Please do not complete these forms before scheduling an appointment.
If you would like to schedule an appointment, please call:

(844) TVH-WELL **(844) 884-9355**

Once this form has been completed, please return to ________________________ on or before ___________.
Please bring a photo I.D., insurance card and all prescription medications
in the original containers to your appointment.

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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.

Updated April 16, 2024

OUR COMMITMENT TO YOUR PRIVACY

At The Villages Health, we are committed to handling and using your protected health information ("health information") with care. This Notice of Privacy Practices ("Notice") describes what information we collect, and how and when we use or disclose that information. It also describes your rights related to your health information. This Notice applies to records containing your health information that are created or retained by us, and will be followed by all health care professionals, employees, medical staff, and other individuals providing services at The Villages Health. We reserve the right to change this Notice. Any revision to this Notice will apply to all health information we maintain about you in the past and in the future. We will not use or disclose your health information without your authorization, except as described in this Notice. The current version of this Notice in effect will be posted on our website and at our office. You may also contact the Privacy Officer for a copy.

Our Responsibilities

The Villages Health System is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice as currently in effect
- Notify you following a breach of your unsecured health information
- Follow the terms of this Notice that are in effect at the time

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you exercise those rights.

Right to Inspection and Copies

You have the right to get an electronic or paper copy of your medical record. This right does not include psychotherapy notes or health information that is not part of your designated record set. To obtain copies or request inspection of your medical information, you must submit your request in writing to the Privacy Officer, whose contact information is included at the end of this Notice. We may charge a reasonable fee that will be in compliance with applicable law. We may deny your request in limited circumstances. If your request is denied, you may request a review of our denial.

Right to Request an Amendment

You can ask us to correct the health information we maintain about you if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. Please provide us with a reason for your request and identify the records you would like amended. If we agree to your request, we will notify you and amend your information. In certain circumstances, we may deny your request. If your request is denied, we will inform you in writing and explain your rights. Please note that we cannot completely delete information contained in your medical record and the change requested by you will appear as an addendum to the existing record.

Right to an Accounting

You may request a list (an accounting) of the times we shared your medical information for six years prior to the date of your request, who we shared it with, and why. Please note the accounting will not include disclosures made for treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months. To request an accounting, submit your request in writing to the Privacy Officer.

Right to Request Restrictions

You can ask us not to use or share certain medical information for treatment, payment, or our operations. We are not required to agree to your request, and we may deny your request if it would affect your care. If we agree to your request, our agreement will be in writing, and we will comply with the restriction unless (i) the information is needed to provide you with emergency care or (ii) we are required or permitted by law to disclose it. If you pay in full for a service or health care item out-of-pocket, you can ask us not to share that information for the purpose of payment or operations with your health insurer. We will agree to this request unless a law requires us to share that information.

Right to Confidential Communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will agree to all reasonable requests. To request confidential communications, you must make a written request to our Privacy Officer specifying the requested method of contact for billing purposes, or the location where you wish to be contacted. You do not need to give a reason for your request.

Right to a Paper Copy of This Notice

You are entitled to receive a paper copy of this Notice at any time, even if you agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Right to a Personal Representative

If you have given someone the legal authority to exercise your rights and choices as described by this Notice, we will honor such requests once we verify their authority.

DISCLOSURES REQUIRING AUTHORIZATION

We will not disclose your health information without your authorization except as provided for in this Notice or provided by law. Additionally, we will require your written authorization for the following disclosures:

- Most disclosures of psychotherapy notes
- Use of PHI in marketing
- Sale of PHI

You have the right to revoke your authorization by submitting your revocation in writing to the department or clinic location where you signed your authorization, or to our Privacy Officer. However, your revocation will not apply to actions already taken based on your authorization or disclosures already made.

PERMISSIBLE USES & DISCLOSURES

We may use or share your health information in the following ways, without your prior authorization.

Treatment

We may use or disclose your health information for treatment, including management and coordination of your care.
For example, health information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. We may also use your health information to inform you of potential treatment alternatives, or use or disclose your health information to coordinate your health care treatment with other health care providers. For example, a doctor treating you for a certain condition may ask another doctor about your overall health condition, and your health information may be disclosed between these doctors for your treatment.

Payment

We may use or disclose your health information to bill and collect payment for services. For example, we may disclose your health information a to your health insurance plan so it will pay for your care. We may also share your health information with other health care providers to assist in their billing and collection efforts. We may use your health information to provide you with an estimate of charges that may apply to the services you receive at TVH and to communicate with you about whether or not TVH participates in your health plan as needed to help you understand what your payment obligations will be for the services we provide.

Health Care Operations

We may use and disclose your health information for healthcare operations. For example, members of the medical staff, the risk or quality improvement risk manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide. In some circumstances, we may also share health information with other health care providers for their health care operations, subject to any requirements under state and federal laws.

Compliance with Law

We will share your health information if state or federal laws require it, including with the Department of Health and Human Services for the purpose of confirming our compliance with federal privacy laws.

Business Associates

There are some services provided to our organization through contracts with vendors (or “Business Associates”). Examples include an Electronic Medical Record (EMR) system, billing company, or legal services. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we’ve asked them to do. To protect your health information, we require each the Business Associate to agree in writing to safeguard your health information.

Family & Friends

We may disclose your health information to individuals who you have chosen to involve in your medical care unless you object to such a disclosure. If you are not able or available to tell us your preference for disclosing your health information with others involved in your care, we may go ahead and share the information in emergencies or if we believe in our professional judgment that it is in your best interest. For example, we may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care. If your health information is used for such notification, it would be limited to your name, general condition, and location. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Disaster Relief

Subject to any additional state law requirements, in the event of a disaster, we may disclose your medical information to organizations assisting in disaster relief efforts unless you tell us not to and that decision will not interfere with our ability to respond in emergency circumstances.

Treatment Areas

We have implemented reasonable safeguards to protect your health information when receiving treatment at our facilities. However, while special care is taken to maintain patient privacy and prevent disclosures of your health information in treatment areas where other patients may be present, some patient information may be incidentally overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer or your health care provider.

Research

We may use or disclose your information for research purposes, but only if we first fulfill the conditions under applicable law for such use or disclosure of your health information. We will comply with any additional requirements under state laws in effect at the time, as applicable.

Medical Examiners and Funeral Directors

We may disclose health information to a coroner, medical examiner, or funeral directors consistent with applicable law to carry out their duties. We will comply with any additional and applicable requirements under state laws in effect at the time, if any.

Organ Procurement Organizations
Subject to applicable state law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising
We may also use your information for fundraising purposes. If we do contact you for fundraising.

Food and Drug Administration (FDA)
We may disclose health information to the FDA related to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation
We may disclose health information to the extent authorized by and to the extent necessary to comply with state laws relating to workers compensation or other similar programs established by law.

Public Health
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Other Government Requests
We may disclose health information for law enforcement purposes or with law enforcement officials when permitted by law. We may also share health information with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Court Orders and Subpoenas
We can share your health information in response to a court or administrative order, or in response to a subpoena. We will comply with applicable laws in effect at the time when making such disclosures.

Public Health & Safety
Subject to certain conditions, we can share your health information for the following purposes:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions
- Reporting suspected abuse or neglect
- Preventing or reducing a serious threat to health or safety

Health Information Exchanges
The Villages Health participates in one or more health information exchanges ("HIE"). HIEs that allow health care providers and business associates acting on their behalf to share health information about patients with other health care providers or other healthcare entities, for treatment purposes or as otherwise as permitted by law. For example, information about your past medical care and current medical conditions and medications can be available to us or to your other health care providers, if they (or their business associates acting on their behalf) participate in the same HIE. You will have the chance to opt-in to participate in the HIE before your information is shared. If you have agreed to participate in a HIE and would like to revoke your consent or opt-out of participation, you may do so by notifying the Privacy Officer, whose contact information is included at the bottom of this Notice.

COMMUNICATIONS

Communication from Offices
We may call your home or cell phone number provided by you and leave a message on voice mail or in person in reference to items that assist us in providing services to you and coordinating your care, such as appointment reminders, insurance and billing, and other calls pertaining to your clinical care.

Risks Related to Unsecured Electronic Communications
Using any unsecured electronic communication (such as regular email or standard text messaging) to communicate with us can present risks to the security of your health information. These risks include possible interception of the information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices. We do not recommend communicating with us via unsecured email, text messages, or any other unsecured electronic means. We offer patients other and more secure means for communicating about health information with The Villages Health and its providers. By choosing to communicate with us via unsecured electronic communication platforms, you are acknowledging and accepting these risks involved and understand that you are responsible for any charges applied by your telecommunications carrier. If you choose to contact us via text messaging or standard email, we may respond to you in the same manner or choose to refrain from text messaging with you, or otherwise limit the information included if we are not able to verify your identity. Additionally, you should understand that use of email, text messaging, and/or any other form of electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment and should never be used in a medical emergency.

Questions and Concerns
If you have questions and would like additional information, you may contact the Practice's Privacy Officer at (352) 674-6060. If you believe that your privacy rights have not been followed as directed by applicable law or as explained in this Notice, you may file a complaint with us. Please send any complaint to The Villages Health Privacy Officer at the address provided below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

The Villages Health
Attention: Privacy Officer
1020 Lake Sumter Landing
The Villages, FL 32162
Telephone: (352) 674-6060
Email: tvhprivacy.officer@thevillageshealth.com

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Patient Financial Responsibility
I understand that in consideration of the services to me or the patient for which I am responsible for (the “Patient”), I am directly and primarily responsible to pay for services and procedures rendered at **The Villages Health**. I understand that I am responsible for any applicable deductible or co-payments. **The Villages Health** will provide self-pay patients with a good faith estimate, in writing or electronically, of the total expected cost of any healthcare items or services upon request or when scheduling such items or services. I am responsible for notifying **The Villages Health** of any existing insurance that may apply, and understand that I may be billed for services if I do not provide insurance information to **The Villages Health.**

Assignment of Insurance Benefits
I hereby authorize **The Villages Health** to file a claim for payment with my insurance company and/or Medicare (if applicable) for services provided to the Patient and I request that payments for such services be made directly to **The Villages Health** and/or any physician providing services to the Patient. If the insurance company fails to pay for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **The Villages Health**.

Responsibility to Provide Proof of Insurance
I understand that it is my responsibility to provide **The Villages Health** with a copy of my current insurance card. I will notify The Villages Health immediately upon any change in my insurance.

Non-Covered Services
There may be a service I desire, or that is suggested or provided that is not covered under my insurance plan or Medicare (“Non-Covered Services”). I understand I must pay for “Non-Covered Services”.

Release of Information & Communication
I authorize **The Villages Health**, any physician examining and/or treating the Patient, and their business associates to release to any third party payer (such as UnitedHealthcare or Blue Cross) or other health care providers providing services to the Patient, all medical information and records and information concerning the Patient’s diagnosis and treatment when requested by such third party for its use in connection with processing a claim for payment for the services provided to the Patient, or when necessary to facilitate the provision of treatment services to the Patient. I specifically consent to the release of all health information and medical records related to the Patient for the purposes specified herein, including , without limitation, the results of HIV (AIDS) tests and related information, substance use disorder (“SUD”) treatment information, genetic information, information related sexually transmitted diseases (“STD”), and any information may relate to chemical dependence, depression or other psycho-emotional or mental health conditions. I understand that if I do not consent to the release of information for payment purposes, **The Villages Health** and other healthcare providers will not be able to bill my insurance other third party and I may be billed directly for these services. If I provide a phone number or email address, I authorize **The Villages Health** to contact me via telephone call or text messaging at the number or address provided, which may be through an auto-dialer. I understand that I am responsible for keeping my contact information current and agree to be responsible for any fees applied by my telephone communications carrier. I further acknowledge that systems may take time to update, and that I may receive messages that are not current until systems are updated.

Medicare — Patient’s Certification/Authorization to Release Information and Payment Request
I certify that the information given by me in applying for payment under title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to the treatment shall be assigned to the physician treating me. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at The Villages Health Care Center’s office.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS (CONT.)

The Villages Health accepts payments in: Cash, Check and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to **The Villages Health**, and send to **The Villages Health**.

By signing, I acknowledge understanding the above patient information.

Patient's Name

First Name ______________________ MI ____ Last Name ______________________

Patient's Date of Birth ______ — ______ — ________
MONTH DAY YEAR

SIGN HERE **Patient's Signature** ______________________ **Date** ____ / ____ / ____

SIGN HERE **Guardian/Power of Attorney Signature** ______________________

Person responsible for payment if different than above
Please sign as self if you are the responsible party. If not, please have responsible party sign, such as parent, guardian, etc.

First Name ______________________ MI ____ Last Name ______________________

Relationship to Patient ______________________

Address ______________________ City ____________ State ______ Zip ______

SIGN HERE **Responsible Party's Signature** ______________________

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ______________________________

Date of Birth (mm/dd/yyyy): ______________________________

Address: ______________________ City: ______________ State: ________ Zip: ________

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: The Villages Health Phone: (844) TVH-WELL (844-884-9355)

Address: Please deliver to your care center (see last page of this packet for address) Fax: (855) 604-6305

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X ______________________________ ______________________________

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: ______________________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient Information

Patient's Name ______________________ Date of Request ____________ Home Phone ____________

Address ______________________ Date of Birth ____________ Cell Phone ____________

Email ______________________

*Authorized Representative (if other than the patient) ______________________

*Authority of Authorized Representative ☐ Guardian ☐ Health Care Power of Attorney ☐ Health Care Surrogate ☐ Parent of Minor

☐ Representative of Deceased Patient ☐ Other ______________________

Information to be Released

☐ Specified Records for Date(s) of Service: _____ /_____ /_____ *to* _____ /_____ /_____

☐ Provider Name(s) ______________________

☐ Last History & Physical Exams ☐ Last Emergency Room Records ☐ Last Operative Reports/Consults ☐ Last Imaging Reports/Films

☐ Last Physician Progress Notes ☐ Other Records (specify) ______________________

Information for Request/Release (Circle One):

REQUEST: Requesting Patient Records *From* Outside Facility   RELEASE: Releasing Patient Records *To* Outside Facility

This section to be completed if records will be requested or released to or from another medical facility/practice/provider to The Villages Health.

Medical Facility Practice/ Provider Name ____________ Contact Name ____________ Phone ____________

☐ Mail Address ______________________ City ____________ State ________ Zip Code ________

☐ Fax ______________________

Records to be sent to: The Villages Health Attn: Medical Records

900 Main Street, Suite 204 Lady Lake, FL 32159 | (Phone) 352-674-8700 (Fax) 855-604-6305

Purpose of Disclosure: ☐ Continuing Medical Treatment/Continuity of Care ☐ Other (Please Specify) ______________________

SUBSTANCE USE DISORDER/TREATMENT, AIDS/HIV, MENTAL HEALTH, & GENETIC INFORMATION

Unless otherwise indicated below, I hereby specifically authorize the release of psychological, psychiatric, substance use disorder and treatment information, sexually transmissible disease information, including human immunodeficiency virus ("HIV") testing/treatment and AIDS related information, and genetic information as it concerns the above-referenced patient. I specifically authorize the disclosure of genetic information, behavioral/mental health information, substance use disorder information ("SUD"), sexually transmitted disease information ("STD"), immune deficiency syndrome ("AIDS"), and Human Immunodeficient Virus ("HIV") information, unless indicated here:

DO NOT release: ______________________

Right to Revoke Authorization: I may revoke this authorization by submitting my request in writing to the department where I submitted this authorization but understand that such revocation will not apply to actions already taken by my healthcare provider prior to my revocation.

Authorization:

I hereby authorize the use or disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided. I further understand that I have a right to receive a copy of this authorization upon request. I understand that information released in response to this authorization could potentially be re-disclosed and may no longer be protected by privacy laws. I understand that my provider may charge a reasonable fee, as allowed by law, for a copy of my medical records. I understand that this authorization will expire one year from the signature date below.

______________________ ______________________

Signature of Patient or Patient's Authorized Representative   Date

The Villages Health®

CONSENT TO MEDICAL TREATMENT

Consent to Treatment. I, or my authorized representative, consent to employed and/or contracted providers at **The Villages Health (or "TVH")**, to evaluate and treat my medical condition as may be deemed necessary or advisable in the judgment of my physician or other provider. Absent an emergency, if the treatment has significant risks, then an additional consent would be obtained by **The Villages Health**. I understand that providing medical care is not an exact science and no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

Communications About My Treatment. I agree that by providing my landline, cell phone number(s) or email address. I am giving express consent for **The Villages Health**, its staff, employees, independent contractors, assignees, successors, and agents, to contact me at these numbers or email addresses, or any number or email address that is later acquired for me and to leave live or pre-recorded messages or text messages regarding my healthcare-related matters, my account, or my bill related to any services I receive. I understand and agree that I am responsible for any charges from my telecommunications provider related to such communications, and that using any unsecure electronic communication (such as regular email or standard text messaging) to communicate can present risks to the security of information. These risks include possible interception of the information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices. I agree to accept these risks and confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Providing a telephone or cell phone number is not a condition of receiving services.

Consent to Obtain Prescription History. I authorize **The Villages Health** and its affiliated providers to view my external prescription history via the RX History service. I understand that my history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff of TVH, and it may include prescriptions back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

Consent to Obtain Vaccination History. I authorize the **The Villages Health** and its affiliated providers to view my vaccination history via Florida Shots. and to disclose my health information with mass immunization providers that provide vaccination services to The Villages Health and its patients. I understand that my history from multiple other unaffiliated medical providers or pharmacies may be viewable by my providers and staff and TVH, and it may include vaccination history back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

Consent to Disclosure of Health Information. I understand that part of providing quality treatment services to me requires access to my medical and treatment history. To facilitate my treatment and coordination of my care, I hereby authorize and request that copies of my medical/health records be provided to The Villages Health and authorize **The Villages Health** to disclose my health information with other outside health care providers providing treatment services to me. I understand that **The Villages Health** and its business associates acting on its behalf, any provider and/or my insurance company may obtain, use and/or disclose my health information for the purposes of treatment, payment, and normal health care operations. This includes without limitation, all medical records in paper or electronic form, complete plans of treatment, progress summaries, treatment notes, including without limitation mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use or abuse information, genetic information, and any other appropriately related documents or information reasonably requested to facilitate providing treatment to me if/when included in my records. I further understand that **The Villages Health** and its providers may participate in research. I consent to the use and disclosure of my health information as described in this section for research purposes when an institutional review board has approved the research and for reviews preparatory to such research. I authorize use and disclosure of my health information for the purposes described in this consent.

I certify that I have read the forgoing, received a copy thereof and I am the patient or am duly authorized by the patient as patient's authorized representative to execute this Consent to Medical Treatment.

SIGN HERE **Patient's Signature** ______________________ ______________________

PRINT NAME

Guardian/Power of Attorney Signature ______________________

SIGN HERE **Relationship to Patient** ______________________ **Date** ______________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND COMPLIANCE WITH HIPAA STANDARDS

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices (pages 2 and 3), which states how we may use and/or disclose your health information. Your signature on this form is to acknowledge receipt of the Notice and your agreement for The Villages Health to use and disclose your health information.as described in the Notice of Privacy Practices. You may refuse to sign this acknowledgement if you wish.

I authorize The Villages Health to leave medical information pertaining to my care by the following methods:

Home Telephone ☐ Yes ☐ No ☐ OK to leave voice mail?

Work Telephone ☐ Yes ☐ No ☐ OK to leave voice mail?

Cell Phone ☐ Yes ☐ No ☐ OK to leave voice mail?

SMS/Text ☐ Yes ☐ No

E-mail ☐ Yes ☐ No

**If authorizing communications via text messaging or email, I acknowledge the risks involved related to my protected health information as described in the Notice of Privacy Practices and agree to accept such risks.*

I authorize The Villages Health, and hospitals where I may be a patient, to leave medical information pertaining to my care with the following people:

Spouse ☐ Yes ☐ No ____________________ ( ) ____________ ____________

PRINT SPOUSE'S NAME | SPOUSE'S PHONE NUMBER | SPOUSE'S DOB

Other ____________ ____________ ( ) ____________ ____________

PRINT NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | DOB

Other ____________ ____________ ( ) ____________ ____________

PRINT NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | DOB

Other ____________ ____________ ( ) ____________ ____________

PRINT NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | DOB

I acknowledge that I have been offered and/or received a copy of this office's Notice of Privacy Practices. I understand that at the discretion of The Villages Health I may be asked to update this information periodically.

SIGN HERE **Patient's Signature** ____________________ ____________________

PRINT NAME

SIGN HERE **Guardian/Power of Attorney Signature** ____________________

Relationship to Patient ____________________ **Date** ____ / ____ / ____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this Patient. It could not be obtained because:

☐ The Patient refused to sign. ☐ Due to an emergency situation it was not possible. ☐ We could not communicate with the Patient.

☐ Other. Explain ____________________

____________________ ____________________ ____________

EMPLOYEE'S PRINTED NAME | EMPLOYEE SIGNATURE | DATE

PATIENT DEMOGRAPHIC INFORMATION

General Information

Last Name ______________ First Name ______________ MI ______

Nickname/Preferred Name ______________ Previous Name ______________

Date of Birth ____/____/____

Driver's License State ______________ Driver's License Expiration Date ____/____/____

Mailing Address ______________ City ________ State ________ Zip ________

Home Phone (______) ______________ Cell Phone (______) ______________ SMS/Text ☐ Yes ☐ No

Work Phone (______) ______________ Email ______________

Preferred Contact Method ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail ☐ Portal

Race

☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Other______________ ☐ Decline to Answer

Ethnicity

☐ Hispanic/Latin ☐ Not Hispanic/Latin ☐ Decline to Answer Preferred Language: ______________

Gender

☐ Male ☐ Female

Marital Status

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Seasonal

If Seasonal, Enter Dates ______________ Seasonal Address ______________ Seasonal City ________

Seasonal State ______ Seasonal Zip ________ Villages ID ________ Villages Neighborhood ______________

Miscellaneous Information

Guardian (if applicable) ______________

Emergency Contact ______________ Relationship ______________

Home Phone ______________ Cell Phone (______) ______________

Next of Kin ______________ Relationship ______________ Phone (______) ______________

Current or Former Employer ______________

Guarantor (Person to Whom Statements are Sent) ______________

Guarantor DOB ______________ Relationship to Patient ______________

Guarantor Mailing Address ______________ City ________ State ________ Zip ________

Pharmacy Contact

Primary Pharmacy Name ______________

Primary Pharmacy Phone (______) ______________ Primary Pharmacy Fax (______) ______________

Primary Pharmacy Address ______________ City ________ State ________ Zip ________

Secondary Pharmacy Name ______________

Secondary Pharmacy Phone (______) ______________ Secondary Pharmacy Fax (______) ______________

Secondary Pharmacy Address ______________ City ________ State ________ Zip ________

Referring Provider Name ______________ Referring Provider Phone (______) ______________

PATIENT DEMOGRAPHIC INFORMATION (CONT.)

Current or Previous Primary Care Physician

NAME	CITY	STATE	PHONE ( )	☐ CURRENT

Current or Previous Specialists

NAME	SPECIALTY	CITY/STATE	PHONE	
			( )	☐ CURRENT
			( )	☐ CURRENT
			( )	☐ CURRENT
			( )	☐ CURRENT

INSURANCE INFORMATION

Primary Insurance

REQUIRED INFORMATION: PLEASE NOTE: Insurance is considered a method of reimbursing the member fees paid by you to the doctor and it is not a substitute for payment, unless our office is a provider for your insurance company.

Insurance Company ______ Member ID# ______ Group Number ______

Group Name ______ Issue Date / / Expiration Date / /

Policy Holder's

Last Name ______ First Name ______ MI ______

Mailing Address ______ City ______ State ______ Zip ______

Date of Birth / / Relationship to Patient ______

Secondary Insurance

Insurance Company ______ Member ID# ______ Group Number ______

Group Name ______ Issue Date / / Expiration Date / /

Policy Holder's

Last Name ______ First Name ______ MI ______

Mailing Address ______ City ______ State ______ Zip ______

Date of Birth / / Relationship to Patient ______

Prescription Drug Coverage Plan Name ______ Medicare Part D Plan Name ______

All co-pays, coinsurance, and deductibles are expected to be paid in full at the time of your visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and/or cost of collection. If this account is assigned to a collection agency, an administrative fee will be applied. I agree to be contacted via telephone or text messaging, which may be through an auto-dialer related to my account and outstanding balances.

SIGN HERE **Patient's Signature** ______ **Date** / /

SIGN HERE **Guardian/Power of Attorney Signature** ______

MEDICATION INFORMATION

Note: Please bring ALL medications you are currently using (in their original containers) to your FIRST appointment.

Allergies/Intolerances

Type of Medication	Type of Reaction
Example: Penicillin	*Rash*

Current Prescription, Non-prescription Medications, and Supplements

This may include ointments, creams, inhalers, and eye drops or any items for which you would need a prescription or over-the-counter medications. This may include items that are used on an as-needed basis.

Name	Strength (Formulation)	Frequency	Purpose	Refill required in the next 90 days?	Supply	Supply
Example: Lisinopril	*10 mg (tablets)*	*Once daily*	*Blood Pressure*			
Example: Advil	*200mg (capsules)*	*1 capsule every 6 hours*	*Headaches*			
Example: Fish Oil	*500mg (tablets)*	*1 twice daily*	*Heart Health*			
				☐ No	☐ 90 day	☐ 30 day
				☐ No	☐ 90 day	☐ 30 day
				☐ No	☐ 90 day	☐ 30 day
				☐ No	☐ 90 day	☐ 30 day
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				☐ No	☐ 90 day	☐ 30 day
				☐ No	☐ 90 day	☐ 30 day

SOCIAL HISTORY

Diet and Exercise

What type of diet are you following? ☐ REGULAR ☐ VEGETARIAN ☐ VEGAN ☐ GLUTEN FEEE ☐ SPECIFIC ☐ CARBOHYDRATES ☐ CARDIAC ☐ DIABETIC

What is your exercise level? ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _______________

What types of sporting activities do you participate in? ____

Education and Occupation

What is the highest grade level of school you have completed or the highest degree you have received?_____________________________

Are you currently employed? ☐ YES ☐ NO

Activities of Daily Living

Are you able to care for yourself? ☐ YES ☐ NO

Substance Use

Do you or have you ever smoked tobacco? ☐ NERVER SMOKED ☐ FORMER SMOKER ☐ CURRENT EVERY DAY SMOKER ☐ CURRENT SOME DAYS SMOKER

Has tobacco cessation counseling been provided? ☐ YES ☐ NO

What is your level of alcohol consumption? ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

Do you use illicit or recreational drugs? ☐ YES ☐ NO

What is your level of caffeine consumption? ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

Advanced Directive

Do you have an advanced directive? ☐ YES ☐ NO

Do you have an out of hospital DNR? ☐ YES ☐ NO

Do you have a medical power of attorney? ☐ YES ☐ NO

Marriage and Sexuality

What is your relationship status? ☐ UNKNOWN ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ DOMESTIC PARTNER ☐ OTHER

Are you sexually active? ☐ YES ☐ NO

How many children do you have?__________

Home and Environment

Have there been any changes to your family or social situation? ☐ YES ☐ NO

Are you a caregiver? ☐ YES ☐ NO

Where do you live? ☐ SINGLE-LEVEL HOUSE ☐ MULTI-LEVEL HOUSE ☐ APARTMENT ☐ TRAILER ☐ CONDO ☐ OTHER

Do you have any pets? ☐ YES ☐ NO

Do you have smoke and carbon monoxide detectors in your home? ☐ YES ☐ NO

Are you passively exposed to smoke? ☐ YES ☐ NO

Are there any smokers in your house? ☐ YES ☐ NO

Do you use sunscreen routinely? ☐ YES ☐ NO

SOCIAL HISTORY (CONT.)

Public Health and Travel

Have you recently traveled abroad? ☐ YES ☐ NO
Have you been to an area known to be high risk for COVID-19? ☐ YES ☐ NO
In the 14 days before symptoms onset, have you had close contact with a laboratory confirmed COVID-19 while that case was ill?
☐ YES ☐ NO

Lifestyle

Do you feel stressed (tense, nervous, or anxious, or unable to sleep at night)? ☐ NOT AT ALL ☐ ONLY A LITTLE ☐ TO SOME EXTENT ☐ RATHER MUCH ☐ VERY MUCH
Do you use your seatbelt or car seat routinely? ☐ YES ☐ NO

General Social History

Total number in household? ________
Occupational exposures? ☐ YES ☐ NO
Where are you from? ____
City/neighborhood in which you live? ____
If a resident of The Villages® Community, what year did you move here? ____
Do you have local family? ☐ YES ☐ NO
What is your support system in the event of a medical crisis? ☐ FAMILY ☐ FRIENDS ☐ CAREGIVER ☐ OTHER ☐ NONE
Illicit drug use? ☐ NEVER ☐ YES-IN PAST ☐ YES-CURRENT USE
Quitting smoking? ☐ INTERESTED IN QUITTING ☐ READY TO QUIT ☐ NOT READY TO QUIT
Type of exercise? ____
Domestic Violence? ☐ YES ☐ NO
Do you understand the medication you are taking? ☐ YES ☐ NO
Do you have any financial concerns related to the medications you are taking? ☐ YES ☐ NO
Do you have any other barriers related to the medications you are taking? ☐ YES ☐ NO
Do you have any communication barriers? ☐ NONE ☐ COGNITIVE ☐ VISION ☐ LANGUAGE ☐ HEARING
Does the family or caregiver have any communication barriers? ☐ NONE ☐ COGNITIVE ☐ VISION ☐ LANGUAGE ☐ HEARING
Recreational Drug Use (marijuana, cocaine, etc.)? ☐ YES ☐ NO
During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages have you consumed?
☐ NO ALCOHOL AT ALL ☐ 1 DRINK/WEEK ☐ 2-5 DRINKS/WEEK ☐ 6-9 DRINKS/WEEK ☐ 10+ DRINKS/WEEK
Religious preference? ____

Additional Advanced Directives

DNR ☐ YES ☐ NO
Five Wishes ☐ YES ☐ NO
Guardian ☐ YES ☐ NO
Health Care Surrogate ☐ YES ☐ NO
Living Will ☐ YES ☐ NO
Power of Attorney ☐ YES ☐ NO

FAMILY HISTORY

Family Member with a History of *(Please define who had history and what age if applicable):*

Condition	Relative	Diagnosed Age	Deceased Age
☐ Abdominal Aortic Aneurysm:			
☐ Breast Cancer:			
☐ Colon Cancer:			
☐ Coronary Artery Disease:			
☐ Diabetes Mellitus:			
☐ Hypertension:			
☐ Malignant Melanoma:			

Condition	Relative	Diagnosed Age	Deceased Age
☐ Mental Illness:			
☐ Osteoporosis:			
☐ Ovarian Cancer:			
☐ Prostate Cancer:			
☐ Skin Cancer:			
☐ Stroke:			
☐ Thyroid Cancer			
☐ Uterine Cancer:			
☐ Other:			

SURGICAL HISTORY *Please provide brief details & dates in the spaces below.*

IMPLANT HISTORY

List any implants, date implanted, and the UDI for the device.

Device Type ________ Date of Implant ___/___/___ UDI ______________ Site ______ Side ☐ Left ☐ Right ☐ Bilateral

Device Type ________ Date of Implant ___/___/___ UDI ______________ Site ______ Side ☐ Left ☐ Right ☐ Bilateral

Device Type ________ Date of Implant ___/___/___ UDI ______________ Site ______ Side ☐ Left ☐ Right ☐ Bilateral

HOSPITALIZATIONS (in the last 5 years)

Please list all dates, reasons and complications for hospitalizations below.

DATE OF HOSPITALIZATION	REASON FOR HOSPITALIZATION	COMPLICATIONS
/ /		
/ /		
/ /		
/ /		

PAST MEDICAL HISTORY

Please complete the following in as much detail as possible. If you cannot recall certain information, that is okay.

DIAGNOSES/CONDITIONS *Please check all that apply.*

Cardiovascular

- ☐ Atrial Fibrillation
- ☐ Blood Clotting Disorder
- ☐ Cardiac Catheterization
- ☐ Deep Venous Thrombosis
- ☐ Defibrillator Vascular
- ☐ Disease
- ☐ Elevated Cholesterol
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Valve Disorder
- ☐ High Blood Pressure
- ☐ Implantable
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Peripheral Arterial Disease
- ☐ Stent Placement/Angioplasty
- ☐ MRI: ☐ Yes ☐ No ☐ Compatible ☐ Unknown

Abdominal Aortic Aneurysm Screening [AAA Ultrasound] (DATE OF LAST EXAM)__________________

Other ____

Endocrine

- ☐ Diabetes (Type 2)
- ☐ Overactive Thyroid
- ☐ Osteopenia
- ☐ Diabetes (Type 1)
- ☐ Underactive Thyroid
- ☐ Osteoporosis (weak bones)

Do You Take Insulin? ☐ Yes ☐ No

Do You Have an Insulin Pump? ☐ Yes ☐ No

Thyroid Nodules ☐ Yes ☐ No

Thyroid Ultrasound: year__________ facility____________________________

Thyroid Biopsy: year__________ facility____________________________

Thyroid Pathology: year__________ facility____________________________

DEXA (Bone Density) Scan (DATE OF LAST EXAM) _________________________ NORMAL ☐ ABNORMAL ☐ UNKNOWN ☐

Fractures (please specify date and type of fracture) ____

Other ____

Gastrointestinal

- ☐ Cirrhosis
- ☐ Colon Polyps
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Heartburn/Reflux
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel
- ☐ Ulcer

Other ____

Hepatitis C Screening in the past? ☐ YES ☐ NO

Last Colonoscopy (YEAR OF LAST EXAM)___________________________ NORMAL ☐ ABNORMAL ☐ UNKNOWN ☐

Genitourinary

- ☐ Chronic Kidney Disease
- ☐ Enlarged Prostate
- ☐ Erectile Dysfunction
- ☐ Kidney Cysts
- ☐ Kidney Stones
- ☐ Overactive Bladder/Incontinence
- ☐ PSA Screen (DATE OF LAST EXAM) _____________
- ☐ Urinary Tract Infections

Gynecological

	NORMAL	ABNORMAL	UNKNOWN
Cervical Cancer Screening (Pap) (DATE OF LAST EXAM) ________	☐	☐	☐
DEXA (Bone Density) Scan (DATE OF LAST EXAM) ________	☐	☐	☐
Mammogram (DATE OF LAST EXAM) ________	☐	☐	☐

Menstrual Period (DATE OF LAST) ________

Are you sexually active? ☐ Yes ☐ No Birth Control ☐ Yes ☐ No Type ________

New Sexual Partners Since Last Pap Smear ☐ No ☐ Yes Pessary ☐ Yes ☐ No HPV Vaccine ☐ Yes ☐ No

☐ Sexually Transmitted Diseases (Chlamydia, Gonorrhea, Genital Herpes, HPV, Syphilis, Trichomoniasis)

Age at First Period ________ Age at First Child ________ Age at Menopause________

Number of Pregnancies ________ Number of Deliveries ________ Number of Abortions ________

Number of Living Children ________ Number of Miscarriages ________

Neurologic/ Psychiatric

☐ Anxiety ☐ Migraines ☐ Post- Traumatic Stress Disorder

☐ Dementia ☐ Neuropathology ☐ Stroke

☐ Depression ☐ Parkinson's Disease Stroke ☐ Transient Ischemic Attacks (TIA)

Other ________

Oncologic (Cancer) and Hematologic (Blood Disorders) *Please provide year of diagnosis and check if disease is in remission or active.*

	YEAR OF DIAGNOSIS	REMISSION	ACTIVE		YEAR OF DIAGNOSIS	REMISSION	ACTIVE
Anemia	________	☐	☐	Ovarian Cancer	________	☐	☐
Breast Cancer	________	☐	☐	Prostate Cancer	________	☐	☐
Cervical Cancer	________	☐	☐	Skin Cancer	________	☐	☐
Colon/Rectal Cancer	________	☐	☐	Thyroid Cancer	________	☐	☐
Lung Cancer	________	☐	☐	Uterine Cancer	________	☐	☐
Other ________		☐	☐				

Orthopaedic/ Podiatry

☐ Ankle Fracture ☐ Hardware ☐ Yes ☐ No ☐ Recurring Ankle Sprains

☐ Foot Fracture ☐ Heel Pain

☐ Foot Pain ☐ History of Fractures ☐ Yes ☐ No

Other ________

Pain Management

☐ Back Pain ☐ Neck Pain ☐ SI Joint Dysfunction

☐ Cervical/Lumbar Radiculopathy ☐ Neuropathic Pain ☐ Spinal Compression Fractures

☐ Failed Back Syndrome ☐ Sciatica ☐ Spinal Stenosis

Other ________

Pulmonary

☐ Asbestos Exposure/Asbestosis ☐ COPD ☐ Pulmonary Nodules
☐ Asthma ☐ Emphysema
Other ______________________________

Rheumatologic/ Joint Disease

☐ Cervical Disc Disease ☐ Lumbar Disc Disease ☐ Raynaud's Syndrome
☐ Connective Tissue Disease ☐ Lupus ☐ Rheumatoid Arthritis
☐ Fibromyalgia ☐ Osteoarthritis ☐ Sjogren's Syndrome
☐ Gout ☐ Psoriatic Arthritis
Other ______________________________

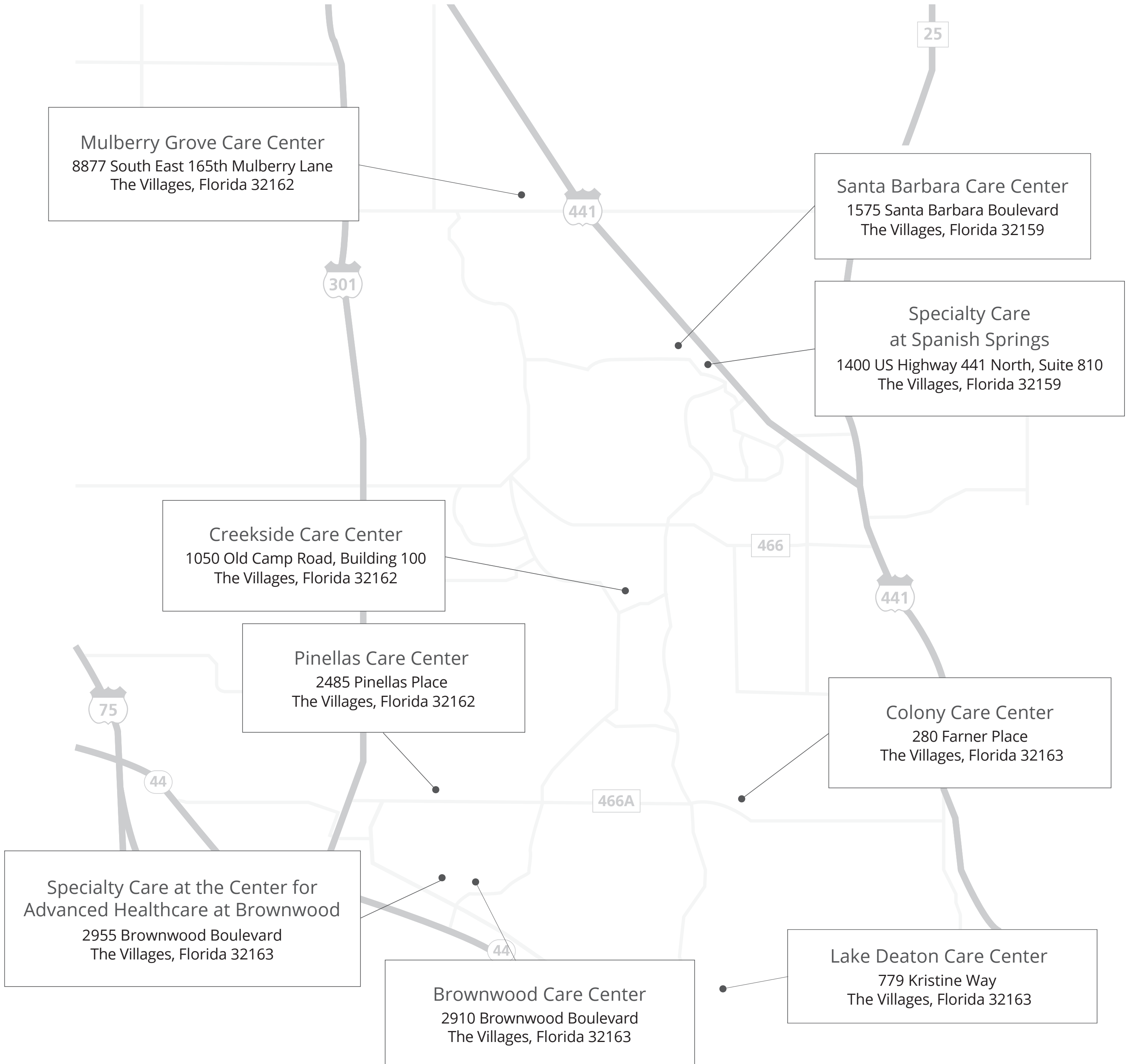
Skin

☐ BCC (Basal Cell Carcinoma) ☐ SCC (Squamous Cell Carcinoma) ☐ Skin Cancer/Melanoma
Skin Disease: ☐ Dermatitis ☐ Eczema ☐ Itching ☐ Psoriasis ☐ Rosacea
Other ______________________________

Person completing this medical history is ☐ Patient ☐ Other ______________________________
PRINT NAME
Relationship to Patient ______________________________

9 CONVENIENT LOCATIONS

Need to contact your care center? Give us a call at
(844) TVH-WELL (844) 884-9355



For the latest information, please visit TheVillagesHealth.com

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