PHARMACY ______________________________ PHONE # ______________

INSURANCE ______________________________

POLICY HOLDER ______________________________ DOB ______________

PERSON TO NOTIFY IN CASE OF EMERGENCY ______________________________

RELATIONSHIP TO PATIENT ______________________________ PHONE # ______________

I, THE UNDERSIGNED, ASSIGN DIRECTLY SHORES MEDICAL CENTER ALL MEDICAL BENEFITS INCLUDING, BUT NOT LIMITED TO, MEDICARE, MEDICAID AND ANY OTHER COMMERICAL INSURANCE PAYMENTSPAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAIN BY INSURANCE. I ALSO AUTHORIZE THE RELEASE OF ALL NESESSARY INFORMATION TO SECURE PAYMENT OF MY BENEFITS ON ALL CLAIMS FILED ELECTRONICALLY OR MANUALLY BY THIS OFFICE.

SIGNATURE ______________________________ DATE ______________

REASON FOR TODAY'S VISIT ______________________________

MEDICAL HISTORY INFORMATION

SYMPTOMS:		PAIN, WEAKNESS, OR NUMBNESS IN:	
CHEST PAIN	YES___ NO___	ARMS	YES___ NO___
SHORTNESS OF BREATH	YES___ NO___	BACK	YES___ NO___
HIGH BLOOD PRESSURE	YES___ NO___	FEET	YES___ NO___
IRREGULAR HEARTBEAT	YES___ NO___	HANDS	YES___ NO___
SWELLING OF ANKLES	YES___ NO___	HIPS	YES___ NO___
CHILLS	YES___ NO___	LEGS	YES___ NO___
DIZZINESS	YES___ NO___	NECK	YES___ NO___
SWEATS	YES___ NO___	SHOULDERS	YES___ NO___
BLURRED VISION	YES___ NO___		
LOSS OF WEIGHT	YES___ NO___		
GAIN OF WEIGHT	YES___ NO___		

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

AIDS	YES___ NO___	BLEEDING DISORDER	YES___ NO___
CANCER	YES___ NO___	DIABETES	YES___ NO___
EMPHYSEMA	YES___ NO___	HISTORY OF A STROKE	YES___ NO___
KIDNEY DISEASE	YES___ NO___	SCARLET FEVER	YES___ NO___
LIVER DISEASE	YES___ NO___	BLOOD DISORDER	YES___ NO___
RHEUMATIC FEVER	YES___ NO___	HIGH CHOLESTEROL	YES___ NO___

DO YOU HAVE ANY ALLERGIES? ________________________________

HEALTH HABITS:

TOBACCO YES___ NO___ CAFFEINE YES___ NO___ ALCOHOL YES___ NO___

MEDICATIONS:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________
7. ______________________ 8. ______________________

DO YOU HAVE A PACEMAKER OR DEFIBILLATOR? YES___ NO___

MAKE ______________________ IMPANT DATE ______________________

HAVE YOU EVER HAD A HEART ATTACK? YES___ NO___

BYPASS__________ CATHETERIZATION __________ ANGIOPLASTY__________

DATE ______________________ WHERE ______________________

WHEN WAS YOUR MOST RECENT BLOODWORK DONE?

DATE ______________________ WHERE ______________________

HAVE YOU HAD ANY OF THE FOLLWING?

ECHOCARDIOGRAM__________ CAROTID ULTRASOUND__________

NUCLEAR STRESS TEST__________ TREADMILL STRESS TEST__________

DATE ______________________ WHERE ______________________

Shores Medical Center

169 E Granada Ave Ormond Beach, FL 32176
3512 S Atlantic Ave Daytona Beach Shores, Fl 32118
Ph: 386-767-9544 Fax: 386-767-9914

HIPPA AUTHORIZATION

FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1998 (HIPP) Privacy Standards.

Shores Medical Center maintains a confidential policy with all patients' medical information.

Patients Name: ________________________________ **Date of Birth:** ______________

Please list the names of those that you give this office permission to speak with or share your medical information.

I authorize Shores Medical Center to use or disclose the following information:

___ **All of my medical information**
___ **Medical information related to mental health**
___ **Medical information related to HIV/AIDS**
___ **Medical information related to substance abuse**

Hereafter known as Medical Records.

The names listed below have permission to discuss and/or receive information on medical condition:

Name: ________________________________ **Relation:** ______________________

Name: ________________________________ **Relation:** ______________________

Name: ________________________________ **Relation:** ______________________

Name: ________________________________ **Relation:** ______________________

The reason for this authorization is General Purpose. At my request (general).

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Act. I have a right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon the authorization. My written revocation must be submitted, signed and witnessed to the above address on this document.

Patient Signature: ________________________________ **Date:** ________________

Printed Name of Patient: ________________________________

SHORES
medical centers

3512 S. Atlantic Ave.
Daytona Beach Shores, FL 32118
(386)767-9544 • Fax (386) 756-0501

RELEASE OF INFORMATION AUTHORIZATION FORM

Name: ______________________________ Date of Birth ______________

Address: __________________ City: __________ State: _____ Zip: __________

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM:

Name: ____

Address: ____________________ City: ______________ State: _____ Zip: ________

Phone: ____________________ Fax: ____________________

Last office Visit: _____ Radiology Report: _______ Laboratory Reports: _______

All Medical Records: ____________ Other: __________________

TO BE RELEASED TO:

SHORES MEDICAL CENTERS

3512 S ATLANTIC AVE

DAYTONA BEACH SHORES, FL 32118

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

This request is only good for 90 days, we will require another release information form. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

____
DATE

______________________ ______________________
Patient Name Patient Signature

Shores Medical Centers
Practice Financial Policies

Thank you for choosing Shores Medical Centers for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees, and coverage limits.

PLEASE KEEP THESE POLICIES FOR FUTURE REFERENCE

Insurance Coverage

Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records. It is important that we have your correct information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Before your appointment, please be sure your provider is in-network and the services are covered under your plan. Our doctors do not participate with all insurance plans. You can see a list of plans that our physicians participate with on our website (http://shoresmedicalcenters). If your provider is out-of-network, you will be billed for the costs of care. If you would like a cost estimate, we would be happy to provide one. We will also help you find out if you have out-of-network benefits. Refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim to your plan.

Co-payments/Co-insurances/Deductibles

You are expected to pay your co-payment and any co-insurance and/or deductible amounts at the time of service.

Payments

Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card (*American Express, MasterCard, Visa and Discover*). We do not accept traveler's checks.

As a service to our clients, we provide a courtesy (bill pay reminder) call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Other Bills

If you receive in-patient or out-patient hospital care, you will receive a hospital bill for those services. Hospital services and bills are separate from Shores Medical Centers services and bills. If you have questions, please contact the hospital billing office.

SHORES MEDICAL CENTERS

Non-Medical Fees

Shores Medical Centers does not complete disability forms or Medicare DME forms specifically for electric wheelchairs and scooters. Please refer to your ordering physician for completion of these forms.

Additional fees apply to the following:

• Returned Check	$35.00
• Copying of Medical Records	$1.00/page for 1st 25 pages and $0.25/page afterward $30.00 for CD Copy
• Completion of Other Forms, i.e. FMLA	$25.00 for 1st 6 pages and $1.00/page afterward

Cancelled, Rescheduled and Missed Appointments

Shores Medical Centers requires a courtesy call within 24 hours (1 business day) prior to cancelling or rescheduling an appointment. Please note that weekends and holidays are not considered business days. If you miss your appointment, or do not cancel with the required notice, additional fees apply:

• Office Appointment	$25.00
• Second Consecutive Office Appointment	$50.00
• Third Consecutive Office Appointment	Discharge

Out-of Network Providers

If the doctor is not in your insurance plan, the following apply:

- Full payment is due at the time of service for routine visits.
- Payment expected on the date of service may be an estimate of your total charges.
- You will be quoted an estimated fee before services/procedures are performed.
- A deposit is required prior to the date of service for elective surgeries and procedures.
- Even if you have out-of-network benefits, you are ultimately responsible for the full fee charged.
- If payment is sent directly to you, you must reimburse Shores Medical Centers immediately.

Non-Covered Services

Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients. Any service not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds

All credit balances will automatically be applied to any open balance on your account. A refund is issued (less any outstanding balances) when an overpayment has been identified. If you feel a refund is due and you have not received one, please contact our billing office at (386) 265-0583.

Failure to Pay

If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

Policy and Fee Changes

These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our Managers for more details or call the billing office at (386) 265-0583.

I have read and acknowledged this financial policy and have had the opportunity to ask questions. I consent to services rendered by Shores Medical Centers under the terms of this financial policy. I will retain a copy of this policy for my reference.

____

Guarantor Signature/Date

Shores Medical Centers
Practice Financial Policies

SHORES MEDICAL CENTERS COPY

I have read and acknowledged this financial policy and have had the opportunity to ask questions. I consent to services rendered by Shores Medical Centers under the terms of this financial policy. I will retain a copy of the financial policy for my reference.

____

Guarantor Signature/Date

Shores Medical Centers - Office No Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Shores Medical Centers defines a "No-show" appointment as any scheduled appointment in which the patient either:

Does not arrive to the appointment.

Cancels with less than 24 hours' notice

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to keep an appointment, it:

Potentially jeopardizes your health.

Prevents other patients that are waiting for much needed care to schedule a timely appointment; please be considerate and keep all planned appointments.

Potentially creates liability to the physician and practice when you fail to adhere to your physician's care plan.

How to Avoid Getting a "No-Show"

1. *Appointment Confirmation*

Shores Medical Centers will contact you by phone before your appointment to confirm your appointment. A confirmation reminder will either be made via a land line call, mobile cell call, or text message. If we are unable to speak with you, we will leave a brief message noting our reminder of your appointment.

2. *Give 24 Hours' Notice if You Need to Cancel*

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care. If it is less than 24 hours before your appointment and something comes up, please give the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year you may be dismissed from the clinic for NON- COMPLIANCE

No Show Charges of $25.00 First no show Office/Nurse Appointment
No Show Charges of $50.00 2nd no show Office/Nurse Appointment
No Show Charges of $75.00 -$100.00 no show for any Procedure Appointment
(Amount to be determined by type of procedure)

Patient dismissal is at the discretion of your physician.
If you are dismissed from the clinic, any remaining scheduled appointments will be cancelled.

Only emergency medical care will be offered within the first 30 days of dismissal.

I have read and understand the Shores Medical Centers "No Show" Policy as described above.

______________________________ Date:______________ Patient/ Responsible Person Signature

Print Name: ______________________________