Welcome to
Cooper Family Medical

Please keep this letter so you have access to this information at any time you need it.

The doctor is available 24 hours a day for your urgent healthcare needs and will return your call. Avoid expensive emergency room co-pays and long waits.

▶ Please call our office at (941)744 5510 ◀

- If you have an urgent healthcare need during business hours, 8:00am-5:00pm, we will make the necessary arrangements to see you.

- **Preferred Hospital:** Your doctor has selected this hospital because of their confidence and professional rapport they have with the hospital and the specialists.

▪ MANATEE MEMORIAL HOSPITAL •

- **Preferred Laboratory:**

• LAB CORP. • QUEST

- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your doctor will need to see you in the office to assure your continued recovery.

- If you are a Medicare patient: your doctor encourages you to be seen at least every six (6) months. This will help both you and your doctor maximize preventative care.

- Scheduling appointments: Call our office to schedule your appointment and be sure to always bring your medication with you to each appointment. If you are unable to keep your appointment, please call us at least 24 hours in advance so we can offer that appointment to someone else with a healthcare need.

You will be subject to a fee of $50.00 if the appointment is not canceled
AT LEAST 24 HOURS IN ADVANCE

- To avoid receiving a bill: Call the office before seeing a specialist or undergoing a procedure as Humana requires a referral. DO NOT GO FOR LAB TESTS, XRAYS, PHYSICAL THERAPY, ETC. UNTIL OUR OFFICE IS NOTIFIED

Cooper Family Medical

Date: _____

General Information:

Patient Last Name	first Name	MI	Dale of Birth

Home Phone Number	Cell Phone Number	E-Mail Address

Home Address	City	State	Zip

___ - ___ - ____ (Social Security #)

Male Female (Please Circle)

Single Married Divorced Widowed (Please Circle}

Employer: _____

Pharmacy: _____

Primary Insurance Carrier	Policy ID
HMO PPO POS OTHER (Type Of Plan)	( ) Insurance Carrier Phone #

Primary Card Holder's Name/Relation: _____ DOB: _____

Second Insurance Carrier	Policy ID
HMO PPO POS OTHER {Type Of Plan)	[ ) Insurance Carrier Phone #

IMPORTANT: In case of an emergency, who would we contact?

Name	Relationship

Address{Street/City/Zip)	[ ) Home Phone

{) Cell Phone	( ) Work Phone

"1 understand that I am financially responsible for all charges, whether or not paid *by* Insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medicat information to determine benefits payable to related services. By signing this form, I hereby give cooper Family Medical consent to perform medical treatment."

(Patient/Guardian Signature) _____ Date _____

Pt. Name:_____

Pt. Date of Birth:_____

Patient Medical History

Date of last Physical Exam: _____

Smoking History:
Current: Packs per day:_____ Former: Packs per Day: _____ Never

Alcohol History:
Do you currently drink alcohol Yes No If yes, How much? _____

Current Drug use?: Marijuana LSD Cocaine Heroin Speed Other

Marital Status: Married Divorced Single Widowed

Do you have any children: _____ If so, how many: _____

Are you employed: Yes No

Surgical History:

List any time you have been under anesthesia or have had any surgeries:

Do you have any hardware or artificial joints or limbs:

Allergies:

Please list any drug, food, or environmental allergies:

Allergy:	Reaction:

Medications:

Name:	Dose:	How Often?:	What is it for?:

Preventative History:

Last Physical/GYN Exam: _____

Last Complete Bloodwork: _____

Last Eye Exam: _____

Last Mammogram: _____

Last Bone Density/DEXA: _____

Last Colonoscopy/Cologuard: _____

Last Prostate Exam: _____

Last Influenza Vaccine: _____

Last COVID Vaccine: _____

Last Tetanus Vaccine: _____

Do you see any specialists on a yearly basis? If so, who? _____

Family History:

Are you adopted? Yes No

Relation	Age if Living	Major Health Problems	Age at death	Cause of death
Father				
Mother				
Siblings				

Physician Signature: _____

Cooper Family Medical, PLLC

5123 4th Avenue Circle East
Bradenton, Florida **34208 P:(941)744-5510**
F:(941)744-5166

Patient Name: _____

Payment Policy

All patients must complete our Patient Payment Registration form prior to seeing our medical providers,

Thank you for choosing Cooper Family Medical, PLLC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided upon request.

All Payments Due at Time of Service

_____ Initial This office maintains a pay at time of service policy. You will need to know your insurance policy in advance in order to be aware of the portion of your visit for which you will be responsible. If you accrue a credit balance, we will maintain that credit balance on your account and apply it to a future balance that may accumulate. If a credit balance exceeds $30.00, we will refund the credit by check to the address on your account. The policies are designed to comply with the Fair Debt Collection Practices Act and any applicable state laws. If your account goes to collections, we will no longer provide medical services to you, at which that time you will then be discharged from Cooper Family Medical.

Regarding Insurance

_____ Initial Regarding insurance plans where we are a participating provider, all payments are due including but not limited to deductibles from previous visit copay, and/or non- covered services and will be collected upon your arrival. Your Insurance policy is a contract between you and your insurance company - we are NOT party to that contract We cannot bill your insurance unless you provide timely clear and accurate insurance information. you have new insurance, or a change in insurance plans, you must provide us with clear and accurate insurance Information within 30 days of your visit for your Insurance to be billed. If you are unable to provide this information within 30 days you will be responsible for any visits that may have occurred.

Statements & Claim Submission

_____ Initial We will submit your claims and assist you in any *way* reasonable we can help to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. We will send you a statement should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. When you receive your explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. There will be a $35 charge for check denied by your bank and returned to the office for any reason. If your account is over 90 days past due for nonpayment, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if your account remains unpaid, we may refer your account to the three major credit bureaus which may adversely effect your credit.

Minor Patients

_____ Initial The adult accompanying a minor and the parents(or guardian) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office visit.

Divorced Parents/ Legal Custody Issues

_____ Initial The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out BEFORE your child's appointment. If a separate patent Is responsible for payment, we are not party to this arrangement. Payment is due in full at the time of service, and *we* will prepare a receipt of payment verification purposes.

Appointment Reminders and Missed Appointments

_____ Initial Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. We are not able to guarantee a reminder call for each visit, but we will certainly try.

Unless canceled **AT LEAST 24 HOURS IN ADVANCE**, our policy is to charge the person who is scheduled for the appointment a missed appointment fee at the rate of $50.00. Please help us serve our entire patient population best by keeping scheduled appointments. Patients who miss three or more appointments without notice may be dismissed and may no longer receive medical treatment at our medical practice.

Cooper Family Medical, FLLC is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guideline.

_____	_____	_____
Printed Name of Patient/Responsible Party	**Signature of Patient/Responsible Party**	**Date**

Cooper Family Medical

Name: _____ Date of Birth: _____

HIPAA

Do We Have Permission to:

Mail medical Information to your home? Yes___ No ___

Leave a detailed message on your home/cell answering machine for:

Appointment Information? Yes___ No ___
Billing Information? Yes___ No ___
Other Medical Information? Yes___ No ___

Leave a detailed message on your work answering machine for:

Appointment Information? Yes___ No___
Billing Information? Yes___ No ___
Other Medical Information? Yes___ No___

I give permission to share information with the following person{s):

Appointment Information: _____ Relation: _____
Billing Information: _____ Relation: _____
Medical Info (including biopsy & lab results): _____ Relation: _____
Emergency Contact: _____ Relation: _____

With my consent, Cooper Family Medical may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Cooper Family Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Cooper Family Medical use and disclosure of informatlor. according to the Notice of Privacy Practices, and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize the release of any medical information necessary to all my insurance companies to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize paymen direct to Cooper Family Medical. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize use of this form for all my insurance submissions. I authorize Cooper Family Medical to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and Insurance claim for submission. Under penalty of perjury, I declare that I have read the forgoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature:_____Date:_____

Witness Signature(CFM Employee):_____Date:._____

Cooper Family Medical

Request for protected health Information/Patient authorization for Release of Records

Patient Name: _____ S.S. #: _____

Date of Birth: _____Patient Phone Number: _____

Treatment Dates to be released: _____

Request information from:	Release information to:
_____ _____ _____ _____	Cooper Family Medical 5123 Fourth Avenue Circle E. Bradenton, Fl. 34208 Phone: 941-744-5510 Fax: 941-744-5166

Purpose of the Disclosure: Insurance Legal Continuing Care Personal Other (specify): _____

Specific Description of the Information to be disclosed:

___ Hospital Records ___ Pathology Reports ___ Therapy Records
___ Radiology Report ___ EKG ___ Mammogram
___ OV Note ___ Lab Results ___ Orders
__ Other (Specify): _____

Specific information to NOT be disclosed: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by the Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department. I understand that my revocation is not effective to the extent that the persons or the organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize this medical facility and/or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release this medical facility and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information, or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 180 days from the date signed.

This information may include Medical, Surgical, Psychiatric, Substance Abuse, and HIV/Aids information. I authorize that this information may be faxed when applicable.

_____ _____
Signature Date

_____ _____
Patient's Representative Signature and Authority to Sign Date

_____ _____
Witness Date