Patient name_____ Date of Birth_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

New Patient Health History

Dr. William L. Morse

Name:_____ Date:_____

Age: ____ Date of Birth:_____ Reason for visit today:_____

Do you have or have you ever had: (Circle those that apply)

Alcoholism	Anemia	Anorexia	Arthritis	Asthma	Bleeding Disorder	Bulimia
Cancer	Cataract	Chemical Dependency	Diabetes	Emphysema	Epilepsy	Glaucoma
Goiter Gout	HIV	Heart Disease	Hepatitis	Herpes	High Cholesterol	High Blood Pressure
Kidney Disease	Liver disease	Migraine	Miscarriage	Pacemaker	Polio	Prostate Problems
Psychiatric Care	Rheumatic Fever	Stroke	Suicide Attempt	Thyroid Problems	Ulcers	Other

Please list your medications and the dose: _____

_____

Please list your allergies and tell us your reaction: _____

_____

Please list all surgeries you have had and the year: _____

_____

Do your parents, grandparents, children or siblings (brothers and sisters) have any of the following: M=mother, F=father; G=grandparents; S=siblings; C=children

Please circle those that apply

Alcoholism M F G S C	Allergies M F G S C	Arthritis M F G S C	Asthma M F G S C	Alzheimer's M F G S C	Bowel Problems M F G S C	Cancer M F G S C
Depression M F G S C	Diabetes M F G S C	Seizure M F G S C	Glaucoma M F G S C	Heart attack Before age 60 M F G S C	Heart Disease M F G S C	High Cholesterol M F G S C
High Blood Pressure M F G S C	Kidney Problems M F G S C	Mental Illness M F G S C	Migraine M F G S C	Obesity M F G S C	Osteoporosis M F G S C	Skin Disease M F G S C
Stroke M F G S C	Suicide M F G S C	Thyroid Problems M F G S C	Other M F G S C			

Do you or have you ever smoked? If yes, for how long and how many packs?
If you quit, when did you quit?_____

Do you use any other tobacco products? If yes, what do you use and how often?

_____

Do you drink alcohol? If yes, how much and often? If you quit, when did you quit?

_____

Please tell us the last time you had any of the following done:

Physical exam	Pap smear	Flexible Sigmoidoscopy
Colonoscopy	Cholesterol check	Blood transfusion
Tetanus shot	Flu shot	Pneumonia shot
Mammogram	Dexa Scan	PSA

We believe that healing comes form not just treating the body, but also the mind and the spirit. Please te us a little more about yourself by answering the following questions:

What is your ethnicity/race? _____

What is your job? _____

Do you use products with caffeine? If yes, which one and how often?_____

_____

Do you use any drugs not previously mentioned? If yes, which ones? (heroin, marijuana, cocaine for example)_____

What is your spiritual/religious preference?_____
Are you actively involved?_____

What is your current level of stress on a daily basis? (Scale of 0 through 10, with 0 being no stress at all and 10 being the most stress you can imagine.)_____

What is your primary language? _____
Do you require an interpreter?_____

Do you have an advanced directive? _____ (If yes, please provide us with a copy For our files)
Would you like information regarding advanced directives?_____

Is there anything else about yourself that you feel we should know?

_____

_____

I certify that the information I have provided is correct to the best of my knowledge I will not hold my provider or members of the staff responsible for any errors or omissions that I may have made while completing this form.

Patient's signature: _____ Date: _____

REGISTRATION FORM

Date:_____

Doctor: Morse_____

Married Single Divorced Widower (Please circle one) Race: ___ Sex ____

Patient Name:_____ Birthdate: _____ SS#_____

Mailing address:_____City: _____

State: _____ Zip Code: _____ Home Telephone: _____

Patient Employer: _____ Business Phone:_____

Guarantor/Spouse Name:_____ Birthdate:_____

Spouse's employer:_____

What person will be paying for these visits?_____

Address of above: _____

Name of person to contact in an emergency: _____

Relationship: _____ Telephone number:_____

Address of above person:_____

First and last name of dependent children living at home:

1. _____Sex ____Birthdate:_____SS#_____
2. _____Sex:____Birthdate: _____ SS# _____
3. _____Sex: ____Birthdate: _____ SS# _____

Email address: _____ (Ask about our Patient Portal)

Name of insured: _____ Social Security #_____

Medicare number: _____ Medicaid Number: _____

Insurance company name:_____ Policy number: _____

Insurance Company Address:_____

Group #_____ Group employer name: _____

Employer address: _____

I AUTHORIZE TALLAHASSEE PRIMARY CARE ASSOCIATES TO RELEASE MEDICAL INFORMATION REGARDING MYSELF AND MY FAMILY NECESSARY TO PROCESS INSURANCE CLAIMS.

_____

Signature

INSURANCE CERTIFICATION AND ASSIGNMENT / AUTHORIZATION OF TRATMENT.

I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any third party payers is correct. I assign payment to Tallahassee Primary Care Associates of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance or any other charges incurred which are not paid by my insurers or other third party payers together with all costs of collection , if necessary including a reasonable attorney's fee if collected by or through an attorney at law. A Photostat copy of this agreement shall be valid as the original.

The undersigned certifies that he/she has read the forgoing and is the patient or the parent or guardian of the patient and is duly authorized as patient's agent to execute the above and accept it's terms, including the provision of treatment authorization.

Date: _____ Patient:_____

Parent or legal guardian:_____ Relationship to patient;_____

PATIENT ACKNOWLEDGEMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Primary Care Associates, P.A. ("TPCA") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Primary Care Associates prior to signing this document, and I acknowledge that the TPCA Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Primary Care Associates is also available on the website for TPCA at www.TallahasseePrimaryCare.com. I understand that my physician is a part of TPCA, and that this notice applies to the protected health information that my physician, as a part of TPCA, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information by for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TPCA, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TPCA is a member of and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including the Tallahassee BigBendHealth.com , is included on page 2 of this document . This information exchanged in these activities may include my protected heath information. I hereby authorize such transmission. I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Privacy Officer through email at Compliance@TallahasseePrimaryCare.com or by mailing a written request to Privacy Officer at 1803 Miccosukee Commons Drive, Tallahassee, Fl 32308.

TPCA reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseePrimaryCare.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TPCA of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency a reasonable attorney's fees if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

The undersigned certifies that he/she has read the foregoing and is the patient or the parent or guardian of the patient and is duly authorized as patient's agent to execute the above and except its terms, including the provision of treatment authorization.

Patient name: Print_____

Sign_____

Date: _____

Parent or legal guardian name: Print_____

Sign_____

Date:_____

Explain Your Relationship to Patient: _____

Description of Personal Representative's Authority: _____

_____

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Recent important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Primary Care Associates, P.A. participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of our local resource of HIE in Tallahassee through BigBendHealth.com and the Big Bend Regional Healthcare Information Organization ("BBRHIO").

BBRHIO is a Florida nonprofit, public benefit corporation organized and federally recognized 501(c)(3) of the Internal Revenue Code. Unless you specifically opt out as provided below your personal health information will be provided to BBRHIO. Tallahassee Primary Care Associates and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

A Regional Healthcare Information Organization ("RHIO") is a group of organizations and stakeholders that exchanges data electronically to improve the quality, safety, and efficiency of healthcare delivery. RHIOs are ordinarily geographically defined entities that arrange for the means to exchange information electronically. They also develop and maintain HIE standards. To successfully exchange information, RHIOs must build their data exchange on sound principles and processes.

BBRHIO is locally owned and managed, and consists of numerous well-established and respected local health care organizations and stakeholders. The Board of the BBRHIO is comprised of local health care providers, and is solely under the control of the local Board. BigBendHealth.com, which is the website of the BBRHIO, is a first-of-its-kind health resource that creates economic benefits, a connected workforce, improved medical care and a breakthrough in records management. The purpose of "BigBendHealth.com" is to be the essential communication resource and HIE for health care in the Capital region. Additionally, BigBendHealth.com is the largest active Health Information Exchange ("HIE") in Florida with millions of records for over 300,000 unique patients in the system and processing over 400,000 new messages a month.

STATEMENT OF PURPOSE: BBRHIO seeks to reduce the cost and improve the quality and efficiency of health care provided by the Participants through the electronic management and exchange of health information acquired or generated by them in providing, paying for, and reporting on patient care items and services. The Participants anticipate that the electronic management and exchange of such information will simultaneously help eliminate unnecessary repeat testing, increase the accuracy of medical diagnoses, improve medical treatment, and improve outcomes for patients. BBRHIO operates a Regional Health Information Network ("RHIN") to facilitate the electronic transmission, limited storage, and sharing of health information among participating providers of health care services, third-party payers for health care services, and other interested parties in their respective regions in a manner that complies with all applicable laws and regulations, including without limitation those protecting the privacy and security of health information. The intent of BBRHIO and for each of the organizations that participate is to share information for administrative claims and/or treatment purposes. Specifically, this effort is intended to provide a collaborative framework through which the parties can securely share information for administrative claims and/or treatment purposes.

Information on this effort and participation, as well as general information related to the Tallahassee health care community, can be found at www.BigBendHealth.com.

Patient's Communication Instructions, Patient's Release and Acknowledgement

Patient Name (PRINT): _____

Date of Birth: _____

Patient Address: _____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):

____I would like to UPDATE or CHANGE my telephone and/or email contact information

____I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare

____I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare

---

Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

____Home phone number - leave message to return call – no particulars NUMBER: _____

____Home phone number - leave message with particulars NUMBER: _____

____Work phone number - leave message to return call – no particulars NUMBER: _____

____Work phone number - leave message with particulars NUMBER: _____

____Cell number - leave message to return call – no particulars NUMBER: _____

____Cell number - leave message with particulars NUMBER: _____

____Email_____ (Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

____Other (EXPLAIN AND PROVIDE DETAILS)_____

____Other (EXPLAIN AND PROVIDE DETAILS)_____

Who are you authorizing our office to discuss your health situation with? (Please list all names)

____Discuss with no one

____Spouse: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Child: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Sibling: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Other: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Other: circle AUTHORIZED or UNAUTHORIZED (Name_____)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name_____Relationship_____Phone: _____

This authorization will expire on: _____(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Primary Care Associates' Notice of Privacy Policies.

_____ _____

Signature of Patient or Legal Guardian Date

If not the patient, explain relationship and legal authority: _____

Patient's Authorization For Release of Protected Health Information and Medical Records

Patient's Name _____
(Last, First, Middle/Maiden)

Patient's Address: _____City _____State _____Zip_____

Date of Birth _____ Phone Numbers_____

I authorize my physician and/or administrative and clinical staff at Tallahassee Primary Care Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	Person or Entity to Disclose Information:
Name/Organization: _____	Name/Organization: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record __ Billing Records __ Office Notes __ Ultrasound Reports
__ Lab Reports __ Surgery Records __ Mammogram Reports
__ Obstetrical (OB) Records __ Pap Smear / Biopsy Reports __ Other (specify): _____

DATES OF SERVICE: _____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance, ___ Workers' Comp.

Other _____

This authorization will expire on: _____(If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

___I DO ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, and all medical records and clinical information relating thereto.
*Initials of individual giving authorization:*_____

___I DO ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for mental health or psychiatric conditions.
Initials of individual giving authorization: _____

___I DO ___I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for drug or alcohol abuse, drug-related and/or alcohol-related treatment.
*Initials of individual giving authorization.*_____

I have read and understand the nature of this authorization and I have been provided a copy of TPCA's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at ***Tallahassee Primary Care Associates, P.A., Administrative Offices 1803 Miccosukee Commons Drive, Tallahassee, Florida 32308, Attn: Compliance Officer or email Compliance@TallahasseePrimaryCare.com.*** I understand that a revocation is not effective to the extent that my physician or Tallahassee Primary Care Associates has taken action in reliance upon this 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. I also understand that such revocation does not affect TPCA's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health 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 HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient Date
(If applicable, attach document of guardianship or Power of Attorney)

Patient Name _____ Date of Birth _____

Email Address _____

Due to changes in healthcare regulation, we are required to seek some additional information from our patients. Please assist us in updating your medical records as prescribed by the Federal Register:

"In general, we do require that all demographic elements that are listed in the objective be included in a record in certified EHR technology. However, we do not desire, nor could we require that a patient provide this information if they are otherwise unwilling to do so. If a patient declines to provide the information or if capturing a patient's ethnicity and race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure."

Wednesday, July 28, 2010
Part II
Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 412, 413, 422, et al
Medicaid and Medicare Programs;
Electronic Health Record Incentive Program; Final Rule

Please note that providing the information below is completely voluntary. Simply check "Prefer not to share" for the information that you do not wish to provide. Thanks for your cooperation!

1. **Gender:** Male _____ Female _____

2. **Ethnicity:** Not Hispanic or Latino _____ Hispanic or Latino _____ Prefer not to share _____

3. **Race:** Caucasian _____ American Indian or Alaska Native _____ Asian _____ Black or African American _____ More than one race _____ Native Hawaiian _____ Other Pacific Islander _____ Prefer not to share _____

4. Your doctor would like to make sure that we provide education materials to you in your language of choice. Please indicate your language preference below:

Primary Language: English _____ Other (please specify): _____

Did you Know:

A summary of your office visit is now available to you upon request. Office visit summaries include a synopsis of your appointment as well as any follow up measures that should be taken as a result. Below are your options for receipt. Check the option that best fits your needs.

_____ 1) TPCA Patient Portal- *Eliminate the need for keeping up with paper and receive it electronically. It's easy! Ask the front desk how to sign up today!*

_____ 2) Available for pick up at the office after 3 business days

TPCA complies with the medical office regulations of the Federal Government, which were developed to improve Health Care Quality and Efficiency transforming the way health care is both practiced and delivered.

_____ _____
Patient/Parent/Guarantor Signature Date

TPCA Tallahassee Primary Care Associates

Tallahassee Primary Care Associates, P.A.
Corporate Policy

FINANCIAL POLICY

- **Payment is always due PRIOR to service:** We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will of course notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.**
- **Our Billing Services:** We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our web site for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT TPCA IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY H.M.O. PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE H.M.O. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR H.M.O.
- **Co-Pays, Deductibles, and Co-Insurances:** Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contract with your insurer, and are your part of your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- **Secondary Insurances:** If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- **Tertiary Insurance: If applicable,** tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at the time of your appointment.
- **Charges for failing to come to your appointment (generally termed "no-show fees"):** The following fees will apply if you fail to present for an appointment:
  $25.00: - Office visits (or as determined by each office), Ambulatory Cardiovascular monitors.
  $50.00: - Ultrasound, CT, Travel Clinic (you must provide notice of cancellation to our Diagnostic Department scheduling personnel at least 24 hours prior to your scheduled appointment time).
  Variable: - Nuclear Medicine Studies (Patients failing to show for an appointment without providing at least 24 hours cancellation notice will be charged the cost of the Radioisotopes, which varies based upon market conditions. This cost has historically fluctuated in the $50-$250 range).

Tallahassee Primary Care Associates, P.A.
Corporate Policy

- **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question, if you believe there is a mistake on your statement, or if you have any concern about your statement transactions, we expect to hear from you in a timely manner (you may contact your physician's office, but for billing questions you may be referred to our billing department, which will most likely be our best resource for your inquiry). We reserve the right to avoid the cost of sending statements to patients who have a small balance outstanding (usually less than $5.00). For small balances, our Patient Registration/Reception staff in your physician's office will collect the balance at your next appointment.
- **Financial Promissory Form:** If you are truly unable to make payment in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Promissory Agreement. In this Agreement, you will have 14 calendar days to submit payment in full. If you do not make payment within 14 calendar days, we will add an **additional $25.00 administrative fee to the original copay, deductible, and/or coinsurance that is due**.
- **Collections:** If no payment is received within our 3rd statement cycle (approximately 90 days or more from your date of service), your account is considered delinquent and may be referred to an outside collection agency. ***Referral to outside collections may damage your credit, so we strongly urge you to contact our Billing Department to work out payment arrangements so that we can avoid this step.*** We will discharge patients who have balances that are referred to an outside collection agency.
- **Payment Plans:** Subject to the following specific rules, we permit payment plans for patients who may need additional time to pay their financial responsibility in full. Patients will adhere to our payment plan policy set forth below:
  - **We will not permit payment plans for individual patient balances of less than $100.00. The minimum balance for a payment plan is $100.00**
  - **If the balance is less than $350, you must pay the balance in full within 6 months.**
  - **Balances greater than $350 must be paid in full within 12 months.**
  - **We will expect you to make minimum payments of $50 per month.**
- **We want you to understand this document and our policies and procedures, and we do not want you to be confused. If** you have any questions or concerns about our Financial Policy, procedures or fees, your physician's office manager or our billing department can help. Please ask questions if necessary before signing below.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Patient Signature: _____

Date: _____

PATIENT INFORMATION (OFFICE USE ONLY)

Patient Name: _____

D.O.B. _____ MRN _____