THE CLARK CLINIC INC

Sumter County Clinic
212 South Florida Street
Bushnell, Florida. 33513
Office # (352) 793-2441

Lake County Clinic
107 W. Central Avenue
Howey-in-The- Hills, FL 34737
Ph# (352) 324-0504

Lake County Clinic
910 W. Myers Blvd.
Mascotte, Fl 34753
Office# (352) 557-8700

The mission of our committed medical team is to our community's life-long wellness by providing quality and compassionate health care.

As our patient you can be assured that we will take the time to address your and your family's needs. Our walk-in clinic appreciates your calling for an appointment, but if necessary, you can walk in for a visit, 8:00am-5:00pm, Monday through Friday and in Bushnell on Saturday from 8:00am – 11:30pm and in Howey-in the-Hills, from 1:00pm-4:30pm. After hours and on the weekends, we have a live on call provider to help you.

Dr. Clark also has hospital privileges at Leesburg Regional, The Villages, Advent Hospital, Waterman, and Dade City Hospital, if there is ever a need to admit someone for medical attention.

Attached you will find the following forms for you to fill out which will assist us in serving your medical needs.

A. Personal Information
B. Responsible Party
C. Insurance Information
D. HIPPA Notice of Privacy Practice
E. Acknowledgments and Consents
    1. Financial Policy
    2. Assignments of Benefits
    3. Consent for Treatment
    4. Consent for Telemedicine
    5. Consent for Rx History
    6. Authorization of PHI
    7. Signature

Please return these items completed to the front desk. Thank you for selecting our healthcare team! We will provide you with the best possible health care. To help meet all your healthcare needs. Please fill out this form completely in ink. If you have any questions or need assistance, please ask.

We Love our patients

Dr. Clark and Team

A. Personal Information

Date_____
Birthdate_____DL#_____Soc. Sec. #_____
Last Name_____First_____Middle Initial_____
Wishes to be called_____
( ) Male ( ) Female ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated
Addrerss_____
City_____ State_____ Zip_____
Home phone_____ Work phone_____ Ext. # _____
Employer_____ Occupation_____
In the event of an emergency, who should we contact?
Name_____Relationship_____
Home phone _____Work phone _____ Ext.# _____
Is the patient the responsible Party? [ ] yes [ ] no **If yes proceed to section C** **If no proceed to section B**.

B. Responsible Party

Who is responsible for the account?
Name_____
Relationship to patient_____
Birthdate_____ Driver's license # _____ Soc. Sec. # _____
Address_____
City _____State _____ Zip _____
Home Phone_____ Work Phone _____ Ext. # _____

C. Insurance Information

Name of insured _____ Relation to patient_____
Insured's Birthdate _____ Insurance Co. _____ Group #_____
DO YOU HAVE ANY ADDITIONAL INSURANCE? [ ] YES [ ] NO, IF YES COMPLETE THE FOLLOWING
Name of insured _____ Relation to patient_____
Insured's Birthdate _____ Insurance Co. _____Group#_____

D. HIPAA Notice of Privacy Practices

THE CLARK. CLINIC [NC has a policy of complying with the Health Insurance Portability and Account- ability Act of 1996 (FIIPAA). Our objective is always to be 100% compliant. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI). Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without your or your guardian's signed authorization. You may review your records by scheduling a time with the office. After review of your records, if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided. If you elect to not allow any other member of your family access to your records; you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual, you may also provide that notice in writing. Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment without your specific authorization. If you are chosen to be part of any research program, you will be required to sign additional authorizations and releases so that your PHI may be used in the program. Under HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allow the practice to file insurance on your behalf. There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI. All efforts will be taken to ensure that your PHI will not be shared with any unauthorized persons. If you are on active duty military or are called to active duty military, under federal law we are required to supply a copy of your record.

ACKNOWLEDGMENT NOTICE OF PRIVACY PRACTICES, FINANCIAL POLICIES AND PATIENT CONSENT

Financial Policy

1. ***PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED***
   We must emphasize that as your medical care provider, our relationship and concern is with and your health, not your insurance company. We realize that emergencies do arise and may affect timely payment of your account. You may receive an additional bill for lab work done or for services rendered that were not charged on the date of service.
2. ***Assignment of benefits***
   I assign to The Clark Clinic all benefits covering medical expenses. I further agree that, should the amount paid be insufficient to cover the entire medical expense, I will be responsible for payment of any differences. I understand that my physician and /or consultants will send me a separate bill for their services and that this authorization and assignment also applies to them.
3. ***Consent for Treatment***
   I consent freely and voluntarily to participate in the treatment that may be ordered by my health care provider. I understand that I may withdraw consent at any time. This may include but is not limited to Telemedicine services, outpatient treatment, and diagnostic procedures by the Clark Clinic as may be deemed necessary or advisable by my physician and /or consultants selected by my physician. If I need additional treatments or procedures my consent will be obtained except in emergencies or unusual circumstances.
4. ***Consent for Telemedicine***
   Telemedicine uses medical and computer equipment as well as electronic communication technologies to enable health care providers at different locations to transfer and share individual patient health information for the purpose of treatment of those patients. I understand the following with respect to telemedicine: The health care provider will not be physically in the same room with me. Individuals may be present with me or with the distant health care provider to operate equipment, or assist with evaluation, examination and/or treatment. I consent to audio/video recording or photography if necessary. The resulting audio, video and images will become part of the medical record and be used for documentation or health care purposes only. Other uses of my information such as research will require my specific authorization. I have the right to withhold or withdraw my consent for telemedicine at any time without affecting my right to future care, treatment, benefits, or programs for which I am otherwise entitled. Alternative methods of care may be available to me, and I may choose other options at any time. I have the right of access to my medical information. I can inspect all medical information documented during a telemedicine encounter and may receive copies of this information in accordance with Florida law. The laws that protect the confidentiality of medical information apply to telemedicine.
5. ***Consent for Access of My Prescription History***
   I voluntarily consent to provide The Clark Clinic access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years. I acknowledge that The Clark Clinic may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from The Clark Clinic, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.
6. ***Authorization of PHI***
   In compliance with HIPPAA'S Privacy Rule, it is the policy of this office to allow properly authorized individuals to have access to your protected health information (PHI). This authorization will remain in effect until revoked in writing by the patient. Please list below the individuals you wish to have access to your protected health information.

   Name _____ Relationship to Patient _____

   Name _____ Relationship to Patient _____

7. ***Signature / Consent***
   I acknowledge that I have received and reviewed the Notice of Privacy Practices, Financial policies, Telemedicine services, access to Prescription history policy, Authorization assignment and patient's Rights & responsibilities pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction. I consent to all of the above notices and the use or disclosure of my protected health information by THE CLARK CLINIC, all its departments, operation, and locations for the purpose of diagnosing or providing treatment, obtaining payment for my healthcare services, or to conduct its health care operations that specifically include all, satellite locations, billing and administration, laboratory and diagnostic center.

I certify that I have read this form, or it has been read to me.

_____ _____
Signature of Patient Printed Name of Patient

_____ _____
Signature of Legal Guardian Printed name of Legal Guardian

_____ _____
Representative's Authority/ Relationship Date Signed

A copy is available online at https://www.theclarkclinic.com/

THE CLARK CLINIC INC

Date of Request_____

Authorization for Release of Medical Information

Patient's Name: _____ DOB: _____

Address:

By signing this form, I hereby authorize the following:

Disclosure of the patient's PHI from:	Disclosure of the patient's PHI to:
Person, class of persons, or organization	**Person, class of persons, or organization**
Address	**Address**
Phone:	**Attn: Records** **Phone: FAX:**

PURPOSE OF REQUEST: (Check one) Transfer of Care ____ Personal _____ Ins Coverage _____ Other _____

TYPE OF RECORDS REQUESTED: (Check One) All Medical Records _____ or OTHER _____

I **understand that** disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results. I **understand that** I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above.

I **understand that** I may refuse to sign this authorization, and that the institution named above cannot deny or refuse to provide treatment if refuse to sign.

I **understand that** I may be charged a fee of up to $1.00 a page for every page copied and that this fee is within the limits allowed by Florida law.

I **understand that** this authorization will expire in one year from the date signed below unless otherwise specified.

I **understand that** once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations.

I **understand the** matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: Date:

Relationship to Patient if requester is not the patient.

Last_____ **First** _____ **Middle** _____ **DOB** _____**Date** _____

To maximize our ability to serve your medical needs, we would like to ask you a few questions about your health. Please fill out and return to the front desk. All information is treated as confidential.

Chronic Conditions

Please circle the following conditions you have been diagnosed with.

Anemia	Heartburn
Asthma	High Blood Pressure
Arthritis	High Cholesterol
Cancer	Hypertension
Chronic Bowel Irregularity	Migraines
COPD	Obesity
Diabetes	Sleep Apnea
Heart Disease	Tuberculosis

Other : _____

Sleep

Please circle the appropriate answer.

- Has anyone ever told you that you snore? Yes/No
- Do you have restless legs? Yes/No
- Do you wake up feeling well rested? Yes/No
- Do you ever wake up with a dry mouth? Yes/No
- Do you ever feel sleepy during the day? Yes/No
- Do you ever wake up with a headache? Yes/No

Allergies

Please circle the appropriate answer:

- Do you have any food allergies? Yes/No
- Do you have any environmental allergies? Yes/No
- Do you have any drug allergies? Yes/No

Circle Below those that apply to you:

Asthma Congestion Rash Hives
Sinus Drip Runny Nose Chronic Cough
Sneezing Itchy, Watery Eyes Wheezing

Heart

Please circle the appropriate answer.

- Have you ever had a heart attack? Yes/No
- Do you have a pacemaker? Yes/No
- After exertion, do you feel dizzy, weak, or short of breath? Yes/No
- Have you noticed a swelling in your ankles? Yes/No
- Do you ever notice your heart skips a beat? Yes/No
- Do you ever experience chest pain? Yes/No

Lungs

Please circle the appropriate answer.

- Have you been diagnosed with a breathing problem? Yes/No
- Do you experience shortness of breath? Yes/No
- Do you cough throughout the day? Yes/No
- Have you smoked cigarettes for over 10 years? Yes/No

MD/ARNP: I have reviewed this survey, and am recommending the following tests: (circled)

NO TESTING NEEDED EKG ECHO HOLTER US PFT SLEEP ALLERGY TESTING Signature:_____

A copy is available online at https://www.theclarkclinic.com/

HEALTH HISTORY

PATIENT NAME_____DOB_____/_____/_____

To help us meet all your healthcare needs, please fill out this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

When was your last physical exam? _____

Do you have now, or have you had within the past year:
(Circle "no" or "yes", leave blank if uncertain)

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____

_____

_____

_____

Weakness or paralysis	no	yes	Wheezing	no	yes	Joint pain or stiffness	no	yes
Tire easily or weakness	no	yes	COPD	no	yes	Muscle cramps or spasms	no	yes
Obesity	no	yes	Purple fingers or lips	no	yes	Sleeplessness	no	yes
Change in appetite	no	yes	Swelling of hands, feet or ankles	no	yes	Seizures	no	yes
High Cholesterol	no	yes	Difficulty in breathing	no	yes	Depression	no	yes
Persistent fever	no	yes	Tuberculosis	no	yes	Memory loss	no	yes
Night sweats or hot flashes	no	yes	Leg cramps	no	yes	Poor coordination	no	yes
Skin rash	no	yes	Difficulty swallowing	no	yes	Dizziness or fainting spells	no	yes
Skin trouble or changes	no	yes	Heartburn	no	yes	Sensitivity to cold or heat	no	yes
Change in nails or hair	no	yes	Frequent belching	no	yes			
Headaches	no	yes	Abdominal cramping	no	yes	**Men only:**		
Easy bleeding or bruising	no	yes	Nausea	no	yes	Impotence	no	yes
Anemia	no	yes	Vomiting	no	yes			

Blurred vision	no	yes	Hemorrhoids	no	yes	**Women only:** Age period began		
Eye pain	no	yes	Chronic constipation	no	yes	How many days do periods last? _____ How many days between periods?		
Infected eyes	no	yes	Rectal bleeding	no	yes	Is the flow heavy?	no	yes
Ringing in the ears	no	yes	Dark urine	no	yes	Do you bleed or spot between periods?	no	yes
Decrease in hearing	no	yes	Yellow jaundice	no	yes			
Frequent nosebleeds	no	yes	Frequent urination (day)	no	yes	Type of birth control used.		
Frequent colds	no	yes	Frequent urination (night)	no	yes	Date of last period?		
Sinus trouble	no	yes	Increase in thirst	no	yes	Date of last pelvic exam?		
Loss of smell	no	yes	Painful urination	no	yes	Date of last mammogram?		
Persistent hoarseness	no	yes	Leakage of urine	no	yes			
Sore throat	no	yes	Blood in urine	no	yes			
Sore tongue or gums	no	yes	Vomited or coughed up blood	no	yes			

X _____ _____

Signature of patient or parent if minor — Date