IMA Medical Group

# DEMOGRAPHICS FORM

| | | | | | | |
|---|---|---|---|---|---|---|
| Today's date: | Previous Doctor Name, Address, Phone: | | | | | |
| **PATIENT INFORMATION** | | | | | | |
| Patient's last name: First: Middle: | | | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | Email Address: | Birth date: / / | Age: | Sex: ☐ M ☐ 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: | ☐ Dr. | ☐ Newspaper | ☐ Insurance Plan | ☐ Hospital | | |
| ☐ Family | ☐ Friend | ☐ Drove By (Sign) | ☐ Church Ad | ☐ Web Search | ☐ Billboard | ☐ Newsletter | ☐ 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? ☐ Yes ☐ No | | | | | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) | | | |
| Is this patient covered by insurance? ☐ Yes ☐ No | | | | | | |
| Please indicate **primary** insurance | ☐ Medicare | ☐ CarePlus | ☐ Freedom | ☐ Simply | ☐ Optimum | |
| ☐ Amerigroup | ☐ Wellcare | ☐ BetterHealth ☐ | BCBS ☐ Aetna ☐ UHC ☐ Devoted | ☐ Other | | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ | |
| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other | | |
| Name of **secondary** insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: | | | |
| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ 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.: ( ) | | | |

IMA Medical Group

# HEALTHY HISTORY QUESTIONNAIRE

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

| | |
|---|---|
| Name *(Last, First, M.I.)* ☐ M ☐ F | DOB: |
| Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ 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 |
| | | |
| | | |
| | | |
| | | |

IMA Medical Group

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

**Any Other Health problems not listed above**

### Hospitalization

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

### Surgeries

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

IMA Medical Group

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** ☐ Alive ☐ Dead | | ☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Prostate Cancer | Children | ☐ M ☐ F | |
| **Mother** ☐ Alive ☐ Dead | | ☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Breast Cancer ☐ Ovarian Cancer | | ☐ M ☐ F | |
| Sibling | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | ☐ Alive ☐ Dead | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | ☐ Alive ☐ Dead | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | ☐ Alive ☐ Dead | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | ☐ Alive ☐ Dead | |

## HEALTH MAINTENANCE

| | | | **DATE OF LAST VISIT** |
|---|---|---|---|
| Have you ever had an EKG? | ☐ Yes | ☐ No | |
| Have you ever had a Colonoscopy | ☐ Yes | ☐ No | |
| Have you ever had a blood transfusion? | ☐ Yes | ☐ No | |
| Have you ever had a Prostate Exam? (Man Only) | ☐ Yes | ☐ No | |
| Have you ever had Mammogram? (Woman Only) | ☐ Yes | ☐ No | |
| Have you ever had a Dexa Exam? (Woman Only) | ☐ Yes | ☐ No | |
| Have you ever had a Pap smear? (Woman Only) | ☐ Yes | ☐ No | |
| Have you ever had Blood Work? | ☐ Yes | ☐ No | |
| Have you had your flu shot this year? | ☐ Yes | ☐ No | |
| Have you had your COVID-19 Vaccines? | ☐ Yes | ☐ No | First shot:<br>Second shot:<br>Booster: |
| | | | Second Booster: |

Patient Signature:_____ Date: _____

IMA Medical Group

# AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I,_____,
*<print patient's name>*

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

Name:
_____

Address:
_____

Phone:
_____

Name:
_____

Address:
_____

Phone:
_____

Name:
_____

Address:
_____

Phone:
_____

**Patient Signature:**

_____

**Dated:**_____

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

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

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

Name (First Middle Last): _____

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

Address: _____City: _____State: _____Zip: _____

***You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.***

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

**OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]
**FROM WHOM:** ALL information sources [See page 2 for details]
**TO WHOM:** Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider): Medical Home Alliance, LLC, and its affiliates d/b/a IMA Medical Group
**PURPOSE:** To provide me with medical treatment and related services, and to evaluate and improve patient safety and quality of medical care provided to all patients.
**EFFECTIVE PERIOD:** This authorization/permission form will remain in effect until the day you withdraw your permission.
**WITHDRAWING YOUR PERMISSION:** You can withdraw your permission at any time by giving written notice to the person or organization named above in "The Whom."

**In addition:**

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

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

Print Name of Legal Representative (if applicable)

_____

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

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

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

**Explanation of Form**
**"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"**

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

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

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

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

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

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

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

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

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

IMA Medical Group

# Advance Directive Notice

In the State of Florida, all competent adults have the right to an "advance directive". An advance directive enables you to state your choice regarding certain medical decisions or to name someone to make those choices for you should you become unable to do so.

In Florida, there are three kinds of advance directives:

**Living Will:** spells out medical treatments you would and would not want to be used to keep you alive, as well as your preferences for other medical decisions, such as pain management or organ donation.

**Health Care Surrogate:** is a person you authorize via a Designation of Health Care Surrogate form to make medical decisions for you when you are unable to make your own decisions.

**Power of Attorney for Health Care:** allows you to name one or more persons to make your health care decisions if you are unable to make them for yourself. The person you appoint is called your health care agent.

**If you have any of the Advance Directives listed above we must receive a copy if you wish us to follow their instructions.**

**Copies of forms of Advance Directives are available online including on the IMA website.**

Below, my signature certifies I have read and fully understood the foregoing Advance Directive Notice.

Print Name:_____ Date:_____

Signature:_____

# Consent for Medical Treatment

I hereby voluntarily consent to all healthcare services ordered and provided by IMA Medical Group ("IMA"). I understand that I will be informed about the course of my treatment, its benefits and risks, along with possible alternative methods.

Healthcare services may include, without limitation, routine physical and mental examinations, blood tests, diagnostic and monitoring tests, x-rays and other imaging studies, the prescribing of medications, and referrals to specialists.

During the course of your care at IMA Medical Group it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis including DNA analysis.

DNA analysis involves the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with applicable law.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) containing your DNA may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the collection and transfer of your DNA for diagnostic medical purposes and also the transfer of any and all biological specimens collected by or deposited with IMA Medical Group to a third party cleaning or disposal.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until IMA changes its services and asks me to complete a new consent form.

## Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by my insurance, unless specifically exempted by my insurance company's contract with IMA.

## Assignment of Benefits

I hereby assign private insurance, medical benefits, and any other health plan benefits to IMA. A copy of this assignment is considered valid as the original.

## Consent to Contact

By providing my telephone or cellular telephone number to IMA providers, I agree to receive automated calls, prerecorded messages, and/or text messages related to my healthcare from IMA providers. I acknowledge and agree that the text messages, which will be sent via unencrypted means, may contain Protected Health Information (PHI) and there is some risk of disclosure or interception of these messages.

I may revoke or withdraw this consent at any time. Withdrawal of consent for text (messages can be made by replying STOP). Withdrawal of consent to receive automated calls and prerecorded messages must be made in writing.

Print Name:_____ Date:_____

Signature:_____

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

_____

# IMA Medical Group Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**Your Rights:**

**Medical record access:**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge you a fee for this.

**Correcting your medical record:**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communication:**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to reasonable requests.

**Ask us to limit what we use or share:**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information:**

- You can ask for a list (accounting) of the times we’ve shared your health information, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll

provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice:**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you:**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated:**

- You can complain if you feel we have violated your rights by contacting us by sending a letter to IMA Medical Group, Chief Compliance Officer, 6675 Westwood Blvd., Orlando, FL 32821, by calling 1-855-694-6432 or by e-mailing **compliance@inhealthmd.com**
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington,
- D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

**Your Choices:**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest.
- We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- When more restrictive laws require your written authorization release of the information such as substance abuse treatment records, HIV/AIDS status, psychotherapy notes, etc.

**Our Uses and Disclosures:**

We typically use or share your health information in the following ways.

**To treat you:**

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

**To run our organization:**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

**To bill for our services:**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

**Other ways we may share health information:**

We are allowed or required to share your information in other ways, such as for public health, research, or other legally authorized reasons. We have to meet many conditions in the law before we can share your information for these purposes.

- We can share health information about you in response to a court or administrative order, or in response to a subpoena and in lawsuits and legal actions.
- For Public Health and Safety issues including:
    - Preventing disease.
    - Helping with product recalls.
    - Reporting adverse reactions to medications.
    - Reporting suspected abuse, neglect, or domestic violence.
    - Preventing or reducing a serious threat to anyone's health or safety.

- Health research.
- If state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- To organ procurement organizations if you are an organ donor.
- With a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law

**Our Responsibilities:**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*This IMA Medical Group Notice of Privacy Practices is effective January 1, 2025.*

**Acknowledgement:**

I have received a copy of IMA Medical Group's Notice of Privacy Practices.

Print Name: _____ Date: _____

Signature: _____

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

_____

## Patient Code of Conduct

IMA Medical Group ("IMA") is committed to providing high-quality, exceptional care to our patients. The organization supports optimal health and well-being in a safe, respectful, and compassionate environment. The following actions, language, and behaviors will not be tolerated while visiting or receiving care at an IMA facility or event:

- Racial or discriminatory acts
- Physical attacks or violence
- Obscene or foul language
- Sexual harassment
- Destruction of property
- Stealing
- Violating patient privacy and confidentiality
- Disrupting another patient's care and/or experience
- Video or audio recording of patients, visitors, or staff

IMA providers and their patients enter a mutual partnership that requires not only trust and respect but also engagement. Consistent attendance and adherence to appointments and treatment recommendations is critical to improved health outcomes. As a result, the following expectations must be followed by all IMA patients.

- Attending scheduled appointments.
- Confirming appointment reminder calls or messages.
- Arriving on time for appointments.
- Rescheduling appointments within 24 hours in compliance with IMA's No-Show Policy.

*Failure to adhere to the guidelines outlined by IMA Medical Group will result in documentation and review by the administration for possible disenrollment from our membership. Disenrolled members will be prohibited from using IMA Services in the future.*

IMA Medical Group

# REQUEST FOR PATIENT HEALTH INFORMATION FORM

Patient Name: _____ SS#: _____

Telephone: _____ DOB: _____

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

Name of Healthcare Facility from which Records are Requested:_____

Phone: _____ Fax: _____

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

Dates of Service Requested: ____/____/_____ through _____/_____/_____

Reason for Disclosure: _____

**Please include the following information:**

| | | | |
|---|---|---|---|
| | Abstract (All notes & diagnostic results) | | History & Physical Notes |
| | Consultation Notes | | Progress Notes |
| | Discharge Summary | | Operative / Procedure Notes |
| | Emergency Room Notes | | Therapy Notes |
| | Lab Results | | Pathology Results |
| | Radiology Reports (CT, MRI, X-ray etc.) | | Radiology Images (DICOM – CD / DVD) |
| | Other – specify: | | |

**MAIL INFORMATION TO:** **IMA MEDICAL GROUP**

**6675 Westwood Boulevard, Suite 475, Orlando, FL 32821**

**FAX TO: 866-914-1818** **EMAIL: medicalrecords@inhealthmd.com**

# No-Show Policy

Thank you for trusting your primary care to IMA Medical Group ("IMA"). When you schedule an appointment with IMA, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment please contact our office as soon as possible, and no later than **24 hours** prior to your scheduled appointment time. Notification allows the clinic to better utilize appointments for other patients in need of prompt medical care.

**All scheduled appointments must be cancelled or rescheduled at least 24 hours prior to the appointment.**

- If you no-show, cancel or reschedule an Office Appointment with less than a **24-hour** notification you may be subject to a **$10.00** fee.
- In the event you have three (3) no shows, cancelled, or rescheduled appointments with less than a 24-hour notification, you may be subject to dismissal from the IMA clinic.

We understand that unavoidable circumstances may cause you to cancel or reschedule within 24 hours. Fees in this instance may be waived with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication.

By signing below, you have acknowledged you have read, understood, and agree to this No-Show Policy.

_____ _____

Printed Patient Name Date

_____

Patient Signature

IMA Medical Group

# TELEHEALTH CONSENT FORM

Effective Date: _____ Address: _____

Patient Name: _____ _____

Date of Birth: _____ Phone Number: _____

## 1. Purpose

This form provides information about receiving healthcare services via telehealth from Medical Home Alliance, LLC, d/b/a IMA Medical Group and documents your consent to participate. Telehealth uses secure electronic communications (such as video conferencing, phone calls, or secure messaging) to deliver healthcare services when you and your provider are not in the same location.

## 2. Nature of Telehealth Services

Telehealth may include, but is not limited to:

- Medical evaluations, diagnoses, and treatment plans
- Prescribing medications (if appropriate)
- Monitoring of ongoing health conditions
- Review of medical records, imaging, and lab results
- Patient education and counseling

## 3. Benefits of Telehealth

I understand that potential benefits of telehealth may include:

- Convenience – Access to care without travel time or transportation arrangements.
- Improved Access – Ability to see providers that may not be available locally.
- Continuity of Care – Easier follow-up and ongoing monitoring of health conditions.
- Reduced Exposure – Limiting exposure to contagious illnesses in waiting rooms.
- Time Efficiency – Shorter wait times and reduced time away from work or home.

## 4. Risks and Limitations

While telehealth can offer convenience and improved access to care, I understand that:

- My provider may determine that an in-person visit is necessary.
- Technology may fail, and alternative arrangements may be required.
- Certain physical examinations or diagnostic tests may not be possible via telehealth.
- Information transmitted electronically may be intercepted despite security safeguards, although reasonable measures will be taken to protect my privacy.

## 5. Potential Costs

I understand that:

- Telehealth services may be billed to my insurance plan in the same manner as in-person services.
- Depending on my insurance coverage, I may be responsible for co-pays, deductibles, or co-insurance.
- If my insurance plan does not cover telehealth services, I may be personally responsible for the full cost.
- I am responsible for confirming my coverage with my health plan prior to my telehealth appointment.

**6. Confidentiality**

- All telehealth services will comply with HIPAA privacy and security standards.
- Electronic communications will be encrypted and protected to the extent possible.
- My medical information will be documented in my health record, just as with in-person services.

**7. Patient Rights**

I understand that:

- I may refuse telehealth services or request in-person care at any time.
- I have the right to refuse or withdraw consent for telehealth services at any time without affecting my right to future care or benefits.
- My telehealth consent remains in effect unless revoked in writing.
- If I am experiencing a medical emergency, I should call 911 or go to the nearest emergency department rather than relying on telehealth.

**8. Patient Acknowledgment & Consent**

By signing below, I:

- Acknowledge that I have read and understand the information in this form.
- Understand the risks, benefits, and limitations of telehealth.
- Understand potential costs and my responsibility to confirm insurance coverage.
- Consent to participate in telehealth services provided by Medical Home Alliance, d/b/a IMA Medical Group and its providers in accordance with Federal and Florida State law.

Patient or Legal Representative Signature: _____

Printed Name: _____

Date: _____

Relationship to Patient (if applicable): _____

**Notice to Patients:** Telehealth is not appropriate for all conditions. If you believe your condition requires an in-person evaluation, please inform your provider.