Erica L. O'Donnell D.O., P.A.
1400 Hand Ave, Suite K, Ormond Beach, FL 32174
Telephone: (386) 671-2771 Fax: (386) 671-6458

MEDICAL HISTORY

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet your healthcare needs, please fill out this form in its entirety. If you have any questions, or require assistance, please ask us – we will be happy to help.

TODAY'S DATE: _____

Patient Name: _____ Date of Birth: _____

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

Social Security Number: _____

Primary Phone # _____ Secondary Phone # _____

E-Mail: _____

May we use the above e-mail for patient portal access? Yes ☐ No ☐

ALLERGIES: (Please mark all that apply)

Food: No Allergies If So, Please List: _____

Drugs: __ No Allergies If So, Please List: _____

Latex [Y/N] *(Please Circle)*

Previous Primary Care Provider: _____

Specialists: _____

_____

Reason for Establishing: _____

Preferred Pharmacy: _____ Address: _____

Phone Number: _____

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY: Please mark all that apply. Indicate relative, and if relative died from the condition.

Condition	**Relative**	**Cause of Death [Y/N]**	**Condition**	**Relative**	**Cause of Death [Y/N]**
□Asthma			□Hypertension		
□Glaucoma			□Stroke		
□Arthritis			□Heart attack		
□COPD			□Thyroid Disease □Hypo| □Hyper		
□Diabetes| Type □I □II			□Kidney Disease		
□Depression/Anxiety			□Other: _____		
□Heart Disease			□Breast Cancer		
□Blood Disorder			□Prostate Cancer		
□High Cholesterol			□Cancer Type _____		

SOCIAL HISTORY:

Do you use Tobacco products? □ I Have Never Used Tobacco □ Yes, currently: ___ packs/day

□ Former Tobacco User **Start Date: _____** □ I Use Chewing Tobacco

Quit Date: _____

*Prior to quitting; how many packs per day were smoked? _____

Do you Consume Alcohol? □ No Alcohol □ Daily Alcohol, ___ drinks per day

Are you a social drinker? □ No □ Yes

If yes, how many drinks do you consume a week?

□ Rarely □ Occasionally □ 1-2 per week □ 3-5 per week □ More than 5 per week

Recreational Drugs? □ No □ Yes _____ OCCUPATION: _____

MARITAL STATUS:

□ Single □ Married □Married with Children □ Divorced □ Separated □ Widowed

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Please mark all that apply *(if you have ever received medication or treatment for the following conditions)*

Condition	**Condition**
□ Asthma	□ Stroke
□ COPD	□ Anemia
□ Depression	□ Blood Disorder
□ Insomnia	□ Kidney Disease
□ Heartburn	□ Arthritis □ Osteo □ Rheumatoid
□ Glaucoma	□ Seizure Disorder
□ Diabetes □Type I □Type II	□ Gout
□ High Cholesterol	□ Pregnancies # _____ □Cesarean # _____
□ High Blood Pressure	□ Cancer Type _____
□ Thyroid Disease □Hypo □Hyper	□ Other: _____
□ Heart Disease	□ Other: _____

SURGICAL HISTORY: Please list surgeries and dates *(Approximate date if unknown)*

Year	**Type**	**Year**	**Type**

SCREENING AND PREVENTION: Please indicate when it last performed *(Approximate date if unknown)*

Procedure	**Date**	**Procedure**	**Date**
Mammogram		Colonoscopy	
DEXA/Bone Density		Flu Vaccine	
Pap		Pneumonia Vaccine	
Lab Work		Shingles Vaccine	
Prostate Cancer Screening		Other Colorectal Cancer Screening	

Patient Name: _____ Date of Birth: _____

MEDICATION LIST: *(Please include **all** prescriptions as well as over-the-counter medications, vitamins, and supplements)*

Medication	Strength	Directions	Ordering Physician

Patient Name: _____ Date of Birth: _____

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CONSENT TO TREAT

I hereby consent to allow **Erica L. O'Donnell, D.O., P.A.** physicians, nurse practitioners, and other authorized healthcare professionals and staff to provide medical evaluations, treatment, diagnostic testing, procedures, and other healthcare services as deemed appropriate by the treating provider.

I understand that the practice will use its professional judgment in recommending and providing care. I acknowledge that no guarantees or assurances have been made regarding the outcome or results of any examination, treatment, procedure, or diagnostic testing.

To protect the privacy, safety, and confidentiality of our patients, providers, and staff, **audio and/or video recording of any employee, including physicians, nurse practitioners, or other members of the healthcare team, is prohibited without prior written authorization from the practice.** Unauthorized recording may result in termination of the patient-provider relationship in accordance with applicable policies and procedures.

Patient Name (Print): _____

Signature of Patient or Legal Representative: _____

Relationship to Patient (if applicable): _____

Date: _____

Patient Name: _____ Date of Birth: _____

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Financial Policy

Thank you for choosing **Erica L. O'Donnell, D.O., P.A.** as your healthcare provider. We appreciate the opportunity to participate in your medical care and are committed to providing you with high-quality healthcare services.

Please understand that **payment for services is an important part of your treatment agreement with our practice.** This Financial Policy explains your financial responsibilities and helps us provide efficient, quality care to all our patients.

Insurance

As a courtesy, we will submit claims to your **primary insurance carrier** for covered services provided by physicians or other healthcare professionals in our practice who participate with your insurance plan.

Your health insurance policy is a contract between **you and your insurance company.** Our practice is not a party to that contract, and payment by your insurance carrier is never guaranteed.

You are responsible for:

- All co-payments, deductibles, and co-insurance amounts.
- Any non-covered or non-authorized services.
- Services denied by your insurance company.
- Charges that exceed your insurance benefits.

If your insurance company has not paid your claim within **60 days** of the date of service, or if the claim is denied, the remaining balance may become your responsibility.

Choosing to Receive Treatment

Your healthcare provider may recommend services, tests, procedures, medications, or treatments that are medically appropriate for your care. Insurance companies may determine that some services are not covered or are only partially covered.

Choosing to receive a recommended service means you understand that you are financially responsible for any amount your insurance company does not pay.

Financial Policy (continued)

Examples of services that may not be covered by all insurance plans include, but are not limited to:

- Annual physical examinations
- School, sports, employment, or camp physicals
- Vaccines and immunizations
- Shingles vaccine
- Pap smear examinations
- Prostate cancer screening
- Laboratory testing
- Electrocardiograms (EKGs)
- INR testing
- Allergy testing
- Drug screenings
- Services excluded by your individual insurance policy

Payment

Payment is due at the time services are rendered unless the Office Manager has approved prior financial arrangements.

We accept cash, checks, and most major credit and debit cards.

Returned checks are subject to applicable bank fees and administrative charges.

Billing and Collections

Patients are responsible for keeping their insurance information current and providing accurate billing information.

If your account becomes delinquent, additional collection efforts may be necessary. Accounts referred to for collection may be subject to reasonable collection costs, attorney's fees, court costs, and other expenses permitted by applicable law.

If you are experiencing financial hardship, please contact our Office Manager before your account becomes delinquent. We are happy to discuss payment arrangements when appropriate.

Patient Name: _____ Date of Birth: _____

Financial Policy (continued)

Patient Acknowledgments

Please initial each item indicating you have read and understand the following policies.

_____ Prescription Refills

Prescriptions are typically issued during your office visit. For refill requests outside of a scheduled appointment, please contact your pharmacy and request that they send an electronic refill request to our office.

Please allow **48 business hours** for routine refill requests. Prescription refills are not processed on weekends or holidays.

Our practice utilizes secure electronic prescribing (e-Prescribing) whenever possible. Certain medications, including controlled substances, may require an office visit before additional refills are authorized.

_____ Controlled Substance Prescriptions

Patients receiving controlled substance prescriptions must comply with our Controlled Substance Agreement, including required follow-up appointments, urine drug screening, and any other monitoring deemed medically appropriate by their healthcare provider.

_____ Medical Records

Copies of your medical records will be provided in accordance with applicable federal and Florida law. Any fees permitted by law for copies or postage will be disclosed before records are released.

Records received from another healthcare provider remain the property of that provider and must be obtained directly from their office.

_____ Laboratory Services

You are responsible for verifying which laboratory participates with your insurance plan and understanding your laboratory benefits before services are performed. Our office cannot guarantee insurance coverage for laboratory testing.

Patient Name: _____ Date of Birth: _____

Financial Policy (continued)

_____ Workers' Compensation and Third-Party Liability

Our practice does not participate in Workers' Compensation insurance and does not provide care for injuries resulting from workers' compensation claims or third-party liability claims, including motor vehicle accidents.

Please notify our staff before scheduling if your visit relates to a workplace injury or accident.

Patient Financial Responsibility

By signing below, I acknowledge that:

- I have read and understand this Financial Policy.
- I understand that I am financially responsible for all charges not paid by my insurance company.
- I agree to pay all applicable co-payments, deductibles, co-insurance, and non-covered charges.
- I authorize payment of insurance benefits directly to **Erica L. O'Donnell, D.O., P.A.** when applicable.
- I understand that failure to comply with this policy may result in additional collection activity as permitted by law.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Patient Name: _____ Date of Birth: _____

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NOTICE OF PRIVACY PRACTICES

Introduction:

At Erica O'Donnell D.O., P.A., we are committed to providing patient care and using health information responsibly while protecting your rights. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. This notice is effective September 01, 2019, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information:

Each time you visit Erica O'Donnell D.O., P.A., a record of your visit is made. Typically, this record contains your symptoms, examination notes, test results, diagnoses, treatment, and a plan for future care of treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were provided,
- Tool in educating health professionals, source of data for our planning and marketing, and
- Tool with which we can access and improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Notice of Privacy Practices (Continued)

Your Health Information Rights

Although your health record is the physical property of Erica O'Donnell D.O., P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Rights upon request,
- Obtain an accounting disclosure of your health information as provided in 45 CFR 164.538,
- Request communications of your health information by alternative means or at alternative locations, request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
    - Request health information to be disclosed to another medical facility,
    - Revoke your health information except to the extent that action has already been taken or mandated by law.

Our Responsibilities

Erica O'Donnell D.O., P.A. 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,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right change our practices and to make new provisions effective for all protected health information we maintain. Should our information practice change, we will post a revised notice visible in our office.

We will not use or disclose your health information without your authorization, except as described in this notice. We will no longer use or disclose your health information after we have received a written revocation of the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our office at (386) 673-0517.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Office for Civil Rights. The address for the OCR is listed below:

Officer for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201

Notice of Privacy Practices (Continued)

Notification: We may use or disclose your protected health information, as permitted or required by law, to notify or assist in notifying a family member, personal representative, caregiver, or another individual you have identified regarding your location, general condition, or matters related to your care or payment for your care. We may also share information with individuals involved in your care when, in our professional judgment, doing so is in your best interest or as otherwise permitted by applicable law.

If you wish to limit or change the individuals with whom we may share your information, please notify our office in writing.

Communication from offices: To assist in carrying out Treatment, Payment, and Health Care Operations (TPO), we may communicate with you using the contact information you provide. These communications may include but are not limited to: appointment reminders; information regarding your treatment or follow-up care; prescription or refill notifications; laboratory, imaging, and other test results; billing and payment information; insurance matters; and other communications related to your health care.

Unless you instruct us otherwise, we may: call your home, mobile phone, or other designated phone number and leave a message with you, on your voicemail, or with an individual who answers the phone when appropriate; send text messages to the mobile phone number you provide for appointment reminders and other communications related to your care; send emails to the email address you provide for communications related to your care, including patient statements, appointment reminders, and notifications that information is available in your patient portal, mail correspondence, including appointment reminders, billing statements, and other information related to your care, to the mailing address you provide; post information, including laboratory and imaging results, visit summaries, educational materials, and secure messages, to your patient portal. You may also receive email or text notifications advising you that a new message or document is available on your patient portal.

Communication with family: Our healthcare providers and staff may, using their professional judgment and as permitted by applicable law, disclose protected health information that is directly relevant to a family member, other relative, close personal friend, caregiver, or any other individual you identify as being involved in your care or the payment for your care. Such disclosures will be limited to the information necessary for that person's involvement in your care or payment for your care.

If you prefer that we do not communicate with certain individuals or wish to designate specific individuals with whom we may share your health information, please notify our office in writing.

Open treatment areas: At times, patient care may be provided in treatment areas where complete privacy cannot be guaranteed. Although we make every reasonable effort to safeguard your privacy and discuss your health information as discreetly as possible, there may be occasions when limited information is inadvertently overheard by other patients, visitors, or staff during your treatment.

Notice of Privacy Practices (Continued)

If you have concerns about discussing your health information in an open treatment area or would prefer additional privacy, please notify a member of our staff or the Office Manager. We will make reasonable efforts to accommodate your request whenever possible.

Marketing: We may contact you by telephone, voicemail, text message, email, mail, or through our Patient Portal to provide appointment reminders, follow-up instructions, information regarding your treatment, test results, prescription refill reminders, or other communications related to your healthcare.

We may also contact you to inform you about treatment alternatives, preventive health services, wellness programs, disease management services, or other health-related benefits and services that may be of interest to you.

If you prefer not to receive certain types of communications or would like to change your communication preferences, please notify our office in writing. We will honor your request to the extent required by applicable law.

Food and Drug Administration (FDA): We may disclose your protected health information to the **U.S. Food and Drug Administration (FDA)** or other individuals or entities acting under its authority, as permitted or required by law, for purposes such as reporting adverse events, product defects or problems, biologic product deviations, tracking regulated products, enabling product recalls, repairs, or replacements, or conducting post-marketing surveillance and other activities related to the safety, effectiveness, or quality of FDA-regulated products.

Public Health: We may disclose your protected health information to public health authorities or other government agencies authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability. These disclosures may include reporting diseases, injuries, vital events (such as births or deaths), conducting public health surveillance, investigations, or interventions, reporting adverse events, or carrying out other public health activities as required or permitted by applicable law.

Law Enforcement: We may disclose your protected health information to law enforcement officials as required or permitted by applicable law, including in response to a court order, warrant, subpoena, summons, or other lawful legal process, and as otherwise authorized under the HIPAA Privacy Rule.

We may also disclose your protected health information to health oversight agencies authorized by law to conduct audits, investigations, inspections, licensure, or disciplinary actions, civil, administrative, or criminal proceedings, or other activities necessary for oversight of the healthcare system, government benefit programs, or compliance with applicable laws.

In addition, federal law permits members of our workforce or our business associates to disclose protected health information to an appropriate health oversight agency, public health authority, or attorney if they believe in good faith that we have engaged in unlawful conduct or have

Notice of Privacy Practices (Continued)

otherwise violated professional or clinical standards that may have endangered one or more patients, workers, or members of the public, as permitted by applicable law.

IF YOU HAVE QUESTIONS REGARDING THIS POLICY, PLEASE CONTACT THE OFFICE MANAGER.

Acknowledgment of Receipt of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Erica L. O'Donnell, D.O., P.A.

We are required by law to provide you with a copy of our **Notice of Privacy Practices**, which explains how we may use and disclose your protected health information and describes your rights regarding your health information.

By signing below, I acknowledge that I have been offered and/or provided access to a copy of Erica L. O'Donnell, D.O., P.A.'s Notice of Privacy Practices.

I understand that I may request a copy of the Notice of Privacy Practices at any time.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Patient Name: _____ Date of Birth: _____

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Controlled Drug Agreement

I am aware that if a provider from Erica O'Donnell D.O., P.A. prescribes a narcotic analgesic to me to lessen the pain for my condition or any controlled drug for my diagnosis, the medication has certain risks associated with it.
These risks may include, but are not limited to, sleepiness, drowsiness, constipation, nausea, vomiting, dizziness, itching, allergic reaction, slowing of respiratory rate, slowing of reflexes and reaction time, physical addiction and dependence and mental addiction. This medication may lessen the pain but not provide complete pain relief.

In accepting the prescription for controlled medication(s), I agree with the following:

- I will make the doctor aware of all other medication(s) I take
- I am aware of the possible side effects and risks of these medications and will have all recommended laboratory studies
- I will not use any illegal or illicit substance including, but not limited to, marijuana, cocaine, etc.
- I will not seek or use any other narcotic medication(s) except for those prescribed to me by my physician at Erica O'Donnell D.O., P.A.
- I will not share or sell my medication(s)
- I will not operate heavy machinery or drive a motor vehicle while under the influence of these medications
- I will be subject to discussing alternative, non-narcotic therapy at any interval during my treatment
- **I understand that I am responsible for my medication. The medication is prescribed in a 30-day supply. It will not be replaced or filled early for any reason.**
- I understand that I must be seen by the prescribing physician **every 30 days.**
- I understand that I am subject to random drug screening tests, which may not be covered by my insurance, and I am responsible for balances associated with this test
- I will not call the doctor requesting a refill, I will instead make an appointment for renewal of my medication(s)
- I understand that at any time during my treatment I may be referred to a pain management specialist for further evaluation
- **I understand that failure to abide by this agreement could result in termination of the medication being prescribed and/or discharged from the care of the doctor.**

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Patient Name: _____ Date of Birth: _____

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Controlled Substance Drug Screening Policy

All patients receiving a prescription for a controlled substance will be subject to random urine drug screening multiple times a year. Patients refusing or claiming that they are unable to provide a sample for a urine drug screen will not receive a prescription for a controlled drug. All patients receiving a drug screen will be charged a fee of $15.00. This charge is not covered by most insurance plans. We will be collecting the fee from the patient. If your insurance does allow the charge, we will credit your account.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Patient Name: _____ Date of Birth: _____

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Authorization for Discussion of Medical Records

Patient Name: _____ DOB: _____

I have been made aware of the policy and procedures of Erica O'Donnell D.O., P.A. as they relate to HIPAA Requirements.

☐ Yes ☐ No I authorize medical information to be left on the answering machine at the phone number provided by me. Phone: _____

☐ Yes ☐ No I authorize medical information to be sent to the patient portal associated with the e-mail address provided by me. E-mail: _____

☐ Yes ☐ No I authorize Erica O'Donnell D.O., P.A. to discuss my medical history with the following individuals other than my emergency contact:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact Information

Emergency Contact:

_____

Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: ___ Same as Patient _____

City: _____ State: _____ Zip: _____

Patient Signature: _____ Date: _____

This authorization shall remain in effect for one year from the date signed above or until: □_____ (*Specify Date;* ***not to exceed one year***); unless revoked in writing prior to specified dates.

Patient Name: _____ Date of Birth: _____

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Patient Portal Policy and Acknowledgment

Our practice offers a secure Patient Portal to provide convenient access to certain health information and to facilitate communication with our healthcare team.

Appropriate Uses of the Patient Portal

The Patient Portal may be used to:

- View portions of your medical record.
- Review laboratory and imaging results when released by your provider.
- Request for prescription refills.
- Request appointments.
- Receive educational materials and visit summaries.
- Send secure, non-urgent messages to your healthcare team.
- Update certain personal and contact information.

Appropriate Use

The Patient Portal is intended for **non-emergency, non-urgent communications only.**

Do NOT use the Patient Portal for:

- Medical emergencies.
- Urgent medical concerns requiring immediate attention.
- Time-sensitive symptoms such as chest pain, shortness of breath, severe bleeding, signs of stroke, or other serious conditions.

If you are experiencing a medical emergency, call **911** or go to the nearest emergency department.

Response Time

Portal messages are reviewed during normal business hours, Monday through Friday, excluding holidays. While we strive to respond as quickly as possible, please allow up to **two (2) business days** for a response.

Patient Portal Policy and Acknowledgment (continued)

Prescription refill requests may require additional processing time depending on the medication and your provider's review.

Privacy and Security

The Patient Portal is a secure method of communication. Please protect your username and password and do not share your login credentials with others. If you believe your account has been accessed without your authorization, notify our office immediately.

For your privacy, email and text messages sent by our office may only notify you that new information is available in your Patient Portal and will not contain detailed protected health information.

Patient Responsibilities

By using the Patient Portal, you agree to:

- Maintain accurate contact information.
- Keep your login credentials confidential.
- Review messages and test results promptly.
- Understand that not all requests can be completed through the portal and that an office visit may be required when medically appropriate.

Patient Acknowledgment

I acknowledge that I have been offered access to the Patient Portal and have received information regarding its appropriate use. I understand that use of the Patient Portal is voluntary, that it should not be used for emergencies or urgent medical concerns, and that I am responsible for protecting my login credentials.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

If signed by a personal representative:

Representative Name: _____

Relationship with Patient: _____

Patient Name: _____ Date of Birth: _____

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Frequency of Visits

Regular follow-up visits are an important part of maintaining your health and ensuring that preventive care, chronic disease management, medication monitoring, and recommended screenings are addressed appropriately.

All patients of **Erica L. O'Donnell, D.O., P.A.** are expected to have routine follow-up visits at least **twice annually**, unless a different schedule is recommended by the healthcare provider based on the patient's individual medical needs.

The frequency of visits may vary depending on your diagnoses, medications, treatment plan, and overall health status. Patients with certain conditions may require more frequent monitoring, including but not limited to:

1. Chronic Conditions Requiring at Least Every 6-Month Follow-Up

Patients with conditions such as:

- Hypertension (high blood pressure);
- Hyperlipidemia (high cholesterol);
- Prediabetes;
- Hypothyroidism or hyperthyroidism;
- Other stable chronic medical conditions requiring ongoing monitoring;

may be required to have follow-up visits at least every six (6) months.

2. Conditions Requiring at Least Every 3-Month Follow-Up

Patients with conditions such as:

- Diabetes;
- Multiple chronic medical conditions or a complex medical history;
- Use of Schedule III-V controlled medications;
- Other conditions requiring closer monitoring as determined by the healthcare provider;

may be required to have follow-up visits at least every three (3) months.

3. Conditions Requiring Monthly Follow-Up

Patients receiving:

- Chronic pain management;
- Schedule II controlled medications;
- Other medications or treatments requiring close monitoring;

may be required to have monthly follow-up visits or visits at another interval determined appropriate by the healthcare provider.

4. Weight Loss Medication Follow-Up

Patients prescribed weight loss medications are required to have follow-up visits at least every three (3) months unless otherwise directed by their healthcare provider.

These visits allow the provider to monitor medication effectiveness, evaluate safety, assess progress, and review lifestyle changes necessary for achieving and maintaining long-term weight management goals.

5. Forms and Medical Documentation

Patients requesting completion of medical forms or paperwork, including but not limited to disability forms, Family and Medical Leave Act (FMLA) paperwork, work-related forms, school forms, or other documentation, may be required to schedule an appointment.

Appointments allow the healthcare provider to obtain the necessary information and complete documentation accurately based on current medical status.

Failure to maintain required follow-up appointments may result in delays in medication refills, completion of forms, or continuation of certain treatment plans.

By signing below, I acknowledge that I have read and understand the Frequency of Visits Policy. I understand that follow-up requirements are based on my individual healthcare needs and the medical judgment of my healthcare provider.

Patient Name (Print): _____

Date of Birth: _____

Patient/Legal Guardian Signature: _____

Date: _____