OMNI HEALTHCARE

Patient Information		
Last Name:	First Name:	Middle Name:
Date of Birth:	Social Security #	Sex: ____Male____Female
Street Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Marital Status: __Single __Married __Divorced __Widowed __Separated		Student Status: __Full Time __Part time __Not a Student
Email Address:		
Employment Status: ____Full Time ____Part Time ____Not Employed ____Self Employed ____Retired ____Military		
Race, Ethnicity & Language Information		
Race: ___White ___African American/Black ___Hispanic ___Asian ___American Indian/Alaska Native ___Native Hawaiian ___Other_____		
Ethnicity: ___ Hispanic/Latino ___Not Hispanic/Latino ___Other:_____		
Primary Language Spoken: ___English ____Spanish ___Other: _____		
Referring & Primary Physician Information		
Referring Physician Name:		
Street Address:		
City:	State:	Zip:
Phone Number:	Speciality:	
Primary Care Physician Name:		
Street Address:		
City:	State:	Zip:
Guarantor Information (Who is responsible for you financially if different from the patient)		
Name:		Relationship to Patient:
Street Address:		
City:	State	Zip:
Home #:	Cell #	Work #:
Date of Birth:	Social Security #	Sex: ____Male____Female
Email Address:		
Emergency Contact Information		
Name:	DOB:	Relationship to Patient:
Street Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Pharmacy Information		
Pharmacy Name:		
Pharmacy Address:		
City:	State:	Zip:
Phone #:	Fax #:	

Last Name:	First Name:	DOB:
Insurance Information		
Is your visit Related To: ___Auto Accident ___ Workers Compensation		
Primary Insurance Company:		Policy #:
Group Name:		Group #:
Policy Holder Name:		Effective Date:
Relationship to Patient:		Policy Holder Date of Birth:
Policy Holder Social Security #:		Policyholder Sex: ____Male____Female
Secondary Insurance Company:		Policy #:
Group Name:		Group #:
Policy Holder Name:		Effective Date:
Relationship to Patient:		Policyholder Date of Birth:
Policy Holder Social Security #:		Policyholder Sex: ____Male____Female

_____ _____

Signature of Patient/Legal Representative **Date**

Pediatric History Questionnaire

Patient Name: _____**Date of Birth:** _____**Date**: _____

Household: Please list all those living in the child's home			
Name	**Relationship to child**	**Birth date**	**Health problems**
Are there siblings not listed? If so, please list their names, ages, and where they live:			
What is the child's living situation if not with both biological parents?	__ Lives with adoptive parents __ Joint custody __ Single custody __ Lives with foster family		
If one or both patients are not living in the home,how often does the child see the parent(s) not in the home?			

Birth History	
SECTION ONLY APPLIES TO NEWBORNS AND CHILDREN UP TO 5 YEARS OF AGE	
___Don't know birth history	
Birth weight:_____ Was the baby born term? ___Yes ___ No ___Weeks Were there any prenatal or neonatal complications? __Yes __ No Explain:_____ _____ _____ Was a NICU stay required: __ Yes __ No Explain:_____ _____ During pregnancy, did mother Use tobacco: __Yes __No Drink alcohol:__Yes __No Use drugs or medications: __Yes __No __Used prenatal vitamins What: _____ When: _____	Was the delivery: __Vaginal __Cesarean If cesarean, Why?_____ _____ _____ ___ Was initial feeding __Formula __Breast milk How long breastfed? ____ Did your baby go home with mother from the hospital? __Yes __No Explain:_____ _____ _____ _____ ___

Social History (DK=don't know)				
	Yes	**No**	**DK**	**Explain**
Do you consider your child to be in good health?				
Does your child use tobacco?				
Does your child use alcohol or drugs?				
Is your child sexually active?				
Does you feel your family has enough to eat?				
Does your child have a history of family violence?				
Social History (DK=don't know)				
	Yes	**No**	**DK**	**Explain**
Are there any pets in your home?				How many? ____ What type? _____

Pediatric History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date**: _____

				_____
Is there anyone who smokes inside your home?				
Does anyone in your home own a gun?				

List previous surgical procedures.	
Name of Procedure	**Date of Procedure**

Has your child been hospitalized ___ Yes ___ No
Explain: _____
_____

List all current prescribed, over the counter medications, and herbal remedies.		
Medication Name	**Dosage**	**Frequency**
List any allergies to medicine or dyes		
List all other allergies		

Patient Medical History: Does your child have, or has he/she ever had, (DK=don't know)				
Condition	**Yes**	**No**	**DK**	**Explain**
Chickenpox				
Frequent ear infections				
Problems with ears or hearing				
Nasal allergies				
Problems with eyes or vision				
Asthma, bronchitis, bronchiolitis, or pneumonia				
Patient Medical History Continued: Does your child have, or has he/she ever had, (DK=don't know)				
Condition	**Yes**	**No**	**DK**	**Explain**
Any heart problem or heart murmur				
Anemia or bleeding problem				
Blood transfusion				

OMNI HEALTHCARE

Pediatric History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date**: _____

HIV				
Organ Transplant				
Malignancy/bone marrow transplant				
Chemotherapy				
Frequent abdominal pain				
Constipation requiring doctor visits				
Recurrent urinary tract infections and problems				
Metabolic/Genetic disorders				
Cancer				
Kidney disease or urologic malformations				
Bed wetting (After 5 years old)				
Sleep problems: snoring				
Chronic or recurrent skin problems (Acne,eczema,etc.)				
Frequent Headaches				
Convulsions or other neurologic problems				
Tuberculosis				
Obesity				
Diabetes				
Thyroid or other endocrine problems				
High blood pressure				
History of serious injuries/fractures/concussions				
ADHD/anxiety/mood problems/depression				
Developmental delay				
Dental Decay				
Sexually transmitted infections				
Pregnancy				
(For girls) Problems with her periods				
Had her first period				Age of first period:
Does your child have any other serious illness or medical conditions?				

Biological Family History : Have any family members had the following? (DK=don't know)					
Diagnosis	**Yes**	**No**	**DK**	**Who**	**Explain**
Child hearing loss					
Nasal allergies					
Asthma					
Tuberculosis					
High blood pressure					
High cholesterol					
Anemia or bleeding disorder					

Pediatric History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date**: _____

Dental Decay					
Cancer					
Heart disease					
Liver disease					
Kidney disease					
Thyroid disease					
Diabetes					
Bed wetting (After 10 years old)					
Obesity					
Alcohol abuse					
Drug abuse					
Mental Illness/depression					
ADHD					
Developmental disability					
Autism					
Learning disabilities					
Immune problems, HIV, or AIDS					
Tobacco use					
Additional Family History:					

_____ _____

Signature of Parent/Legal Representative **Date**

Consent Agreement

Patient Name: _____Date of Birth: _____

Consent for Treatment:
I give consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction; including x-ray, laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in my course of diagnosis and treatment, cells,tissues, and/or parts may be removed from my body. I authorize my physician and his/her personnel to preserve or use such cells, tissues, or parts for teaching purposes and/or to dispose of any cells, tissues, or parts that are removed.

Authorization For Release of Medical Information:
I understand that my medical information, including complete medical records, test results, immunization records, and billing information, may be released to my insurance company, other medical professionals, other medical care institutions, and/or my patient portal for treatment and/or payment purposes.

General Acknowledgements:
I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations and treatments. I understand and agree that I may be observed and/or receive care from medical, nursing, and other healthcare students in training at my physician's office. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

Minors/Dependents:
I understand that children under the age of 18 will require the signature of a responsible adult party on all registrations forms.

Communication and/or Disclosure
For ongoing communication regarding your healthcare and for your privacy, please select the following alternative or limitations below...

OMNI Healthcare May:

- Call you at home or cell? _____ Yes _____ No _____ Home _____ Cell
  If yes, Can we leave the following information on your home answering machine or voicemail:

  Appointment information _____ Yes _____ No
  Billing Information _____ Yes _____ No
  Medical Information _____ Yes _____ No
  Labs/Prescriptions _____ Yes _____ No

- Call you at work? _____ Yes _____ No
  If yes, Can we leave the following information on your work answering machine or voicemail:

  Appointment information _____ Yes _____ No
  Billing Information _____ Yes _____ No
  Medical Information _____ Yes _____ No
  Labs/Prescriptions _____ Yes _____ No

I give permission to share the following information with person (s) named below:

Name: _____ Relationship _____
Appointment information: ___Yes ___ No Billing Information: ___Yes ___ No Medical Information: ___Yes ___No

Name: _____ Relationship _____
Appointment information: ___Yes ___ No Billing Information: ___Yes ___ No Medical Information: ___Yes ___No

Name: _____ Relationship _____
Appointment information: ___Yes ___ No Billing Information: ___Yes ___ No Medical Information: ___Yes ___No

_____ _____
Signature of Patient/Legal Representative **Date**

_____ _____
Witness Signature **Date**

CONSENT TO TREAT A MINOR

To Parents and Guardians of Minor Children:

As a general rule, we require the consent of a ***parent or legal guardian*** in order to provide health care services to a minor child (someone under the age of 18). With so many parents working outside the home or with other commitments, we realize that you may not be able to accompany your child on every visit to the clinic. If your minor child presents to the clinic unaccompanied, we will not be able to see the unaccompanied minor. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have consent for treatment the appointment will be rescheduled.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed a ***Consent to Treat a Minor*** form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child when deemed necessary by qualified medical personnel. Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present photo ID upon checking the patient in for the appointment. This consent form will remain in effect until revoked in writing. You may request this form from any member of our clinic staff.

By law, minors have the right to consent to certain health care without a parent or guardian's consent. A minor may consent to medical:

- If the minor is emancipated (legally independent) or married to someone at or above age 18
- In the event emergency care is necessary
- For birth control and pregnancy-related care at any age
- For outpatient drug and alcohol abuse related treatment beginning at age 13
- For outpatient mental health treatment beginning at age 13
- For sexually transmitted diseases, including HIV, beginning at age 14

If a minor consents to care as allowed by law, he or she can request confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or guardian, without the minor's express written permission. It is the philosophy of this clinic to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their health care including those areas noted above. For legal and other reasons, parent or guardian involvement may not always be possible. Rest assured that we would continue to provide health care services that are in the best interests of your minor child.

Patient name: _____ Date of birth: ___ / ___ / ___
Patient name: _____ Date of birth: ___ / ___ / ___
Patient name: _____ Date of birth: ___ / ___ / ___

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians at OMNI Healthcare, Inc., to act as agent(s) for the undersigned to consent to physical examination, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of Florida, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital. I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.

CONSENT TO TREAT A MINOR

In an emergency, it is understood that authorization is granted to the physicians at Omni Healthcare in advance of any specific diagnosis, treatment or hospital care rendered to the above named patient. Authorization is granted to provide authority and power on the part of the physicians to provide all such medical or surgical diagnosis, treatment or hospital care which the aforementioned physician(s), in the exercise of his or her best judgment, may deem advisable.

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at Omni Healthcare to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

This authorization is valid:

☐ For any and all medical treatment including preventative care, school/sports physicals & vaccines.
☐ Today's visit only ___ / ___ / ___
☐ For this specific problem(s) or a specific date range. Please specify _____

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

Parent or legal guardian: (Print Name) _____ Date: ___ / ___ / ___

Parent or legal guardian signature: _____

Witness: (Print Name) _____ Signature: _____

Patient Financial Policy

Patient Name: _____Date of Birth: _____

Thank you for choosing OMNI Healthcare as your Healthcare provider. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Patient Financial Responsibility:
Copayments, coinsurance, deductibles, and fees for non-covered services are due at time of service. If no insurance is to be filed by OMNI Healthcare, or if OMNI Healthcare is not a participating provider, **full payment is due** at the time services are rendered. Payment arrangements will be made with a signed payment agreement and the approval of the office manager.

Insurance Claims:
Primary Insurance: OMNI Healthcare will file claims with the patient's insurance upon the patient's submission of proof of insurance; (insurance card indicating coverage identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at time services are rendered. Upon receipt of the insurance card, OMNI Healthcare will submit the claim indicating patient payment at the time of service. In the event OMNI Healthcare does not receive a valid insurance policy within the timely filing requirements of the insurance carrier the balance for services will be the responsibility of the patient/guardian.

Secondary Insurance: Claims will be filed to secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

Worker's Compensation:
Workers Compensation will be filed if the patient notified OMNI Healthcare upon scheduling an appointment and supplies billing information upon arrival. Detail of the accident will be required and a workers compensation form will need to be completed.

Auto Accidents
Payment of visits for auto accidents will be due at time of service. OMNI Healthcare will provide a health insurance claim form and details of examination upon patient signature for release of records.

Accounts Past Due:
Payment from statement is due upon receipt. Delinquent accounts may result in small claims court, a collection agency, credit bureau reporting and/or discharge from practice. After 90 days, an account will be turned over to collections. The person will be financially responsible for all collection costs including attorney fees of not less than 30% and court costs. A patient may remit in full for all outstanding charges owed on an account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status with the practice.

Medical Records:
If you request records from OMNI Healthcare, there will be a fee of $1.00 per page for the first 25 pages and a fee of $0.25 for every page after which must be paid prior to receiving your records.

Missed Appointments
Patients must call with at least 24 hours advance notice of an appointment to cancel or reschedule. If not OMNI Healthcare reserves the right to add a $25 fee to your account.

_____ _____
Signature of Patient/Legal Representative **Date**

_____ _____
Witness Signature **Date**

Pediatric Office & Prescription Refill Policies

Patient Name: _____Date of Birth: _____Date: _____

- **Vaccination Schedule**
  _____ Initial - This pediatric office is committed to following the CDC recommended schedule of vaccinations. As a patient/parent/caretaker I understand this, and I commit to following the recommended CDC schedule of vaccinations as long as I continue to receive services at this office.

- **Copays and Self Pay Payments**
  _____ Initial - Copays for insured patients are to be paid at time of check-in. Self-pay payments are to be paid in full at time of service for all uninsured patients.

- **Late Arrivals**
  _____ Initial - After 15 minutes, patients will be considered late. At that time, it is up to the provider's discretion to have the patient reschedule or be worked back into the schedule.

- **Broken appointment:**
  _____ Initial - Patients must call office with at least 24 hours advance notice of the appointment to cancel or reschedule. If not there will be a $25.00 charge added to your account. Patients with 3 or more broken appointments without good reason could result in dismissal.

- **Confirming appointments:**
  _____ Initial - It is our policy to confirm all appointments. It is the patient's responsibility to remember their own appointment. If the patient does not call or show for their appointment this is considered a broken appointment

- **Prescription Refills**
  _____ Initial
  We will require 48-72 hours for all prescription refills. This will include:
    - Patient phone in requests
    - Pharmacy refill requests
    - Patient walk in requests
    - Patient portal requests

******All pain medications must be picked up as they can no longer be called into the pharmacy.**

Thank you for your cooperation.

_____ _____

Signature of Patient/Legal Representative **Date**

Authorization to Disclose Protected Health Information

(Copy of records takes 7 to 14 business days to process)

PLEASE PRINT CLEARLY- You must provide full mailing address or this form will be returned to you

Patient Name: _____ SSN: _____ Medical Record # _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____(work)_____ DOB: _____

1. I authorize the use or disclosure of the above named individual's Protected Health Information as described below.
2. I hereby authorize OMNI Healthcare: _____ release to or obtain from (circle one)

   Name: _____
   Address: _____
   City: _____ State: _____
   Phone : _____ Fax :_____

3. The type and amount of information to be used and disclosed is as follows: (includes dates where appropriate)

   ☐ Progress Notes ☐ Medication List ☐ Immunization Record

   ☐ Laboratory Results from (date) _____ to (date) _____

   ☐ X-Ray and Diagnostic Reports from (date) _____ to (date) _____

   ☐ Entire Record ☐ Other _____

4. REASON FOR REQUEST: (PLEASE CHECK ONE)

   ☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Clinical Research ☐ Marketing

5. Medical records are to include any and all of Federal and State protected information to include diagnosis, treatment and/or examination related to mental health related care, drug and/or abuse, HIV testing/AIDS, and sexually transmitted-diseases.
6. I hereby release OMNI and its employees from any and all liability that may arise from the release of information as I have directed.
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by the federal confidentiality rules. If I have questions about disclose of my health information, I can contact the Medical Records Department and obtain a copy of the Privacy Notice.

   Printed Name of Patient :_____ Date: _____

   Signature of Patient: _____

   Witness Name: _____ Date: _____

Notice of Privacy Practices Acknowledgement Form

Patient Name: _____Date of Birth: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides a safeguard to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of the policies have been *our* practice for years. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services- www.hhs.gov.

OMNI HEALTHCARE has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding witch identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office,examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling charts, patient records, PHI (Protected Health Information) and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We do this by telephone, email, U.S. Mail, or by any means of convenience for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable and informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies for insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The undersigned certifies that he/she read the foregoing, received a copy of the Notice of Privacy Practice, and is the patient, patients guardian, or legal representative.

_____ _____

Signature of Patient/Legal Representative **Date**

_____ _____

Witness Signature **Date**