CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD Iveth Mastrapa, ARNP Edgar Peralta-Lee, ARNP
Yedy Hernandez, ARNP Jannette Troche, AG-ACNP-BC

Date: _____

Dear New Patient:

On behalf of Dr. Pedro Ortega, we would like to welcome you to our practice. Thank you for choosing us to provide all of your Primary Care needs. For your convenience, our offices are open **Monday-Thursday 7:30 a.m. to 6:00 p.m. We are closed on Fridays.**

As part of the preventative health care that we practice, all new members are given a physical examination. After this initial visit, we will be seeing you on a regular basis, the frequency of which you will be seen will depend on your individual needs.

Included with this letter are our office policies regarding hospitalizations, referrals, authorizations, prescription refills, etc. Please familiarize yourself with these policies and bring a signed copy with you at your first visit or we will have a copy for you to sign at that time.

We look forward to providing you with quality medical services in the most courteous and efficient manner possible.

If you have any questions, please do not hesitate to call us.

Sincerely,

Central Florida Primary Care

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD Iveth Mastrapa, ARNP Edgar Peralta-Lee, ARNP
Yedy Hernandez, ARNP Jannette Troche, AG-ACNP-BC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY - We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. This notice takes effect as of April 21, 2015 and will be in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at Central Florida Primary Care, 3727 N. Goldenrod Rd., Suite 106 Winter Park, FL 32792, Phone: (407) 478-0028 Fax: (321) 203-4720.

USES AND DISCLOSURES OF MEDICAL INFORMATION - We use and disclose medical information about you for treatment, payment, and health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, CMS, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Copies of your medical information may be delivered to any other physician who is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you to provide appointment reminders, and to attempt to call you to notify you that lab test results are available. We may use your name and your location in our facilities directories.

We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues.

INDIVIDUAL RIGHTS - This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You may have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We will charge a cost-based fee for copying of records and for postage.

QUESTIONS AND COMPLAINTS - You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

X _____

Signature of Patient or Legal Guardian Date

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD Iveth Mastrapa, ARNP Edgar Peralta-Lee, ARNP
Yedy Hernandez, ARNP Jannette Troche, AG-ACNP-BC

CONSENT TO USE OR DISCLOSE HEALTHCARE INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting one of our offices. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health operations as described in our Notice. These disclosures may be by phone, mail, fax or electronic transmission. **Unless you indicate otherwise in writing, if you allow a third party other than one of the practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party.** You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Central Florida Primary Care may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information ("PHI") to the following individuals:

Name:	**Relation:**
Name:	**Relation:**
Name:	**Relation:**
Name:	**Relation:**
Name:	**Relation:**

I have read and understand the information in this acknowledgement. I am the patient or I am authorized to act on behalf of the patient to sign this document. By signing below, I will acknowledge and agree to the above conditions.

X _____

Signature of Patient or Legal Guardian Date

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD Iveth Mastrapa, ARNP Edgar Peralta-Lee, ARNP
Yedy Hernandez, ARNP Jannette Troche, AG-ACNP-BC

FINANCIAL POLICY

INSURANCE: We accept most insurances, Commercial and Medicare. We are not contracted with worker compensation carriers. Please call your insurance company to assure if your office visit will be covered. *Patients are responsible for copays, co-insurance, and/or deductibles at time of visit.*

LAB SERVICES: We do have the ability to collect blood work in our in-house lab ***for a convenience fee of $20*** *for patients with insurance. Pricing for Self-Pay patients is dependent on the blood work needed*. We also send our patients out to the laboratories that their insurance companies are contracted with. Insurance companies change their contracts with laboratories all the time, so each patient needs to know which laboratories their insurance allows them to go to. This will help us send them to the correct laboratory. We work very diligently to make sure you are sent to the correct lab. If for any reason a lab bill is denied for payment, it is not the doctor's or the practice's responsibility to pay this bill. **All lab bills are the patient's responsibility.** If you choose to go to another lab, which is not paid by your insurance you will be responsible for the balance.

PATIENT'S RESPONSIBILITY: *Our policy states that as a courtesy to our patient, we submit their claims to their insurance companies as a way of helping them ensure the payments are sent for the services that we rendered.* We are not responsible for claims that are not filed in a timely manner for reasons such as wrong insurance information given, wrong ID numbers or claims that are sent to the wrong insurance address. **Ultimately, it is the patient's responsibility for payment of services that are rendered**. *The patient is responsible to pay the balances left from deductibles, co-insurance or any balance due to a change in co-pay amounts within 30 days after the insurance pays your claim.*

PAYMENTS: ***ANY*** *and* ***ALL*** co-payments, deductibles and co-insurances which are determined by the patient's insurance company, ***are required to be paid at the time services are rendered***. For self-pay patients we require payment in full for all services. Exceptions may be made in order to assist a patient due to financial hardship. We are dedicated to helping patients obtain the healthcare they need.

FORMS OF PAYMENT: We accept cash, HSA, FSA and credit card (Visa, MasterCard, Discover or American Express). ***There is a 4% convenience charge for all credit card payments.***

FORMS: Our Medical Providers will be happy to complete FMLA and other needed paperwork for our patients. Please be advised that the patient is required to request FMLA forms from their employer and must submit the documents to our office with enough time for completion. Forms will not be filled out immediately, they **can take up to 3-5 business days** to give the providers' ample time to review the patient's record and fill them out accordingly.

Please be advised that there is a **minimum $35 fee** charged for FMLA and other forms. Payment is required prior to completion of the form. Fees are nonrefundable.

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD Iveth Mastrapa, ARNP Edgar Peralta-Lee, ARNP
Yedy Hernandez, ARNP Jannette Troche, AG-ACNP-BC

FINANCIAL POLICY (page 2)

NO SHOW POLICY: Patients' sign this agreement at the time a patient becomes part of the practice, so they understand how important it is for us to help all patients obtain an appointment. ***There is a $45 no show fee that will be assessed to the patient's account automatically if the patient does not show up or call within 24 hours to cancel the appointment.***

COLLECTION PROCESS: We work diligently to resolve all claims with the patient's insurance companies. We send patient statements/bills every month to each patient with a balance. This is done each month along with a collection letter attached to the second and third request. At the end of 60 days, we call each patient to remind them that a balance for services rendered has not been paid as of today and it is past due. We try to obtain payment for these accounts. If payment is not received in the allotted time, we then transfer this patient's account to our in-house collections and the account is placed in a frozen status. When all efforts have been exhausted, we then dismiss the patient from the practice after giving them one last chance to pay their balance. Although we will be able to provide emergency services to you on a cash only basis for the next 30 days, you must arrange to have medical services elsewhere. A 35% handling fee will be added to all patient balances when they are transferred to an outside collection agency and will become the patient's responsibility to pay. At which time the patient will be dismissed from our practice.

REFUND POLICY: All refunds to the insurance companies and patients are done at the end of each month if there are no pending claims. ***We do not refund any payments made by a self-pay patient that is in the process of obtaining insurance.*** The patient has the option to reschedule their appointment and wait for their insurance to be active.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and /or payment for services provided to me, I assume financial responsibility and will pay all such charges in full prior to my next office visit. Failure to pay any balances will result in a canceled/rescheduled appointment.

_____ _____

Signature of Patient /Responsible Party Name of Patient/Responsible Party (please print)

Date: _____ Relationship to Patient: _____

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD Iveth Mastrapa, ARNP Edgar Peralta-Lee, ARNP
Yedy Hernandez, ARNP Jannette Troche, AG-ACNP-BC

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SSN: _____-_____-_____

I, _____ hereby authorize Central Florida Primary Care to:

□ Release records to: □ Obtain records from:

Name of Facility/Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

For the purpose of:

□ Continuity of treatment □ Personal records □ Transfer in/out □ Other: _____

Items to be released or obtained: (Please mark all that apply)

□ Complete Records □ Diagnostic test results □ Lab results

□ Pathology/Cytology results □ Radiology reports □ Consult/Progress notes

□ ER/Hospital notes □ Clinical/Discharge reports □ Office notes

□ Other (specify): _____

I understand that this content is revocable upon written notice to the facility, except to the extent that actions by the facility have been taken in reliance on this authorization, and that this consent shall remain in force for a period of 365 days from the date it was signed, in order to effect the purpose for which it is given.

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part II) prohibits making further disclosure of any protected health information without the specific written consent of the undersigned or as otherwise permitted by such regulations.

I hereby authorize Central Florida Primary Care to: obtain/release the information specified above to the organization or individual named on this request. I understand that such may include information regarding the following conditions: Drug Abuse or Alcoholism, HIV/AIDS and Sexually Transmitted Disease Testing, Sickle Cell Anemia, and/or Psychiatric, Psychological or Psychotherapeutic notes.

X_____ _____

Signature of Patient or Legal Guardian Date

Please send requested records to:

3727 North Goldenrod Road, Suite 106, Winter Park, FL 32792 Phone: (407) 478-0028 Fax: (321) 203-4720

6150 MetroWest Boulevard, Suite 205, Orlando, FL 32835 Phone: (407) 781-0088 Fax: (407) 781-0087

12554 South John Young Parkway, Suite 105, Orlando, FL 32837 Phone: (407) 559-3800 Fax: (407) 559-3801