Manatee
Physician Alliance

Dear Valued Patient,

Thank you for choosing 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 one of our 3 Urgent Care Walk-In Clinics, see reverse side for locations 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

Doctors of Manatee
1720 Manatee Avenue East
Bradenton, FL 34208
941-216-2878

Lakewood Ranch Medical Group
8340 Lakewood Ranch Blvd., Suite 210
Bradenton, FL 34202
941-782-2800

Lakewood Ranch Primary Care – Rye Road
1854 Rye Road East
Bradenton, FL 34212
941-216-3939

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

North River Family Health Center
606 4th Avenue West
Palmetto, FL 34221
941-722-7785

Specialist

Bradenton Cardiology Center
316 Manatee Avenue West
Bradenton, FL 34205
941-748-2277
8340 Lakewood Ranch Blvd., Suite 290
Bradenton, FL 34202
941-556-8930

Bradenton Neurology
200 3rd Avenue West, Suite 110
Bradenton, FL 34205
941-746-3115

Manatee Surgical Alliance
232 Manatee Avenue East
Bradenton, FL 34208
941-254-4957

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

Manatee Urgent Care

4647 Manatee Avenue
West Bradenton, FL 34209
941-745-5999
M – Sat; 8am – 7pm
Sunday; 8am – 5pm

9908 State Road 64 East
Bradenton, FL 34212
941-747-8600
M – Sat; 8am – 7pm
Sunday; 8am – 5pm

6272 Lake Osprey Drive
Sarasota, FL 34240
941-907-2800
M – F; 8am – 7pm
Sat – Sun; 8am – 5pm

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

Manatee Physician Alliance

Name: _____ DOB: _____

Reason for visit: _____

Preferred Pharmacy (Name/Location): _____

DO YOU HAVE ANY ALLERGIES: _____

List of Medications **CURRENTLY** taking (prescribed, over the counter and vitamins):

Name: _____ Strength: _____ How Often: _____

Name: _____ Strength: _____ How Often: _____

Name: _____ Strength: _____ How Often: _____

Name: _____ Strength: _____ How Often: _____

Name: _____ Strength: _____ How Often: _____

If you have additional medications please list on back of form.

Medical History (mark ALL that apply):

- ☐ ADD
- ☐ ADHD
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bladder Cancer
- ☐ Bowel Problems
- ☐ Breast Cancer
- ☐ Breathing Difficulties
- ☐ Cancer (type): _____
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Problems
- ☐ Lung Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pancreatic Cancer
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polymyalgia
- ☐ Prostate Cancer
- ☐ Psoriasis
- ☐ Psychiatric Problems
- ☐ Pulmonary Embolism
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Sjogren Syndrome
- ☐ Stroke / CVA
- ☐ Other: _____

_____

_____

Surgical / Procedures (mark ALL that apply):

- ☐ ACL Surgery / Reconstruction
- ☐ Adenoids removed
- ☐ Appendix removal
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Cardiac Bypass Surgery
- ☐ Cardiac Catheterization
- ☐ Cataract Surgery
- ☐ Colon resection
- ☐ Colostomy / Reversal
- ☐ C-Section
- ☐ D&C (Dilation & Curettage)
- ☐ Defibrillator Implant

Name: _____ DOB: _____

- ☐ Gallbladder removal
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Splenectomy
- ☐ Tonsils removed
- ☐ Total Joint replacement
- ☐ Lumpectomy
- ☐ Lymph node biopsy
- ☐ Mastectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Pacemaker
- ☐ PTCA (Angioplasty)
- ☐ Shoulder Surgery
- ☐ Other not listed: _____

Women's Health:

	Date	Results	
Last menstrual period	_____	☐ Normal	☐ Abnormal
Pap / Pelvic Exam	_____	☐ Normal	☐ Abnormal
Last Mammogram	_____	☐ Normal	☐ Abnormal
Bone Density	_____	☐ Normal	☐ Abnormal

Number of Pregnancies: _____ Deliveries: _____ Miscarriages: _____ Abortions: _____

Health Maintenance:

	Date	Results	
Physical Exam/Wellness Visit	_____	☐ Normal	☐ Abnormal
Cholesterol	_____	☐ Normal	☐ Abnormal
Colonoscopy	_____	☐ Normal	☐ Abnormal
EGD	_____	☐ Normal	☐ Abnormal
Prostate / PSA	_____	☐ Normal	☐ Abnormal
Stress Test / Nuclear Stress Test	_____	☐ Normal	☐ Abnormal

Immunizations:

	Month / Year		
Hepatitis A	#1 _____	#2 _____	
Hepatitis B	#1 _____	#2 _____	#3 _____
Gardasil (HPV)	#1 _____	#2 _____	#3 _____
Influenza	_____	Pneumonia	_____
Tetanus	_____	Zostavax (Shingles)	_____
TB Skin Test	_____	Chicken Pox	_____

Social History:

Smoker: ☐ Never ☐ Formerly ☐ Currently

If YES, mark ALL that apply: ☐ Cigarettes ☐ Cigars ☐ Chewing/Dipping Tobacco ☐ Electronic Cigarettes

How much per day: _____ How many years: _____ Quit Date: _____

Name: _____ DOB: _____

Alcohol use: ☐ Never ☐ Daily ☐ Social Estimated daily consumption: _____

Are you sexually active? ☐ Yes ☐ No
Are you using a form of birth control? ☐ Yes ☐ No If yes, type: _____

Have you ever had a STD? ☐ Yes ☐ No If yes, type: _____

Street drug use: ☐ Never ☐ Previous ☐ Currently Type of Drug(s): _____
Do you feel safe at home? ☐ Yes ☐ No

Living Will / POA: Do you have a living will? ☐ Yes ☐ No
Do you have Durable Power of Attorney for healthcare? ☐ Yes ☐ No

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Family History: ☐ Adopted ☐ Unknown

Mother Living: ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

Father Living: ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

(Please list any serious medical history that runs in your family)

Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent

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Provider List: (Physician/Practice Name)

Cardiologist _____

Gastroenterologist _____

General Surgeon _____

Neurologist _____

OBGYN _____

Primary Care _____

Urologist _____

Other _____

Hospital Admission(s) / ER Visit(s):	Year	Diagnosis

Manatee Physician Alliance

NOTICE of PRIVACY PRACTICES

A copy of ***Facility's*** 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 ***Facility*** 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 ***Facility*** 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

Facility 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. ***Facility*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Facility*** 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 ***facility*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Facility*** 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 ***Facility***. Any photographs or other images taken will become part of my medical record. ***Facility*** 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 ***Facility*** will provide me with information and forms prior to such procedures. . I grant ***Facility*** 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 ***facility*** to search for 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 ***facility***.

_____ _____

Patient's Name (Please Print) Signature

_____ _____

Patient Representative (If patient is unable to sign) Signature