Welcome to Flagler Family Medicine, PA

We respect your time and would like to make your visit as efficient as possible.

Arrive 15 minutes before your scheduled appointment time

To avoid delays when you arrive, please complete the enclosed forms in advance then mail, fax 904-808-4608 or return them to our office 2-3 days prior to your scheduled appointment.

Please note: We will reschedule your appointment if the paperwork is not provided in advance or incomplete.

Thank you,
Flagler Family Medicine Management
Welcome to your Patient Centered Medical Home

Thank you for choosing us to be part of your healthcare team. We look forward to working with you to make sure you receive the care you need and keep you healthy and happy.

Our practice provides personalized primary care, preventive and health maintenance care and access to various specialty services. We also fully coordinate care for our patients with disabilities, chronic illness and other complex medical conditions.

We hope that the information provided on this guide will answer many of the questions you may have about our practice.

Contact us

Office hours: This office is open Monday-Thursday 7-6:30, Friday 7-4, Saturday 9-1

Main phone number: (904) 826-3469
Use this number to schedule appointments, answer your general questions, and connect you with team members.

Web address: www.FlaglerFamilyMedicine.com
You can also contact us by secure messaging via your dedicated patient portal through this website.

After-hours care

If you would like to speak to a clinician to help you decide how to treat an illness after hours or to help you decide whether to go to the emergency room, call (904) 826-3469. This is a special after-hours service we offer and they will have access to your records and your team as needed.

If you receive care at an emergency room or urgent care center, please let us know by calling (904) 826-3469 within 48 hours so we can assist with follow-up care as needed.

Special accommodations

The Practice is accessible by wheelchair. People with limited sight should bring a companion to ensure clear communication. People with limited hearing can request deaf interpreter services free of charge.

Please let us know if you prefer to receive your care in Spanish.

Our locations

Palm Coast
28 Old Kings Rd N, Ste A, Palm Coast FL 32137
PH: 386-225-4670
FX: 904-808-4608

St. Augustine/Flagler Hospital Campus
130 Health Park Blvd, St. Augustine FL 32086
PH: 904-826-3469
FX: 904-808-4608

St. Augustine/Shoppes of Murabella
52 Tuscan Way, Suite 205, St. Augustine FL 32092
PH: 904-826-3469
FX: 904-808-4608

East Palatka
199 Hwy 17 South, Suite 101, East Palatka FL 32131
PH: 386-325-5232
FX: 904-808-4608

All Physicians at Flagler Family Medicine are Board Certified in Family Practice.

Todd Batenhorst, MD  │  Linda Clonch, MD  │  Frederick Dolgin, MD  │  Andrew Gunn, MD  │  Michael Look, DO
Carlos Sanchez, MD  │  Erin Scales, MD  │  Warren Whitlock, MD  │  Christopher Zub, DO  │  Jerry Weed, DPM
Joann Fritsch, ARNP  │  Melissa Senior, ARNP  │  Cathy Youngstrom, PA  │  Suzanne Weed, ARNP  │  Sarah Swiatowicz, PA
appointments
If you would like to speak to a nurse about your symptoms, follow the phone menu options to speak with your physician’s nurse.

If you have an emergency illness or symptom that requires immediate, urgent attention, call 911. If you need an appointment for illness or a symptom, call (904) 826-3469 and press option #2.

If you need a check-up, follow-up visit, or annual visit please call the main number (904) 826-3469 and press option #2.

Patients who are more than 15 minutes late may be required to reschedule their appointments.

appointment checklist
Your insurance card.
A list of current prescription and non-prescription medications, vitamins and supplements.
A good description of the problem, how long you have had it and how it affects you.
A list of questions you would like to discuss with your provider.
A list of other health care providers you have visited.

payment options
We participate in most insurance plans, including Medicare. Be sure to check with us to confirm that we accept your insurance before making an appointment.

Please be prepared to pay your co-pay and/or patient balance at the time of service. We accept checks, Visa, MasterCard, Discover, American Express, and cash.

We are happy to answer questions, discuss payments or your bill anytime by calling (904) 826-3469 and press option #5 for the billing department.

You may pay your bill online at www.FlaglerFamilyMedicine.com

prescriptions
For refills of prescriptions please contact your pharmacy.

If you need a written prescription, leave a voice message on our prescription line.

Please allow 48 hours for us to refill your prescriptions. We will contact you only if there is a problem or we have a question about your prescription refill request.

Please remember that refills can only be given to patients who have been seen within the past year. If you have not been seen for more than a year, you will need to schedule an appointment.

If you have questions about a new prescription or about discontinuing medication(s), please call your provider’s nurse.

After hours, urgent refills will be handled by the doctor on call.

Laboratory & Diagnostic Tests
If your provider orders laboratory and/or diagnostic tests you will be referred to the facility preferred by your medical insurance plan.

A member of your team will call you to discuss the results of testing and needed follow up.

All laboratory and diagnostic results will be available on your patient portal after the physician reviews the results.

If you have not received your results within four weeks, please call our office.

www.FlaglerFamilyMedicine.com
~Patient Information~

Last Name: ___________________ First Name: ___________________ M.I: ______

Street Address: ____________________________ Apt #: _____________

City: ____________________________ State: _____ Zip Code: _____________

Home Phone: ___________________ Cell: ____________

Work Phone: ____________ EXT: ______ Email Address: ________________

Birth Date: _______________ Social Security #: _____________________________

Gender: □ Male □ Female □ Transgender

Marital Status: □ Married □ Single □ Divorced □ Widowed

Student ? : □ Not a student □ Full-time student □ Part-Time Student

Employer Name: ______________________________

Employer Address: ______________________________

~Emergency Contact~

Name: ______________________________ Relation: ____________

Home Phone: ___________________________ Cell: __________________ Work: ________________

*******If the person resides with you please give us a second contact person*****

2nd Name: ______________________________ Relation: ____________

Home Phone: ___________________________ Cell: __________________ Work: ________________

~Insurance~

Guarantor:

Last Name: ______________________________ First Name: ___________________________ MI: ______

Date of Birth: ___________________ Social Security: ____________________________

Telephone: ____________________________

Primary Insurance Name: ______________________________

Address: ______________________________

Effective Date: ______________ Subscriber Number: ____________________________

Group Number: ____________________________

Secondary Insurance Name: ______________________________

Address: ______________________________

Effective Date: ______________ Subscriber Number: ____________________________

Group Number: ____________________________

~Preferred Pharmacy~

Name: ______________________________ Address: ________________________________
Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor.
2. For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional Co-Payment, Deductible or Co-Insurance. Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.

Missed appointment: Unless canceled at least 24 hours in advance, you may be subject to $50.00 no-show fee at the physician’s discretion. Please help us serve you by keeping scheduled appointments.

Co-pays and Balances: Co-pays are due at the time of service. If we need to bill you for the co-pay, there will be an additional $5.00 processing fee. You will also be asked to pay any outstanding patient balance.

Insufficient Fund Fee: Checks that are returned will be charged a $45.00 insufficient funds fee.

Collection Fee: Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and I understand and agree to its provisions.

____________________________________  ________________________________
Signature of patient or responsible party  Date
E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Flagler Family Medicine, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Flagler Family Medicine, PA to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

<table>
<thead>
<tr>
<th>Print Patient Name</th>
<th>Patient DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Patient or Guardian</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Relationship to Patient
Authorization of Use and Disclosure of Protected Health Information

Patient Name: ______________________________________________________________
Date of Birth: _________________________________ SSN: _________________________

I. My Authorization
You, Flagler Family Medicine may use or disclose the following health care information:

☐ ALL my health information maintained by you.
☐ My health information relating to the following treatment or condition: _________________
☐ My health information for the date(s):___________________________________________
☐ Other:  _____________________________________________________________________

You may disclose this health information to:
Name (or title) and organization: _________________________________________________
Relationship: (parent, child, sibling, legal guardian, etc.): ____________________________

Name (or title) and organization: _________________________________________________
Relationship: (parent, child, sibling, legal guardian, etc.): ____________________________

Name (or title) and organization: _________________________________________________
Relationship: (parent, child, sibling, legal guardian, etc.): ____________________________

This Authorization ends:  ☐ on (date) ____________________________________________
☐ When the following event occurs ___________________

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:
• To take part in a research study; or
• To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Flagler Family Medicine at the address provided below. If I do, it will not affect any actions already taken by Flagler Family Medicine based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

• 130 Health Park Blvd St Augustine, FL 32086
• 199 S. Highway 17 Suite 101 East Palatka, FL 32131
• 28 Old Kings Rd North Suite A, Palm Coast, FL 32137
• 52 Tuscan Way, Suite 205, St. Augustine, FL 32092

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_________________________________________                  _______________________
Patient or legally authorized signature                                         Date

Patient is unable to sign because of (minor, disabled, etc.) ______________________________
### Condition Table

<table>
<thead>
<tr>
<th>Condition</th>
<th>You</th>
<th>List Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td>Anemia</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td>Leukemia</td>
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<tr>
<td>Stroke</td>
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<td>Sickle Cell</td>
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<tr>
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<td>Bleeding Problems</td>
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<td>Gallstones</td>
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<tr>
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<td>Seizures</td>
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<td>Tuberculosis</td>
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<td>Kidney Problems</td>
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<td>Alcoholism</td>
</tr>
<tr>
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<td>Suicide</td>
</tr>
<tr>
<td>Glaucoma / Eye Problems</td>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td>Skin Rash</td>
<td></td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

### Operations / Surgeries:

- [ ]

### Last Colonoscopy:

- [ ]

### Other Hospitalizations:

- [ ]

### Blood Transfusions:

- [ ]

### Medications:

- [ ]

### Last Pneumonia Vaccine (Pneumovax or Prevnar):

- [ ]

### Last Flu Vaccine:

- [ ]

### Allergies:

- [ ]

### Occupation / Work History:

- [ ]

### Any exposure to pesticides, chemicals, or other hazards?

- [ ]

### Family / Household: (Who lives at home with you?)

- [ ]

### Habits:

- Cigarettes: [ ] PPD [ ] X [ ] years Quit in [ ] (year)
- Other Tobacco Products:
- Drug Use: Caffeine (coffee/colas)
- Seat Belt Use: [ ] Yes [ ] No [ ] Exercise:

### For Women Only

- Age of first menstrual period [ ] How many days between periods? [ ]
- How many days does it last? [ ] Is bleeding heavy or light? [ ]
- Date of last menstrual period [ ] Was it normal? [ ]
- If menstrual periods have stopped, have you had any bleeding since? [ ]
- Any Vaginal Discharge? [ ] Yes [ ] No [ ]
- Method of Preventing Pregnancy [ ]
- Pregnancies [ ] Births [ ] Abortions/Miscarriages [ ]
- Last Mammogram: [ ] Last Bone Density: [ ]
- Last Pap Smear: [ ]
- Any other concerns? [ ]

### Name:

- [ ]

### Social Security:

- [ ]

### Birth Date:

- [ ]

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

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HIPAA Notice of Privacy Practices
Revised 2013

Flagler Family Medicine
130 Health Park Blvd
St. Augustine, FL. 32086
Phone-904-826-3469

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 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 our 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, 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: 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, employee review, training of medical students, licensing, fundraising, 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.
USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 the 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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER Phone-904-826-3469 ex 111 email-sbailey@flaglerfamilymed.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI–Revised March 2013
I hereby acknowledge that I have received or have been given the opportunity to receive a copy of (Flagler Family Medicine) Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

____________________________________________________
Patient Name (Type or Print)                                          Patient’s Date of Birth

____________________________________________________
Signature of Patient or Parent/Legal Guardian                                      Date
Please see one of our front office staff to sign up today!

Flagler Family Medicine, PA
130 Health Park Blvd
St. Augustine, FL. 32086
Phone (904) 826-3469
Fax (904) 808-4608
Practice Website: flaglerfamilymed.com

Access your own personal Patient Portal by visiting
https://mycw4.eclinicalweb.com/bato/jsp/100mp/login.jsp
Flagler Family Medicine

Is now offering our patients secure internet access to their medical information online, so you may view your personal health record at any time or place with internet access.

You will be given a user name and password, and will receive periodic updates through your personal e-mail address on file.

- Request appointments (for non-urgent issues*)
- Request prescription refills
- View medical records (PHR)
- Receive available educational material
- View current and past statements
- Pay bills online
- Send messages to clinical staff
- Receive health maintenance reminders

...all from the comfort of your home!

Get Web-Enabled

You will have access to our secure server with your user name, and password.

Please provide us with a non-work/employment related e-mail address, and you can access your personal health record from a Smart Phone or any computer with an internet connection.

*The Patient Portal is not intended for use in emergencies! If you require urgent medical care, call 911.
Patient Portal Policy and Procedures

**DO NOT** use Portal to communicate if there is an emergency.

**Proper subject matter:**

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow-up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc) are not permitted
- We do not refill controlled substance medications drugs on the patient portal. You can request a refill but MUST come in to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message.

**Current functionality of Patient Portal:**

- Email and secure messaging for non-urgent needs.
- Refill request *(must* include pharmacy information)
- Viewing of lab results that have been sent to you.
- Viewing and printing of continuity of health record.
- Viewing and updating of health information.
- Viewing of selected health information (allergies, medications, current problems, past medical history). * Note- You can make changes/additions to your health records, medication list, etc. but this will not change your permanent record without our review of the information.
- Referral requests
- Appointment request
- Billing questions
- Updating your demographic information (address, phone # etc) and updating insurance information.

**All communication via portal will be included in your chart.**

**Privacy:**

- All messages sent to you will be encrypted.
- Messages from you to the staff should be through this portal or they will not be secure.
- We will keep all email lists confidential and will not share this with other parties.
- Any member of our staff may read your messages or reply in order to help the Physician that has been e-mailed. This is similar to how a phone message is handled.
- Our system will check when messages are viewed, so you do not need to reply that you have read it.
Response Time:

- We will normally respond to non-urgent message inquiries within a timely manner. Please contact the office if you need a immediate response.

Patient and Family Request for Patient Portal

I hereby request access to the Patient Portal maintained by Flagler Family Medicine, PA for the patient named below. I understand that Flagler Family Medicine takes seriously its responsibility to safeguard the privacy of its patients and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign-on and password that I am assigned and will not share my log-in information with anyone else. I agree that Flagler Family Medicine will not be liable for any disclosure of information due to unauthorized use of my sign-on and password. If I feel my sign on and password combination has been compromised, I will contact Flagler Family Medicine immediately or go to the portal and request a new password.

I understand that the Patient Portal will only allow me to view my records for the patient. If I accidentally gain access to another patient’s information, I will cease to view it and notify Flagler Family Medicine immediately. In no event will I deliberately attempt to access information for any person other than myself. I represent to Flagler Family Medicine that I am a personal representative of the Patient with the right to access the Patient’s health information, or that the patient has expressly authorized me to have access. If my status as personal representative changes so that I no longer have such rights, or if the Patient’s authorization expires or is revoked, I will immediately cease using the Patient Portal to access the Patient’s information and will notify Flagler Family Medicine.

Patient Name (print):______________________________________  DOB: _________________

Email Address: __________________________________________

Patient Name (signature):__________________________________

-OR-

Parental Guardian: ________________________________________