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 select one:** Non Hispanic • Hispanic • Decline to Answer
Race:**Select 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 _____

12/2015

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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:**_____

12/2015

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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

12/2015

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.

12/2015

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

BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

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 <u>FAX</u> all records to us or send on <u>CD</u> .

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

Send records from: _____ (date) to: _____ (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:

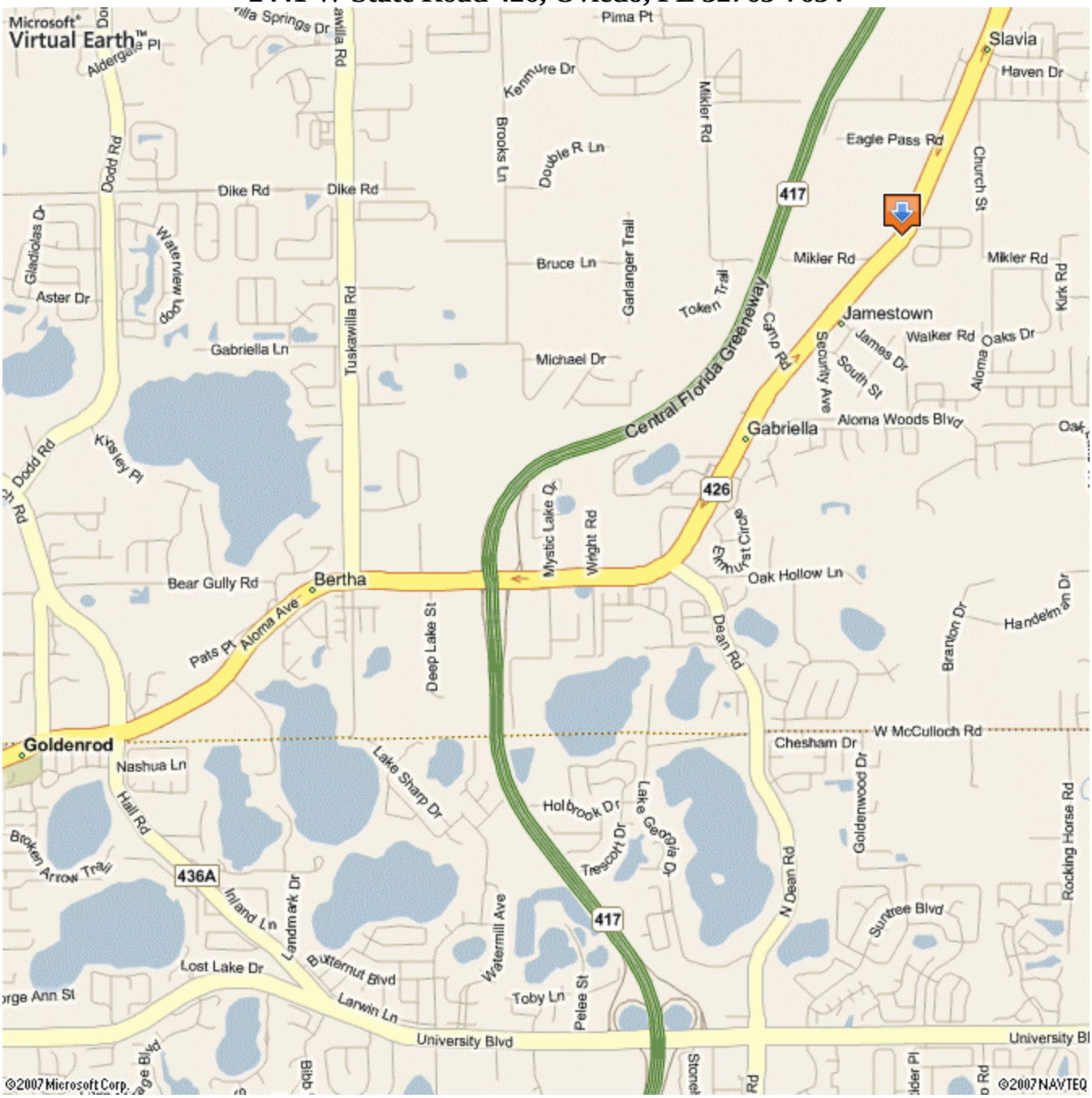
By: _____

Date Mailed: _____

12/2015

BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

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



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