John T. Littell M.D.
Caring for Your Entire Family
ADULT MEDICINE • WOMEN'S HEALTH CARE • DERMATOLOGY
PEDIATRICS • URGENT CARE • HOSPITAL & NURSING HOME CARE
1541 SW 1st Ave. Suite 103 • Ocala, FL 34471 • www.JohnLittellMD.com • Phone: 352-414-5990 • 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 5:00 p.m. (Dr. Littell is in office available to see patients until 2:00 p.m. the office remains open until 5:00 p.m.)
Thursday:	8:00 a.m. to 5:00 p.m.
Friday:	8:00 a.m. to 5:00 p.m.

Same day appointments are always available for existing patients and we make every effort to extend the same to new patients wanting to join the practice.

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 link on the left side of the page. 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. If the prescription is a controlled medication, we will contact you after it has been signed off by Dr. Littell to let you know it is ready to be picked up and taken to the pharmacy.

Dermatology services are also available in our office.

Welcome to our practice and thank you for choosing the practice of Dr. John T. Littell, M.D. as your primary care office for all your needs.

Thank you,
Management

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CHILD MEDICAL HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____

Household family members:

Mother's Name: _____ Age: ___ Father's Name: _____ Age: ___

Sibling's Name: _____ Age: ___ Sibling's Name: _____ Age: ___

Sibling's Name: _____ Age: ___ Sibling's Name: _____ Age: ___

Religious Preference (if any): _____

Caffeine Use # per Day: _____

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)

_____ _____

_____ _____

_____ _____

Immunizations: __ Tetanus __ Pneumonia Shot __ Hepatitis Series __ Flu Shot

Have you had: __ Measles __ Mumps __ German Measles __ Chicken Pox

Whom may we thank for referring you to us? _____

FEMALES PLEASE COMPLETE (Ages 12 and older)

Menstrual Flow (circle all as needed): Regular Irregular Pain/Cramps

_____ Days of flow _____ Length between cycles _____ 1st day of last period

Number of: ___ Pregnancies ___ Abortions ___ Miscarriages ___ Live Births

Birth Control Method: _____

Are you experiencing: ___ Flushing ___ Menopause Symptoms

Age when periods fist started: _____

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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

Home Phone:(___) ___ - ___ Cell 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: _____

INSURANCEE 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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MEANINGFUL USE PATIIENT REGISTRATION FORM

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including you preferred language, race, and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process.

Please complete the information below:

Patient Name: _____ D.O.B.: _____ Age: _____

E-mail Address: _____ Date: _____

Race:

___ African-American

___ Arabic

___ Caucasian

___ Filipino

___ Hispanic

___ Other

Ethnicity:

___ Hispanic

___ Non-Hispanic

Primary Language:

___ Arabic

___ Chinese

___ English

___ French

___ Korean

Please provide information about previous immunizations (Including date or year of the last given)

Flu Vaccine: _____ Pneumococcal Vaccine: _____ Tetanus Vaccine: _____

Male:

Colonoscopy: _____

Female:

Colonoscopy: _____

Mammogram: _____

Tobacco use (circle one):

Never Current Every Day Smoker Current Smoker (not daily) Former Smoker

PRIVACY POLICY

The office of John T. Littell, M.D. is required by law to maintain the privacy and security of your health information and provide individuals with notice of it legal duties and privacy practices with respect to health information. The office of John T. Littell, M.D. is required to abide by the terms of the Notice of Privacy Practices currently in effect. The office of John T. Littell, M.D. reserves the right to change the terms of the Notice of Privacy Practices at any time to make new Notice provision effective for all health information that it maintains. Upon your request, we will provide you with a current copy of the Notice of Privacy Practices.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your Protected Health Information ("PHI") under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act ("HIPPA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI included demographic information that can be used to identify you such as your name, address, and telephone number; information concerning your past, present, o future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, or future payment for health care. Your PHI may be maintained by us electronically and/or on paper.

We understand that information about you and your health is very personal and therefore, we will strive to protect your privacy as required by law. We will only use and disclose your personal health information ("PHI") as allowed by applicable law.

_____

Printed Patient Name

_____ _____

Patient/Guardian Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____

Printed Name Relationship to patient

_____ _____

Signature Date

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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

1. 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.
2. Authorization for release of PHI covering the period of healthcare (check one)
   a. ☐ from (date) _____ - to (date) _____ OR
   b. ☐ all past, present and future periods.
3. I hereby authorize the release of PHI as follow (check one)
   a. ☐ My complete health record (including records relating to mental health care, communicable diseases, HIV / AIDS, and the treatment of alcohol/drug abuse. OR
   b. ☐ 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): _____
4. 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**: _____
5. I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that the person(s) 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.
6. This authorization shall be in force effective nine (9) months after my death or _____ (date or event) at which time this authorization expires.
7. 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.

_____ _____ _____

Patient Name (PRINTED) Signature of Patient/Guardian Date

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FINANCIAL POLICY

PAYMENT IS EXPECTED WHEN SERVICE ARE RENDERED

- Co-payments, where applicable and previous balance are due upon check-in.
- Any deductible or co-insurance is due upon check out.
- You are responsible for understanding what your insurance plan will or will not cover.
- We will not bill insurance companies that we are non-participating with.
- We as that you reschedule your appointment if you are unable to pay your financial responsibility at the time of service.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- A copy of your current insurance card is required at each visit.
- Please contact your insurance company with any questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than 1 patient account, we may offset and overpayment in one account to another.
- We will assess a $35 service fee for any checks returned unpaid.
- If your payment is not received within 30 days, your account will be considered delinquent.

WE USE COLLECTIONS AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with credit reporting agencies.
- If you have a balance due, payment may be required before appointments are scheduled.
- If we incur any collection costs, these will be added to the balance you owe.
- If your account is transferred to a collection agency, you will be discharged from the practice.

NOTIFY US TO CANCLE AN APPOINTMENT

- If you need to cancel an appointment contact us AT LEAST 24 hours before the appointment.
- If you miss an appointment or are late in cancelling it, we may access a $25.00 fee.
- If you frequently miss or cancel appointments, you may be discharged for the practice.

WE USE AUTOMATED & ELECTRONICE SYSTEMS FOR REMINDERS & ACCOUNT FOLLOW UP

- You authorize our agents to contact you using any contact information you provide to us including e-mail addresses and wireless phone numbers. (Please note some wireless plans assess fees)

I have read the above financial policy of John T. Littell, M.D. & Associates and agree to its terms. I am responsible for any balances due on my account and any other patients(s) listed below.

If the patient is not you, please name: _____ _____
_____ _____

Signature of patient/guardian/authorized representative: _____ Date _____

Printed name:_____

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OFFICE POLICIES & CONSENT FOR TREATMENT

I _____, agree to follow the following policies in place by John T. Littell, MD.

Call First Policy

- If there is an issue in which I feel that I need to go to the emergency room:
  - I agree to contact the office of John T. Littell, MD first.
  - I understand same day appointments are available.
  - I understand that Dr. John Littell is available 24/7.
  - I understand that when calling the office there is a direct line to Dr. John Littell's personal cell phone to reach him for any issue after hours.

Prescription/Referral/Form Completion Policy

- I understand that all prescriptions/referrals/forms take up to ***72 hours*** to be processed.
- I understand that all controlled substances are a physical prescription that Dr. John Littell must sign.
- I understand that all controlled substances must be picked up in person.
- I understand that upon picking up any controlled substance there must be a physical signature that the controlled substance was picked up.

Financial Policy

- I understand that my account must be current on all payments to receive any medications.
- I understand that my account must be current on all payments to continue to receive medical care.
- I understand that if my account is not current on all payments I may be refused treatment or prescriptions.
- I understand there is a $25 cancellation fee for any missed appointments.

I understand I have the right to discuss the treatment plan with my physician. I understand I have the right to ask questions about any treatments or test my provider wants to follow. I understand by signing this document I give permission for treatment by the office of John T. Littell, MD.

I understand that if I continue do not follow these policies I will be discharged from the practice and must find a new primary care physician.

_____ _____

Patient / Guardian Print Date

_____ _____

Patient / Guardian Signature Date of Birth

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

  Address _____
  _____

  Phone Number _____ Fax Number _____
- I authorize this information to be released to:
  John T. Littell, M.D. & Associates
  1541 SW 1st Ave.
  Suite 103
  Ocala, FL 34471
  Phone: 352-414-5990 Fax: 407-343-1611
- Specific description of the PHI that I authorize for disclosure:

- Specific description of the purpose for each use or disclosure (or write "At the request of the individual in the space)

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 subject 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 Number: _____ - _____ - _____

_____

Relationship or Authority of Personal Representative (If Applicable)