ATTENTION !!!!

You are **REQUIRED** to change your primary care with your insurance company.
The number is on the back of your insurance card.

If you do not change your primary care before your first appointment and we see you,

YOUR INSURANCE WILL NOT PAY

At that point you will be responsible to pay that bill in full according to the Medicare guidelines.

Thank You

Dr. Khan's Staff

Dr. Hasibul Khan
West Florida Medical Associates. P.A.

PRACTITIONER ASSESSMENT AND INSURANCE INFORMATION

PLEASE COMPLETE THE FOLLOWING FORM AND BRING IT WITH YOU TO SCHEDULE YOUR FIRST APPOINTMENT- YOUR DOCTOR WILL NEED TO REVIEW YOUR HEALTH RISK ASSESSMENT.

General Information:

_____ _____ _____/_ _/_____
Patient Last Name First Name MI DOB

__( )_____ ( )_____
Home# Cell#

Home Address City State Zip

SS#_____-_____-_____ Male Female (Please Circle) Single Married Divorced Widowed (Please Circle one)

Employer Email

_____ _____
Primary Insurance Carrier Policy ID

HMO PPO POS OTHER _____ ( ) _____
(Type of plan) Insurance Carrier Phone#

Second Insurance Carrier Policy ID

HMO PPO POS OTHER _____ ( ) _____
(Type of plan) Insurance Carrier Phone#

Important: In case of emergency, who would we contact?

_____
Name Relationship

_____ (___)_____
Address (Street/City/Zip) Home Phone#

(___)_____ (___)_____
Cell Phone# Work#

I understand that I am financially responsible for all charges, whether paid by said Insurance. It is my responsibility to pay any deductible amount due at time of service or any other balance not paid by Insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

Patient Name: _____ DOB: _____

ADVANCED DIRECTIVES

(For Compliance with the

Have you executed an advanced directive? Yes ____ No ____

If YES, is this directive in the form of:

____ A Living Will

____ A Durable Power of Attorney

____ A Health Care Surrogate

Have you provided this office with a copy of Advanced Directive? Yes ____ No ____

If you would like more information regarding advanced directives, please ask the nurse or receptionist.

I have been provided with information regarding the "PATIENT SELF-DERTERMINATION ACT"

_____

Signature of Patient or Representative Date

Please provide us with the following information:

Race	Ethnicity	Language
White:	Non-Hispanic:	English:
African American:	Hispanic:	Spanish:
Asian:	Unknown:	Indian (Hindi, Guajarati, etc.):
Native American / Eskimo		Other:
Pacific islander / Native Hawaii:		
Other:		
Unknown:		

_____

Signature of Patient or Representative Date

Please Pay Your Copay/ other balance at the Check-out Desk and ALWAYS take your Receipt.

2135. Pine Ave,
Inverness, FL, 34452

Comprehensive Primary Care

HASIBUL H. KHAN, MD

Phone: (352) 560-3000

Fax: (352) 419-6513

ONTROLLED SUBSTANCE CONTRACT

** IF YOU ARE NOT CURRENTLY TAKING A CONTROLLED SUBSTANCE, WE STILL REQUIRE A SIGNATURE ON THIS FORM **

Patient Name: _____ DOB: _____

** By signing this contract, you agree to the following:

1) You MUST have a scheduled office visit with the physician who orders the controlled substance every month to refill the prescription. No walk-in visits.
2) Your use of the medications will be re-evaluated at least every three months.
3) NO refills order will be given on evenings or weekends.
4) Any dosage changes MUST be requested in person during your office visit and will NOT be changed over the phone. If symptoms are worse, you MUST be seen in the office or proceed to the nearest emergency room.
5) You agree to fill any controlled substances at only one pharmacy of your choosing. Your selected pharmacy is _____
6) You agree to safeguard all medications/written prescriptions from loss or theft as police reports are not accepted. A lost or stolen medicine/written prescription will NOT be replaced under any circumstances. No other types of controlled medications will be given in its place.
7) If you are referred to pain management, we will no longer prescribe pain medication.
   **You understand the following:
   A. Patients who take opiates or other controlled substances can possibly develop psychological and/or physical dependence and tolerance.
   B. Opiates and other controlled substances may harm your mental and physical ability required to do tasks that can be unsafe such as driving or operating machinery.
   C. You should not take opiates or other controlled substances with alcohol.
   D. Tablet(s) must be taken whole. Do NOT break, crush, chew or inject any controlled substances.
   E. You allow the doctor to work with any city/state/federal law enforcement agency such as the DEA and FLA Board of Pharmacies to check your possible misuse or sale of the product. You also allow your doctor to share a copy of this agreement with the pharmacy. You agree to give up the right to privacy or confidentiality with respect to these organizations.
   F. If you do not follow this protocol, the doctor may stop the medicine or stop care.
   G. Unethical behavior such as taking controlled substances for reasons other than prescribed will result in discharge from the practice.
   H. You agree to RANDOM DRUG SCREENS to monitor your adherence.

_____ _____

Patient Signature Date:

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

Patient Last Name: _____ Patient First Name: _____ D.O.B. _____

List each medication; it's dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How often?	When Started?

Are you allergic to any medications: Yes [ ] No [ ] If yes, please list medications and the reactions.

Medication	Reaction

Please Pay Your Copay/ other balance at the Check-out Desk and ALWAYS take your Receipt.

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Registration Form

Patient Medical History

Patient Last Name: _____ Patient First Name: _____ D.O.B. _____

Date of last physical exam: _____ Previous Physician Name: _____

Physician Address: _____

Past History (Personal and Allergies): Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation			CVA/TIA			Migraine Headache		
Anemia			Diabetes			Nervous Breakdown		
Alcohol Overuse			Emphysema/COPD			Paralysis		
Allergies (Other than Medications)			Falls			Ostomies_____		
Arthritis			Gallbladder Disease			Rheumatic Fever		
Bleeding Disorder			Gout			Seizures		
Cancer Location:			HIV / AIDS			Sexually Transmitted Diseases		
Cardiac Arrhythmias			Heart Attack/MI			Sickle Cell Anemia		
Pacemaker			Other Heart Disease (CHF/CAD)			Sleep Disorder		
Chicken Pox			Hepatitis			Stomach Ulcers		
Colitis			High Blood Pressure			Thyroid Disease		
Depression			Jaundice			Vascular Disease		
			Kidney Disease					
			Measles / Mumps					

PERSONAL HABITS:

1) Have you ever smoked? [ ] Yes [ ] No If yes, are you a regular smoker now? [ ] Yes [ ] No

Have you used chewing tobacco? [ ] Yes [ ] No If yes, Number of yrs. _____ If No, when did you quit?_____

2) Do you regularly drink alcohol? [ ] Yes [ ] No If yes, how often: _____

3) Have you ever used any of the following: Marijuana [ ] LSD [ ] Heroin [ ] Cocaine [ ] Speed [ ] Other [ ]

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

CONTINUED

OPERATIONS: List and indicate approximate year.

_____
_____
_____
_____
_____

SERIOUS INJURIES: List injuries & give approximate dates.

_____
_____
_____
_____
_____

HOSPITALIZATIONS: (Other than operations)

List reasons and approximate dates

_____
_____
_____
_____
_____

DIAGNOSTIC TESTS / EXAMS:

	Last test / Exam Date	Location / Provider
EYE EXAM:	_____	_____
FOOT EXAM:	_____	_____

IMMUNIZATIONS: (Please give dates)

Hepatitis B _____ Flu _____ Polio _____ Typhoid _____

Smallpox _____ Tetanus _____ Pneumococcal _____ Chicken Pox _____

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Registration Form

Personal History Continued

Family History

	Living	Deceased	At What Age	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

Social History

Currently Smoking? Yes_____ No _____ If yes: Thinking About Quitting? Yes _____ No ____

Have you ever smoked? Yes ____ No ____

If Yes, What: Cigarettes ____ Cigars ____ Other _____ How many per day? _____

Year you quit? _____

Do you Drink? Yes____ No ____

If Yes, What do you drink? Beer ____ Wine ____ Other _____

How many drinks? _____

How often do you drink? Daily____ Weekly ____ Monthly ____ Yearly _____

Immunizations

Tetanus: Yes ____ No ____ If yes, when? _____

Flu Shot: Yes ____ No ____ If yes, when? _____

Pneumonia: Yes ____ No ____ If yes, when? _____

Shingles Vaccine: Yes ____ No ____ If yes, when? _____

Screenings

Women	Men
Mammogram:	Prostate Cancer?
Pap Screening:	Colonoscopy:
Menopausal:	Bone Density:
Colonoscopy:	Last Eye Exam:
Bone Density:	
Last Eye Exam:	

West Florida Medical Associates, P.A.

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Registration Form

Personal History Continued

Have you had any falls in the past year? Yes_____ No ____

If yes, How many? _____ When: _____

Any Injuries? _____ If yes, Where? _____

Were you hospitalized? _____

Do you use

Eye Glasses: Yes ____ No ____

Contacts: Yes ____ No ____

Hearing Aids: Yes ____ No ____

Dentures: Yes ____ No ____

Artificial Limbs: Yes ____ No ____ If yes, what: _____

Pace Maker: Yes ____ No ____

I.U.D.: Yes ____ No ____

Authorization for Treatment

As a patient being examined and treated by the physician and / or staff, I hereby voluntarily consent to the administration of appropriate treatment.

Signature: _____ Date: _____

Please Pay Your Copay/ other balance at the Check-out Desk and ALWAYS take your Receipt.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

West Florida Medical Associates, P.A.
3775 N. Lecanto Hwy.
Beverly Hills, Florida 34465

West Florida Medical Associates, P.A.
801 Medical Ct. East
Inverness, Florida 34452

PCP CHANGE REQUEST

Date: _____

Patient Name: _____

D.O.B.: _____

Previous PCP

Dr. _____

_____

_____

New PCP

Dr. _____

_____

_____

I hereby request to have my PCP changed to the NEW PCP listed above:

Patient Signature: _____

Employee Signature: _____

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

Please fill in your previous doctor's name, phone number and fax number on line 7 and sign and date the bottom of next form so that we can request your medical records for continuation of care.

Please Pay Your Copay/ other balance at the Check-out Desk and ALWAYS take your Receipt.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Please Pay Your Copay/ other balance at the Check-out Desk and ALWAYS take your Receipt.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

Patient Name: _____

This is to certify that the preceding information I have given is correct. I hereby give my permission to

Dr. _____ to administer treatment and preform such minor procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I also agree to accept full responsibility for payment of all fees associated with the examination and/or treatment, and all costs incurred in the collection of such fees. I authorize payment directly to the Doctors, otherwise payable to me.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Your insurance policy is a contract between you (the Insured) and the insurance company (the insurer). Should payment not be received from the insurance company within a customary and reasonable period of time (usually 60-90 days), the patient (or responsible party thereof) assumes all responsibility for the account in full. The balance on all accounts, once they have been turned over to patient responsibility, are due and payment within 10 days after receiving the statement.

Attention: Medicare Patients

Our Clinic has been approved as Rural Health Clinic. Medicare claims are processed by BCBS of Tennessee, they require that a signature from you signifying that you are allowing us to file Medicare claims for you and request payment to us. Your signature will allow us to release any medical information that Medicare may need to process your claim.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

PLEASE READ AND SIGN THE FOLLOWING TO PERMIT PAYMENT OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC

I request payment of authorized Medicare benefits on my behalf for any services furnished to me by _____, I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits related services.

Patient Signature: _____ Date: _____

Medicare Number: _____ Date: _____

Please Pay Your Copay/ other balance at the Check-out Desk and ALWAYS take your Receipt.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

DESIGNATED ALTERNATE FORM

Patient Name: _____

I give my permission for Dr. _____

Or its staff to release my medical information (i.e., test results, appointment times, etc.) as well as a copy of such, and written prescriptions to the following family members and/or friends:

Name: _____ (Relationship to patient): _____

Name: _____ (Relationship to patient): _____

Name: _____ (Relationship to patient): _____

Signature: _____ Date: _____

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CARFULLY.

Introduction

In order to provide health care services, West Florida Medical Associates must obtain and maintain protected health information from you, the patient. This *"Notice of Privacy Practices"* describes they types of information that is collected and your rights with regards to that information.

Protected Health Information (PHI) means information that is individually identifiable as to the current patient or applicant for health care treatment, payment or operations. This information is obtained from the applications for health care coverage, surveys, claims for payment filled by health care providers, referrals made by health care providers, and your medical records. PHI may also be obtained over the telephone from you. Other sources of PHI include group health plan administrators, employers, and business partners such as third-party administrators, consultants and other entities in obtaining health care information.

PHI includes the following:

- Your health history
- Your medical records
- Your name, address and date of birth
- Your marital status
- Sex
- Social Security Number
- Information regarding your dependents
- Other similar information that relates to past, present or future medical care

Use and disclosure for treatment: Your PHI may be disclosed to health care providers including doctors, nurses, laboratory technicians, medical students and other health care personnel involved in your treatment.

Use and disclosure for payment: Your PHI may be used and disclosed to individuals involved in payment for your treatment in order to determine eligibility for payment and eligibility for plan benefits. Your PHI may be shared with persons involved in the utilization review, to assist in subrogation of health care claims, or other adjudication procedures.

Use and disclosure for health care operations: Your PHI may be used and disclosed for plan operation purposes including underwriting, premium rating, submitting clams for stop-loss coverage, quality review assessments, audits, business planning, legal services or administrative services.

West Florida Medical Associates may share this information with its business partners including for purposes of utilization reviews, appropriateness of care reviews, consultation with outside health care providers, consultants, and attorneys. West Florida Medical Associates requires its business partners to sign a contract specifying their compliance with our privacy policies.

In order to ensure the privacy of your Protected Health Information@, West Florida Medical Associates has developed privacy policies and procedures. Procedures are based on appropriate administrative, technical and physical safeguards necessary to maintain confidentially of your Protected Health Information@. Such information is limited to those individuals that have legitimate business need for that information. This protection extends to use of your Protected Health Information@ by West Florida Medical Associates business partners.

Non-routine disclosures of personal health information

In situations not covered by your consent, West Florida Medical Associates will ask for your authorization to use or disclose your Protected Health Information@. This may be to release your personal information to your employer for workers' compensation purposes, for automobile insurance claims, for marketing purposes, or for research purposes. West Florida Medical Associates will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization and will only use or disclose the minimum amount of information necessary to preform the non-routine function. In most circumstances, authorization may only be made by the person to whom the Protected Health Information@ pertains. In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be too incapacitated to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.

Non-routine disclosures may be made to:

- The health plan sponsor for payment or other claims purposes
- Organ donation and tissues transplant entities, if you are an organ or tissue donor
- The Military if you are a member of the armed services
- Workers' compensation carriers
- Public health agencies
- Law enforcement personnel in response to legal requirements
- Coroners, medical examiners, funeral directors
- Legal representatives in response to court order or legal proceedings
- National security and intelligence agencies as authorized by law
- Correctional institutions if you are an inmate

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

Your Rights:

You have the right to review your Protected Health Information@ maintained by West Florida Medical Associates and to obtain a copy of such information. A reasonable fee may be charged for copies of you health information records.

You also have the right to request amendments to your Protected Health Information@ or to register a complaint with our office manager. Requests for amendments must be made in writing and must include a reason for the requested amendment.

You have a right to request an accounting of disclosers of your Protected Health Information@ made by West Florida Medical Associates. This request must be made in writing and may not be for a period longer than six years.

You have the right to request a restriction on Protected Health Information@ that may be disclosed. West Florida Medical Associates is not required to agree to this request.

You have the right to request that communications regarding your Protected Health Information@ from West Florida Medical Associates be made at a certain time or location. The request must be in writing, West Florida Medical Associates will accommodate all reasonable requests.

Changes to Privacy Practices:

If West Florida Medical Associates changes its privacy policies and procedures, an updated "Notice of Privacy Practices" will be provided at your next visit to West Florida Medical Associates.

This notice was published and becomes effective on April 14, 2003

The Patient-Centered Medical Home & You: Frequently Asked Questions (FAQ) for Patients and Families

What is a Patient-Centered Medical Home?

A Medical Home is all about you. Caring about you is the most important job of your Patient Centered Medical Home. In this personal model of health care, your primary care provider leads a team of health care professionals that collectively take responsibility for your care. They make sure you get the care you need in wellness and illness to heal your body, mind and spirit.

Your personal provider and an extended team of health professionals build a relationship in which they know you, your family situation, your medical history and health issues. In turn, you come to trust and rely on them for expert, evidence-based health care answers that are suited entirely to you or to your family.

How will a Medical Home lead to better care for me?

There are many benefits to being in a Medical Home:

- Comprehensive care means your medical home helps you address any health issue at any given stage of your life
- Coordination of care occurs when any combination of services you and your provider decide you need are connected and ordered in a rational way, including the use of resources in your community
- Continuous care occurs over time and you can expect continuity in accurate, effective and timely communication from any member of your health care team.
- Accessible care allows you to initiate the interaction you need for any health issue with a physician or other team member through your desired method (office visit, phone call, or electronically) and you can expect elimination of barriers to the access of care and instructions on obtaining care during and after hours.
- Proactive care ensures you and your provider will build a care plan to address your health care goals to keep you well, plus be available for you when you get sick.
- Evidence based care means that your care team keeps up to date with the latest medical research and clinical practice guidelines and will work with you to personalize your care to fit your preferences and your goals.

Who is my Medical Home Team?

Your team may include a doctor, nurse practitioner, licensed practice nurse, medical assistant or health educator, as well as other health professionals. These professionals work together to help you get healthy, stay healthy, and get the care and services that are right for you. When needed, your personal doctor arranges for appropriate care with qualified specialists.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

What does my Medical Home Team do for me?

The Medical Home team is your team. They provide you with the care you need when you need it and customize your care to meet your needs and expectations. We help you set appropriate health goals and work with you to meet them. We will spend enough time with you to ensure you understand what you need to do to successfully meet your goals and answer any questions you might have. We help you understand all your options for care, so you can decide what care is best for you. And we will always treat you with the respect you deserve as a full partner in your healthcare.

What type of services does my Medical Home provide for me?

We provide comprehensive, compassionate and continuous care for people of all ages.

- Same day appointments
- Preventive care and physicals
- Chronic disease management (such as diabetes, heart disease, arthritis, asthma and more)
- Acute care for illnesses
- Annual Visits, screenings and Flu vaccinations
- Well woman exams
- Diabetic Group classes to help you lead a healthy lifestyle
- 24x7 phone access to your care team
- Online electronic access to your medical records
- Referrals to vetted specialists and mental health providers « Management of multi-specialty care plans

Will my Medical Home help me take care of myself?

The care you receive in a Medical Home goes beyond the office visit with your personal clinician.

- We want to make sure you develop a clear idea of how to care for yourself.
- We want to help you set goals for your care and help you meet your goals one step at a time
- We want to encourage you to fully participate in recommended preventive screenings and services
- We will recommend tools and education materials you can use to improve your condition and manage your health
- We will give you information about classes, support groups, or other types of services to help you learn more about your condition and stay healthy
- We will provide you with information about resources in your community to help you manage your health and your wellbeing
- We will provide you with resources and, if needed, appropriate referrals to behavioral health specialists to help you make and sustain healthy changes to lifestyle or to address mental health conditions for you and other family members

How can my Medical Home help if I need to see specialists or go to a hospital?

Your medical home team will coordinate your care with all your other health care providers. They will recommend quality specialists for you and your family and will work with your specialist and the hospital to continuously plan and manage your care.

With your consent, your medical home team will inform specialists and hospitals about your medical conditions, your preferences and your goals and will follow up to obtain information after your specialty visit or your hospital stay. We will also follow up with you and your family to make sure your get the care you need and that you understand your plan of care.

Can my Medical Home help me when I have an emergency?

If you have a medical emergency, please dial 9-1-1.

For other clinical problems or medical advice, call your Medical Home first. Depending on the nature of the problem, we may be able to save you an expensive and inconvenient trip to the emergency room for problems best addressed by your personal primary care provider. You can reach a Medical Home team member via telephone 24x7, and same day appointments are always available.

If you do go to the emergency room, please make sure you let the staff know who your primary care provider is and ask that they contact your Medical Home as soon as possible so we can help them take better care of you and your family.

What can I do to help my Medical Home team take better care of me?

You are encouraged to actively participate in your care.

- Understand that you are a full partner in your own health care
- Learn about your condition and what you can do to stay as healthy as possible
- As best you can, follow the care plan that you and your medical team have agreed is important for your health

Do your best to communicate with your Medical Home team

- Tell us all about your health, your medical history and the health history of your family
- Bring a list of questions to each appointment. Also, bring a list of any medicines, vitamins, or remedies you use.
- If you don't understand something your doctor or other member of your medical home team says, ask them to explain it in a different way
- If you get care from other health professionals, always tell your medical home team so they can help coordinate for the best care possible
- Talk openly with your care team about your experience in getting care from the medical home so they can keep making your care better.

West Florida Medical Associates, P.A.

Please fill out Clearly in Black or Blue Ink

Registration Form

How do I access my Medical Home?

We offer convenient same-day and next-day appointments, after-hours phone access and extended hours

Monday	8:00 AM – 4:30 PM
Tuesday	8:00 AM - 4:30 PM
Wednesday	8:00 AM – 4:30 PM
Thursday	8:00 AM 4:30 PM
Friday	8:00 AM - 4:00PM

To make an appointment, call (352)560-3000

For clinical advice and all other matters, please call (352)560-3000We respond in a timely manner to your phone calls or electronic messages sent through the Patient Portal.

For all urgent matters, please contact us by phone. For all non-urgent matters, general information and to make an appointment, please call us during normal business hours.

How do I transfer my records to my Medical Home?

We will need your consent to obtain your medical records from your previous primary care provider or from specialists you have seen in the past. Consent forms are available in your new patient package.

You can also call our front desk during business hours if you need extra copies sent to you or ask the receptionist for assistance on the phone or when you visit with us.

Can I be in a Medical Home if I don't have health insurance?

We accept many insurance plans and in some cases cash patients. Call us to discuss your particular situation. Once you become a patient in our practice, we provide you with the same access and care regardless of your health insurance status.

Beginning January 1st, 2014 most people will be required by law to have health insurance.

Depending on your financial situation, you may be eligible for government subsidies to buy private health insurance, or you may be eligible to enroll in Medicaid.

For more information and useful tools to check your eligibility visit Healthcare.gov or ask one of your care team members for assistance. Additionally, please visit the Florida Department of Children and Families ACCESS website for information about assistance programs http://www.myflorida.com/accessflorida/.