Orlando Internal Medicine
Your Care is Our Concern!

RAVI AKELLA, M.D. • NICOLE REDA, A.P.R.N.

Dear Patient,

We are pleased to welcome you to Orlando Internal Medicine, where Your Care Is Our Concern! It is our goal that this letter will provide you with helpful information regarding your upcoming visit. For your convenience we have included New Patient Forms as well as a map to our location. Please complete and return these forms either by fax, USPS mail or hand deliver to our office before your scheduled appointment to expedite your initial visit with us. If you are unable to complete and return these forms before your appointment, please arrive **20 minutes prior** to your scheduled appointment.

Please notify us at least 24 hours in advance if you are not able to keep this appointment.

Please bring the following:

- These Forms Completed if not already faxed or sent to our office
- All current medications in their original bottles
- Insurance card(s)
- Your Co-Payment
- Photo ID

Sincerely,

The Physicians & Staff

ORLANDO INTERNAL MEDICINE

1507 S. Hiawassee Rd ● Suite 107● Orlando, Florida 32835 ● (407) 445-9545 ● Fax (407) 445-9365

ORLANDO INTERNAL MEDICINE

PATIENT INFORMATION

Name ____
Last First Middle Any Other Preferred First Name

Address ____
Street or P.O. Box Apt. #

____
City State Zip

Home Phone ____________________ Work Phone ____________________ Ext. ________

Cellular Number ____________________ Email Address ____________________ Work / Home

Sex Male / Female Birth Date ____________ Marital Status ____________ Referred By: ____________

Ethnicity: **Please select one:** Non Hispanic • Hispanic • Decline to Answer
Race:**Select one:** White • Black • Asian • Native American/Eskimo • Pacific Islander • Other/Unknown• Decline to Answer

Social Security # ____________________ Driver's License # ____________________

Employer ____________________ Spouse or Parent Name & Work Phone ____________________

Pharmacy Name / Location ____________________ Pharmacy Phone ____________________

PRIMARY INSURANCE HOLDER (or Person Responsible for the Bill):

☐ PLEASE CHECK IF RESPONSIBLE PARTY IS A PATIENT OF THIS PRACTICE
(Fill out any information that is different from above)

Name ____
Last First Middle **Relation to Patient**

Address ____
Street or P.O. Box Apt. #

____
City State Zip

Sex Male / Female Birth Date ____________________ Social Security # ____________________

Home Phone ____________________ Pager or Cellular Number ____________________

Employer ____________________ Work Phone ____________________ Ext. ________

Primary Insurance Co. ____

Secondary Insurance Co. ____

EMERGENCY INFORMATION ☐ Please check if primary contact is a patient of this practice.

Contact in case of emergency – List at least two people and include phone numbers and relation: ____________________

____

In order to keep costs at a minimum for our patients, payment is collected at the time services are rendered. If you have insurance with one of the groups with which we participate, we will file a claim. It is the responsibility of the insured to know the assigned PCP and network locations. We will provide to all others a statement with the information required by your insurance company so that you can easily forward your claim for reimbursement. Any balances that are unpaid after 90 days will be be turned over to a collection agency unless a signed payment arrangement has been made.

Insurance Authorization and assignment

I hereby authorize ORLANDO INTERNAL MEDICINE to release my insurance carrier any information concerning my illness and treatment, including possible HIV, AIDS, psychiatric or drug & alcohol information. I hereby assign to the physician all payments for medical services rendered to myself and dependents. I understand that I am responsible for any amount not covered by my insurance including fees for "no show" appointments, completion of documents and telephone consultations, all of which I acknowledge are not billable to insurance. I understand that any returned checks may be re-deposited electronically and will have fees assessed.

Medical Consent

I authorize all medical providers at ORLANDO INTERNAL MEDICINE to treat me medically in the office or hospital for any illness or injury that I may incur.

Signature of Patient or Responsible Party ______________________________ Date ____________ 03/2021

ORLANDO INTERNAL MEDICINE

MEDICAL HISTORY

Please fill out completely and accurately. This becomes part of your permanent record and will help us to make recommendations regarding your care.

PATIENT NAME: ____ DATE OF BIRTH:______________________

PAST MEDICAL HISTORY:

Have you a history of:	Check if yes
ALLERGIES / HAY FEVER	❑
ANEMIA	❑
ARTHRITIS	❑
ASTHMA / EMPHYSEMA / COPD	❑
BLOOD CLOT	❑
CANCER	❑
CHEST PAINS / ANGINA	❑
CHOLESTEROL PROBLEMS	❑
DEPRESSION OR ANXIETY	❑
DIABETES	❑
HEADACHES / MIGRAINES	❑
HIGH BLOOD PRESSURE	❑
HIV / AIDS	❑
INTESTINAL DISORDERS	❑
MITRAL VALVE PROLAPSE OR RHEUMATIC FEVER	❑
OTHER HEART PROBLEMS	❑
SEIZURES	❑
SLEEP DISORDERS	❑
STROKE / TIA	❑
THYROID PROBLEMS	❑
ULCERS	❑

DRUG USE : ____

TOBACCO USE: ____
(PACKS PER DAY & # OF YEARS)

ALCOHOL USE: ____
(AVERAGE AMOUNT OR FREQUENCY)

EXERCISE: ______________________________ HOBBIES: ____________________

EDUCATION COMPLETED: ____

# of Pregnancies: ______________ # of Deliveries: ______________ # of Miscarriages:_______

Frequency of Periods: ________________Last Menstrual Period__________Last PAP __________

Any Foreign Travel____

FAMILY HISTORY:

	√	Which family member? Maternal or Paternal
DIABETES		
HIGH BLOOD PRESSURE		
HEART ATTACK		
HIGH CHOLESTEROL		
STROKE		
ASTHMA		
SUICIDE/DEPRESSION		
ALCOHOLISM		
CANCER (& WHAT TYPES)		
OTHER		

Current Medications & doses:____

____

____

Allergies to Medicine and your reaction: ____

____

Spouse/Children/Parents' Names & Ages:____

____

Previous Illness/Injuries/Hospitalizations/Surgeries including year:______________________

____

____

____

Last Tetanus Booster:____________ **Occupation & Employer:**______________________________

The above information is true and complete to the best of my knowledge.

Signature________________________________ **Today's Date:**________________________________

03/2021

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EXHIBIT 5 - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Orlando Internal Medicine may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Orlando Internal Medicine's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Orlando Internal Medicine reserves the right to revise its Notice of Privacy Practices at anytime to meet changing legal requirements. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Orlando Internal Medicine - Privacy Officer at 1507 S. Hiawassee Road, Suite #107, Orlando, FL 32835.

With my consent, Orlando Internal Medicine may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Orlando Internal Medicine may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Orlando Internal Medicine may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Orlando Internal Medicine's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Orlando Internal Medicine may decline to provide treatment to me.

______________________________ ______________________________
Signature of Patient or Legal Guardian — Print Name of Patient or Legal Guardian

______________________________ ______________________________
Patient's Name — Date

I authorize Orlando Internal Medicine to discuss any and all of my PHI, including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC or AIDS information with the following individuals:

____
(Name & relationship)

____
(Name & relationship)

______________________________ ______________________________
Signature of Patient or Legal Guardian — Date

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PLEASE FILL OUT THIS FORM FOR COMPLIANCE WITH THE PATIENT SELF DETERMINATION ACT, PASSED 1992 BY THE STATE OF FLORIDA.

ADVANCED DIRECTIVES

PATIENT NAME: ______________________ **DATE OF BIRTH:** ___________________

An Advanced Directive can be in the form of a living will, durable power of attorney, or health care surrogate. Is there an Advanced Directive written and executed on your behalf (or the patient's behalf, if you are responsible for the patient)? Yes _______ No _______

If yes, is this Directive in the form of:

___________ a Living Will,
___________ a Durable Power of Attorney, or
___________ a Health Care Surrogate

If you have executed an Advanced Directive in any of the above formats, have you provided this office with a copy for your medical records? Yes ________ No ________

If you would like more information regarding Advanced Directives, please ask our office staff.

____ __________________________
Signature of Patient or Responsible Party Date

We can also incorporate a copy of any of your directives into your medical records for future reference if you provide a copy to our office.

03/2021

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WELCOME TO

Orlando Internal Medicine

Your Care is Our Concern!

Get to know our practice and the tools and services we provide to better care for our patients!

Follow us on Facebook or Twitter @Orl_InternalMed

OIM Guest Wifi Password—4074459545

Patient Portal

ACCESS YOUR MEDICAL INFORMATION ONLINE—ANYTIME! You can create your FREE portal account using your smartphone and start accessing your records immediately! From the portal you can:

Request Prescription Refills	Send A Message To Our Staff	Access Lab Results
Request Appointments	Track Your Health History	And More!

The Patient Portal is the FASTEST way to communicate with our team. Just ask one of our staff members and we can help you get started TODAY!

Referrals

Referrals to specialists can take 24-48 hours to process and some insurances may require even more time. Please make sure your referral is approved before your appointment.

Records

Requests for copies of medical records will require a Consent form signed by the patient or guardian. Once the form and service fees are received by our office, please allow 48 hours for processing.

Appointments

We try to schedule all follow-up appointments before you leave the office. If you have an acute need we can generally accommodate patients within 24 hours. Well visits can typically be scheduled within 1 week. Please give 24 hours notice to cancel or reschedule your appointment. Failure to give notice will result in a $50 No Show fee that is NOT covered by insurance.

Medical Clearance For Surgery

Pre-testing for surgery is generally required within 30 days of your surgery. You must have an office visit to complete clearance checks and have tests ordered.

Medication Refills

Please give at least 24-48 hours notice for medication refills. On Fridays, submit your request before 2pm. The overnight/weekend on-call providers will NOT refill medications.

Some medications cannot be refilled without an appointment. Please make note and schedule your follow—up visits in advance.

Don't forget — for the fastest response, use the patient portal to submit your request!

Bring your medication bottles to each appointment so we can make sure your medication lists are always up-to-date!

Labwork

Routine labwork is generally required as part of your annual wellness visit to assess your overall health and well-being. Additionally labs may be ordered whenever your provider deems it necessary to assess any conditions and make decisions regarding a plan of care. Please note, we do not have any authority regarding laboratory billing or out-of-pocket costs for these services. Our goal is to make recommendations which provide all patients with the highest quality of care. We follow guidelines for care established by the American Board of Internal Medicine. If you have questions regarding your lab benefits, please contact your insurance carrier.

Note — for your convenience, we can save you a trip to the lab by drawing labs in the office. There is a $10 fee for this service that is NOT covered by insurance. This service does not impact your insurance benefits for labs. This is strictly an optional service to save you time and travel!

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