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

MMH Internal Residency Clinic
250 2nd Street East, Suite 4G
Bradenton, FL 34208
941-708-8199

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 210
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

Financial Agreement

Financial Policy: Our group participates with most major insurance carriers. It is your responsibility to check with your insurance to find an in-network provider. ***It is imperative that the office has your correct insurance information on file at all times. It is ultimately your responsibility to know the benefits provided under your insurance plan.*** As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances greater than 90 days will be considered delinquent and placed in collection status. All costs associated with sending the patient to collections will be the responsibility of the Guarantor.

Payment: Payment will be required at the time the services are rendered. We will collect all outstanding balances within Manatee Physician Alliance, LLC and for services performed at the time of visit. 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.

Non-Covered Services: Your insurance company may diem some services as non-covered by your policy. It is your responsibility to know what services are non-covered by your plan. You will be fully responsible for these services per your insurance company. Your insurance plan may determine that some services are not medically necessary and you may be billed for those services. Please check with your insurance with additional questions.

Referrals: Your insurance may also require a referral for a service. We require no less than 2 business days to obtain referrals / authorizations from your primary care physician and / or your insurance company. Additional processing time may be required by your individual carrier.

Self-Pay Uninsured Policy: We will gladly offer a self-pay **UNINSURED** discount rate for services rendered. By accepting this discount rate, you are stating you have no insurance and agree to the cash price as **PAID IN FULL** and will not seek reimbursement from any outside entity.

Financial Agreement: The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and / or dependents. I hereby authorize my insurance company to pay and hereby assign benefits directly to Manatee Physician Alliance, LLC. I further acknowledge that any insurance benefits, when received and paid, will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility in accordance with any contractual agreements with my insurance and when governed by state / federal law. Full payment is due at the time of delivery of service unless other arrangements have been made or mandated by law. I understand that I have the primary duty and obligation to pay my doctor for his / her services, notwithstanding any contract I may have with any third party payor (i.e. insurance company, employer, etc.). I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement.

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship.	Date

HIPAA / Photograph Disclosure

HIPAA DISCLOSURE: By signing below, I understand that Manatee Physician Alliance shall not publish or otherwise make generally available any protected individually identifiable health information or data that identifies a patient for purposes other than treatment, payment or other health care operations without his/her express written consent. I understand that this does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for patients. I understand that this office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As a patient of Manatee Physician Alliance, I understand that I have the right to request special privacy protections. I have the right to request restrictions on certain uses and disclosure of my health information, by written request specifying what information I want to limit and what limitations on use or disclosure of that information I wish to have imposed. I hereby acknowledge that this medical practices' Notice of Privacy Practices has been made available to me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of this notice.

Photography / Videotape / Audiotape Release: I authorize Manatee Physician Alliance, LLC and / or its subsidiaries, partnerships, limited partners, general partners, parent companies or affiliates including but not limited to Universal Health Services, Inc. and UHS of Delaware, Inc. to photograph, videotape, audiotape or interview me, and I authorize Manatee Physician Alliance, LLC to publish and use such materials or any portion thereof in its sole discretion and in any manner it desires including but not limited to informing and educating the public as well as to commercially promote, advertise and / or market the services of the hospital. I hereby waive any right to compensation for Manatee Physician Alliance, LLC use such materials which may display my likeness, photographs, images, voice, statements and name and release Manatee Physician Alliance, LLC and its employees and agents from liability for any causes of action or claims of damages relating to Manatee Physicians Alliance, LLC use of such materials including but not limited to any claims of invasion of privacy, defamation, infringement of my right of publicity, copyright infringement. I understand and acknowledge that any photograph, videotape, audiotape or printed or published materials could be reproduced by unknown persons or organizations and republished via internet or other media without my knowledge or consent.

I recognize and understand that I may be providing and disclosing my protected health information of which I would have the right to full confidentiality and privacy. I authorize Manatee Physician Alliance, LLC to publicize and / or reproduce such protected health information as referenced above and release and waive any claims against Manatee Physician Alliance, LLC, its employees, agents, officers and directors from any causes of action or claims of damages relating to the disclosure of such information and the privacy requirements of Health Insurance Portability and Accountability Act (HIPAA) or any other law. As referenced below, I have the right to revoke this authorization, However, I acknowledge and agree that nay revocation of this authorization will not change any actions that Manatee Physician Alliance took before I did so and it will be able to used and disclose the information I provided prior to the revocation.

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship	Date

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

Medical Information Release and Message Authorization

Patient Name: _____

Do we have permission to;

- Send test results to your home? ☐ Yes ☐ No
- Send appointment card reminder to your home? ☐ Yes ☐ No

I authorize the providers and representatives of Manatee Physician Alliance, LLC to leave messages regarding (check ALL that apply);

Appointments:	☐ Home	☐ Cell	☐ Work
Test Results:	☐ Home	☐ Cell	☐ Work
Billing Information:	☐ Home	☐ Cell	☐ Work

I give permission to share **appointment** information with the person(s) listed below;

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission to share **medical** information with the person(s) listed below;

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission to share **billing** information with the person(s) listed below;

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient: _____ DOB: _____

Print Name: _____ Date: _____