ROOT & BRANCH WELLNESS

Dr. William Fleming
Family Medicine

Thank you for choosing to become a patient at Root & Branch Wellness. **Please complete the enclosed paperwork and return to our office, before we can schedule your initial appointment.**

On the day of your appointment please bring your insurance card and picture I.D. as well as any payment due at the time of service

We ask our new patients to arrive at least 20 minutes prior to the scheduled appointment time to allow time for check-in and pre-registration with our clinical staff.

We would also like to advise you of our policy regarding appointment changes. When changing an appointment, we do ask for a minimum of 24 hours notice. As a courtesy, we call and text to remind you of your appointment, in order to give you ample time to make changes. Excessive no shows, same day cancellations or rescheduling your appointment with less than 24 hours notice could result in a **$25.00 charge or discharge** from our practice and possibly other ROOT & BRANCH WELLNESS LLC providers. Your cooperation with this matter is greatly appreciated.

Should you have any further questions or concerns, please do not hesitate to contact my office at 850-325-6005.

PLEASE PRINT:

Patient Name: _____ DOB: _____

Address _____

Phone #: _____ Email: _____

Insurance Name: _____

ID Number: _ _ _ _ _ _ _ _ _ Group Number: _____

3606 Maclay Boulevard South, Suite 102, Tallahassee, FL 32312
Phone: (850) 325-6005 Fax: (850) 755-5979

ROOT & BRANCH WELLNESS

WELCOMES YOU TO THE HIGHEST QUALITY OF CARE. PLEASE TAKE THE TIME TO FILL OUT THIS FORM AS ACCURATELY AS POSSIBLE SO WE CAN APPROPRIATELY ADDRESS YOUR HEALTH NEEDS. THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION IS PROTECTED IN ACCORDANCE WITH FEDERAL PROTECTIONS FOR THE PRIVACY OF HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

PATIENT'S PERSONAL HISTORY

DATE: _____

FIRST NAME: _____ **MI**: _____ **LAST NAME**: _____ **SUFFIX**: _____

DATE OF BIRTH: _____ AGE: _____

SOC SEC NUMBER: _____ GENDER: FEMALE MALE OTHER: _____

RACE/ETHNICITY: _____

LANGUAGE SPOKEN MOST OFTEN: _____ DO YOU NEED AN INTERPRETER? ☐YES ☐NO

CURRENT HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ OTHER:

CHIEF COMPLAINT / CONCERNS:

MEDICAL HISTORY PLEASE LIST ALL CHRONIC AND MAJOR MEDICAL CONDITIONS YOU HAVE HAD AND THE YEAR OF DIAGNOSIS (EXAMPLES: ALCOHOLISM, ASTHMA, CANCER, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, KIDNEY DISEASE, MENTAL ILLNESS, STROKE, OTHER)

WOMEN, PLEASE INDICATE THE NUMBER OF PREGNANCIES _____ DELIVERIES _____ MISCARRIAGES/ABORTIONS _____

PLEASE INDICATE THE DATE OF YOUR LAST:

EYE EXAM: _____ PAP SMEAR: _____ FLU SHOT: _____

DENTAL EXAM: _____ MAMMOGRAM: _____ PNEUMONIA SHOT: _____

PHYSICAL EXAM: _____ DEXA SCAN: _____ TETANUS SHOT: _____

COLONOSCOPY: _____

SURGICAL HISTORY PLEASE LIST ALL SURGERIES WITH THE DATE (YEAR) OF THE PROCEDURE

MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING PRESCRIPTION, OVER THE COUNTER AND HERBALS/SUPPLEMENTS

NAME OF MEDICATION	DOSE	FREQUENCY	NAME OF MEDICATION	DOSE	FREQUENCY

ALLERGIES PLEASE LIST ALL MEDICATION ALLERGIES AND THEIR ASSOCIATED REACTIONS

_____ _____

_____ _____

No Known Drug Allergies (NKDA)

FAMILY HISTORY PLEASE LIST ALL MEDICAL CONDITIONS IN YOUR FAMILY (EXAMPLES: ALCOHOLISM, ASTHMA, CANCER, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, KIDNEY DISEASE, MENTAL ILLNESS, STROKE, OTHER)

FATHER_____ PATERNAL GRANDFATHER_____

MOTHER_____ PATERNAL GRANDMOTHER_____

SIBLING_____ MATERNAL GRANDMOTHER_____

SIBLING_____ MATERNAL GRANDFATHER_____

CHILDREN_____ OTHER_____

CHILDREN_____ OTHER_____

CHILDREN_____ OTHER_____

SOCIAL HISTORY

MARITAL STATUS:

☐ SINGLE ☐ MARRIED ☐ SEPARATED

☐ DIVORCED ☐ WIDOW ☐ OTHER

SPOUSE/PARTNER'S NAME:_____

CHILDREN: (NAMES AND BIRTHDATES)

_____

_____

_____

WHO LIVES IN YOUR HOME WITH YOU?_____ FAITH/RELIGION_____

DO YOU HAVE ANY RELIGIOUS BELIEFS THAT AFFECT YOUR HEALTHCARE? _____

ARE YOU A STUDENT: ☐YES ☐NO WHAT SCHOOL DO YOU ATTEND? _____

OCCUPATION: _____ EMPLOYER: _____

DESCRIBE YOUR DIET:_____

EXERCISE: ☐YES ☐NO HOW MANY MINUTES PER DAY? _____ HOW MANY DAYS PER WEEK? _____

CAFFEINE: ☐YES ☐NO HOW MANY DRINKS PER DAY? _____

TOBACCO: ☐YES ☐NO HOW MANY PACKS PER DAY? _____ FOR HOW MANY YEARS?_____

DO YOU WANT TO QUIT? _____ WHEN DID YOU QUIT? _____

ALCOHOL: ☐YES ☐NO HOW MANY DRINKS PER DAY? _____ HOW MANY DAYS PER WEEK?_____

DRUG USE: ☐YES ☐NO Describe: _____

HAVE YOU EVER BEEN SEXUALLY ACTIVE? ☐YES ☐NO ARE YOU CURRENTLY? ☐YES ☐NO

LIFETIME TOTAL NUMBER OF PARTNERS:_____ MALE _____ FEMALE _____ BOTH _____

BIRTH CONTROL METHOD: _____

ROUTINELY WEAR YOUR SEATBELT: ☐YES ☐NO

ROUTINELY WEAR A HELMET: ☐YES ☐NO

PREFERRED PHARMACY:_____ PHONE:_____

ADDRESS:_____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY ROOT & BRANCH WELLNESS.

_____ _____

PATIENT OR GUARANTOR SIGNATURE DATE

_____

PRINTED NAME

Patient name: _____ Date of Birth: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ",/" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _0___ + ____ + ____ + __ _

=Total Score: __ _

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Terms of Use
Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD ® is a trademark of Pfizer Inc.

Reference
Spitzer, R. L., Kroenke, K., Williams, J. B. W., Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097.

Root & Branch Wellness LLC
Policy

FINANCIAL POLICY

- **Payment is always due PRIOR to service**: We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will of course notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.**
- **Our Billing Services**: We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our web site for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT ROOT & BRANCH WELLNESS LLC IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY
  H.M.O. PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE H.M.O. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR H.M.O.
- **Co-Pays, Deductibles, and Co-Insurances**: Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contract with your insurer, and are your part of your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- **Secondary Insurances**: If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- **Tertiary Insurance: If applicable, t**ertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at the time of your appointment.
- **Charges for failing to come to your appointment (generally termed "no-show fees"):** The following fees will apply if you fail to present for an appointment:
  $25.00: - Office visits (or as determined by each office), Ambulatory Cardiovascular monitors.
  $50.00: - Ultrasound, CT, Travel Clinic (you must provide notice of cancellation to our Diagnostic Department scheduling personnel at least 24 hours prior to your scheduled appointment time).
  Variable: - Nuclear Medicine Studies (Patients failing to show for an appointment without providing at least 24 hours cancellation notice will be charged the cost of the Radioisotopes, which varies based upon market conditions. This cost has historically fluctuated in the $50-$250 range).

Root & Branch Wellness LLC
Policy

- **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question, if you believe there is a mistake on your statement, or if you have any concern about your statement transactions, we expect to hear from you in a timely manner (you may contact your physician's office, but for billing questions you may be referred to our billing department, which will most likely be our best resource for your inquiry). We reserve the right to avoid the cost of sending statements to patients who have a small balance outstanding (usually less than $5.00). For small balances, our Patient Registration/Reception staff in your physician's office will collect the balance at your next appointment.
- **Financial Promissory Form:** If you are truly unable to make payment in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Promissory Agreement. In this Agreement, you will have 14 calendar days to submit payment in full. If you do not make payment within 14 calendar days, we will add an **additional $25.00 administrative fee to the original copay, deductible, and/or coinsurance that is due**.
- **Collections:** If no payment is received within our 3rd statement cycle (approximately 90 days or more from your date of service), your account is considered delinquent and may be referred to an outside collection agency. ***Referral to outside collections may damage your credit, so we strongly urge you to contact our Billing Department to work out payment arrangements so that we can avoid this step.*** We will discharge patients who have balances that are referred to an outside collection agency.
- **Payment Plans:** Subject to the following specific rules, we permit payment plans for patients who may need additional time to pay their financial responsibility in full. Patients will adhere to our payment plan policy set forth below:
    - **We will not permit payment plans for individual patient balances of less than $100.00. The minimum balance for a payment plan is $100.00**
    - **If the balance is less than $350, you must pay the balance in full within 6 months.**
    - **Balances greater than $350 must be paid in full within 12 months.**
    - **We will expect you to make minimum payments of $50 per month.**

We want you to understand this document and our policies and procedures, and we do not want you to be confused. If you have any questions or concerns about our Financial Policy, procedures or fees, your physician's office manager or our billing department can help. Please ask questions if necessary before signing below.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Patient Signature: _____

Date: _____

PATIENT INFORMATION (OFFICE USE ONLY)

Patient Name: _____

D.O.B. _____ MRN _____

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Root & Branch Wellness LLC is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Root & Branch Wellness LLC prior to signing this document, and I acknowledge that the Root & Branch Wellness LLC Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Root & Branch Wellness is also available on the website at **www.rootbranchclinic.com**. I understand that my physician is a part of Root & Branch Wellness, and that this notice applies to the protected health information that my physician, as a part of Root & Branch Wellness, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of Root & Branch Wellness, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that Root & Branch Wellness participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.hienetworks.com is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Office Manager through email at by mailing a written request to Privacy Office at 3606 Maclay Boulevard South, Suite 102, Tallahassee, FL 32312.

Root & Branch Wellness reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at **www.rootbranchclinic.com.**

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to Root & Branch Wellness of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Root & Branch Wellness participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through HIE Networks (www.hienetworks.com)

ROOT & BRANCH WELLNESS

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

HIE Networks is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction Unless you specifically opt out as provided below your personal health information will be provided to organizations such as HIE Networks under secure methods with HIPAA compliant agreements. Root & Branch Wellness and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation can be found at www.HIENetworks.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Print Patient Name

Signature

Date

ROOT & BRANCH WELLNESS

NOT APPLICABLE/NOT A MINOR
(SKIP THIS PAGE)

ROOT & BRANCH WELLNESS

Consent for Services of a Minor Child

In almost all cases, Root & Branch Wellness LLC requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services in the Diagnostic Imaging Center, Lab, Clinical Services departments and/or primary physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Root & Branch Wellness, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing Root & Branch Wellness LLC and its medical professional to provide medical care must be signed by the appropriate person.

I, (We) _____and _____do hereby state that I am (we are) the parents or legal guardians of (child's name)) _____, of minor age born on _____.

Please initial options below*

_____(I) We authorize and consent to all professional services provided at or arranged within the primary care office and their ancillary department(s).

_____(I) We authorize and consent to any medically necessary treatment within the primary care office only and not ancillary department(s).

_____(I) We do not give consent for _____(list specific test/services) services.

Signature(s) of parent(s) or guardian(s) Date

_____ _____

The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parent and/or **legal guardian.**

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Consent expires on: _____*(If not dated, then it will expire one year from signed date)*

All completed signed forms should be scanned as the document type, CONSENT FOR MINOR CHILD.

Root & Branch Wellness LLC does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.

ROOT & BRANCH WELLNESS

PATIENT'S COMMUNICATION INSTRUCTIONS, PATIENT'S RELEASE AND ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth: _____

Patient Address: _____ City: _____ State: _____ Zip code: _____

TELL US WHATYOU WOULD LIKETO AUTHORIZE OR LIMITWITHTHIS FORM (check all that apply):

- ☐ **I would like to UPDATE or CHANGE my telephone and/or email contact information**
- ☐ **I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare**
- ☐ **I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare**

Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

☐ Home phone number- leave message to return call- no particulars NUMBER: _____

☐ Home phone number- leave message with particulars NUMBER: _____

☐ Work phone number - leave message to return call- no particulars NUMBER: _____

☐ Work phone number - leave message with particulars NUMBER: _____

☐ Cell number - leave message to return call - no particulars NUMBER: _____

☐ Cell number- leave message with particulars NUMBER: _____

☐ Email._____ (Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

☐ Other (EXPLAIN AND PROVIDE DETAILS}_____

☐ Other (EXPLAIN AND PROVIDE DETAILS}_____

Who are you authorizing our office to discuss your health situation with? (Please list all names)

☐ Discuss with no one

☐ Spouse: circle AUTHORIZED or UNAUTHORIZED (Name: _____

☐ Child: circle AUTHORIZED or UNAUTHORIZED (Name: _____

☐ Sibling: circle AUTHORIZED or UNAUTHORIZED (Name: _____

☐ Other: circle AUTHORIZED or UNAUTHORIZED (Name: _____

☐ Other: circle AUTHORIZED or UNAUTHORIZED (Name_____

IN CASE OF EMERGENCY, OR IFWE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name_____Relationship_____Phone:_____

This authorization will expire on: _____{Info date is specified. it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Root & Branch Wellness LLC's Notice of Privacy Policies.

_____
Signature of Patient or Patient Legal Authority

_____ _____
Relationship to Patient Date

ROOT & BRANCH WELLNESS

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ City: fdafds State: _____ Zip: _____

Phone Number: _____

I authorize my physician and/or administrative and clinical staff at Root & Branch Wellness or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Medical Provider to Receive Information:	**Previous Medical Provider to Disclose Information**
Name/Organization: **William Fleming, DO**	Name/Organization:
Address: **3606 Maclay Boulevard S, Suite 102**	Address:
City. State. Zip: **Tallahassee, FL 32312**	City. State. Zip:
Phone: **(850) 325-6005** Fax: **(850) 755-5979**	Phone: Fax:

If previous patient at TPCA, please note previous physician.
William Fleming, DO
Other: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

- ☐ Complete Medical Record
- ☐ Billing Records
- ☐ Lab Reports
- ☐ Surgery Records
- ☐ Obstetrical (OB) Records
- ☐ Pap Smear/ Biopsy Reports
- ☐ Office Notes
- ☐ Mammogram Reports
- ☐ Ultrasound Reports
- ☐ Other (specify): _____

DATES OF SERVICE: All Dates of Service Specific Dates:

PURPOSE: ☐ Changing Physicians ☐ Personal Copy to Patient ☐ Attorney ☐ Insurance ☐ Workers Compensation

Other Physician Re-Location Other:

This authorization will expire on: _____ (If no date is specified. it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

☐ I DO \ ☐ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus. the causative agent of AIDS). the results of such tests. the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions.** and all medical records and clinical information relating thereto.
Initials of individual giving authorization: _____

☐ I DO \ ☐ I DO NOT authorize the release of all information. Including but not limited to the medical/clinical record and other information pertaining to any evaluation. treatment and/or hospitalization for **mental health or psychiatric conditions.**
Initials of individual giving authorization: _____

☐ I DO \ ☐ I DO NOT authorize the release of all information. Including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.

Initials of individual giving authorization _____

I have read and understand the nature of this authorization and I have been provided a copy of Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization. in writing. at any time by sending such written notification to the practice's Privacy Officer at ***Root & Branch Wellness LLC, 3606 Maclay Boulevard South, Suite 102, Tallahassee, Florida 32312, Attn: Office Manager.*** I understand that a revocation is not effective to the extent that my physician or Root & Branch Wellness has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect Root & Branch Wellness's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment. payment. enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research. or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization. it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain. inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ Signature of Patient or Patient Representative

_____ Witness

_____ Relationship to Patient

_____ Date