

PREMIERMED FAMILY AND SPORTS MEDICINE

Patient Registration Packet

Please e-mail this entire packet completed to info@premierfsm.com

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Last Name: _____

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Secondary Phone: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Sex: ☐ Male ☐ Female Gender: _____ Pronouns: _____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native

Hawaiian or Pacific Islander ☐ Decline Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

INSURANCE

Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relation to Patient: _____

Date of Birth: ____/____/____ Policy Holder SSN: _____ - _____ - _____

Type: ☐ HMO ☐ PPO ☐ EPO ☐ Other

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relation to Patient: _____

Date of Birth: ____/____/____ Policy Holder SSN: _____ - _____ - _____

Type: ☐ HMO ☐ PPO ☐ EPO ☐ Other

Consent to Communicate by Secure Text Message

I authorize PremierMED Family & Sports Medicine to communicate with me by text message regarding my healthcare, including appointments, test results, prescriptions, billing, and other medical information.

PremierMED uses a secure text messaging service that integrates with our electronic medical record to help protect your health information. However, I understand that electronic communication, including text messaging, carries some risk and cannot be guaranteed to be completely secure. I acknowledge that there is a small risk that my information could be intercepted or accessed by an unauthorized person.

By signing below, I consent to receive text messages from PremierMED Family & Sports Medicine regarding my care.

Patient or Legal Guardian Signature: _____ Date: ____ / ____ / ____

HIPAA Authorization for Disclosure & Emergency Contact

Patient Name: _____ Date of Birth: ____/____/____

Authorization

I authorize PremierMED Family & Sports Medicine to disclose my protected health information (PHI), as permitted under HIPAA, to the individual(s) listed below. These individuals may receive and discuss my medical care, appointments, medications, billing, and insurance information by phone, voicemail, email, fax, mail, or in person, as appropriate.

Authorized Individual 1, Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Date of Birth : ____/____/____ Address: _____

Authorized Individual 2, Disclose Protected Health Information

Name: _____ Relationship: _____ Phone: _____

Date of Birth : ____/____/____ Address: _____

Authorized Individual 3, Disclose Protected Health Information

Name: _____ Relationship: _____ Phone: _____

Date of Birth : ____/____/____ Address: _____

Purpose of Authorization

☐ At my request ☐ Family/Caregiver ☐ Emergency Contact ☐ Other: _____

Limitations Unless indicated, this authorization applies to all PHI.

☐ Laboratory Results ☐ Imaging/Scans ☐ STD/STI Results ☐ Mental Health Information (where permitted)
☐ Other: _____

Duration and Revocation

This authorization remains effective for one (1) year from the date signed unless revoked earlier in writing. Revocation does not affect disclosures already made.

Acknowledgment

I understand this authorization is voluntary, may be revoked in writing, and that information disclosed under this authorization may no longer be protected by HIPAA if re-disclosed by the recipient. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form.

Signatures

Patient Name (Printed): _____

Patient/Legal Guardian Signature: _____

Relationship (if not Guardian): _____ Date: ____/____/____

Authorization for Release of Medical Information

Patient Name

Date of Birth

Phone

Email

PLEASE SIGN FOR FUTURE USE.

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form may be revoked in writing and otherwise expires five years from the date listed below. **Note: If these records obtain any information from previous providers, or information about cancer diagnosis, drug/alcohol abuse, sexually transmitted diseases, HIV/ AIDS, and mental health you are hereby authorizing disclosure of this information.

Patient or Parent/Guardian Signature

Date

In office use only

Name of Clinic/Physician Releasing Records

Phone

Fax

RECORDS REQUESTED BY:

☐ Gary Visser, MD, FAAFP
☐ Adam Langley, MD, FAAFP
☐ Matthew Pierce Ganovsky, MD
☐ Maria Harrington, APRN
☐ Lesley Jereissati, PA-C
☐ Ruth Hey, APRN
☐ Carolyn Knopfle, APRN
☐ Krista Punto, APRN
☐ Laura Mendoza, PA-C

Please include the following and fax to our office:

☐ STAT: PATIENT IN OFFICE
☐ ROUTINE: Send records ASAP
☐ Progress notes / HPI / H&P
☐ Pathology Reports
☐ Radiology Exams
☐ Immunization Records
☐ All Diagnostic Result

2940 Maguire Road, Suite 200, Ocoee, FL 34761

Phone: 407-581-9065 Fax: 321-348-5827

www.PremierFSM.com

MEDICAL HISTORY (Leave blank if no past/current medical history)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

SURGICAL HISTORY (Leave blank if no surgical history)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you currently see any specialists? (Please list the name, specialty, and location.)

Do you need any referrals today? If so, please state the type of specialist and the reasoning for the referral. If you have the provider picked out please list that as well.

CURRENT MEDICATIONS (Leave blank if not currently taking medications)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGIES/MEDICATION SIDE EFFECTS (Please list the agent/medication and reaction)

SOCIAL HISTORY

Occupation: _____ Employer: _____
☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

Who lives with you?

☐ Spouse/Partner ☐ Children ☐ Roommates ☐ Parents ☐ Other

Tobacco use (including cigars/vape/smokeless):

☐ Current everyday ☐ Current someday ☐ Former smoker ☐ Never used

Alcohol use (beer/wine/liquor):

☐ 1-3 ☐ 4-6 ☐ 7+ per ☐ Day ☐ Week ☐ Month ☐ Year ☐ No alcohol use

FEMALES

Currently menstruating: Date of last menstruation: ____/____/____

☐ Normal cycles ☐ Abnormal cycles, please explain: _____

No longer menstruating:

☐ Natural menopause ☐ Hysterectomy Date ____/____/____ ☐ Other _____

Are you breastfeeding or pregnant? ☐ Yes ☐ No

Are you using any type of birth control?

If yes, what kind and when did you start using it? _____

If not, are you interested in discussing birth control options during your visit? ☐ Yes ☐ No

Date of last PAP smear: ____/____/____ Date of last mammogram: ____/____/____

MALES

Date of last prostate exam: _____

Have you noticed any testicular pain or lumps/bumps? ☐ Yes ☐ No

If so, location _____ how long as this been present? _____

Preferred LAB: _____

Preferred Imaging Facility: _____

ALL

Date of last ☐ Colonoscopy ☐ Cologuard ☐ FOBT: ____/____/____
 Last DEXA scan: ____/____/____
 Last eye exam: ____/____/____ Performing provider: _____
 Last annual wellness exam: ____/____/____ Performing provider: _____
 How often do you exercise? _____
 Do you eat a well-balanced diet? ☐ Yes ☐ No
 Are you on any special diet or dietary restrictions? _____

VACCINATIONS

Shingles ☐ Yes ☐ No
 Influenza ☐ Yes ☐ No
 Pneumonia ☐ Yes ☐ No
 Tetanus, Diphtheria, Pertussis (Tdap) ☐ Yes ☐ No
 Hepatitis A ☐ Yes ☐ No
 Hepatitis B ☐ Yes ☐ No
 COVID19 ☐ Yes ☐ No

Are you interested in receiving any vaccines during today's visit? ☐ Yes ☐ No

FAMILY HISTORY

Father: ☐ Living ☐ Deceased
 History of: ☐ High blood pressure ☐ Diabetes ☐ Cancer, type: _____ ☐ Stroke
 Other _____

Mother: ☐ Living ☐ Deceased
 History of: ☐ High blood pressure ☐ Diabetes ☐ Cancer, type: _____ ☐ Stroke
 Other _____

Other significant family history: _____

PREFERRED PHARMACY

Name: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

OFFICE USE ONLY

SCANNED PICTURE ID: _____ SCANNED INSURANCE CARD: _____
 ALL FORMS REVIEWED BY: _____

Marketplace/ACA Care Insurance Financial Policy

The Affordable Care Act (ACA) created the Advance Premium Tax Credit (APTC) to assist patients in paying their health insurance premiums. This tax credit does not subsidize the entire premium, and as such, you are responsible for paying the remainder of your health insurance premium.

If you purchased your health insurance through the ACA website (www.healthcare.gov), you are required to make your monthly premium payments to avoid a 90-day grace period, which puts you at risk of losing your coverage if payment is not made in full at the end of the grace period.

According to federal regulation §156.270, your insurance carrier is required to notify us if you have defaulted on your premium payments. If we receive such notification from your insurance carrier, we will send you a statement for the balance due on your account for services rendered at PremierMED Family and Sports Medicine. Your account will be placed in a self-pay status until your premium's payments are made in full (we will call your insurance carrier for confirmation of payment). If your policy is canceled due to non-payment of premiums, your account with PremierMED Family and Sports Medicine will remain in a self-pay status.

If your balance with PremierMED Family and Sports is not paid in full after 90 days, your account will be forwarded to a collection agency to collect on your account.

By signing this policy below, the patient/parent confirms that:

I understand and acknowledge that I am personally responsible to pay PremierMED Family and Sports Medicine in full for services that my health insurance payer will not cover due to non-payment of my health insurance premiums. I further understand and acknowledge that my account will be placed in a self-pay status, and I am at risk for my account being forwarded to a collection agency if I do not pay my balance in full.

I confirm that I have **not** purchased insurance through ACA (www.healthcare.gov). I have insurance through my employer or another private/commercial or Medicare plan, or I am a self-pay patient.

Patient Name/Signature

Date

I confirm that I **have** purchased insurance through ACA at www.healthcare.gov; I will comply with this policy regarding my account.

Patient Name/Signature

Date

Patient Financial Policy

Our goal at PremierMED Family and Sports Medicine is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our financial policy allows us to maintain a good flow of communication and run an efficient medical practice.

We verify insurance eligibility for every patient prior to their scheduled appointments and for all walk-in patients. To maintain a strong financial standing while providing excellent medical care, we have implemented a financial policy of collecting all copays, deductibles, and co-insurances the day of your visit. If we find that you have overpaid, we will issue a refund once the Billing Department reviews your Explanation of Benefits (EOB). If you still have patient responsibility left over, we will send you a statement with a balance due.

FOR PATIENTS WITH INSURANCE:

It is your responsibility to know and understand your insurance policy coverage to include visits, annual wellness visits, labs and procedures.

If you are responsible for a deductible or co-insurance, we will collect a fee up front for your visit, if you have further responsibility, you will be billed for these services:

- **INSURANCE** – We will file claims on all visits and procedures. When we file a claim on your behalf, it is with understanding that benefits will be assigned to PremierMED Family and Sports Medicine, LLC dba PremierMED Family and Sports Medicine. You are responsible for all co-payments, deductibles, co-insurance, and non-covered services. *****THE ULTIMATE RESPONSIBILITY FOR UNDERSTANDING YOUR INSURANCE BENEFITS REGARDING PAYMENTS, PREVENTATIVE SERVICES, COVERAGE FOR PHYSICIAN AND LAB SERVICES, PATHOLOGY, RADIOLOGY, AND VACCINATION COVERAGE RESTS WITH YOU. *****

- **AFTER HOURS** - If you are seen **after 5pm during the week, or on Saturday, it is considered after-hours**. The after-hours reimbursement billing code (99050) will be submitted for such visits. Your insurance plan may or may not cover this, and therefore, you may or may not incur patient responsibility. Once we receive the explanation of benefits (EOB) from your insurance company, our billing department will review your account to determine your responsibility and send you a statement for remittance of payment if necessary.

- **PREVENTATIVE PHYSICALS WITH LAB REVIEW OR OTHER ADDRESSED ISSUES/CONCERNS**

INITIALS

While your physical exam (preventative/wellness exam) may be covered by your insurance plan, the lab review component of the visit, or other acute complaints or medication refills addressed during the exam are not considered preventative and will be billed as such. This portion of your visit may or may not be covered by your insurance, and you will be responsible for any remaining balance applied by your insurance company.

- **PAYMENTS:**

- o CASH PAYMENTS – Payments of **\$25 or less** are cash only. Please note the following:
- o We will not accept credit or debit card payments for **\$1.00, \$2.00, or \$5.00** payments.
- o ACCEPTED TYPES OF PAYMENT: Cash, Visa, MasterCard, and Discover. NO PERSONAL or BUSINESS CHECKS will be accepted.

- **LAB FEES (except Medicare)** **INITIALS**

If your provider orders labs, you are welcome to visit a LabCorp or Quest lab facility. We do offer you the convenience of having your labs drawn at PMFSM; a lab draw/convenience fee of \$25 will be collected for **physical exams, your initial visit, or any follow-up visit. This includes labs drawn during a walk-in visit.** Your lab specimen(s) will be sent to LabCorp or Quest based on your insurance.

- **NEW PATIENTS** – New patients are responsible for co-payments/co-insurances/self-pay fees up front. Payment arrangements for first visits are not authorized.

- **ADMINISTRATIVE FEES/ FORMS** **INITIALS**

PremierMED Family and Sports Medicine prides itself on providing excellent medical care and customer service to you and your family. We encourage you to schedule an appointment specifically for the completion of the document. This ensures that the document is completed accurately. We require that you must be an established patient with a physical exam within a rolling calendar year. We can also provide administrative services to patients upon request. If you require a specific form, paperwork, or letter for your employer or other reasons, we will charge an administrative fee based on the request. Fees must be paid in full before the letter or administrative service is completed. You must allow 7 days for any form(s) to be completed. You will be notified when your letter or paperwork is complete and ready for pick-up at the front desk.

1. Letter typed and printed on company letterhead, and signed by the physician or other provider (example: special travel arrangements, requirements for service, work accommodations, etc.): **\$25**
2. Forms or paperwork for work accommodations (not FMLA), handicap parking placards: **\$25**
3. Family Medical Leave Act (FMLA): this requires a face-to-face encounter/appointment with a physician. You will be charged your normal office visit fee, and an **additional \$50** to complete the FMLA packet.
4. Disability (Short or Long Term): you must be an established patient for at least one year with a physical before disability forms are completed: **\$50**
5. Requests for admission into a nursing home or assisted living facility: you must be an established patient for at least one year with a physical: **\$25**
6. 3rd party request for paper records **\$1 per page up to \$25 plus the cost of mailing.**

Patient Status and Appointment Policy

- PATIENT EXPECTATIONS:** At PremierMED Family and Sports Medicine, we do regular check-ups, counseling, and screenings to prevent illness and disease progression. Annual Wellness Exams and Well Woman Exams are considered wellness visits. Complete physical exams are preventative visits that screen patients for common health conditions and include a head-to-toe assessment. A baseline reading of your lab results, blood pressure, temperature, pulse, respirations, weight, height, and other vital functions depending on your age and level of activity. We request all patients 21 and over to have labs drawn 7-10 days prior to their annual physical exam. **Annual Wellness Exams cannot be scheduled during the same visit as new patient consultation, acute visit, or other requested appointments** **YOU WILL BE EXPECTED TO HAVE AN ANNUAL PHYSICAL AND AGE-RELATED SCREENING EXAMS TO RETAIN YOUR PATIENT STATUS. If you are unable or unwilling to comply with these expectations, we encourage you to seek care at another practice.**
- LATE APPOINTMENT & CANCELLATION POLICY/FEEs** – In the event that you need to cancel or reschedule your appointment, a 24-hour notice during business hours is required. Appointments cancelled within the same day, marked as a no show or if you arrive late (or call to notify of late arrival) **more than 10 minutes**, your appointment will be cancelled/rescheduled and subject to cancellation fee of \$50. If you arrive late, but before the 10 minutes, you may still be seen, but other patients showing on time for their appointment will be seen first.
- APPOINTMENTS** – Office visits are by appointments only. However, if you develop sudden illness and require an appointment on the same day, we will do our best to accommodate you. Please understand that you may be seen by a different provider for that particular visit in order for us to care for you in a timely manner. Informing our reception staff beforehand about the nature of your appointment will ensure your appointment is equipped with enough time for your visit. We provide our patients with three forms of appointment reminders: email and text messages, and phone call. **It is your responsibility to confirm your appointment.**
- HOSPITAL ADMISSIONS** – If you are admitted to the emergency department and/or the hospital, please make sure to inform the hospital admission staff of your primary care physician's name, follow ups with your primary care physician is required 7-14 days after your hospitalization to help avoid readmissions and/or complications.
- AFTER HOURS ANSWERING SERVICE** - If you contact our office after business hours, an after-hours answering service will be available. This service is only to assist you with acute (non-life threatening) urgent situations. **Please note this is not for emergencies, call 911.** Appointment cancellations, prescription refill requests, referral requests, and knowledge of test results are services NOT offered with the after-hours answering service.
- NON-COVERED SERVICES** – Medicare and certain other insurance companies will only pay for services that they determine to be “reasonable and medically necessary”. If Medicare or another insurance company determines that your visit with our physician or nurse practitioner is not “reasonable and medically necessary”, they will deny payment for that service. **You will be responsible for anything not covered by Medicare or your insurance company.** All labs are

submitted based on appropriate codes to a lab based on one's medical condition.

- **PAST DUE ACCOUNTS** – Unpaid balances must be resolved **prior** to being seen in the office. If necessary, you can visit portal.athenahealth.com to pay your balance. If your account is 90 days past due, your account is subject to collections from a third-party collection agency.
- **CARD ON FILE** - PremierMED Family and Sports Medicine will require you to have a card on file in order to schedule an appointment. This will be used to collect outstanding balances. You may also use your card on file to pay time-of-service payments. Payments will be processed up to \$200.

Prior Authorization, Referrals, Prescription Refill, and Controlled Substances Policy

Our goal at PremierMED Family and Sports Medicine is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our Prescription Refill and Controlled Substances Policy allows us to maintain a good flow of communication and run an efficient medical practice. Please review the policy below:

MEDICATION FOR CHRONIC CONDITIONS

1. All new patients must establish with a PremierMED Family and Sports Medicine provider prior to having a prescription refilled.
2. Additional lab tests may be required to determine the exact dosages of prescribed medications; your insurance may or may not cover these tests. It is your responsibility to check with your insurance company to determine what they will cover.
3. Please contact your local or mail order pharmacy to request a refill 1-2 weeks prior to your refill date. Your pharmacy will then contact us by fax, please allow up to 3 business days for a response. DEA law states that all controlled substance medications require a 3 month follow up in office, we CANNOT submit a temporary refill.
4. Depending on the type of medication you are on; you must be seen by a PremierMED Family and Sports Medicine provider every three to six months (or more frequently if necessary) to have your prescription refilled. This will be considered a regular office visit and billed accordingly. You will also be required to have bloodwork at least every six months for medications for chronic conditions.

CONTROLLED SUBSTANCE AGREEMENT

1. Controlled substances (pain, sleep, muscle relaxants, stimulants, testosterone/hormone replacement) are tracked by the State of Florida Prescription Drug Monitoring Program (PDMP). Pharmacies and physicians can track your usage of controlled substances through obtaining an online report, which annotates physicians who have prescribed, and pharmacies who have dispensed these medications.
2. If the physicians at PMFSM are dispensing a controlled substance (non-narcotic pain medication, sleep medication, muscle relaxant, ADHD medications, testosterone, or hormone replacement), **you are required to have a face-to-face encounter every 3 months for prescription refills.**
3. New patients who request a controlled substance for acute pain may receive one prescription of pain medication or controlled substance (at the discretion of the physician) after a PDMP report is obtained.
4. I will attend all office visits and will come immediately if asked.
5. I will not go to the ER or to other providers for these or similar medications. I am personally responsible for their medication(s). I will treat them as other valuables. Medicines will not be replaced if lost, stolen, or destroyed.
6. I will not give medication(s) to anyone else or take anyone else's medication(s).
7. I will not request early refills or take more than the prescribed amount.
8. For safety reasons, refill requests will only be honored at the time of my appointments, during office hours, currently 8AM-5PM Mon-Thu, 8AM-1PM Fri.
9. I will inform my doctor of any new medications or medical conditions.
10. I agree to allow PremierMED to perform any urine, blood, or breath tests needed to make sure I use my medications correctly.
11. It is my responsibility to comply with applicable laws while taking these medications.
12. My providers may discuss my medications with other appropriate individuals or entities to ensure safety.
13. I understand that there can be side effects from these medicines, including sedation, itching, nausea, vomiting, difficulty urinating, constipation, and other problems.
14. I understand that I may become addicted to these medications.
15. I understand that suddenly stopping these medications may be dangerous.
16. If I violate these conditions, my providers may not refill the medications and may require that I obtain help to decrease my use of these medications.
17. I know that violating these conditions may result in my dismissal from the practice with no more than 30 days' notice.
18. I further agree that my pain medication or other prescriptions may be stopped or decreased at any time, for any reason, by my providers.
19. I understand that the above is not a complete list. I will be careful and will exercise caution and common sense. I will be completely honest, open, and accurate about my use of these and all other medications. I will ask questions if I do not understand something or if I feel that I may be having trouble with the medication.

PRIOR AUTHORIZATIONS FOR MEDICATIONS AND REFERRAL FOR SPECIALISTS

We will make every effort to ensure that you receive the safest, most effective, and reasonably priced prescription drugs that are best suited for your healthcare. We also abide by regulations set by insurance companies and government agencies. Many health insurance companies or plans are requiring Prior Authorization or approval for your medication.

All referrals and prior authorizations to specialists or imaging centers require 48-72 hours for processing. For authorization procedures and/or pharmacy approvals please contact your health insurance company for further information.

Acknowledgement of PremierMED Family and Sports Medicine Registration Packet 2026

Patient Name

Date of Birth

☐ I have read and agree to the "PATIENT FINANCIAL POLICIES"

Patient or legal guardian signature

Date

☐ I have read and agree to the "PATIENT STATUS AND APPOINTMENT POLICIES"

Patient or legal guardian signature

Date

☐ I have read and agree to the "PRIOR AUTHORIZATION, REFERRALS, PRESCRIPTION REFILL, AND CONTROLLED SUBSTANCES POLICY"

Patient or legal guardian signature

Date

A copy of these policies will accompany your consent in your medical record and can be provided to you for your record as well.

