



DEMOGRAPHICS FORM

| | | | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------|------------------------------------|---------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|--|----------------------------------|--|------------------------------|--|--------------------------------|--|
| Today's date: | | Name of Previous Doctor: | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | |
| Patient's last name: | | First: | | Middle: | | <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | | | | | | | | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | | Email Address: | | | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |
| Street address: | | | Social Security no.: | | | Home phone no.: () | | | | | | | | | |
| Cell Phone No: | | City: | | State: | | ZIP Code: | | | | | | | | | |
| Occupation: | | Employer: | | | Employer phone no.: () | | | | | | | | | | |
| Chose this Office because it was referred by: | | <input type="checkbox"/> Dr. | | <input type="checkbox"/> Newspaper | | <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital | | | | | | | | | |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Drove By (Sign) | <input type="checkbox"/> Church Ad | <input type="checkbox"/> Web Search | <input type="checkbox"/> Billboard | <input type="checkbox"/> Newsletter | <input type="checkbox"/> Mail-Out | | | | | | | | |
| Name of Person who referred you: | | | | Other family members seen here: | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | |
| Person responsible for bill: | | Birth date: / / | | Address (if different): | | Home phone no.: () | | | | | | | | | |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| Occupation: | | Employer: | | Employer address: | | Employer phone no.: () | | | | | | | | | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | <input type="checkbox"/> Medicare | | <input type="checkbox"/> CarePlus | | <input type="checkbox"/> Freedom | | <input type="checkbox"/> Simply | | <input type="checkbox"/> Optimum | | | | | |
| <input type="checkbox"/> Amerigroup | | <input type="checkbox"/> Wellcare | | <input type="checkbox"/> BetterHealth | | <input type="checkbox"/> BCBS | | <input type="checkbox"/> Aetna | | <input type="checkbox"/> UHC | | <input type="checkbox"/> UHC | | <input type="checkbox"/> Other | |
| Subscriber's name: | | Subscriber's S.S. no.: | | Birth date: / / | | Group no.: | | Policy no.: | | Co-payment: \$ | | | | | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | | <input type="checkbox"/> Spouse | | <input type="checkbox"/> Child | | <input type="checkbox"/> Other | | | | | | | |
| Name of secondary insurance (if applicable): | | | | Subscriber's name: | | | | Group no.: | | Policy no.: | | | | | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | | <input type="checkbox"/> Spouse | | <input type="checkbox"/> Child | | <input type="checkbox"/> Other | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | Relationship to patient: | | Home phone no.: () | | Work phone no.: () | | | | | | | |

I AUTHORIZE **D4A MEDICAL GROUP** TO PROVIDE ANY MEDICAL CARE DEEMED NECESSARY ACCORDING TO THEIR PROFESSIONAL OPINIONS. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO **D4A MEDICAL GROUP**. I AUTHORIZE THE RELEASE OF ANY INFORMATION BY. TO MY INSURANCE CARRIER PERTINENT TO MY HEALTH INSURANCE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

I UNDERSTAND THAT SERVICES RENDERED TO ME MAY NOT BE ELIGIBLE FOR BENEFITS UNDER MEDICARE, MEDICAID OR OTHER INSURANCES OR PAYORS. SERVICES NOT ELIGIBLE FOR BENEFITS MAY INCLUDE TESTS AND PROCEDURES THAT ARE NOT COVERED, OR THOSE DELIVERED BY HEALTH CARE PROVIDERS WHO DO NOT PARTICIPATE WITH MY INSURANCE PLAN. NON-COVERED SERVICES MAY ALSO INCLUDE THOSE MY PHYSICIAN DETERMINES MEDICALLY NECESSARY, BUT ARE LATER DETERMINED UNNECESSARY BY MY INSURANCE PLAN. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ANY NON-COVERED SERVICE.

Patient/Guardian signature

Date



HEALTHY HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
And will become part of your medical record

| | | | | | |
|-----------------------------------|-------------------------------------------------------|------------------------------------|----------------------------------|------------------------------------|-----------------------------------|
| Name (<i>Last, First, M.I.</i>) | <input type="checkbox"/> M <input type="checkbox"/> F | DOB: | | | |
| Marital Status: | <input type="checkbox"/> Single | <input type="checkbox"/> Partnered | <input type="checkbox"/> Married | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced |
| Previous or referring Doctor: | | | | | |

PREFERRED PHARMACY TO SEND YOUR PRESCRIPTIONS TO

| | | |
|-----------------|----------|--|
| Pharmacy | Name: | |
| | Address: | |
| | Phone: | |

Allergies to Medications

| Name of Drug | Reaction You Had |
|--------------|------------------|
| | |
| | |
| | |

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

| Name the Drug | Strength | Frequency Taken |
|---------------|----------|-----------------|
| | | |
| | | |
| | | |

Consent to Obtain External Prescription History

I, _____, authorize IMA Medical Group and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that my prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff of IMA Medical Group, and it may include prior prescriptions from previous years.

Signature

Date



PERSONAL HEALTH HISTORY

PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

PERSONAL HEALTH HISTORY

Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

| Current | | Past | | Current | | Past | | | | | |
|---------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| Allergic rhinitis | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Melanoma | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Ovarian | <input type="checkbox"/> | <input type="checkbox"/> | Erectile Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | Low back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Prostate | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | Lupus | <input type="checkbox"/> | <input type="checkbox"/> |
| Anesthesia issues | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Skin (exc Melanoma) | <input type="checkbox"/> | <input type="checkbox"/> | Gallstones | <input type="checkbox"/> | <input type="checkbox"/> | Lymphoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Cardiomegaly | <input type="checkbox"/> | <input type="checkbox"/> | Gastritis | <input type="checkbox"/> | <input type="checkbox"/> | Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> | Cardiomyopathy | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Menorrhagia | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Carotid artery stenosis | <input type="checkbox"/> | <input type="checkbox"/> | GERD | <input type="checkbox"/> | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| Aortic stenosis | <input type="checkbox"/> | <input type="checkbox"/> | Cataract | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Myocardial Infarction | <input type="checkbox"/> | <input type="checkbox"/> |
| Arterial thrombosis | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis (Osteo) | <input type="checkbox"/> | <input type="checkbox"/> | Colon Polyp | <input type="checkbox"/> | <input type="checkbox"/> | Hematuria (Blood in Urine) | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Arterial Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis (Rheuma) | <input type="checkbox"/> | <input type="checkbox"/> | Cong. Heart Fail(CHF) | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | Overactive Bladder | <input type="checkbox"/> | <input type="checkbox"/> |
| Atrial Fibrillation | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B, C (circle type) | <input type="checkbox"/> | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| B12 deficiency | <input type="checkbox"/> | <input type="checkbox"/> | Coronary Artery Disease | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Rectal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stent, Leg | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer, Breast | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type 1 | <input type="checkbox"/> | <input type="checkbox"/> | Hyperthyroidism | <input type="checkbox"/> | <input type="checkbox"/> | Stent, Heart | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer, Colon | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type 2 | <input type="checkbox"/> | <input type="checkbox"/> | Hypothyroidism | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer, Lung | <input type="checkbox"/> | <input type="checkbox"/> | Eczema | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Any Other Health problems not listed above

Hospitalization

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |

Surgeries

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |



FAMILY HEALTH HISTORY

| AGE | | SIGNIFICANT HEALTH PROBLEMS | | AGE | | SIGNIFICANT HEALTH PROBLEMS | |
|--------------------------------|----------------------------|------------------------------------------|-----------------------------------------|--------------------------------|--------------------------------|-----------------------------|--|
| Father | | | | Children | | | |
| <input type="checkbox"/> Alive | | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes 1 | | <input type="checkbox"/> M | | |
| <input type="checkbox"/> Dead | | <input type="checkbox"/> Diabetes 2 | <input type="checkbox"/> CAD | | <input type="checkbox"/> F | | |
| | | <input type="checkbox"/> Prostate Cancer | | | | | |
| Mother | | | | | | | |
| <input type="checkbox"/> Alive | | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes 1 | | <input type="checkbox"/> M | | |
| <input type="checkbox"/> Dead | | <input type="checkbox"/> Diabetes 2 | <input type="checkbox"/> CAD | <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer | | | | |
| Sibling | <input type="checkbox"/> M | | | <input type="checkbox"/> M | | | |
| | <input type="checkbox"/> F | | | <input type="checkbox"/> F | | | |
| | <input type="checkbox"/> M | | | <input type="checkbox"/> M | | | |
| | <input type="checkbox"/> F | | | <input type="checkbox"/> F | | | |
| | <input type="checkbox"/> M | | | Grandmother | <input type="checkbox"/> Alive | | |
| | <input type="checkbox"/> F | | | <i>Maternal</i> | <input type="checkbox"/> Dead | | |
| <input type="checkbox"/> M | | | Grandfather | <input type="checkbox"/> Alive | | | |
| <input type="checkbox"/> F | | | <i>Maternal</i> | <input type="checkbox"/> Dead | | | |
| <input type="checkbox"/> M | | | Grandmother | <input type="checkbox"/> Alive | | | |
| <input type="checkbox"/> F | | | <i>Paternal</i> | <input type="checkbox"/> Dead | | | |
| <input type="checkbox"/> M | | | Grandfather | <input type="checkbox"/> Alive | | | |
| <input type="checkbox"/> F | | | <i>Paternal</i> | <input type="checkbox"/> Dead | | | |

HEALTH MAINTENANCE

| | | | | DATE OF LAST |
|-----------------------------------------------|------------------------------|-----------------------------|--|--------------|
| Have you ever had an EKG? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a Colonoscopy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a blood transfusion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a Prostate Exam? (Man Only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had Mammogram? (Woman Only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a Dexa Exam? (Woman Only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a Pap? (Woman Only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Have you ever had a Blood Work? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

Patient Signature: _____ Date: _____



LIVING WILL/DESIGNATION OF HEALTHCARE

Declaration made this _____ day of _____, _____
I, _____ willfully and voluntarily make known my desire that my
dying not be artificially prolonged under the Circumstances set forth below, and I do
hereby declare that:

If at any time I am incapacitated and;

- _____ I have a terminal condition, or
_____ I have an end-stage condition, or
_____ I am in a persistent vegetative state

And if my attending or treating physician and another consulting physician have
determined that there is no reasonable medical probability of my recovery from such
condition, I direct that life-prolonging procedures be withheld or withdrawn when the
application of such procedures would serve only to prolong artificially the process of dying
and that I am permitted to die naturally with only the administration of medication or the
performance of any medical procedure deemed necessary to provide me with comfort care
or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final
expression of my legal right to refuse medical or surgical treatment and to accept the
consequences for such refusal. In the event that I have been determined to be unable to
provide or express and inform consent regarding the withholding, withdrawal, or
continuation of life-prolonging procedures, I wish to designate my surrogate to carry out
the provisions of this declaration.

I fully understand that this designation will permit my designee to make health care
decisions, except for anatomical gifts, unless I have executed an anatomical gift
declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf;
to apply for public benefits to defray the cost of health care; and to authorize my admission
to or transfer from a health care facility. I further affirm that this designation is not being
made as a condition of treatment or admission to a health care facility. I will notify and
send a copy of this document to my surrogate, so they may know to carry out the
provisions of this declaration:

Name: _____

Address: _____

Phone: _____

Patient Signature: _____

Witness 1:

Signed: _____

Name: _____



AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Declaration made this _____ day of _____, _____,
(day) (month) (year)

I, _____, give permission to IMA Medical Group to discuss any of my medical information with the following individuals:

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

Signed: _____

Witness 1: Signed: _____

Name: _____

Witness 2:

Signed: _____

Name: _____



AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

Patient Name: _____ SS# _____
Telephone: _____ DOB: _____/_____/_____
Address: _____ City: _____ State: _____

Name of Healthcare Facility from which Records are Requested: _____ Ph: _____ Fax: _____
(Please Print)
Address: _____ City: _____ State: _____ Zip: _____
Dates of Treatment Requested: _____ Reason for Disclosure: _____

**MAIL INFORMATION TO: IMA MEDICAL GROUP
6675 Westwood Blvd, Suite 475, Orlando, FL, 32821**
FAX TO: 866-914-1818 or Email: medicalrecords@inhealthmd.com

I hereby authorize **IMA MEDICAL GROUP** to obtain the health information indicated below that is contained in my patient records to the recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, genetic testing information, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Check a Box

| | | | | | |
|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | Complete Record Last 5 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Radiology Reports |
| <input type="checkbox"/> | Laboratory Reports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pathology Reports |
| <input type="checkbox"/> | Other (Specify) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical Therapy |
| <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- Drug/ Alcohol Abuse or Treatment HIV/ AIDS Test Results or diagnoses Genetic Testing Information
 Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.**

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the Recipient may no longer be protected by law.

Signature of Patient or Legal Representative

Date Signed

Printed Name:

Relationship if not Patient:

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.



Notice of Privacy Practices

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

- ❖ At IMA Medical Group, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- ❖ The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care or your primary doctor.
- ❖ We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- ❖ We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- ❖ We may share your medical information with our business associates, such as billing service. We have a written contract with each business associate that requires them to protect your privacy.
- ❖ We may use your information to contact you. For example, we may send newsletters or other information.
- ❖ We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- ❖ We may release some or all of your health information when required by law.
- ❖ If this practice is sold, your information will become the property of the new owner.
- ❖ Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- ❖ You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- ❖ You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- ❖ As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy your health information, with a few exceptions: Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- ❖ You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- ❖ You have the right to receive a copy of this notice.
- ❖ If we change any of the details of this notice, we will notify you of the changes in writing.
- ❖ You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact one of the staff members at IMA MEDICAL GROUP at (407) 845-0330.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of IMA MEDICAL GROUP Notice of Privacy Practices.

Print Name: _____ Date: _____

Signature: _____

If signing as a parent or guardian, please note the name of the patient:



NO SHOW POLICY

In an effort to better serve our patients, we require a 24-HOUR ADVANCE NOTICE, if you are not able to keep your appointment. Same-day Cancellations will be treated as **NO SHOW**.

I _____,
understand the importance of keeping my appointment and agree to notify the office at least 24 hours in advance, if I am unable to keep it.

I also understand that if I do not give the required advance notice, I will be charged a \$20.00 No-Show fee.

Patient

Date

Witness

Date