

MORRIS MEDICAL CENTER, P.A.

DARELD R. MORRIS II, D.O., FFADEP
2621 Cleveland Ave., Ft. Myers, Fl 33901
Ph :(239) 418-0775 Fx: (239) 418-0630

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved by our staff. We will be happy to help you process your insurance claim-form for you. . We accept assignment of benefits only from the insurance companies, in which we are participating.

Returned checks and account balances older than 30 days may be subject to additional collection fees and interest charges of 11/2% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable.

This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as medical providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Responsible Party (print name):_____

Responsible Party (signature):_____ **Relationship to patient:** Self – Spouse-Parent

Date:_____

Morris Medical Center, P.A.

Last Name: _____ First _____ Middle _____

Date of Birth: ____ - ____ - ____ Age: _____ Social Security#: _____ - ____ - ____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Home#: () _____ Cell#: _____ Wk#: _____

Please let us know how you were referred to our office: _____

Email address: [www.](#) _____

(email is used for our monthly news letter, and to notify you of any changes in the practice)

Married ____ Single ____ Divorced ____ Widow ____ Student ____

If married name of spouse: _____ Spouse Social Security _____

Spouse date of birth _____ Spouse wk # _____ Spouse cell# _____

In case of an emergency: Name and Phone # of person to contact on your behalf?

Name _____ Phone# _____

Insurance: Blue Cross Blue Shield – Medicare – Southcare

Policy# _____ Group # _____ Co-pay _____

Form of payment for visits: ____ Cash ____ Credit Care ____ Check

Medical Lifetime Signature Form: Is Medicare your primary insurance? Yes ____ No ____

Name as it appears on Medicare Id Card: _____ Id# _____

I authorize the release of any medical information necessary to process any claim(s) to this Physician. I also request payment of government benefits wheather to myself, if assignment is accepted on my particular claim(s), I agree to pay any deductible or co-insurance for that particular claim(s). **Please read the following acknowledgement of non-covered services:** My Physician has advised me that based on Medicare part B guidelines any services may be denied as not medically necessary by their review panel, even though the panel has not examined me. Therefore, I acknowledge and accept liabilities for payment of services which my physician feels are necessary for my health and welfare.

Signature: _____ **Date:** _____

Auto Accident (Auto Insurance): Insurance Company: _____ Phone _____

Mailing address: _____

Claim# _____ Date of Accident: _____

Adjuster Name: _____ Attorney: _____

Attorney Phone#: _____

FAMILY HISTORY (check any that apply to you)

- _____ Alcoholism
- _____ Asthma
- _____ Bleeding Disorder
- _____ Cancer
- _____ Diabetes
- _____ Blaucoma
- _____ Epilepsy/convulsions
- _____ Heart Disease
- _____ High Blood Pressure
- _____ Kidney Disease
- _____ Mental Illness
- _____ Migraine
- _____ Osteoporosis
- _____ Stroke
- _____ Thyroid Disease
- _____ Other(explain)_____

HABITS (CHECK ANY THAT APPLY TO YOU)

- _____ Alcohol (Type)_____ Daily intake_____
- _____ Salt-Daily intake_____
- _____ Fat-Daily intake_____
- _____ Coffee-cups/day_____
- _____ Smoke/packs/day_____

How long have you smoked?_____

Are you interested in quitting?_____

- _____ Sleep: Difficulty fallining asleep
- _____ Continuity Disturbances
- _____ Early Morning awakening
- _____ Daytime Drowsiness
- _____ Exercise Routine

Year of last vaccine listed?

Tetanus_____ Flu_____ Pneumonia_____

Females:
Pregnant yes / no
Planning Pregnancy yes/no
Menstral Flow: Reg/Irregular
Pain/Cramps_____
_____Days of Flow
Length of cycle_____
1 st Day of Last Period_____
Number of
_____pregnancies_____abortions
_____miscarriages_____Live births
Type of Birth
Control_____
Last Pap Smear_____
Normal_____Abnormal_____
Last Mammogram_____

List any Medications you are Currently taking:

MEDICAL HISTORY:(Please circle any that apply to you)

- _____ Ringing in ear
- _____ Ear infections
- _____ Dizziness/fainting
- _____ Failing vision
- _____ Eye infections
- _____ Nose Bleeds
- _____ Sinus Trouble
- _____ Sore Throat
- _____ Hayfever/Allergies
- _____ Pneumonia
- _____ Bronchitis/chronic Cough
- _____ Asthma/Wheezing
- _____ Chest pain
- _____ High Blood Pressure
- _____ Heart murmur
- _____ Swollen ankles
- _____ Leg pain walking
- _____ Varicose Veins
- _____ Phlebitis
- _____ Loss of appetite
- _____ Difficulty swallowing
- _____ Indigestion/heartburn
- _____ Peptic ulcers
- _____ Abdominal pain-chronic
- _____ Gull bladder trouble jaundice/hepatitis
- _____ Change in bowel habits
- _____ Diarrhea/constipation
- _____ Diverticulosis/crohn's colitis
- _____ Bloody or tarry stool
- _____ Hemorrhoids
- _____ Hernia
- _____ Urine infections
- _____ Frequent urination
- _____ Blood in urine_____Painfull Urine_____ Loss of control_____
- _____ Decrease in flow force_____
- _____ Kidney stones
- _____ Veneral Disease
- _____ Urethreal Discharge
- _____ Chronic Fatigue
- _____ Recent Weight loss
- _____ Anemia_____Bruise easy
- _____ Cancer
- _____ Diabetes
- _____ Thyroid Disease
- _____ Convulsions/seizures
- _____ Stroke
- _____ Tremor/handshaking
- _____ Muscle Weakness
- _____ Numbness Tingling sensation
- _____ Heataches-frequent
- _____ Arthritis/rheumatism
- _____ Osteoporosis
- _____ Back pain-recurrent
- _____ Bonfracture/joint injury
- _____ Gout_____Fout pain_____ Cold Numb Feet_____
- _____ Rashes/hives
- _____ Psoriasis/Eczema
- _____ Nervousness/Depression
- _____ Memory Loss
- _____ Moodiness Excessive
- _____ Phobias
- _____ Mental Illness
- _____ Lactose Intolerance
- _____ Prostate Disease
- _____ Sexual menstrual Dysfunction
- _____ Frequent infections
- _____ Diptheria_____ Tetanus_____ Chicken Pox_____ Polio_____
- _____ Measles_____ Mumps_____ Rubella_____
- _____ Scarlett Fever_____ Tuberculosis_____ Herpes_____

ACKNOWLEDGEMENT OF RECEIPT OF THE PRIVACY NOTICE

I acknowledge that I have received a paper copy of the Provider's Notice of Privacy.

Signed by Patient or Representative

Date

_____ The patient / representative unable to acknowledge in writing the receipt of the Provider's Notice Of Privacy due to the following reason(s):

Morris Medical Center Authorized Representative: _____

Date: _____

Morris Medical Center
2621 Cleveland Ave.
Fort Myers, FL. 33901
(239) 418-0775

Morris Medical Center, P.A

Patient authorization for disclosure of protected health information

I, _____, D.O.B _____,

SS# _____, authorize Morris Medical Center and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellations, and tender payment on my behalf.

Name: _____

Name: _____

Name: _____

Name: _____

Signature

Date

Witness

Date

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**NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE 4/15/03**

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices relating to your health information; and to abide by the terms of the Notice that are currently in effect.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment and health care operations.

For Treatment. We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses and health aides as well as by physical therapists, pharmacists, and suppliers of medical equipment or other persons involved in your care. For example, we will contact your physician to discuss your plan of care as needed.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid or another third party payer. For example, we may contact Medicare or your health plan to confirm your coverage or to request prior approval for services that will be provided to you.

For Health Care Operations. We may use and disclose your health information as necessary for health care operations, such as management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to another entity with health care operations or health care fraud and abuse detection or compliance activities. For example, health information of many patients may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways I which we may use or disclose your health information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify, including clergy, who is involved in your care.

Emergencies. We may use or disclose your health information as necessary in emergency treatment situations.

As Required By Law. We may use or disclose your health information when required by law to do so.

Business Associates. We may disclose your protected health information to a contractor or business associate who needs the information to perform services for AF/CT. Our Business associates are committed to preserving the confidentiality of this information.

Public Health Activities. We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability; reporting child abuse or neglect or reporting births and deaths.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure actions or for activities involving government oversight of the health care system.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose health information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may disclose your health information for research purposes, including , for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

Research. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose health information about you to a disaster relief organization.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Workers' Compensation. We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

Inmates/Law Enforcement Custody. If you are under the custody of a law enforcement official or a correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purpose covered by the Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to AF/CT. At your request, AF/CT will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care. All requests for restrictions must be made in writing.

We are not required to agree to your requested restriction (except that if you are competent you may restrict disclosures to family members or friends). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your clinical or billing records or other written information that may be used to make decisions about your care, subject to some exceptions. Your request must be in writing. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional designated by AF/CT who did not participate in the decision to deny.

Request Amendment. You have the right to request amendment of your health information maintained by AF/CT for as long as the information is kept by or for AF/CT. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by AF/CT, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for AF/CT; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by AF/CT.

If we deny your request for amendment, we will give you denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Request an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your health information. This is a listing of disclosures made by AF/CT or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosure made pursuant to your Authorization, and certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of the Notice at any time. **(In addition, you may obtain a copy of this Notice at our website, www.morrismedicalcenter.com)**

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests. All requests must be in writing.

V. **FOR FURTHER INFORMATION OR TO FILE A COMPLAINT**

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact **Director at your local office.**

If you believe that your privacy rights have been violated, you may file a complaint in writing with AF/CT or with the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with AF/CT, contact the **Director at your local office or the Privacy Officer at 239-418-0775**

VI. **CHANGES TO THIS NOTICE**

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by AF/CT as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request.