HARRIS
INTERNAL MEDICINE
THOMAS D. HARRIS, MD

Registration Form

Please Print

Patient Information

Patient Name: (Last, First, Middle)			Date of Birth:	Age:
Sex: ☐ Male ☐ Female	Gender Identity:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow		
Home Address:		City, State, Zip:		
Mailing Address *if different*:				
Home Phone:	Cell Phone:	Work Phone:	Contact Preference: ☐ Home ☐ Cell ☐ Work	
Driver's License Number:		Social Security Number *(needed for billing insurance & medical records):*		

How did you hear about us?

☐ Dr._____ ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend

☐ Online: _____ ☐ Other: _____

Insurance Information

Responsible Party		
Name:	DOB:	Phone Number:
Address if different:		
Primary Insurance		
Name (if uninsured, write self pay):	Address:	
Subscriber		
Name:	DOB:	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Number:	Group Number:	

Emergency Contact *(not living at same address)*

Name:	Phone Number:	Relationship:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Harris Internal medicine or insurance company to release any information required to process my claims.

_____ _____

Signature of Patient or Representative Date

Harris Internal Medicine
Thomas D. Harris, M.D., P.A.
5900 Turkey Lake Road, Suite A, Orlando, FL 32819
Phone: 407.351.9696 Fax: 407.351.8848

NOTICE OF PRIVACY PRACTICES

Patient Name Printed: _____ Date of Birth:_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:
Get an electronic or paper copy of your medical record. You can ask to get or see an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy of summary of your health information, usually within 30 days of your request. *We will charge a reasonable, cost-based fee.*

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your request, and we may say "no" if it would affect your care.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting the office manager in person or over the phone. You can also express concerns to the US Dept. of Health and Human Services by calling 877-696-6775.

Uses and Disclosures:
Treat you. We can use your health information and share it with other health professionals who are treating you.

Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for services. We can use and share your health information to bill and get payment from health plans or other entities.

Required. We can share health information about you as required for help with public health and safety issues. We will share your information if state or federal laws require it.

By signing below, I acknowledge that I have had full opportunity to read and consider the contents of Harris Internal Medicine's Notice of Privacy Practices.

_____ _____
Signature of Patient or Representative Date

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Practice Manager. Please understand that revocation of this consent will not affect any action we took prior to the receipt of your revocation. We may decline to treat you or to continue to treat you if you revoke this consent.

I refuse to consent to Harris Internal Medicine's Notice of Privacy Practices. I have had opportunity to read and consider the contents of Harris Internal Medicine's Notice of Privacy Practices. I understand that refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits.

_____ _____
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CONTROLLED SUBSTANCE POLICY

Controlled substance medications (i.e. narcotics, tranquillizers, and barbiturates) have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. Even if you are not currently prescribed a controlled substance, this form must be signed acknowledging that you are aware of our office controlled substance policy.

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it will not be replaced.

2. Refills of controlled medications:
   a. Will be made only during regular office hours Monday through Friday, in person, once a month, during a scheduled office visit. Refills will NOT be made at night, on weekends, or during holidays.
   b. Will NOT be made if I "run out early," or "lose a prescription," or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   c. Will NOT be made if I am not taking medication as prescribed.

3. I understand that my medication will be terminated if I am receiving the prescribed medication from a different physician and/or clinic.

4. I understand that any treatments with controlled substances are based solely on my medical provider's discretion. It may be necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if my medical provider feels that I am at risk for psychological dependence (addiction); my medications will no longer be refilled.

5. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

6. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.

8. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.

Effective July 1st, 2018, our office will no longer issue prescriptions for opioid medications. You will be referred to a medication use specialist for these medications.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Representative

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Financial Policy

Patient Demographic and Insurance Information

It is critical that we have correct demographic (personal) information about you and about your health insurance coverage in order for us to bill accurately for the services we provide to you. This information includes:

- Your complete name, address, and phone number;
- The name of your insurance company, the group and subscriber number or other identifying numbers;
- Your insurance company's claims filing address and telephone number;
- A copy of your insurance card, which also shows important information about your plan

At each visit we will verify your demographic and insurance information.

Patients with Insurance Coverage

We participate with most commercial insurance plans and Medicare. It is your responsibility to provide us with the most up to date insurance information at the time of service. Failure to do so may result in insurance denials and you receiving a bill for all services rendered. Keep in mind that it is your responsibility to know your insurance benefits prior to your visit.

Verification of Eligibility

We will verify your insurance coverage at the time your visit is scheduled. If your insurance coverage changes after you schedule your appointment, please notify us as soon as possible, before your visit. If we are not able to confirm active coverage, you will be considered "self-pay."

Payment of Copays and Deductibles

All payments are due at time of service. If you are unable to pay your copayment at the time of your visit, we will be happy to reschedule the visit for another date. Deductibles are the amount of money you must pay out of pocket before your insurance will pay. If you have not met your deductible, your insurance carrier will process the claim towards your deductible, but will not make any payment to us, and you will be responsible for payment of the contractual amount approved by your plan. The minimum deductible amount collected at time of service is $57, any additional amounts will be billed to you.

Uninsured/Self-Pay Patients

The discounted payment for a self-pay new patient **visit** (excluding in office procedures and lab tests) is $130.00 for new patients, and for a self-pay follow-up patient **visit** (established patients) is $90.00, which must be paid in full at time of service. Any procedures ordered at the visit are additional and are due at time of service.

Lab Discounts for Self-Pay Patients

For patients without insurance who elect to make payment at the time of service, we offer a significant "prompt pay" lab (bloodwork) discount. This discount applies only to patients without insurance, is only for services provided in our office, and is only available if the discounted amount is **paid in full** at the time of the office visit or diagnostic test.

Non-Covered Services

Our providers follow current internal medicine standard of care and appropriate-use guidelines in ordering diagnostic tests or procedures as part of your care. Please be aware that some of the tests or diagnostic procedures recommended for you by our providers may be determined to be non-covered or may be considered "not medically necessary" based on the benefits provided by your specific insurance plan. You will be financially responsible for the costs of non-covered services and services that your insurance carrier declines to cover as "not medically necessary."

Please understand that even for insurance plans with which we participate, covered benefits may vary from one person's or employer's plan to another, and it is impossible for us to know what is covered under every plan. You are responsible for knowing the covered and non-covered benefits available under your plan. If you have questions, contact your employer's personnel department or your plan directly.

By signing below, I acknowledge that I have read and understand the above financial policies. I understand that I am responsible for assuring that the financial obligations of my health care are fulfilled as promptly as possible.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Representative

For a full copy of our Office Policies and Procedures please ask front desk staff.

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Lab Fee Policy

There is a $20 in-office lab fee for walk-ins. As a convenience we offer lab services outside of regularly scheduled visits. However, when done outside of a visit this is not covered or billable to your insurance. If you do not want to participate in this fee, then you will be given a lab script to have your labs drawn at a participating lab, such as Quest or LabCorp. Medicare patients are NOT subject to this fee.

No Show Policy

There will be a $35 no show fee assessed for any missed appointments not cancelled at least 24 hours in advance. Appointments not cancelled at least 24 hours in advance are considered “no-shows”. A frequent pattern of “no-shows” makes it impossible for our providers to provide appropriate continuity of care and may result in a patient’s discharge from our care. While we understand that personal circumstances sometimes make it necessary for you to cancel your office visit, please notify us as soon as you know you will not be able to keep your appointment.

Please make sure to arrive at your scheduled appointment time. If you are more than 5 minutes late, you may be asked to reschedule your appointment to a later time.

Code of Conduct

Our office has a zero-tolerance policy for aggressive behavior of any kind, including; physical, threatening language, cursing, and yelling. This applies to individuals in office and over the phone. Our policy is always to treat people with respect and professionalism. Our goal is to provide an environment of safety and trust for patients and staff. We appreciate your cooperation with this policy.

By signing below, I acknowledge that I have read and agree to all of the above policies.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Representative

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Form Completion Policy

If your provider is able to complete a *short* form during a scheduled office visit, there is no additional charge.

Fees

There is a **$50 fee** to complete the following types of forms:

FMLA or other employer required medical leave and accommodation forms
Attending Physicians Statement
Disability Forms
Comprehensive Assessment Forms – such as AHCA forms

There is a **$25 fee** to complete the following types of forms:

RECERTIFICATION of FMLA or other employer required medical leave and accommodation forms. *This is only applicable when the initial form was completed by our office*. *If a different office completed the initial certification, it is considered a new form to this office.*

All form completion fees are payable in advance.

Completion Guidelines

Please understand that completion of forms requires time by our providers and staff, including time to receive and review records in most cases, to ensure that they are completed accurately. It may also take up to two weeks before the form is available for pick-up, so please allow sufficient time before the form is needed.

Completion of most forms require an office visit.

Completion of forms are based on objective findings and the determination of how forms are completed (findings, restrictions, time off, etc..) are based on the provider's discretion. Requests for time off and/or restrictions are not guaranteed.

Requested changes of completed forms are subject to review and not guaranteed. Changes will also be made per the providers discretion.

It may be necessary for you to see a specialist or for your provider to review specialist records before forms can be completed. In most cases this cannot be determined until the provider has had a visit with you for form completion.

A visit for form completion does not guarantee that a form will be completed. The visit is necessary to evaluate the need for time off and restrictions and/or to gather objective findings necessary to complete forms.

By signing below, I acknowledge that I have read and agree to all of the above policies.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Representative / Relationship to Patient

Authorization to Disclose Protected Health Information

Complete this form for your health information to be shared with authorized individuals such as family or friends. Unless listed on this form, your protected health information will not be shared unless otherwise permitted by HIPAA guidelines.

I, _____, authorize Harris Internal Medicine to disclose and release my
Printed Name
protected health information described below to:

Name:	Contact Number:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information to be disclosed upon the request of the person named above (Check either A or B):

☐ A. **Disclose my complete health record** (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ B. Disclose my health record, as above, **BUT do not disclose** the following (check as appropriate):
- ☐ Mental Health Records
- ☐ Communicable diseases (including HIV/AIDS and other STDs)
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Other (please specify):

This authorization shall be effective until:

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____, unless I revoke it.

You may revoke this authorization at any time by notifying our office in writing.

_____ _____
Printed Name of Patient giving this authorization Date

_____ _____
Signature of Patient giving this authorization Date