“PLEASE **KEEP THIS COPY** FOR YOUR FUTURE REFERENCE”

WELCOME TO VILLAGES INTERNAL MEDICINE AND SENIOR CLINIC, PA.

Dear patients, to better serve you please observe the following:

1. Please notify us within 24-48 hours if you need to cancel your appointment to allow us to accommodate patients who need immediate medical service

2. If you need to be seen before your scheduled appointment, please call us. We will do our best to accommodate you.

3. To be fair with patients who have scheduled appointments and to avoid waiting, walking in the office without calling is not advisable.

4. To avoid waiting please make sure your medical needs or questions are addressed by the doctor and prescriptions refills are done before leaving the examination room

5. Please allow 3-5 business days for our laboratory work up and diagnostic results to be transmitted to our office from date of your examination.

6. Prescription refills are to be made during scheduled office visits; otherwise please call us or your pharmacy one week before you run out of medications. Refills are to be made only during regular business hours from Monday to Thursday.

7. It is your responsibility to provide us with prescription authorizations form(s) and mail in prescription form(s) if you need one. Call your insurance and have them fax the form(s) at (352) 259-2174. Consider the time element for mail in prescriptions.

8. **COPAYS** and **ANNUAL DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT. WE ACCEPT CASH OR CHECK ONLY.**

9. For ultrasound procedure(s) please notify us 48 hours before the test if you need to cancel. All missed ultrasound appointments will be charged $50.00 per procedure, Stress Test $175.00 per procedure.

10. For diagnostic procedures (dexa scan, CT/MRI, X-rays, ultrasounds, PFT, Stress Test) your insurance will be billed for the test itself and for the doctor who interpreted the test. To assist you with billing questions please call our billing manager

Debbie Coates at (352) 686-2171

We appreciate your cooperation and thank you for your business.

VIMSC Management

Villages Internal Medicine and Senior Clinic, PA

Winston E. Evalle, MD
Villages Internal Medicine & Senior Clinic, PA
3351 Wedgewood Lane, The Villages, FL 32162
Tel: (352) 259-0364 Fax: (352) 259-2174

HIPPA Patient Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in a form, whether electronically, on paper,or orally to be kept properly confidential. This ACT gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA proves penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and/or disclose your health information.

We may use and/or disclose your medical records only for each of the following purposes:

- Treatment – we will use and disclose your Protected Health Information (PHI) to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose information to a home health agency that provides care to you or a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- Payment – your PHI will be used, as needed, to obtain payment for your health care services. This may include eligibility or coverage for insurance benefits. For example, obtaining approval for a hospital stay may require that your PHI be disclosed to the health plan to obtain approval
- Healthcare Operations – We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging other business activities. For example, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name. We may also call you by name in the waiting room. We may use or disclose our PHI, as necessary, to contact you to remind you of an appointment or to anyone who answers your phone.

You have the following rights with respect to your PHI, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to the requested restriction. If we do agree to a restriction, we must abide by it until you request, in writing, to remove it.
- The right to reasonable requests, to receive confidential communications of PHI from us by alternative means or at alternative locations
- The right to inspect and receive a copy of your PHI
- The right to have an amendment filed with your PHI
- The right to receive an accounting of disclosures of PHI
- The right to obtain a paper copy of this notice from us upon request
- The right to review the Notice of Privacy Practices and to receive a written copy

ALL RIGHTS ARE TO BE SUBMITTED TO OUR OFFICE IN WRITING

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI

Winston E. Evalle, MD
Villages Internal Medicine & Senior Clinic, PA 3351 Wedgewood Lane, The Villages, FL 32162
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Personal Information

Last Name:_____ First Name:_____ MI____

Date of Birth: _____ SSN #_____-_____-_____

Sex: M / F Marital Status: M S W D

Email Address:_____ Living Will?: Yes / No

Florida Address

Street Address:_____ Apt #:_____

City:_____ State:_____Zip:_____

Home Phone #:_____ Cell Phone #:_____

Out of State Address

Street Address:_____ Apt #:_____

City:_____ State:_____Zip:_____

Emergency Contact(s)

1. Name:_____
   Relationship: _____
   Phone #:_____

2. Name:_____
   Relationship: _____
   Phone #:_____

Primary Insurance

Company:_____
Policy #:_____
Group #:_____
Phone #:_____

Secondary Insurance

Company:_____
Policy #:_____
Group #:_____
Phone #:_____

PERSONAL HISTORY AND HEALLTH ASSESSMENT

Name:_____ Age: _____ Sex: _____
Date of Birth: _____ Phone #:_____

Drug Allergies: _____ _____ _____

_____ _____ _____

Other Allergies: _____ NKDA _____

CURRENT MEDICATIONS YOU TAKE: **DOSAGE:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other non prescription drugs: _____ _____

_____ _____

_____ _____

Name: _____ **DOB:** _____

MEDICAL HISTORY: Check all that apply.

Check here		Month/ Year
	Hypertension	
	Heart Attack	
	High cholesterol	
	Heart murmur	
	Hypothyroidism	
	Hyperthyroidism	
	Blood clot LEG / LUNGS	
	Peripheral arterdisease-circulation	
	Arthritis	
	Aortic aneurysm	
	Kidney disease	
	Acid reflux	
	Stomach ulcer	
	Diabetes	
	Depression	
	Anxiety	
	Stroke	
	Asthma / COPD	
	Memory loss	

Name: _____ **DOB:** _____

SURGERIES: Check all that apply.

Check here		Month/ Year
	Appendectomy	
	Gallbladder	
	Hysterectomy (female)	
	Prostatectomy (male)	
	Coronary angioplasty: with stent / without stent	
	Cardiac bypass	
	Heart valve replacement	
	Hip replacement: right / left / both	
	Knee replacement: right / left / both	
	Back Surgery	

TESTS:

TEST	Month / Year	Normal	Abnormal
Chest x-ray			
EKG			
Stress Test			
Carotid ultrasound			
Heart ultrasound			
Cardiac catheterization			
Leg circulation ultrasound			

Name: _____ **DOB:** _____

Screening	Date	Where received?	Recommended
Flu Vaccine			
Shingrix dose 1			
Shingrix dose 2			
ZostaVax			
Pneumococcal 23			
Prevnar 13			
Pap smear			
Mammogram – must obtain report			
Dexa scan			
PSA (prostate, specific antigen)			
Colonoscopy – must obtain report			
Digital Rectal Exam			
Stool Slide Test			
Eye Exam			
COVID-19 vaccine (Brand)			
- **Dose 1**			
- **Dose 2**			
- **Booster 1**			
- **Booster 2**			
- **Booster 3**			
RSV vaccine			

Functional Status

Walk with Walker or assistance: Yes No

Exercise Regularly / No Regular Exercise

What Kind _____ How Often _____

Can Play Sports: Yes No What Kind _____

Active Tobacco Use:

Quit in _____ (Year) # of packs / day ____ How many years you smoked _____

Smoking type (circle): Cigarettes Cigars Pipe E-cigarettes Other_____

Active Alcohol Use:

What kind of alcohol _____

# of ounces per day _____

Work History:

Past Work _____

Current Work _____

Family History: Circle all that apply

Colon Cancer Osteoporosis Prostate Cancer Breast Cancer

Stroke Kidney Cancer Other disease in the family?: _____

Heart attack before 55? _____

	Alive/Age	**Deceased/Age**	**Cause of Death**
Mother			
Father			
Brothers			
Sisters			

Who referred you to our office? _____

Signature: _____

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HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payors

Conduct normal healthcare operations, such as quality assessments and physician certifications

I have been informed by you of our Notice of Privacy Practices, containing a more complete description of the use and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices and have received a copy of the Patient's Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not requested to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name_____

Signature_____

Witness _____

Date _____

Villages Internal Medicine & Senior Clinic, PA

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

1. RELEASE OF INFORMATION – I, the below name patient, do hereby authorize any physician examining and/or treating me to release to any third payer, such as an insurance company or government agency, such as Blue Cross or Medicare, and medical condition 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.
2. PHYSICIAN INSURANCE ASSIGNMENT – I hereby authorize payment directly to any physician examining or treating me for surgical and/or medical benefits otherwise payable to me for their services but not to exceed the reasonable and customary charge for these services
3. Medicare/MEDICAID – I certify that the information given by me is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries any information needed for a Medicare/Medicaid claim. I hereby certify all insurance payments shall be assigned to the physician treating me.
4. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT

1. Your insurance is a contract between you and your insurance company. We are not a party to the contract.
2. Not all services are covered benefits under all contracts. All non-covered services, such as refractions, are the financial responsibility of the patient
3. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY AND DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE COMPANY WITHIN A REASONABLE AMOUNT OF TIME, NOT TO EXCEED 60 DAYS.
4. If this account is assigned to an attorney for collection and/or suit to a collection agency, the prevailing party shall be entitled to reasonable attorney's fees and all costs of collections.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

DATE_____ SIGNATURE_____

Winston E. Evalle, MD
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Records Release – HIPAA Compliant

Patient Name: _____ SSN: _____

DOB:_____

Previous Doctor's Name: _____

Address:_____ City_____ State_____ Zip Code_____

Phone #:_____ Fax: _____

Information to be disclosed: Lab reports:_____

___Chest X-ray, EKG ___ECHO/Carotid US ___Lower Extremity US ___CT scan ___ MRI

I authorize and request the disclosure of all protected information of the above-named individual's health information. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information. I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me during my treatment period, including visual fields, photos and operative reports.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

This protected health information is disclosed for the purpose of continued ocular medical care.

I understand the following: see CFR & CFR.40 ©(2) (i-iii)

- I have a right to revoke this authorization in writing at any time, except to the extent information ahs been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information

Any facsimile copy or photography of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date
(See 45CFR & 164.508 (c) (1) (vi)

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date

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PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____

I give my permission to Villages International Medicine & Senior Clinic, PA to release any of my personal health information, including any medical information in my chart to:

1. Name _____ Phone # _____

   Relationship to patient _____

2. Name _____ Phone # _____

   Relationship to patient _____

3. Name _____ Phone # _____

   Relationship to patient _____

4. Name _____ Phone # _____

   Relationship to patient _____

5. Name _____ Phone # _____

   Relationship to patient _____