



2140 Kingsley Ave, Suite 1, Orange Park, FL 32073

Ph: 904-368-6809 | Fax: 904-368-6809

Patient Name: _____

DOB _____

New Patient Packet

Date: _____

Personal Information

Full Name: _____ DOB: ____ / ____ / ____ Age: _____

Sex: Male Female SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Preferred Phone: Home Cell

Email: _____

Preferred Language: _____

Communication Preference: Call Email

Marital Status: _____

Race: _____ Ethnicity: _____ Religion: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Address: _____

Next of Kin (if different)

Name: _____ Relationship: _____

Phone: _____



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Insurance Information

Primary Insurance

Insurance Name: _____ Plan Name: _____

Subscriber ID: _____ Group #: _____

Primary Insured Name: _____ DOB: _____

Relationship to Insured: _____ SSN: _____

Phone: _____ Driver's License: _____

Secondary Insurance

Insurance Name: _____ Plan Name: _____

Subscriber ID: _____ Group #: _____

Secondary Insured Name: _____ DOB: _____

Relationship: _____ SSN: _____

Phone: _____

Pharmacy

Preferred Pharmacy: _____

Location & Phone: _____

Employment

Employment Status: _____ Job Title: _____

Employer: _____

Work Phone: _____



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HEALTH HISTORY

Previous Providers

Previous Primary Care Provider

Name: _____

Clinic: _____

Phone: _____

Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Specialists (last 2-3 years)

1. Name: _____

Specialty: _____

Phone: _____ Fax: _____

2. Name: _____

Specialty: _____

Phone: _____ Fax: _____

3. Name: _____

Specialty: _____

Phone: _____ Fax: _____

Previous Medical Facilities

1. Facility: _____

Type: _____

Phone: _____ Fax: _____

2. Facility: _____

Type: _____

Phone : _____ Fax: _____



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Patient Acknowledgment of Accuracy

I understand that the information I provide in this form is important for my medical care. I certify that the information I provide is complete and accurate to the best of my knowledge.

Current Medical Conditions

Please check any conditions you have been diagnosed with:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart-disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Kidney-disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma / COPD | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Cancer (type):
_____ |
| <input type="checkbox"/> Other: _____ | | |

Past Surgeries or Hospitalizations

Please list surgeries or hospitalizations with approximate year if known:

Medications

Please list all medications you currently take, including prescriptions, over-the-counter medications, vitamins, and supplements:



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Allergies

Do you have any allergies to medications, foods, or environmental factors?

No Yes → Please list:

Reaction(s):

Family Medical History

Please indicate if any immediate family member has had the following conditions:

Diabetes

High blood pressure

heart disease

Stroke

Cancer

Other: _____

Detailed Family History

List medical conditions and/or cause of death if applicable:

Mother: _____

Father: _____

Siblings: _____

Spouse: _____

Children: _____

Additional: _____

Comments:



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Lifestyle

Do you currently smoke?

No

Yes → How much? _____

Do you drink alcohol?

No / No

Yes → How often? _____

Do you use recreational drugs?

No

Yes → Please list: _____

Do you exercise regularly?

No

Yes → Type, frequency, intensity _____



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Review of Systems

System 1: General Health

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness / Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Fever / Chills	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>

System 2: Skin, Hair, & Nails

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Abnormal Pigmentation	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	Brittle Nails	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hair/Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>			



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System 3: Respiratory

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Any Lung Troubles	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic / Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy / Pneumonitis	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	URI (Cold) Now	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

System 4: Cardiovascular

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Awakening in night smothering	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking 2 blocks	<input type="checkbox"/>	<input type="checkbox"/>	Edema / Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Pain in legs	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins / Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>



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System 5: Gastrointestinal

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Appetite Changes	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding with Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Vomit	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease / Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Cramping / Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gas / Bloating	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn / Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids / Piles	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Painful Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Recent change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

System 6: Genitourinary

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Bright's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Burning or Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in force/flow	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Night time Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>



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System 7: Eyes, Ears, Nose, Throat, & Mouth (EENT)

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Blurring	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain / Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Itchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Ears ringing	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Itchy Nose	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Postnasal drip	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing / Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Gum Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

System 8: Hematologic & Endocrine

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Become colder than before	<input type="checkbox"/>	<input type="checkbox"/>	Changes in Hair Growth	<input type="checkbox"/>	<input type="checkbox"/>	Changes in hat	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Sweating / Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Fever / Chills	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Heat / Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Lymph Node Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding after tooth extraction	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Slow to heal	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Weakness / Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
None:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>



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System 9: Neurological

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Gait / Coordination /	<input type="checkbox"/>	<input type="checkbox"/>	Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Tremor / Hand shaking	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>			

System 10: Mental Health

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Depression / anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Panic when stressed	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cry frequently	<input type="checkbox"/>	<input type="checkbox"/>	Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
Seriously thought about hurting self	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Bi-Polar disorder	<input type="checkbox"/>	<input type="checkbox"/>						

System 11: Men Only

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Night urination	<input type="checkbox"/>	<input type="checkbox"/>	Loss of libido	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder/Prostate infection (last 12 mo)	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with erection / ejaculation	<input type="checkbox"/>	<input type="checkbox"/>			



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System 12: Women Only Gynecologic History

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Heavy periods / Irregular / Spotting / Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant / Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes / Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual tension / Bloating / Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>	Pain / Bleeding with sex	<input type="checkbox"/>	<input type="checkbox"/>
Field	Response	Field	Response					
Age at onset of menstruation	_____	Date of last menstruation	_____					
Number of pregnancies	_____	Length of cycle	_____					
Number of live births	_____	Days of flow	_____					
Number of miscarriages	_____	Birth control method	_____					
Number of abortions	_____	Date of last PAP	_____					
Date of last Mammogram	_____							

Additional Comments

Is there anything else your care team should know?

Signature of patient or responsible party: _____

Date: _____



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MEDICAL RECORDS RELEASE FORM

Patient Information

Name: _____

DOB: _____

Phone: _____

Address: _____

Records Release (Office Use Only)

Do NOT complete provider section

Please do NOT complete the "Provider/Facility" section below. This section will be completed by our office to allow this authorization to be used for multiple providers and to ensure accurate processing of your request.

FROM Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

TO: Harbor Physicians, 2140 Kingsley Ave Suite 1, Orange Park, FL 32073 Phone: 904-368-6809

Fax: 904-368-6809

Records to be Released:

All Dates _____ to _____ Specific _____

Purpose:

Continuity Personal Legal Health Insurance Other _____

Authorization expires 12 months from signature unless otherwise noted.

Signature: _____ **Date:** _____

Representative (if applicable): _____

Relationship: _____



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HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Authorized Person(s)

I authorize Harbor Physicians to communicate with and release my protected health information (PHI) to the individual(s) listed below (if any).

I do NOT authorize Harbor Physicians to release my PHI to any individual. I understand that I am choosing not to designate any authorized person.

Name: _____

Relationship: _____

Phone Number: _____

(Additional names may be listed if applicable)

Information Authorized for Release

This authorization includes, but is not limited to: appointments, billing/insurance information, medical records, lab/test results, and other related healthcare information.

Expiration

This authorization expires one (1) year from the date signed, unless otherwise specified below.

Other expiration date: ____ / ____ / ____

Signature

Patient or Representative Signature: _____

Printed Name: _____

Relationship: _____

Date: ____ / ____ / ____



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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Protected Health Information (PHI) includes your name, address, phone number, medical history, treatment information, and billing details.

Your Rights

- You have the right to inspect and copy your medical and billing records within 30 days of a written request.
- You may request corrections if information is incomplete or incorrect.
- You may request confidential communication.
- You may request restrictions on use or disclosure.
- You may request a list of disclosures.
- You have the right to a paper copy of this notice.
- You may file a complaint if your rights are violated.
- Use and Disclosure
- We may use your information for treatment, payment, and healthcare operations.
- We may disclose information as required by law.

Patient or Representative Signature: _____

Printed Name: _____

Relationship: _____

Date: ____ / ____ / ____



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FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

1. Insurance and Appointment Requirements

I understand that it is my responsibility to provide valid insurance information, referral authorization (if required), and applicable copayment at the time of service. Failure to provide required documentation or payment may result in rescheduling or cancellation of my appointment.

2. Copayments and Time-of-Service Payment

I agree to pay all copayments, coinsurance, and any patient-responsible balances at the time of my visit unless prior arrangements have been made.

3. Returned Payments and Administrative Fees

A fee of \$25.00 will be charged for any returned or declined payment, including returned checks or failed electronic payments, as permitted by applicable law.

4. Missed Appointments / No-Shows

I understand that missed appointments or late cancellations may result in a no-show fee, and repeated missed appointments may affect my ability to continue care with this practice.

5. Insurance Billing and Patient Responsibility

I authorize this practice to bill my insurance carrier directly. I understand that insurance coverage is a contract between me and my insurance company, and I am financially responsible for all charges not covered by insurance, including deductibles, copayments, coinsurance, and non-covered services.

6. Delinquent Accounts and Collections

Accounts not paid in a timely manner may be referred to a third-party collection agency. I agree to be responsible for all costs of collection, including reasonable collection fees, attorney fees, and court costs, if applicable.

7. Assignment of Benefits

I authorize payment of medical benefits directly to Harbor Physicians for services rendered. This authorization remains valid until revoked in writing.

8. Eligibility Certification

I certify that I am eligible for insurance benefits at the time services are rendered. If this certification is incorrect, I understand that I am financially responsible for all charges incurred.

9. Payment Agreement

I agree to pay any outstanding balances within 30 days unless other arrangements have been approved in writing by the practice.

Patient Signature: _____ **Date:** _____

Staff Witness: _____

Date: _____



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PATIENT CONDUCT & DISCHARGE ACKNOWLEDGMENT

Patient Name: _____

Date of Birth: _____

1. Acknowledgment of Standards of Care

I understand that this medical practice is committed to providing safe, professional, and medically appropriate care in accordance with applicable clinical standards and policies. I acknowledge that respectful communication and cooperation are necessary for the delivery of effective medical care.

2. Required Patient Conduct

I agree to:

- Communicate respectfully with all providers, staff, and other patients.
- Follow agreed-upon treatment plans or actively discuss concerns before refusing care.
- Comply with clinic policies, instructions, and scheduled appointments.
- Refrain from behavior that disrupts clinic operations or the delivery of care.

3. Behavior That May Result in Discharge

I understand that the following behaviors are considered incompatible with ongoing care in this practice and may result in discharge from the practice, either immediately or after notice at the provider's discretion:

a. Noncompliance

Repeated refusal to follow medical advice, failure to adhere to treatment plans, or repeated missed appointments that compromise care continuity.

b. Disruptive or Inappropriate Behavior

Verbal abuse, harassment, intimidation, profanity, or disruptive behavior toward staff, providers, or other patients.

c. Threatening or Unsafe Behavior

Any threats of violence, aggressive conduct, or actions that create a perceived or actual risk to safety.

d. Interference with Care Delivery

Any action that interferes with clinical workflow, staff duties, or the safe and effective provision of medical services.

4. Termination of Care Relationship

I understand that the provider reserves the right to terminate the patient-provider relationship when clinically or administratively appropriate. This includes situations involving repeated noncompliance, disruptive behavior, safety concerns, or breakdown of trust necessary for care.

If terminated, I understand I may be provided with written notice and reasonable assistance or resources to transition care to another provider, consistent with applicable regulations and continuity of care standards.

5. Acknowledgment of Understanding

By signing below, I acknowledge that I have read, understood, and agree to comply with the terms outlined in this Patient Conduct and Discharge Policy.

Patient Signature: _____ **Date:** _____

Staff Witness: _____

Date: _____



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TELEHEALTH CONSENT FORM (Required for Telehealth Visits)

Patient Information

Name: _____ DOB: _____

Consent

I consent to receive healthcare via telehealth (video, audio, or secure electronic communication). I understand telehealth may be used for evaluation, diagnosis, treatment, and follow-up care, but does not replace all in-person visits. My provider may require an in-person visit if medically necessary.

Florida Compliance

I understand my provider is licensed in Florida and provides telehealth under Florida Statutes §456.47. Telehealth services meet the same standard of care as in-person services when clinically appropriate. Some services, prescriptions, or medications may be limited by Florida law or clinical judgment.

Risks

I understand risks include:

- Technical failure or interruption
- Limited physical examination
- Possible delays in care
- Rare privacy/security risk

Privacy

My information is protected under HIPAA and Florida law, but no electronic system is 100% secure.

Patient Rights

I may refuse or stop telehealth at any time and request in-person care when available.

Emergency Notice

Telehealth is not for emergencies. Call 911 or go to ER if needed.

Consent Statement

I understand and voluntarily agree to telehealth services.

Patient: _____ **Signature:** _____

Date: _____