicate with a (·) for family members who have had any of the following conditions

Relationship	Diabetes	Arthritis
Father		
Mother		
Brother(s)		
Sister(s)		
Son(s)		
Daughter(s)		

Name: _____ DOB: _____

Social History

Please indicate with a (✓) any of the responses that pertain to you

Marital/Living Status:

· Single · Married · Separated · Divorced · Widowed

Employment:

· Working Full Time · Working Part Time · Retired · Self Employed · Unemployed

Exercise:

Do you exercise regularly? · No · Yes

Substances:

Alcohol:

Do you drink alcohol? · No · Yes: _____ Drinks Per Day

Drug Use:

Do you use any recreational drugs? · No · Yes

Tobacco Use

Cigarettes:

· Never

· Former Smoker: _____ Number of Years Quit Date _____

· Current Smoker: _____ Packs per day _____ Number of Years

Other Tobacco: · Pipe · Cigar · Snuff · Chew

Are you interested in quitting? · Not ready to quit · Thinking about quitting · Ready to quit

Review of Systems

Please indicate with a (✓) any of the medical conditions below that pertain to you, if none of the below apply, (✓) Not Applicable

Integumentary:	Vascular:	Musculoskeletal:	Neurology:
☐ Itching	☐ Leg cramping	☐ Muscle or joint pain	☐ Dizziness
☐ Rash	☐ Leg weakness	☐ Stiffness	☐ Fainting
☐ Deformed nails	☐ Clots in legs	☐ Back pain	☐ Seizures
☐ Psoriasis	☐ Feet cold	☐ Redness of joints	☐ Weakness
☐ Skin cancer	☐ Varicose veins	☐ Swelling of joints	☐ Numbness
☐ Eczema	☐ Not Applicable	☐ Trauma	☐ Tingling
☐ Not Applicable		☐ Not Applicable	☐ Tremors
			☐ Not Applicable

Allergies

Please indicate with a (✓) if you have any allergies to medications? · No · Yes, if yes, list below

_____

_____

NEW PATIENTS ONLY: Medication List

_____

_____

_____

_____

_____

_____

_____

OFMC
OCALA FAMILY
MEDICAL CENTER

Ocala Family Medical Center Inc.
2131 SW 20th Place
Ocala, Fl 34471-1391

Dear Patient:

Welcome to OFMC Podiatry Center. Our goal is to improve your quality of life.

It is our policy to charge for missed appointments at the rate of $50.00 dollars and missed procedures at the rate of $100. Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep this appointment please call (352) 237-4133 to reschedule your appointment at least 24 hours in advance.

Sincerely,

The Staff of OFMC Podiatry Center

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

_____
Print Name

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 CENTER

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