Littell Family Medicine
CARING FOR YOUR ENTIRE FAMILY

ADULT MEDICINE • WOMEN'S HEALTH CARE • DERMATOLOGY
PEDIATRICS • URGENT CARE • HOSPITAL & NURSING HOME CARE

300 Park Place Blvd. • Kissimmee, FL 34741 • www.JohnLittellMD.com • Phone: 407-343-1711 • Fax: 407-343-1611

ABOUT OUR PRACTICE

Office Hours:

Monday:	8:00 a.m. to 5:00 p.m.
Tuesday:	8:00 a.m. to 5:00 p.m.
Wednesday:	8:00 a.m. to 2:00 p.m.
Thursday:	8:00 a.m. to 5:00 p.m.
Friday:	8:00 a.m. to 1:00 p.m.

Same day appointments are always available for existing patients. Additionally, our office is accessible by phone **24 hours** a day, 7 days a week. If you have an emergency, please call the office phone number and press 8 to be directly connected to Dr. Littell's cell phone. If he does not answer, please leave a message and he will call you back as soon as possible.

Interactive Patient Portal:
This service will allow our patients to access their medical summary, request refills of medications, update information, ask questions to our providers, and request appointments. The patient portal can be accessed by going to www.johnlittellmd.com and clicking the portal link. When logging into your account, please remember it is case sensitive for login and password.

Prescription Refills:
If you need a prescription refill, please allow up to **72 BUSINESS HOURS** to process your refill request as this is our office policy.

Dermatology Services are also available in our office.

Financial and Office Policies:
Payment is expected at the time of service. Co-pays, co-insurance, deductibles, all due at the time of service. You are responsible to know and understand what your insurance plan will or will not cover. We ask that you reschedule your appointment if you are unable to pay your financial responsibility at the time of service, including past balances. We will assess a $35 service fee for any returned checks from the bank. Past due balances are due prior to making another appointment.

Canceled or Missed Appointments:
If you need to cancel an appointment, contact us at least **24 HOURS PRIOR** to your appointment time, if you contact us after that time there will be a **$50 FEE** assessed to your account. If you miss an appointment and do not call you will have a **$50 FEE** billed to you.
WE USE AUTOMATED & ELECTRONIC SYSTEMS FOR APPOINTMENT REMINDERS.
You authorize our agents to contact you using any contact information you provide to us including e-mail addresses and wireless phone numbers.

I agree to the above terms of John T. Littell, M.D. and Associates, I am responsible for any balances due on my account.

Signature_____

Print Name _____

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ADULT MEDICAL HISTORY

Date: _____

Patient Name: _____ Date of Birth_____

Spouse's Name: _____Age: ___ Marital History: ___Single
Child's Name: _____Age: ____ ___ Married ____#Years
Child's Name: _____Age: ____ ___ Divorced ___#Years
Child's Name: _____Age: ____ ___Widowed

Religious Preference (if any): _____
Last Grade Completed: _____or Degree Obtained: _____
Tobacco Use: _____#of Years Packs/Day: _____ Quit Date _____
Alcohol use: _____Never _____Occasional _____ Weekends _____ Daily
Caffeine Use # per day: _____
Work History: _____
Current Position: _____ Retired _____ Homemaker _____
Types of work done: _____

Current Medications (including ALL prescription and non-prescription, birth control pills, or vitamins):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies (if known): _____
Hospitalizations-Serious Illness-Surgeries-Pregnancies (Please list date and reason)

_____

_____

Whom may we thank for referring you to us? _____

FEMALES, PLEASE COMPLETE

Number of: _____Pregnancies _____Abortions _____Miscarriages _____Live births
Date of Last Pap Smear: _____ Was it: _____Normal _____Abnormal
Date of last Mammogram: _____ Was it: _____Normal _____Abnormal

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PATIENT INFORMATION SHEET

First: _____ Middle: _____ Last: _____

Date of Birth: _____ Social Security #: ___-___-____ (SS# for identification only)

Marital Status: Single Married Divorced Widow(er) Sex: _____Male _____Female

Preferred Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Mailing Address: _____

City: _____ State: _____ Zip Code _____

Employer: _____ Occupation: _____

E-mail Address: _____

Preferred Pharmacy: _____

Address/Phone: _____

_____

Emergency Contact (Nearest relative/friend NOT living with you)

First & Last Name: _____

Relationship: _____ Phone Number: _____

PARENT/GUARDIAN (if patient is a minor)

Mothers Name: _____ Date of Birth: _____
Fathers Name: _____ Date of Birth: _____

INSURANCE INFORMATION

INSURANCE: _____ Policy Holders Name: _____
Member ID#: _____ Co-Pay Amount (if known): _____
Billing Address: _____

if insurance coverage is not through you
Patient's Relationship to Insured: _____
Insured's Name: _____
Insured's Date of Birth: _____
Insured's Social Security #: _____-_____-_____

_____ _____ _____
Print Name Date Signature

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HIPAA PRIVACY AUTHORIZATION FORM

Consent to the Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations

I hereby authorize the release of medical information including my health history, symptoms, examination and test results, diagnoses, treatment, billing and claim, and any plans for future care of treatment.

Authorization for release of PHI covering the period of healthcare (check one)

_____ From (date) _____ to _____

OR

_____ All past, present and future periods.

I hereby authorize the release of PHI as follows (check one)

_____ My complete health record (including records relating to mental health care, communicable diseases, HIV/AIDS, and the treatment of alcohol/drug abuse

OR

_____My complete health record with the exception of the following information (check as appropriate):

_____ Mental Health records
_____ Communicable Diseases (including HIV and AIDS)
_____ Alcohol/Drug Abuse Treatment
_____ Other (please specify):

In addition to the authorization for release of my PHI as described in paragraph 3 of this authorization, I authorize disclosure of information regarding my billing, conditions, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that the person and/or organizations named above have taken action in reliance on this authorization. If I do not sign this form or I later revoke my authorization, the services provided to me by the person or organization listed in paragraph 4 will not be affected in any way.

This authorization shall be in force effective nine (9) months after my death or _____ (date or event) at which time this authorization expires.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be condition on whether I sign this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my directions.

_____ _____ _____

Print Name Date Signature

Privacy Policy available upon request.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PREVIOUS PCP, SPECIALIST OR FACILITY THAT WE NEED RECORDS FROM

- I authorize the following person(s) and/or organization(s) to release my PHI:

  Name(s): _____

  Address: _____

  _____

  Phone: _____ Fax: _____

- I authorize this information to be released to:
  John T. Littell, M.D. & Associates
  300 Park Place Blvd.
  Kissimmee, FL 34741
  Phone: 407-343-1711 Fax: 407-343-1611 or 407-203-2060

- Specific description of the PHI that I authorize for disclosure:
  NO CD'S OR ZIP DRIVES PLEASE

- Specific description of the purpose for each use or disclosure:

  AT THE REQUEST OF THE INDIVIDUAL

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my directions. The confidentiality of this information is protected by federal law. Any information used or disclosed not pertaining to this authorization may be revoked by the recipient and destroyed. I may cancel this authorization in writing at any time.

Signature: _____ Date: _____

Name: _____ SS# _____-_____-_____ DOB: _____

Address: _____

Telephone: _____-_____-_____

_____
Relationship or Authority of Personal Representative (if applicable)