Lakewood Ranch Medical Group

Dear Valued Patient,

Thank you for choosing Lakewood Ranch Medical Group, a Division of Manatee Physician Alliance, LLC, where we strive to offer the best possible medical care. It is our pleasure to welcome you as a patient. This letter is designed to provide you with some important information about our services and office operation.

Emergencies / After Hours: If the office is closed and you have a medical emergency, please dial 911 or proceed to the closest emergency room. For non-life threatening emergencies you may leave a message with our answering service or proceed to our Urgent Care Walk-In Clinic, see reverse side for location and hours. If you'd like to leave a message for the office staff to return your call the next business day, you may call the office number, leave a voicemail or follow the instructions to be connected to the answering service. Prescription refills will NOT be handled after hours, please call during normal business hours. Please refer to our prescription refill policy below.

Prescription Refills: Please call your pharmacy regarding refills on medications at least 72 hours in advance to allow sufficient time for the pharmacy and your provider to receive and respond to your request before you run out of your medication. For maintenance medications, your healthcare provider will prescribe enough refills to last until your next office visit. If you are out of refills, this is an indication of the need to schedule a follow up appointment with your provider.
We do NOT manage chronic pain for long term, as chronic pain patients should be cared for by pain management specialists*. *

Online Health Records (Patient Portal): Provide your email address and automatically receive an invite to gain access to your records online. You'll receive an invitation from IQ Health, where you'll complete the enrollment process. You will gain secure online access to your healthcare records, including but not limited to allergies, immunizations, medications, completed procedures, health problems…etc. This application is free of charge and available with internet connectivity, 24 hours a day, 7 days a week.

Your Opinion Matters: After your visit, you may receive an email from our survey partner, MedicalGPS, LLC. PLEASE take a moment to let us know how we're doing. If someone stood out during your visit, please drop their name in the comments section as we'd love to know.

Payment / Billing Questions: Payment will be required at the time services are rendered. We will collect all outstanding balances within Manatee Physician Alliance, LLC and for services performed at the time of service. Please note that your insurance company may process the claim with a higher patient responsibility. You may receive a statement, from Manatee Physician Alliance, LLC for any balance billing. Method of payment includes Cash, Check, MasterCard, Visa, Discover and American Express. If you have a question regarding your statement you may contact the office directly or our billing office at 888-804-6274.

Forms: Some forms are extensive and will require a fee of $25 at the time of request. There are forms that may require an appointment prior to completion of the requested documents.

Identification: The protection of your identity is important to us. You will be required to produce a government issued photo identification card, along with your insurance card(s) at every visit. We will also scan a copy into your electronic health records.

Other Locations : We have a large network of providers and due to our shared EMR system, will have access to the majority of your health records if seen within our network. Please see full list on below.

PRIMARY CARE

MANATEE PHYSICIAN ALLIANCE

Primary Care - Manatee East
(941) 216-2878
1720 Manatee Avenue East
Bradenton, FL 34208

Primary Care - Manatee West
(941) 708-8081
5225 Manatee Avenue West
Bradenton, FL 34209

Primary Care - North River
(941) 722-7785
606 4th Avenue West
Palmetto, FL 34221

LAKEWOOD RANCH MEDICAL GROUP

Primary Care - Centerpoint
(941) 782-9456
6600 University Parkway, Suite 201
Lakewood Ranch, FL 34240

Primary Care - Lorraine Road
(941) 909-7755
14616 State Road 70 East
Lakewood Ranch, FL 34202

Primary Care - Rye Road
(941) 216-3939
1854 Rye Road East
Bradenton, FL 34212

SPECIALTY CARE

MANATEE PHYSICIAN ALLIANCE

General Surgery
(941) 254-4957
232 Manatee Avenue East
Bradenton, FL 34208

Orthopedic Surgery & Sports Medicine
(941) 900-4600
714 Manatee Ave East
Bradenton, FL 34208

Surgical Oncology & General Surgery
(941) 212-2010
714 Manatee Ave East
Bradenton, FL 34208

Weight Loss Center
(941) 896-9507
232 Manatee Avenue East
Bradenton, FL 34208

Women's Oncology
(941) 746-7507
3425 University Parkway, Suite 102,
Sarasota, FL 34243

LAKEWOOD RANCH MEDICAL GROUP

Obstetrics & Gynecology
(941) 348-1144
6310 Health Parkway, Suite 200
Lakewood Ranch, FL 34202

General Surgery
(941) 254-6767
8340 Lakewood Ranch Blvd., Suite 290
Lakewood Ranch, FL 34202

BRADENTON CARDIOLOGY CENTER

Cardiology - Bradenton
316 Manatee Avenue West
Bradenton, FL 34205

Cardiology - Lakewood Ranch
8340 Lakewood Ranch Blvd., Suite 210
Lakewood Ranch, FL 34202
(941) 748-2277

URGENT CARE

MANATEE URGENT CARE

Urgent Care Center
(941) 745-5999
4647 Manatee Avenue West
Bradenton, FL 34209
Mon - Sat 8 am - 7 pm
Sunday 8 am - 5 pm

Lakewood Ranch Medical Group

Welcome to our practice! Please take a few moments to complete this patient questionnaire and bring it with you to your appointment. Completion of this form will help us facilitate your visit. If you have any questions, please do not hesitate to ask a nurse or physician. We are pleased you have chosen Lakewood Ranch Medical Group for your healthcare.

Patient Name		Today's Date	
Date of Birth		Referred By	
Primary Care MD		Preferred Pharmacy	
What is the reason for your visit	☐Routine annual GYN exam ☐Pregnancy/Obstetrics ☐GYN problem ☐Other	Please describe your health problem	

Medications: **Please include all prescriptions, nonprescription medications, herbs, and supplements**

Drug	Dose	Prescribing Dr.

Allergies:

Medication	Reaction
Do you have a latex allergy?	☐YES ☐NO

Immunizations: ☐ Up to Date Please indicate the date of your last immunization

Tetanus-Diptheria		Influenza		Pneumococcal		HPV/Gardasil	
MMR		Hepatitis B		Varicella		COVID-19	

Personal Medical History **Please mark any conditions that you have or have had in the past**

☐Diabetes ☐High Blood Pressure ☐Heart Disease/Attack ☐Thyroid Disease
☐Asthma ☐ Pneumonia ☐ Bronchitis ☐Stroke/TIA
☐Eating disorder ☐Blood clots (lungs/legs) ☐Cancer, Type: _____ ☐Reflux/Heartburn
☐Anemia ☐Depression ☐Anxiety ☐Seizures
☐Arthritis ☐Back Problems ☐Liver disease/hepatitis ☐Glaucoma or cataracts
☐Kidney Stones ☐Kidney/Bladder infections ☐Tuberculosis ☐HIV/AIDS
☐Infertility ☐Lupus ☐Chickenpox ☐Broken bones
☐Pancreatitis ☐Gallbladder disease ☐Headaches/migraines ☐Bleeding disorder
☐Bowel Problems, type _____ ☐Other disease, _____

Gynecological History:

Last normal menstrual period began		Age of first period	
Age at menopause		How many days between cycles?	
How long are your periods? (days)		Is your period heavy?	☐YES ☐NO
Do you have cramps	☐YES ☐NO	Have you ever had sex?	☐YES ☐NO
Are you sexually active?	☐YES ☐NO	How many lifetime sexual partners?	
Sexual Partners are	☐MEN ☐WOMEN ☐BOTH	Age at first pregnancy?	
Have you ever had a sexually transmitted infection? Please circle the type of infection(s) you have had.	☐YES ☐NO	Gonorrhea Chlamydia Trichomonas Herpes Genital Warts Syphilis Pelvic Inflammatory HPV	
Are you using contraception	☐YES ☐NO	What type of contraception?	

PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (check)	Date of Birth	Marital Status (check)	Primary Care Physician
☐ M ☐ F		☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other: _____	

Preferred Language (check)	Race (check)	Ethnicity (check)
☐ English ☐ Spanish _____	☐ Asian ☐ Black ☐ White ☐ Other: _____	☐ Hispanic ☐ Not Hispanic ☐ Unknown

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: ☐ Patient

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Responsible Party?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact

Check if same as: ☐ Responsible Party

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: ☐ Responsible Party ☐ Emergency Contact

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Guardian?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: ☐ **Self Pay**

Check if same as: ☐ Responsible Party			Check if same as: ☐ Responsible Party		
Subscriber / Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber?		Gender (check) ☐ M ☐ F	What is Patient's Relationship to Subscriber?		Gender (check) ☐ M ☐ F
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zipcode	Insurance Mailing Address	City / State	Zipcode
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature Date

Patient/Legal Guardian Print

Date of last Pap smear		☐Normal ☐Abnormal	
Date of last Mammogram		☐Normal ☐Abnormal	
Date of last Bone Density Testing		☐Normal ☐Abnormal	
Date of last Colonoscopy		☐Normal ☐Abnormal	
Any history of domestic violence, sexual abuse, or assault (rape)	☐YES ☐NO	Do you perform self-breast exams monthly?	☐YES ☐NO
Have you ever had an abnormal Pap smear?	☐YES ☐NO	Have you ever had a Colposcopy or cervical procedure?	☐YES ☐NO

Obstetrical History:

DOB	Type of Delivery(Vaginal, C-Sections, Vacuum, Miscarriage, Abortion)	Weeks Pregnant	Sex	Weight	Epidural (Yes/No)	Complications: Diabetes, High Blood Pressure, Preeclampsia, Depression, or other issues

Family History: Please check any conditions of your blood relatives

☐Diabetes ☐ Stroke ☐High Blood Pressure ☐Heart Disease/Attack ☐High Cholesterol
☐Hepatitis ☐HIV/AIDS ☐Osteoporosis ☐Tuberculosis ☐Birth Defects
☐Alcohol/drug problems ☐Depression ☐ Ovarian Cancer ☐Breast Cancer
☐Colon Cancer ☐Blood clots in lungs/legs ☐Mental Illness
☐Alzheimer's ☐ Other _____

Please specify relationship(s): _____

Mother ☐living ☐deceased Age____ Father ☐ living ☐deceased Age ____

Social History:

Tobacco use	☐Current ☐Past # of packs/day _____ ☐NO	Current Occupation	
Education	☐High School ☐College ☐Other	Marital Status	☐Married ☐Single ☐Divorced ☐Widowed ☐Living with partner
Do you exercise? Type and Frequency	☐YES ☐NO	Alcohol use	☐Current ☐Past ☐ NO # drinks/wk:___ type: ____
Street drug use	☐Current ☐NO ☐Past	Do you wear your seat belt?	☐YES ☐NO
Are you an organ donor? Do you have a living will?	☐YES ☐NO ☐YES ☐ NO	Do you live alone?	☐YES ☐NO
Are you currently employed?	☐YES ☐NO	Is a blood transfusion acceptable in an emergency?	☐YES ☐NO
Have you recently traveled outside the U.S.?	☐YES ☐NO Where?		

Past Surgical History

Date of Surgery	Type of Surgery	Hospital/Doctor

Patient Signature _____ Date: _____

Lakewood Ranch Medical Group
A Division of Manatee Physician Alliance

NOTICE of PRIVACY PRACTICES

A copy of ***Manatee Physician Alliance, LLC*** HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Manatee Physician Alliance, LLC*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: _____ **Relationship** _____

Name: _____ **Relationship**_____

I authorize ***Manatee Physician Alliance, LLC*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ☐ Yes ☐ No

Emergency Contact: _____ **Phone number**_____ **Relationship:** _____

Email Address: _____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Manatee Physician Alliance, LLC strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Manatee Physician Alliance, LLC*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Manatee Physician Alliance, LLC*** of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***Manatee Physician Alliance, LLC*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Manatee Physician Alliance, LLC*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Manatee Physician Alliance, LLC***. Any photographs or other images taken will become part of my medical record. ***Manatee Physician Alliance, LLC*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Manatee Physician Alliance, LLC*** will provide me with information and forms prior to such procedures. I grant ***Manatee Physician Alliance, LLC*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***Manatee Physician Alliance, LLC*** to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***Manatee Physician Alliance, LLC***.

_____ _____

Patient's Name (Please Print) Signature Date

_____ _____

Patient Representative (If patient is unable to sign) Signature Date

Lakewood Ranch Medical Group

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____

I am requesting disclosure of my protected health information for the following purpose:

- ☐ Continuing Care
- ☐ Disability Determination
- ☐ Legal Investigation
- ☐ Other: _____

I **authorize the release of the following:**

- ☐ Provider office note
- ☐ Lab results
- ☐ Diagnostic Reports
- ☐ Other: _____

Items below will not be included unless checked:

- ☐ Psychological Evaluation
- ☐ Alcohol and Drug Abuse Treatment Records
- ☐ HIV Test Results and AIDS Treatment Records

Obtain my health information from:

☐ _____ (____) _____ _____
Facility/Provider's Name Telephone or Fax Number Address City State Zip Code

Release my health information to:

☐ _____ (____) _____ _____
Facility/Provider's Name Telephone or Fax Number Address City State Zip Code

This authorization will expire on ____/___/20____. (If not indicated, authorization will expire one year from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

_____ _____ _____
Patient's signature (required for ages 12 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature Date Signed

This authorization is intended to allow The Pavilion to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. ***FACILITY*** is not liable for such re-disclosures.