EMERALD WATERS
PRIMARY CARE
INTERNAL MEDICINE & PEDIATRICS

Welcome to Emerald Waters Primary Care!

Our goal at Emerald Waters Primary Care is to deliver the highest quality of care possible in a compassionate and caring environment. We are excited you have chosen us for your primary care needs and look forward to being a part of your healthcare team.

We ask that you present your insurance card and picture ID when you arrive to your appointment. Please arrive 20 minutes prior to your appointment time in order to fill out paperwork. To limit delays, we do ask that you arrive on time for your appointment with an understanding that if you are late, it may be necessary to reschedule your appointment to another time or date.

If you are unable to attend your appointment, we ask that you provide us at least a 24-hour notice. Please note our no-show policy within this packet. Although we schedule individual appointments, it can be difficult to adhere to an exact schedule when dealing with complex medical issues. We apologize in advance for any delays and appreciate your understanding.

Please note, in general, we do NOT prescribe:

- Chronic narcotic pain medicine
- Sedatives such as, but not limited to, Xanax or Klonopin
- Prescription sleeping pills for chronic or long-term use

Our office hours are Monday through Thursday from 8:00 am to 5:00 pm, and Friday from 8:00 am to 12:00 pm. We are closed for lunch from 12:00 pm to 1:00 pm and the first Friday of each month.

When leaving a message, please speak clearly, provide your name, date of birth, your phone number, and briefly state the nature of your call. Please note, for your safety, we are unable to diagnose illness over the phone. If you feel you need to make a change to your current medications, you have new symptoms, or your diagnosed symptoms have changed, please schedule an appointment.

If you have any questions, please call our office at 850.898.0149. Thank you for choosing Emerald Waters Primary Care!

Healthy regards,

*Emerald Waters Primary Care*
*Dr. Curtsinger & Staff*

EMERALD WATERS PRIMARY CARE
INTERNAL MEDICINE & PEDIATRICS

# PATIENT REGISTRATION FORM

**PATIENT INFORMATION**

Last Name: _____ First Name: _____ MI: _____ Social Security # _____

Date of Birth: _____ □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone _____ Work Phone _____

Best daytime number to reach you: □ Home □ Cell □ Work □ Would prefer to communicate through Portal

Email: _____ Preferred Language _____

Race: □ Unknown/Declined □ African American/Black □ American Indian Native/Alaskan Native

□ Asian □ Caucasian/White □ Native Hawaiian/Pacific Islander

Ethnicity: □ Unknown/Declined □ Hispanic or Latino □ Not Hispanic or Latino

Occupation: _____ Employment Status: □ Full-Time □ Part-Time □ Not Working □ Student

Emergency Contact: _____ Relationship: _____ Phone: _____

**INSURANCE INFORMTION**

Please provide insurance card and photo ID to scan into your record for authorization and billing purposes.

If you are not the primary person on the insurance, please provide the following information:

Primary insurance holder's name: _____ Date of Birth: _____

Relationship to primary insurance holder: _____ Primary insurance holder's SS# _____

## Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient/ Patient's Representative Signature Date and Time

_____ _____
Print Patient/Patient's Representative Name Relationship to Patient

EMERALD WATERS PRIMARY CARE
INTERNAL MEDICINE & PEDIATRICS

# PATIENT CONSENT AND RESPONSIBILITY AGREEMENT

**Welcome to Emerald Waters Primary Care. We look forward to providing you with quality, comprehensive, and compassionate care.**

**Please review the following patient responsibilities, sign, and return.**

**CONSENT FOR TREATMENT:** I consent to all services as ordered or performed by my provider. This care may include, but not limited to medical examination and treatment, administration of medications, vaccines, point of care testing, and procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

**MEDICAL INSURANCE:** I authorize Emerald Waters Primary Care (EWPC) to bill my insurance or third-party payer. I assign to any medical information that is required for EWPC to receive payment for its services to me. I understand that it is my responsibility to inform my provider of any changes to my demographics and/or insurance. I will provide my insurance and photo ID upon request and consent to have a copy of them scanned into my medical record. I understand that I will be considered "self-pay" and required to pay in full at the time of services rendered if I am unable to provide insurance information at the time of my visit.

**OBLIGATION TO PAY MY BILL:** I understand that all charges for services rendered are due and payable at the time of service. If I have insurance, I agree to pay for any deductibles, co-payments, and/or the patient responsibility portion of the fee at the time of service. I understand that the payment requested is an estimate of insurance coverage and is subject to the actual reimbursable amount. I acknowledge that I am financially responsible for my provider bills which are not paid for by my insurance, and I agree to pay the bill promptly. Established patients may be eligible for a payment plan. Please contact 850.898.0149 for details.

**RETURN CHECK POLICY:** I understand that I am responsible for all service charges and collection fees associated with checks returned from the bank and will pay these fees upon notice. Upon a non-sufficient fund's notification, EWPC will automatically re-deposit the check to attempt to recover my payment (one time only). The NSF fee for EWPC is $35.

**AUTHORIZATIONS:** I understand that it is my responsibility to notify EWPC if my third-party payor requires pre-authorization for procedures, imaging and/or for referrals for specialists. I understand the EWPC staff may assist me, but failure to obtain necessary authorizations before going to a specialist, procedures, and/or imaging, if I change my insurance and an authorization is required, I will provide the new information to EWPC with at least one week notice prior to service(s) so they may attempt to get an authorization.

**REFERRALS:** I understand that referrals may take up to two weeks to process. If I have not heard from the provider that I was referred to within two weeks, I understand that I should call or send a portal message to EWPC to investigate.

**LAB RESULTS:** I understand that I will be notified of my lab results via the portal (if enrolled); otherwise, I will receive a phone notification or letter. Any abnormal labs or normal labs that requires further workup for symptoms may require an appointment.

**COMMUNICATION**: By providing a home/cellular telephone number and email address I give EWPC my permission to use this information to contact me. Contact incudes receiving calls and text/email messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

**PATIENT PORTAL:** I understand that EWPC has a patient portal and may offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program that uses a secure username and password. I acknowledge that the portal does not contain my entire record. I may request specific items be uploaded to the portal. EWPC will email me and invite to the portal upon request and then it may be accessed at 24579.portal.athenahealth.com

**BUSINESS HOURS:** I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

**PATIENT FORMS COMPLETION:** I understand that there is a fee to complete most forms: $50. I acknowledge that these forms may take up to 14 days for processing. I understand that an office visit may be necessary if I request the provider complete certain forms for me. The fee for the forms will be waived if forms are able to be completed during office visit. The visit is subject to co-pay, coinsurance, and/or deductibles.

**PRESCRIPTIONS AND/OR REFILLS:** I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact my pharmacy and allow 48 to 72 business hours to process. Prescriptions may be requested through the patient portal. I understand refill requests will only be processed during office hours.

**CONTROLLED SUBSTANCES:** I understand that controlled substance prescriptions are highly regulated and requires my provider to review the Florida registry, EFORSCE, prior to prescribing the prescription. I understand that this office does not prescribe chronic narcotics under any circumstances and may prescribe other controlled substances on a case-by-case basis.

**APPOINTMENTS:** I agree to bring a list of all over the counter and prescribed medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I may be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment.

**NO SHOW POLICY:** I understand the EWPC may charge me a $20 no-show/last minute cancellation notice fee. I also understand that I may be discharged from the practice if I have three no-shows/last minute cancellations. I acknowledge that it is my responsibility to keep my contact information up to date so that I will receive reminders of my upcoming appointments.

**EXPIRATION:** I understand that this form is effective for twelve (12) months from the date signed. I acknowledge that I can request that it expire prior to this date by providing EWPC with a written request to do so.

**VIDEO SURVEILLENCE:** I understand that non-exam/non-private areas of this practice are under video surveillance and recording is in progress. The use of video surveillance is for the purposes ensuring the safety of patients and staff.

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY EWPC AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.**

| _____ | _____ | _____ |
|---|---|---|
| Patient/ Patient's Representative Signature | Date and Time | Patient's Date of Birth |
| _____ | _____ | |
| Print Patient/Patient's Representative Name | Relationship to Patient | |

EMERALD WATERS
PRIMARY CARE
INTERNAL MEDICINE & PEDIATRICS

## Communication with Family Members and Others Involved in Patient Care

**By signing this form below, I give Emerald Water Primary Care (EWPC) permission to verbally discuss my health care with people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgement of my provider, needs to be shared.**

- **I understand that information may be released to family members or others without this form, if allowed by federal and state law.**
- **I understand that listing a person on this form does not give permission to receive a copy of my protected health records or allow them to consent for health care services on my behalf.**
- **I understand that this form is voluntary and that I am not required to sign it to receive care. I am able to change or revoke this form at any time by providing a new form to the office.**

| Name | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Patient/ Patient's Representative Signature _____ Date and Time _____ Patient's Date of Birth _____

Print Patient/Patient's Representative Name _____ Relationship to Patient _____

# Authorization for Release of Medical Records

EMERALD WATERS PRIMARY CARE
INTERNAL MEDICINE & PEDIATRICS

**Name of Patient** _____ **Date of Birth** _____

**Information to be released:**

□ Complete Record □ Other _____

**The protected health information is being used or disclosed for the following purpose:**

□ Continuity of Care □ Personal Use □ Other _____

Information may be released:

---

**To Emerald Waters Primary Care from the authorized provider(s)/person listed below**

Provider's Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

Provider's Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

---

**From Emerald Waters Primary Care to the authorized provider(s)/person listed below**

Provider's Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

Provider's Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

---

This authorization will expire twelve (12) months from the date of which it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the reception desk or the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Patient/ Patient's Representative Signature Date and Time

_____ _____
Print Patient/Patient's Representative Name Relationship to Patient

**Send records to:**
**Emerald Waters Primary Care**
**7295 Navarre Pkwy, Navarre, FL 32566 • Phone 850.898.0149 • Fax 833.913.2541**

## 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 INFORMAITON. PLEASE READ IT CAREFULLY.

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. This medical information is used by Emerald Waters Primary Care (EWPC)) in many ways while performing normal business activities. Your protected health information may be used or disclosed by EWPC for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospitals to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. EWPC may use or disclose your health information for case management and services. EWPC* may *send the medical information to insurance companies, or community agencies to pay for the services provided you.*
Your information may be used by certain personnel to improve the health care operations. EWPC will also send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons. Investigations related to a missing child.
- Internal investigations and audits by EWPC. Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals. District medical examiner investigations.
- Research approved by EWPC, court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by EWPC will require your written authorization. These uses and disclosures may be for research purposes.

This authorization will have an expiration date that can be revoked by you in writing.

**INDIVIDUAL RIGHTS**

You have the right to request EWPC to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. EWPC is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. EWPC will contact you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by EWPC within 30 days of the receipt of your request to obtain a copy of your protected health information. You must complete the Authorization to Release Medical Records form and submit the request to the office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If EWPC cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and EWPC agree to.

EWPC cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time EWPC is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by EWPC.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. EWPC may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the EWPC.
- Is not protected health information.

- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, EWPC will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. EWPC may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures EWPC may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request.

Appointment reminders: We may mail, email, or call you with health care appointment reminders.

Sign-in-sheets: We may use sign-in sheets in our offices and call your name when pulling you back for treatment.

Satisfaction Surveys: We may use your information to contact you requesting feedback on the services provided to you by EWPC. Your answers will help us provide better care to our patients and community we serve.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

**EMERALD WATERS PRIMARY CARE DUTIES**

EWPC is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how EWPC keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. EWPC has the responsibility to notify you following a breach of your protected health information.

As part of the EWPC's legal duties this Notice of Privacy Practices must be given to you. We are required to follow the terms of the Notice of Privacy Practices currently in effect.

EWPC may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the company website at http://www.emeraldwatersprimarycare.com and will be available at the office.

**COMPLAINTS**

If you believe your privacy health rights have been violated, you may file a complaint with our practice administrator. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. You may mail it to the address below or you may give the compliant to the office in person. You may also send the complaint to the Department of Health and Human Services. EWPC will not retaliate against you for filing a complaint. For questions or concerns, you may contact the practice administrator at 850.898.0149.

**FOR FURTHER INFORMATION**

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice or to the practice administrator.

**EFFECTIVE DATE**

This Notice of Privacy Practices is effective beginning January 3, 2022 and shall be in effect until a new Notice of Privacy Practices is approved and posted.