



# DoCare Clinic

## Family Medicine & Urgent Care



3031 West Cypress St.  
Tampa, Florida 33609  
Phone: 813-878-2222  
FAX: 813-878-2224

3317 W. Gandy Blvd.  
Tampa, Florida 33611  
Phone: 813-878-2222  
FAX: 813-878-2224

410 Broad St.  
Masarkytown, Florida 34604  
Phone: 813-878-2222  
FAX: 813-878-2224

### PATIENT INFORMATION

**Patient's Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**D.O.B:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Martial Status:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

**Number:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

<b>Primary Insurance Information</b>	<b>Secondary Insurance Information</b>
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**Insurance Name**

**Insurance Name**

**Address**

**Address**

**City, State, Zip**

**City, State, Zip**

**Phone**

**Phone**



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**Policy#** \_\_\_\_\_

**Policy#** \_\_\_\_\_

**Group#** \_\_\_\_\_

**Group#** \_\_\_\_\_

**Co-Pay\$** \_\_\_\_\_ **Deductible\$** \_\_\_\_\_

**Co-Pay\$** \_\_\_\_\_ **Deductible\$** \_\_\_\_\_

**Policy Holder Name**

**Policy Holder Name**

**Policy Holder D.O.B.**

**Policy Holder D.O.B.**

**Relationship to Policy Holder**

**Relationship to Policy Holder**

### CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I hereby authorize consent for treatment and release of any necessary information acquired in the course of examination and treatment by physician for processing of my medical claim. I authorize direct payment of my benefits to DoCare Clinic. I agree that any unpaid balance not covered by insurance I will take responsibility for.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return this form to the receptionist, along with your photo id and insurance card, so that we may make a copy for our records. Thank you.

## MEDICAL RELEASE FORM

I \_\_\_\_\_ request my medical records be released to DoCare Walk-In Clinic.

Please Send:

- All Records
- Laboratory and Radiology Reports



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- History and Physical
- Progress Notes / Consultation Reports

To: Dr. Chuma Osuji D.O.  
3031 W. Cypress St.  
Tampa, FL 33609  
(813) 878-2222 (phone)  
(813) 878-2224 (fax)

Signed \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

### Patient Self Determination Act Questionnaire

In order to comply with the Omnibus Reconciliation Act of 7990 and chapter 745, Florida Statutes, please answer the following questions:

Declaration to decline life prolonging procedures (Living Will)

- I have made such a declaration.
- I have NOT made such a declaration.



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### Health care surrogate

- I have designated a health care surrogate.  
 I have NOT designated a health care surrogate.

### Durable Power of Attorney

- I have appointed a Durable Power of Attorney of health care decisions.  
 I have NOT appointed a Durable Power of Attorney of health care decisions.

I have been provided with information regarding the Patient Self Determination Act.

Name (Print or Type)	Signature	Date
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\_\_\_\_\_ *copy of LIVING WILL in chart (if applicable)*

## **HIPAA Notice of Privacy Practices**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:**



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Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

#### Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

#### Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled, in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

#### Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

I, \_\_\_\_\_ acknowledge receipt of DoCare Clinic's Privacy Notice on this date.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



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Patient Refused to Sign

Witness \_\_\_\_\_ Date \_\_\_\_\_