Lake Howell
HEALTH CENTER

Dear Patient,

We are pleased to welcome you to Lake Howell Health Center. We strive to provide the very best in medical care in a friendly environment. It is our goal that this letter will provide you with helpful information regarding your upcoming visit.

For your convenience we have included New Patient Forms. Please complete and return these forms with a photo picture of the front and back of your insurance card either by email **lhhc@lakehowellhealthcenter.com**, USPS mail or hand deliver to our office before your scheduled appointment to expedite your initial visit with us. If you are unable to complete and return these forms before your appointment, please arrive 20 minutes prior to your scheduled appointment.

Please notify us at least 24 hours in advance if you are not able to keep this appointment.

Please bring the following:

- These completed forms if not already sent to the office
- List of current medications
- Insurance card(s)
- Photo ID
- Payment (copay, deductible, co-insurance, etc.)

Sincerely,

Lake Howell Health Center

406 Lake Howell Road | Maitland, FL 32751
Phone: (407) 691-3960 | Fax: (407) 691-3961
www.lakehowellhealthcenter.com

Lake Howell HEALTH CENTER

Welcome to Lake Howell Health Center

Today's Date_____ Email_____

Name Last_____ First_____ Middle Initial____

Street Address_____

City _____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Date of Birth _____ Age____

Marital Status (Select):

◯ Married ◯ Single ◯ Partnered ◯ Divorced ◯ Separated ◯ Widowed

Spouse/Partner's name (if applicable) _____

Gender (Select):

◯ Male ◯ Female ◯ Transgender ◯ Other _____

Race (Select):

☐ White

☐ Black

☐ Native American/Alaska Native

☐ Asian

☐ Native Hawaiian/Other Pacific Islander

☐ Other_____

Employment Information

Employer_____

Occupation _____

Employer Address_____

Employer Phone Number_____

Emergency Contact

Name_____ Relationship_____

Cell phone_____

Lake Howell HEALTH CENTER

Pharmacy

Name_____ Phone Number _____

Address_____

Referred by: _____

Family History

Family Members	Living or Deceased?	Present age or age at death.	Major Illness and/or Cause of Death
Father			
Mother			
Siblings (Name) & Gender			
☐ M ☐ F			
☐ M ☐ F			
☐ M ☐ F			
☐ M ☐ F			
Children (Name) & Gender			
☐ M ☐ F			
☐ M ☐ F			
☐ M ☐ F			
☐ M ☐ F			
☐ M ☐ F			

Is there a family history of anything NOT listed here? (Please explain)

_____

Have you ever had surgery or been hospitalized? (Please explain)

_____

Please list all current prescribed medications and dosages.(include herbal medications or vitamins)

_____

_____

Lake Howell HEALTH CENTER

List any allergies you have. (Sulfa, Penicillin, Bees, Peanuts.)

_____

What major medical problems have you had in your lifetime? *(Cancer, Diabetes, High Blood Pressure, etc.)*

_____

_____

Social History

Years Married/Long-Term Relationship____

Times Married_____

Times Divorced____

Who are you currently living with? (Select one)

- ◯ By Yourself
- ◯ Spouse/Partner
- ◯ Family Members
- ◯ Friends
- ◯ Homeless
- ◯ Other_____

Do You Have Children?

☐ Yes ☐ No

If Yes, List Current ages of Children_____

Do Your Children Live With You?

☐ Yes ☐ No

If no, Where? _____

Do you have family nearby?

☐ Yes ☐ No

Education (Select most recent):

- ◯ Graduate School
- ◯ College
- ◯ Professional or Vocational School
- ◯ High School
- ◯ Other_____

Are You Currently employed?

☐ Yes ☐ No

Have you been arrested or convicted of a crime?

☐ Yes ☐ No

If yes, For What? _____

Have you ever been abused?

☐ Yes ☐ No

If Yes, what type of abuse have you experienced?

- ☐ Physical
- ☐ Sexual (including rape or attempted rape)
- ☐ Verbal
- ☐ Emotional
- ☐ Other_____

Have you ever been in counseling or therapy?

☐ Yes ☐ No

Substance Use:

Have you had treatment for alcohol or drug abuse?

☐ Yes ☐ No

If Yes, Which substance? _____

Lake Howell HEALTH CENTER

Patient Waiver for Addiction/Pain Management

Patient's Name: _____ Date: _____

Dr. Hoffman, his PA-C, and APRN do not bill insurance for Addiction/Pain Management treatment. Even though your addiction/pain management diagnosis is a "covered service" through your insurance plan, we do not file for addiction/pain management treatment nor have "codes" to give you so you can file to your insurance. The treatment here for these services is a "self-pay service" that we provide. If you want your insurance to be filed, or to reimburse you, you will need to find a different physician/facility. Dr. Hoffman is Board Certified in Addiction Medicine and Family Practice, BUT is only contracted with the insurance companies for Family Practice.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive addiction/pain management treatment/services here at Lake Howell Health Center, Dr. Hoffman's office.

I acknowledge that I have been informed in advance of receiving treatment, that Dr. Hoffman, his PA-C, and APRN will not file my insurance and/or give me the information needed (CPT codes, Diagnosis codes) to file to my medical insurance on my own with the intent of getting reimbursed for my addiction/pain management treatment.

Patient Signature: _____ Date: _____

Name of parent or legal guardian (*if applicable)*: _____

Signature of parent or legal guardian: _____

Lake Howell HEALTH CENTER

Patient Treatment Contract

Patient Name: _____ Date: _____

As a participant in treatment for substance abuse and/or dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by the office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse of appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing, or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medications are filled, that behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse of appeal.
7. I agree that my medication/prescription can only be given to me at the regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medication from any doctor, pharmacies, or other sources without telling my physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax) can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medications as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and addictive substances (except nicotine).
14. I agree to provide random urine samples at office visits or in-between office visits when called, and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

Signature: _____ Date: _____

Lake Howell HEALTH CENTER

Lake Howell Health Center
Consent/HIPPA Form

Financial Policy/Authorization to release inform to insurance company

I, Undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to LHHC understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Lake Howell Health Center (LHHC) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

Signature X_____ **Date**:_____

Are you the Guarantor? Yes ☐ No ☐ If not please see the receptionist.

Consent for Treatment & Release information to pharmacy/consulting physician

I acknowledge recognition of the fact that the evaluation and treatment received, may be discussed with a designated pharmacy/consulting physician. I also give LHHC permission to discuss RX history, advised or deemed necessary, to be at the judgment of the physician.

Signature X _____ **Date**:_____

Acknowledgement of receipt of privacy notice (HIPPA)

Health Insurance Portability and Accountability Act

By signing this form, you acknowledge that LHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must attempt to have you sign this form on your first date of service with us after April 2003.This includes the situation where your first date of service occurred electronically. If your first date of service with us was an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ I have received a copy of the Privacy Notice of LHHC

☐ LHHC has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature X_____ **Date**:

Additional Person(s) Authorized to make the use or disclosure of my PHI

We at LHHC value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant other with out written consent), if you want anyone other than your referring physician to have access to your medical information please list their name(s), and relationship(s) below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name_____ Relationship _____

Name_____ Relationship _____

Signature X_____ Date:_____

Witness Signature

The Staff of LHHC complete this section of Acknowledgement Form if not signed by the Patient:

1. Does the Patient have a copy of the Privacy Notice? Y or N
2. Please explain why the patient was unable to sign an acknowledgment form and our efforts in trying to obtain the Patient signature:_____

Employee Signature: _____ Date:_____

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Controlled Substance Agreement

The doctors are being held accountable by the DEA for prescribing controlled substances. Patient non-compliance can no longer be tolerated. It is the patient's responsibility to manage their appointments and medication refills in a timely manner. Responsibility is a part of recovery. We are here to help you with your recovery.

I understand that I have the following responsibilities/guidelines for treatment under Lake Howell Health Center. Please read and initial each line and sign at the bottom of the page.

☐ 1. I will take medication at the dose and frequency prescribed and will not increase or change how I take my medications without the approval of my doctor.

☐ 2. I will schedule my doctor appointments in a timely manner prescribed by my doctor during regular office hours preferably with a 2 week notice. I will not ask for refills or partial refills earlier then agreed, after hours or on holidays and weekends.

☐ 3. I will not request any other medications for my diagnosis from any other health care providers and will inform all physicians what I am taking and who is monitoring medication.

☐ 4. I will protect my prescriptions and medications. I understand that lost, stolen or misplaced prescriptions will not be replaced. If I go into withdrawal I will not hold my physician responsible.

☐ 5. I will keep all follow-up appointments.

☐ 6. I understand that my doctor may stop prescribing the medications if:
   a. If I do not show any improvement in my diagnosis.
   b. I develop rapid tolerance or loss of improvement from the treatment.
   c. I develop significant side effects.
   d. My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from the practice.

Signature: X_____

Date:_____

Lake Howell HEALTH CENTER

FINANCIAL POLICY

The doctors and staff at Lake Howell Health Center would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current—accordingly, all self pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard or Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for you original appointment.
- A returned check will result in a $40 service charge and all future payment being required in the form of cash or credit card.

If you have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your healthcare benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibilities from the date of services are rendered.
- Cancellations within 24 hours and missed appointments will result in a fee of $35.00 for office visits and $50.00 for physicals.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. IF you have any questions about the above information please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	X_____	_____
Patient Name (please print)	Patient Signature	Date
_____	X_____	_____
Patient Name (please print) (if other than patient)	Responsible Signature	Date

Lake Howell Health Center
Kent S. Hoffman D.O., P.A.
Board Certified Addiction Medicine
Board Certified Family Practice
406 Lake Howell Road • Maitland, FL 32751
407-691-3960 Fax: 407-691-3961

Lab Draw Convenience Agreement

For patients who desire LHHC to draw blood at the office, there will be a charge of twenty-five dollars ($25.00) convenience fee each time they have blood drawn in our office.

It is understood that this convenience fee is not considered a “covered service” by your insurance company. Therefore, this fee is not reimbursable by your insurance company.

You are free at anytime to request a written prescription to have your labs drawn at a lab draw station or elsewhere.

By signing this you are aware of this policy:

I have read and agree to abide by the office policy as stated above.

_____ _____

Patient Signature Date