Donald Liebelt, MD
Liebelt Family Medicine, LLC
3515 SE 17th Street, Ste. 100
Ocala, FL 34471
(352) 509-9165

Dear Patient,

Please review our **PRACTICE POLICIES:**

KNOW YOUR MEDICATIONS: Names, dosages, and what they are for, are important for you to know. Keep an updated list of your medications with you. Include a list of supplements you are taking as well.

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 the name and phone number of your pharmacy. We are required by Federal mandate to send as many prescriptions electronically as possible. Exceptions may be made, but electronic is generally faster and more secure.

CALLING FOR REFILLS: We strive to take care of refills at your regularly scheduled appointments. However, at times you may need refills between visits. Please allow 3 business days for us to refill any medications. Additionally, refill requests will not be handled after hours or on weekends. New medications or changing medications, except for generic substitutions, will require an office visit.

OFFICE VISITS: We strive to stay on time, unfortunately, emergencies and complicated medical problems do occur, resulting in a longer wait. We will do our best to minimize your wait time. However, it is important to allow yourself sufficient time when scheduling your appointments.

YOUR INSURANCE: We have made arrangements with many insurers/health plans. We will bill those plans with which we have an agreement. We will collect any required co-payment, co-insurance and/or deductible at the time of service. In the event that your insurer determines a service to be "not covered," you will be responsible for the complete charge.

MINOR PATIENTS: For all services provided to minor patients, the accompanying adult is responsible for payment and insurance information. All minors must be accompanied by a parent or a legal guardian.

MISSED APPOINTMENTS: Missing an appointment or failing to cancel an appointment (during business hours, Monday – Friday) more than 24 hours in advance will result in a $45 charge for a routine office visit and $80 for a wellness visit. Please call us, as soon as possible, if you know you need to reschedule an appointment.

MEDICAL RECORDS: By providing your email, we can send you a secure log in to our Patient Portal. There you will be able to see your Health Summary and tests we have ordered. For any other need of medical records, they may be provided with a signed

consent from you, the patient, or an authorized agent. The State of Florida has set the charge for these as follows:
"For patients and government entities, the reasonable costs of reproducing copies of written or typed documents or reports shall be no more than $1 per page for the first 25 pages and 25 cents for each additional page. Rule 64B8-10.003, Florida Administrative Code." (flmedical.org, Statement on Medical Records)

FINANCIAL AGREEMENT:

Introduction: Health insurance has become very complex. Your health insurance policy is a contract between **you** and the **insurance company**. The physician is not a part of that agreement. In most cases, we will try to help you with coverage issues. Occasionally, however, your insurance company may exclude certain services. It is your responsibility to be familiar with your particular plan and its covered benefits. Rarely, this may result in your insurance determining that a particular service is your responsibility to pay (example: many insurances do not pay for tetanus boosters). If this occurs, it will be your responsibility to pay for such charges.

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 those services are rendered.

Your co-pay, co-insurance and/or deductible payments will be collected at the time of service. For your convenience, we accept cash, check, credit or debit cards. There will be a $30 charge on all returned checks. All past due accounts over 60 days will be charged a 5% late fee on the unpaid balance. On any balance beyond 90 days, collection action may be taken. If it becomes necessary to collect any sum of money due, through an attorney, the patient and/or 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 your insurance coverage, please do not hesitate to ask our front desk staff.

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.

Patient Name **Date**

(Print)

_____

Patient Signature

Donald Liebelt, MD
Liebelt Family Medicine, LLC
3515 SE 17th Street, Ste. 100
Ocala, FL 34471

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Today's Date _____

Patient's Name: _____Date of Birth: _____

Maiden Name:_____ Social Security#:_____

I request and authorize _____to release health information of the patient named above to:

Donald Liebelt, MD and/or
Liebelt Family Medicine, LLC
3515 SE 17th Street, Ste. 100
Ocala, FL 34471
PHONE: (352) 509-9165, ext. 303; FAX: (352) 861-7725

This request and authorization applies to:

_____ All Health Information

_____Health Information relating to the following treatment, condition, or dates: _____

_____

_____Other :_____

ADDITIONAL AUTHORIZATION FOR SPECIAL HEALTH INFORMATION

_____Yes I authorize the release of my Sexually Transmitted Disease (STD) results, HIV/ AIDS testing, whether negative or positive, to the person(s) listed above. I
_____No understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of their test results to anyone.

Definition: Sexually Transmitted Disease(STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia non-specific urethritis, syphilis, VDRL,chancroid, lymphogranuloma venereuem, HIV, AIDS, and gonorrhea.

_____Yes I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
_____No

Patient Signature:_____ Date Signed:_____

* You may complete a new form at any time if you choose to change your authorization status. This authorization expires 365 days after it is signed.

Donald Liebelt, MD
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NOTICE OF PRIVACY PRACTICES AND AUTHORIZED REPRESENTATIVE FORM

Date: _____

I (print name) _____, acknowledge that I have read a copy of Liebelt Family Medicine's notice of Privacy Practices.

In the event that a copy of my personal health information is needed for reasons other than immediate treatment, I hereby authorize the following family members and/or physicians, acting on my behalf, the release of my personal health information (PHI).

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

I understand that I may amend this authorization at any time. I also understand that any other requests for personal health information by anyone other than those listed above will require additional written authorization by me.

Type of Information: PHI may include information regarding diagnosis, treatment, procedures and demographics. It does not include any psychotherapy note. Additionally, this authorization does not provide your Authorized Representative with any authority, either implied or direct, over any treatment or other health care decision that may need to be made for you. You may grant this authority by designating a health care proxy or by setting up a living will.

Intended use of Disclosed Information: I understand that your general policy is not to disclose my personal health information (PHI) to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating the coordination of my health care. I understand that my authorization is voluntary and may be rescinded or amended by me, in writing at any time.

Patient Signature_____

Date_____

AUTHORIZATION OF PHARMACY AND MEDICATION HISTORY MANAGEMENT:

In order to provide our patients with the best medical care and management, we request you grant Liebelt Family Medicine, LLC permission to access your full and entire pharmacy and medication history.

I, _____(printed name),
_____give _____do not give (choose one), my permission to Liebelt Family Medicine, LLC to access my pharmacy and medication history.

Signed_____Date_____

****

INSURANCE INFORMATION:

Insurance: _____ Policy #:_____Group#:_____

Policy Holder Name: _____Relationship to Patient:_____

Policy Holder DOB: _____Social Security Number:_____

Secondary Insurance: _____Policy #:_____

PLEASE READ BELOW, SIGN, AND DATE:

Insurance assignments and authorizations to release information:
I hereby authorize any physician examining and/or treating me to release to any third party (such as an insurance company, or government agency) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I do hereby authorize payment directly to any physician examining or treating me for medical benefits otherwise payable to me for their services but not to exceed the reasonable and customary charge for these services. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I permit a copy of these authorizations and assignments to be used in place of the original, which is on file in the physician's office.

I AGREE THAT SHOULD THE AMOUNT OF THE INSURANCE BENEFIT BE INSUFFICIENT TO COVER THE EXPENSES, I WILL BE RESPONSIBLE FOR PAYMENTS OF THE DIFFERENCE. I WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT DUE FOR PROFESSIONAL SERVICES RENDERED IF THE EXPENSE IS NOT COVERED BY MY POLICY.

Patient Signature:_____

Date:_____

Liebelt Family Medicine Demographic Information

Please fill out **ALL** areas of this form. Thank You!

Patient Name: _____Age: _____ DOB: _____

Male/Female (please circle) Social Security Number: _____

Drivers License Number: _____State of License:_____

Mailing Address: _____

City: _____State: _____ Zip: _____

Email Address: _____

Best phone number to reach you: _____Home/Mobile

Other phone number to reach you: _____Home/Mobile

Work phone: _____

Employer: _____

Employer Address: _____

City: _____State: _____Zip:_____

Please circle answers to the following information:

Marital Status: Single Married Divorced Widowed

Race: Caucasian/White Hispanic African American Black Asian American Indian

Native Hawaiian or other Pacific Islander Other Race Unknown Decline

Language: English Spanish French Italian Other_____ Decline

Ethnic Group: Central American Colombian Cuban Hispanic Latin American

Mexican Puerto Rican Non- Hispanic or Latino Other _____ Decline

****

Emergency Contacts: (<u>Please</u> <u>include</u> <u>one</u> <u>who</u> <u>does</u> <u>not</u> <u>live</u> <u>with</u> <u>you</u>)

Name: _____Phone: _____

Name: _____Phone:_____

PATIENT HISTORY FORM

****Please complete all questions, and write "none" when applicable****

_____ _____Sex: _____M _____F
Patient Full Name Date of Birth

_____ _____
Spouse's Name (if Applicable) Date of Birth

_____ _____
Hospital Preference Pharmacy Preference (Name and Location)

Do you have a Living Will? _____Yes _____No

MEDICAL HISTORY:

Have you experienced unexpected weight loss or gain? _____Yes _____No / Pounds? _____

When was your last EKG? _____Chest X-ray? _____ Tetanus Shot? _____

Colonoscopy? _____ Eye Exam? _____ Hearing test? _____

Please explain any abnormal results:

_____

Have you ever been, or are currently being, treated for any of the following?

N=N0; Y=YES (if YES, please explain)

Ear problems _____
Eye problems _____
Hypertension _____
High Cholesterol _____
Cancer _____
Thyroid Disease _____
Lung Disease _____
Chest Pain _____
Ulcers _____
Hemorrhoids _____
Other Bowel Diseases _____
Urinary Tract Infection _____
Sexual Dysfunction _____
Frequent Nighttime Urination _____
Chronic Back Pain _____
Tuberculosis _____
Diabetes _____

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N=NO; Y=YES (if YES, please explain)

Hay Fever_____
Asthma_____
Heart Disease_____
Dark Tarry Stools_____
Rectal Bleeding_____
Gallbladder Disease_____
Kidney Stones_____
Decreased Urinary Flow_____
Arthritis_____
Anemia_____
Chronic Skin Conditions_____
Psychiatric Problems_____
Other Medical Problems_____

CURRENT MEDICATIONS: * If none, Check here _____NONE.
* Include ALL Supplements, Vitamins, Minerals, over the counter Medications, and prescribed Medications.

Name:_____Dosage_____

Name:_____Dosage_____

Name:_____Dosage_____

Name:_____Dosage_____

Name:_____Dosage_____

Name:_____Dosage_____

ALLERGIES TO MEDICATION: * If none, Check here _____NONE.

Name:_____Reaction_____

Name:_____Reaction_____

Name:_____Reaction_____

Name:_____Reaction_____

*Food? _____Reaction_____

*Other? _____Reaction_____

Continue on next page>

SURGERIES: * If none, check here _____NONE.

Date:_____Place:_____Reason:_____

Date:_____Place:_____Reason:_____

Date:_____Place:_____Reason:_____

HOSPITALIZATIONS: (other than surgeries listed above) *If none, check here _____NONE.

Date:_____Hospital:_____Reason:_____

Date:_____Hospital:_____Reason:_____

Date:_____Hospital:_____Reason:_____

OTHER MEDICAL PROVIDERS/ SPECIALISTS: * If none, check here _____NONE.

Date:_____Name:_____Reason:_____

Date:_____Name:_____Reason:_____

Date:_____Name:_____Reason:_____

Date:_____Name:_____Reason:_____

Date:_____Name:_____Reason:_____

FEMALES ONLY:

Number of pregnancies _____Miscarriages _____Births_____ Any Complications?_____

_____ Type of Birth Control Used? _____

Menstrual Cycle: How often?_____Duration?_____; Heavy____ Moderate____Light_____

Date of last menstrual cycle:_____Pap Smear:_____Mammogram:_____

Have you ever had an abnormal pap smear? ____Yes ____No- If yes, please specify:

Date of pap smear:_____Explain abnormality:_____

Treatment Given:_____Are you still undergoing treatment? ___Yes__No

Have you ever had an abnormal Mammogram? ___Yes___No- If yes, please explain:_____

Continue on next page>

FAMILY MEDICAL HISTORY:

	Living	Deceased	Age (or age at death)	Medical History
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____
	_____	_____	_____	_____

List anyone in your family with the following conditions: *If none, check here _____NONE.

High Blood pressure_____Cancer_____

Heart Disease_____Diabetes_____

Kidney Disease _____Lung Disease_____

Tuberculosis _____Other Diseases_____

PATIENT SOCIAL HISTORY:

Current Employment/Occupation:_____NONE_____

Previous Employment? Occupation:_____NONE_____

Retired? _____Yes _____No; If yes, occupation retired from:_____

Smoker? _____Never _____Current-(# packs/day:_____) _____Quit-(#of years ago:_____)

Alcohol? _____Never _____Current-(how often:_____) _____Quit- (# of years ago:_____)

PATIENT WELL- BEING HISTORY:

Do you take vitamins or herbal supplements? _____Yes ____ No;

If yes, please specify: _____

Do you participate in daily exercise? _____Yes _____No; If yes, please specify:_____