BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

BRADLEY M. BLOCK, M.D. • AMY J. NATION, D.O.
CRAIG P. CHASE, M.D. • SUSAN G. SMOLEN, M.D.

Dear Patient,

We are pleased to welcome you to Block, Nation, Chase, & Smolen Family Medicine. We strive to provide the very best in medical care in a family friendly environment. It is our goal that this letter will provide you with helpful information regarding your upcoming visit. For your convenience we have included New Patient Forms as well as a map to our location. Please complete and return these forms either by fax, USPS mail or hand deliver to our office before your scheduled appointment to expedite your initial visit with us. If you are unable to complete and return these forms before your appointment, please arrive **20 minutes prior** to your scheduled appointment.

Please notify us at least 24 hours in advance if you are not able to keep this appointment.

Please bring the following:

- These Forms Completed if not already faxed or sent to our office
- List of all current medications
- Insurance card(s)
- Your Co-Payment
- Photo ID

Sincerely,

The Physicians & Staff

BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

2441 West State Rd 426 ● Suite 2011● Oviedo, Florida 32765 ● (407) 678-6888 ● Fax (407) 359-5454

BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

PATIENT INFORMATION

Name ____
Last First Middle Any Other Preferred First Name

Address ____
Street or P.O. Box Apt. #

____
City State Zip

Home Phone ____________ Work Phone ____________ Ext. ______

Cellular Number ____________ Email Address ____________ Work / Home

Sex Male / Female Birth Date ____________ Marital Status ____________ Referred By: ____________

Ethnicity: **Please Circle one:** Non Hispanic • Hispanic • Decline to Answer
Race:**Circle one:** White • Black • Asian • Native American/Eskimo • Pacific Islander • Other/Unknown• Decline to Answer

Social Security # ____________ Driver's License # ____________

Employer ____________ Spouse or Parent Name & Work Phone ____________

Pharmacy Name / Location ____________ Pharmacy Phone ____________

PRIMARY INSURANCE HOLDER (or Person Responsible for the Bill):

☐ PLEASE CHECK IF RESPONSIBLE PARTY IS A PATIENT OF THIS PRACTICE
(Fill out any information that is different from above)

Name ____
Last First Middle **Relation to Patient**

Address ____
Street or P.O. Box Apt. #

____
City State Zip

Sex Male / Female Birth Date ____________ Social Security # ____________

Home Phone ____________ Pager or Cellular Number ____________

Employer ____________ Work Phone ____________ Ext. ______

Primary Insurance Co. ____________

Secondary Insurance Co. ____________

EMERGENCY INFORMATION ☐ **Please check if primary contact is a patient of this practice.**

Contact in case of emergency – List at least two people and include phone numbers and relation: ____________

____

In order to keep costs at a minimum for our patients, we do not bill. We would appreciate payment at the time services are rendered. If you have insurance with one of the groups with which we participate, we will file a claim. We will provide to all others a statement with the information required by your insurance company so that you can easily forward your claim to them. Any bills that you are responsible for and are not paid within 60 days will be assessed a "BILLING PROCESSING fee" of $20 and be charged 18% per annum interest.

Insurance Authorization and assignment

I hereby authorize BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE to release my insurance carrier any information concerning my illness and treatment, including possible HIV, AIDS, psychiatric or drug & alcohol information. I hereby assign to the physician all payments for medical services rendered to myself and dependents. I understand that I am responsible for any amount not covered by my insurance.

Medical Consent

I authorize all medical providers at BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE to treat me medically in the office or hospital for any illness or injury that I may incur.

Signature of Patient or Responsible Party ______________________ Date ______________

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BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

MEDICAL HISTORY

Please fill out completely and accurately. This becomes part of your permanent record and will help us to make recommendations regarding your care.

PATIENT NAME: ____ DATE OF BIRTH:______________________

PAST MEDICAL HISTORY:

Have you a history of:	Check if yes
ALLERGIES / HAY FEVER	❑
ANEMIA	❑
ARTHRITIS	❑
ASTHMA / EMPHYSEMA / COPD	❑
BLOOD CLOT	❑
CANCER	❑
CHEST PAINS / ANGINA	❑
CHOLESTEROL PROBLEMS	❑
DEPRESSION OR ANXIETY	❑
DIABETES	❑
HEADACHES / MIGRAINES	❑
HIGH BLOOD PRESSURE	❑
HIV / AIDS	❑
INTESTINAL DISORDERS	❑
MITRAL VALVE PROLAPSE OR RHEUMATIC FEVER	❑
OTHER HEART PROBLEMS	❑
SEIZURES	❑
SLEEP DISORDERS	❑
STROKE / TIA	❑
THYROID PROBLEMS	❑
ULCERS	❑

DRUG USE : ____

TOBACCO USE: ____
(PACKS PER DAY & # OF YEARS)

ALCOHOL USE: ____
(AVERAGE AMOUNT OR FREQUENCY)

EXERCISE: ________________________________ HOBBIES: ________________

EDUCATION COMPLETED: ____

# of Pregnancies: ____________ # of Deliveries: ______________ # of Miscarriages:_______

Frequency of Periods: _______________Last Menstrual Period__________Last PAP __________

Any Foreign Travel____

FAMILY HISTORY:

	√	Which family member? Maternal or Paternal
DIABETES		
HIGH BLOOD PRESSURE		
HEART ATTACK		
HIGH CHOLESTEROL		
STROKE		
ASTHMA		
SUICIDE/DEPRESSION		
ALCOHOLISM		
CANCER (& WHAT TYPES)		
OTHER		

Current Medications & doses:____

____

____

Allergies to Medicine and your reaction: ____________________________________

____

Spouse/Children/Parents' Names & Ages:_____________________________________

____

Previous Illness/Injuries/Hospitalizations/Surgeries including year:__________________

____

____

____

Last Tetanus Booster:__________ **Occupation & Employer:**______________________

The above information is true and complete to the best of my knowledge.

Signature______________________________ **Today's Date:**__________________________

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BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

EXHIBIT 5 - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Block, Nation, Chase & Smolen Family Medicine may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Block, Nation, Chase, & Smolen Family Medicine's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Block, Nation, Chase & Smolen Family Medicine reserves the right to revise its Notice of Privacy Practices at anytime to meet changing legal requirements. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Block, Nation, Chase & Smolen Family Medicine - Privacy Officer at 2441 West State Rd 426, Suite 2011, Oviedo, Florida 32765.

With my consent, Block, Nation, Chase & Smolen Family Medicine may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Block, Nation, Chase & Smolen Family Medicine may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Block, Nation, Chase & Smolen Family Medicine may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Block, Nation, Chase & Smolen Family Medicine restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Block, Nation, Chase & Smolen Family Medicine's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Block, Nation, Chase & Smolen Family Medicine may decline to provide treatment to me.

______________________________	______________________________
Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian
______________________________	______________________________
Patient's Name	Date

I authorize Block, Nation, Chase & Smolen Family Medicine to discuss any and all of my PHI, including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC or AIDS information with the following individuals:

____

(Name & relationship)

____

(Name & relationship)

______________________________	______________________________
Signature of Patient or Legal Guardian	Date

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BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

PLEASE FILL OUT THIS FORM FOR COMPLIANCE WITH THE PATIENT SELF DETERMINATION ACT, PASSED 1992 BY THE STATE OF FLORIDA.

ADVANCED DIRECTIVES

PATIENT NAME: ________________________ **DATE OF BIRTH:** ____________________

An Advanced Directive can be in the form of a living will, durable power of attorney, or health care surrogate. Is there an Advanced Directive written and executed on your behalf (or the patient's behalf, if you are responsible for the patient)? Yes _______ No _______

If yes, is this Directive in the form of:

___________ a Living Will,
___________ a Durable Power of Attorney, or
___________ a Health Care Surrogate

If you have executed an Advanced Directive in any of the above formats, have you provided this office with a copy for your medical records? Yes ________ No ________

If you would like more information regarding Advanced Directives, please ask our office staff.

____ __________________________
Signature of Patient or Responsible Party Date

We can also incorporate a copy of any of your directives into your medical records for future reference if you provide a copy to our office.

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BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.
While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country- claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.
OUR COMMITMENT TO YOU
We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness (es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witness we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.
WHAT WE ARE ASKING YOU TO DO
We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness (es) if you are dissatisfied with your medical care and decide on legal action.
We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you in order to ensure a fair resolution.

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean____.
(Print name of Patient or Guardian)

"Physician" shall be understood to mean Bradley M. Block, MD; Amy J. Nation, D.O.; Craig P. Chase, MD; Susan G. Smolen, MD; other physicians employed by Block, Nation, Chase & Smolen Family Medicine: and the corporation, Block, Nation, Chase & Smolen Family Medicine and Oviedo Medical Research.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert
witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Academy of Family Physicians.

In further consideration for this, Physician agrees to the same stipulations.

(SIGNATURE ON FILE)______________
Physician

____
Patient/Guardian

Effective from Date of Treatment

____
Date of Signature

12/2015

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BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

We believe in paving the way for the future of medicine. The Physicians at Block, Nation, Chase & Smolen Family Medicine often participate in pharmaceutical research trials. There is an opportunity for you, our patients, to participate as well.

What are the benefits to participants?

If you would like to participate in a pharmaceutical medical research study and if you qualify based upon one of your medical conditions (and other criteria, such as coexisting medical problems), then you could receive many benefits. As a participant, our medical care and services for your research study related medical condition would be at no cost to you or your health insurance plan, and you would receive financial compensation for your time & travel to see us; additionally, you would receive medication and testing (such as blood tests or EKG's) without cost to you or your insurance plan for your research study related medical condition. You might also be eligible to receive a new type of medication not yet available at pharmacies, and you will still receive your medical care from the physicians at Block, Nation, Chase & Smolen Family Medicine.

What kinds of medications are being studied?

Many of the medications being researched are already "on the market", but are now being compared to other medications; some medications are not yet "approved" by the FDA for general use by the public, but are in the last phase of testing (through large scale use) in order to seek final FDA approval. At this point of the FDA approval process, these medications have already been through prior phases of required FDA safety testing.

Who Will Be Handling Your Care?

During these pharmaceutical research trials, the physicians at Block, Nation, Chase & Smolen Family Medicine will be working jointly with a full-time nurse from **Oviedo Medical Research, L.L.C.** (or other similar research organization), who will act as our research coordinator. This nurse will be working part time at our office caring for our patients under the supervision of our physicians.

Why am I Receiving This Form to Sign?

The doctors at Block, Nation, Chase & Smolen Family Medicine will identify patients who might be eligible to participate in a pharmaceutical trial based upon their medical conditions. We will then contact patients to discuss their potential interest in participating in the study (as well as more specific details about the study protocol). Most importantly your medical records and personal information are never taken out of our office or shared with any other person or entity outside our practice unless you provide written authorization for us to do so. Thus, because our research nurse is not directly employed by Block, Nation, Chase & Smolen Family Medicine, we cannot allow this nurse to contact you about a research opportunity or review your medial records without your signed approval on this Authorization form.

Authorization for the Use and Disclosure of Medical Record and Individually Identifiable Health Information:

I (the "Patient") hereby authorize the use or disclosure of my medical record and individually identifiable health information as described below for the purpose of pharmaceutical research trials. I understand that the information I am authorizing the persons and entities listed below to receive, disclose, use and review may be re-disclosed as part of an independent clinical research trial and may no longer be protected by federal or state privacy laws and regulations if I choose to participate in (or screen for enrollment in) a pharmaceutical research trial. In most cases all medical record and individually health identifiable information is removed from a patient's file by the research trial before it is re-disclosed for research and review purposes. **But, in ALL cases medical record and individually identifiable health information is never sent to any pharmaceutical company.**

1. Persons/organizations authorized to use, disclose, or review the information:
   Block, Nation, Chase & Smolen Family Medicine and its physicians, staff members, clinical personnel and employees of Oviedo Medical Research, L.L.C. (or other similar research organization).
2. Specific description of information that may be used/disclosed:
   Patient's medical record information including, but not limited to, lab results, diagnostic testing results, progress notes, and clinical research trial information**.** It also includes any HIV/AIDS, mental health, reportable communicable diseases (such as STD's and Hepatitis), and substance abuse treatment information contained in my medical record.
3. The information will be used/disclosed for the following purposes:
   For assessment and evaluation for participation in clinical research trials.
4. I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment from Block, Nation, Chase & Smolen Family Medicine, receive payment, or eligibility for benefits unless allowed by law.
5. The person/organization authorized to use/review the information will receive compensation for doing so. Yes __X__ No____ (But only if you participate in a research trial or go through the screening & testing process of a specific trial; otherwise there is no financial compensation to anyone).
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
   (a) Action has been taken in reliance on this authorization; or
   (b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
8. By signing I revoke all authorizations allowing Compass Research to contact me regarding pharmaceutical research trials.

______________________________ Signature of patient or patient's legal representative

______________________________ Date

______________________________ Printed name of patient or patient's legal representative

______________________________ Relationship to patient or legal authority to act for the patient

*Initial if you prefer to DECLINE this opportunity:*________

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Authorization For Release Of Confidential Information

I, ____, hereby authorize to release all Protected Health Information (PHI) including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC, AIDS, or for care paid for out-of-pocket information or any other records of a sensitive nature:

__________ From: __________ To: __________ To: __________ From:

____
(Name of hospital, agency, or individual)

____
(Address)

____

Bradley M. Block, M.D. Amy J. Nation, D.O.
Craig P. Chase, M.D. Susan G. Smolen, M.D.

2441 State Rd 426, Suite 2011
Oviedo, Florida 32765
(407) 678-6888 **FAX: (407) 359-5454**

To expedite the processing of incoming medical records into patient charts in our electronic medical record system, please FAX all records to us or send on CD .

My records are to be released for the purpose of: ____
(Reason for Release of Records)

Send records from: __________________________________ to: ________________________________
(date) (date)

__ All records, or __ Radiology Reports and Laboratory Reports __ H & P's, Consults, Medical Summaries

__ Immunization Records __ Other:

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Block, Nation, Chase & Smolen Family Medicine has acted in reliance upon this authorization. My written revocation must be submitted to Block, Nation, Chase & Smolen Family Medicine's Privacy Officer at 2441 West State Rd 426, Suite 2011, Oviedo, Florida 32765.

I understand that this consent is revocable upon written notice to Block, Nation, Chase & Smolen, Family Medicine except to the extent that action has already been taken on this authorization. This authorization shall remain valid for a reasonable time (90 days) to accomplish the purpose for which it is given. In accordance with Federal and State regulations, information pertaining to drug or alcohol abuse, HIV testing, AIDS, or for care paid for out of pocket, is prohibited from further disclosure to other parties without written consent from the patient. A general authorization for "Release of Information" by another party is not sufficient for this purpose.

_____________________________ _____________________________________
(Date of Authorization) (Patient's Signature in Full)

_____________________________ _____________________________________
(Date of Birth) (Social Security Number)

_____________________________ _____________________________________
(Witness) (Parent, Legal Guardian or Authorized Representative)

Specific records released as requested:

By: ______________________________________

Date Mailed: ________________________________

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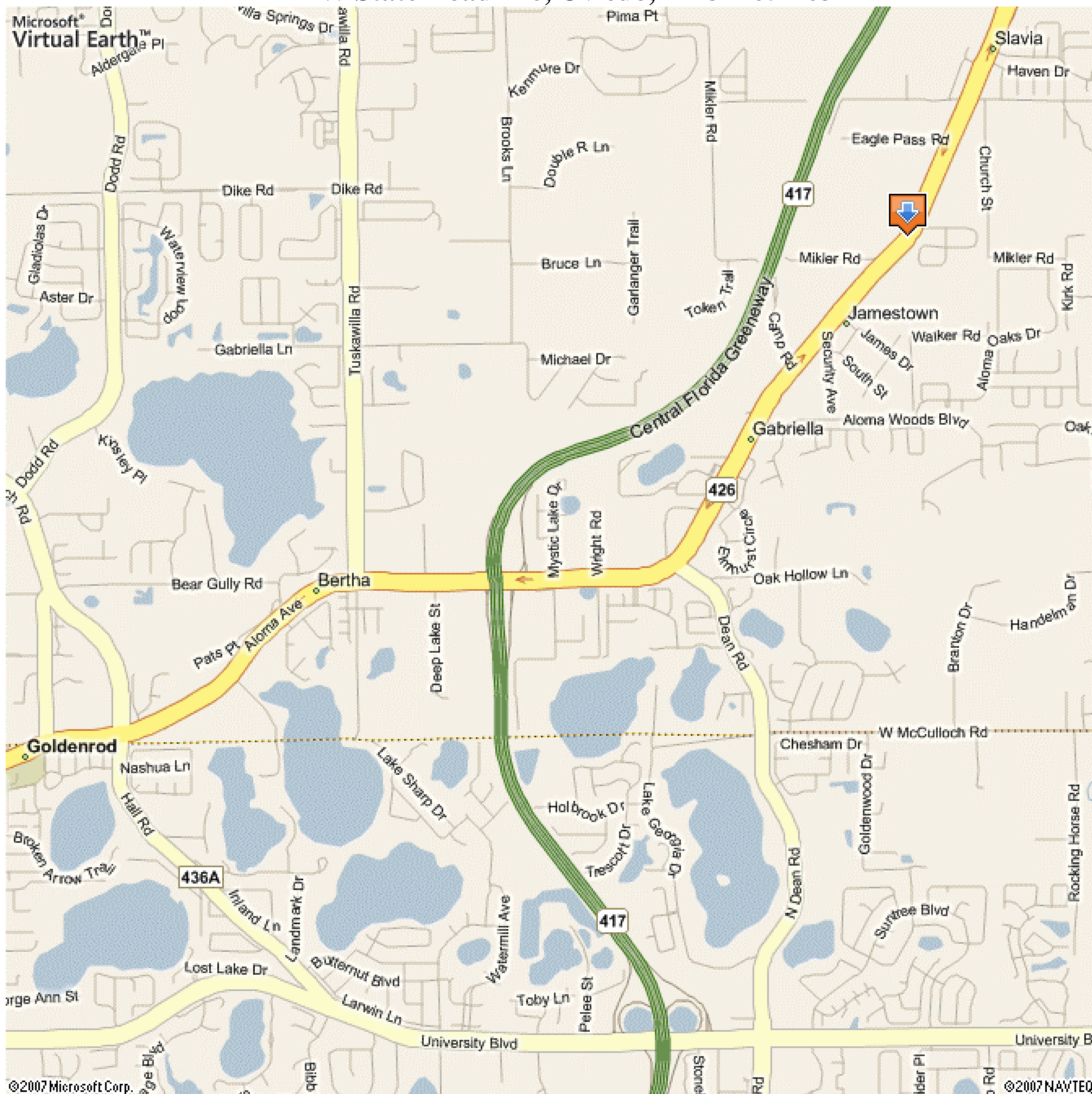
BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

2441 W State Road 426, Oviedo, FL 32765-7634



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