Welcome to Cooper Family Medical. Please keep this letter so you have access to this information at any time you need it.

The doctor is available 24 hours a day for your urgent healthcare needs and will return your call. Avoid expensive emergency room co-pays and long waits.

Please call our office at 941-744-5510

If you have an urgent healthcare need during business hours 8:00 am - 5:00 pm

Please call our office first to guide you through further care.

Preferred Hospital: Manatee Memorial Hospital and/or Lakewood Ranch Medical Center

Your doctor has selected these hospitals because of the confidence and professional rapport they have with these hospitals and their specialists. Your Cooper Family Medical physicians do see their patients at these locations.

Preferred Laboratory: Lab Corp and Quest

- Humana & BCBS- Quest
- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your doctor will need to see you in the office to ensure your continued recovery.
- **If you are a Medicare patient:** Your doctor encourages you to be seen no less than every six (6) months and could be more frequent based on your condition. This will help both you and your doctor maximize preventative care.
- **Scheduling appointments:** Call our office to schedule your appointment and be sure to always bring your medication with you to each appointment. If you are unable to keep your appointment, please call us at least 24 hours in advance so we can offer that appointment to someone else with a healthcare need. You will be subject to a fee of $50.00 if the appointment is not canceled or rescheduled ***at least 24 hours in advance.***
- **To avoid receiving a bill**: Call the office before seeing a specialist or undergoing a procedure as many insurances require a referral. ***Do not go for lab tests, x-rays, physical therapy, etc. until our office is notified.***

Cooper Family Medical, PLLC
5123 4th Avenue Circle East Bradenton, FL. 34208

11565 US Hwy 301 N, Parrish FL. 34219

Office: (941)744-5510 Fax: (941)744-5166

General Information

Date_____________

Patient first name	
Patient last name	
Middle initial	
Date of birth	
Home phone number	
Cell phone number	
E-mail address	
Home address	
Social Security number	
Male or Female	
Single, Married, Divorced, Widowed	
Employer	
Pharmacy	
Primary insurance carrier	
Policy ID	
Type of plan HMO, PPO, POS, OTHER	
Insurance carrier phone number	
Primary cardholders' name/ relationship	

Date of birth	
Second insurance carrier	
Policy ID	
Type of plan HMO, PPO, POS, OTHER	
Insurance carrier phone #	
Important: ***In case of an emergency, who should we contact?***	
Name	
Relationship	
Address	
Home phone	
Cell phone	
Work phone	

" I understand that I am financially responsible for all charges, whether or not paid by Insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable tolerated services. By signing this form, I hereby give Cooper Family Medical consent to perform medical treatment."

Patient/ Guardian Signature ____

Date ____

How did you hear about us?	
	○ Friend or relative- Name: __________________________ ○ Parrish Village News ○ Social Media ○ Humana.com ○ Google ○ Insurance agent- Name______________________________ ○ Other, please specify ________________________________ ○ If you are a Humana member and you enrolled with an agent- what was their name? ____

Patient Medical History

Patient name___________________________

Patient date of birth ____________________

Date of last Physical Exam	
Smoking history:	
Current: Packs per day	
Former: Packs per day	
Alcohol history:	
Do you currently drink alcohol? Yes or no	
If yes, how much and how often?	
Current drug use: Marijuana LSD Cocaine Heroin Speed Other	
Marital status: Single, Married, Divorced, Widowed	
Do you have any children? Yes or no	
If yes, how many?	
Are you employed? Yes or no	
Do you have an advanced directive or a DNR? If yes, we will need a copy on file.	

Surgical History

List any time you have been under anesthesia or have had any surgeries:

Procedure	Dates	Facility location	Provider

Do you have any hardware or artificial joints or limbs?			
Procedure	**Dates**	**Facility location**	**Provider**

Allergies Please list any drug, food, or environmental allergies	
Allergy	**Reaction**

Medications			
Name	**Dose**	**How often?**	**What is it for?**

Preferred Pharmacy	
Pharmacy name	
Pharmacy location	

Preferred Laboratory Facility	
Laboratory facility	
Laboratory location	

Preferred Imaging Facility	
Imaging facility	
Imaging location	

Preventive History			
Please provide as much detail as possible in this chart	**Date**	**Provider/ Specialist**	**Office Location**
Last Physical/ GYN Exam			
Last complete bloodwork			
Last eye exam			
Last mammogram			
Last bone density/ DEXA			
Last Colonoscopy/ Cologuard			
Last prostate exam			
Last influenza vaccine			
Last COVID vaccine			
Last Tetanus vaccine			
Do you see any other specialists on a regular basis? If yes, what specialist?			

Family History

Are you adopted? Yes or No

Relation	Age if living	Major health problems	Age at death	Cause of death
Father				
Mother				
Siblings				

Physician Signature ____

Patient name____

Payment Policy

All patients must complete our Patient Payment Registration form prior to seeing our medical providers

Thank you for choosing Cooper Family Medical, PLLC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided upon request.

	Please initial each statement below
All Payments Due at Time of Service This office maintains a pay at time-of-service policy. You will need to know your insurance policy in advance in order to be aware of the portion of your visit for which you will be responsible. If you accrue a credit balance, we will maintain that credit balance on your account and apply it to a future balance that may accumulate. If a credit balance exceeds $30.00, we will refund the credit by check to the address on your account. The policies are designed to comply with the Fair Debt Collection Practices Act and any applicable state laws. If your account goes to collections, we will no longer provide medical services to you, at which time you will then be discharged from Cooper Family Medical.	
Regarding Insurance Regarding insurance plans where we are a participating provider, all payments are due including but not limited to deductibles from previous visit copay, and/or non- covered services and will be collected upon your arrival. Your insurance policy is a contract between you and your insurance company. We are ***not*** party to that contract, and we ***cannot*** bill your insurance unless you provide timely, clear, and accurate insurance information. If you have new insurance, or a change in insurance plans, you must provide us with clear and accurate insurance information within 30 days of your visit for your insurance to be billed. If you are unable to provide this information within 30 days, you will be responsible for any visits that may have occurred.	
Statements & Claim Submission We will submit your claims and assist you in any *way* reasonable to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. We will send you a statement should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. When you receive your explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. There will be a $35 charge for a check denied by your bank and returned to the office for any reason. If your account is over 90 days past due for nonpayment, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if your account remains unpaid, we may refer your account to the three major credit bureaus which may adversely affect your credit.	
Minor Patients The adult accompanying a minor and the parents (or guardian) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial	

responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office visit.	
Divorced Parents/ Legal Custody Issues The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out ***before*** your child's appointment. If a separate parent Is responsible for payment, we are not party to this arrangement. Payment is due in full at the time of service, and we will prepare a receipt of payment verification purposes.	
Appointment Reminders and Missed Appointments Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. We are not able to guarantee a reminder call for each visit, but we will certainly try. Unless canceled or rescheduled ***at least 24 hours in advance*** our policy is to charge the person who is scheduled for the appointment a missed appointment fee at the rate of $50.00. Please help us serve our entire patient population best by keeping scheduled appointments. Patients who miss three or more appointments without a 24-hour notice may be dismissed and may no longer receive medical treatment at our medical practice.	

Cooper Family Medical, PLLC is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

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

I have read and understand the payment policy and agree to abide by its guidelines.

___________________________ ___________________________

Printed Name of Patient/ Responsible Party Signature of Patient/Responsible Party

____
Date

Patient name__________________________

Patient date of birth _____________________

HIPAA

Do we have permission to:	Yes	No
Mail medical information to your home?		
Leave a detailed message on your home/cell answering machine for:		
Appointment information?		
Billing information?		
Other medical information?		
Leave a detailed message on your work answering machine for:		
Appointment information?		
Billing information?		
Other medical information?		

I give permission to share information with the following person{s):		
Specific information	**Person with permission of shared info**	**Relation**
Appointment information:		
Billing information:		
Medical info (including biopsy & lab results):		
Emergency contact:		
Emergency Contact ***Phone Number***		

With my consent, Cooper Family Medical may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to the Cooper Family 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. By signing this form, I am consenting to Cooper Family Medical's use and disclosure of information according to the Notice of Privacy Practices and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize the release of any medical information necessary to all my insurance companies to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment direct to Cooper Family Medical. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize the use of this form for all my insurance submissions. I authorize Cooper Family Medical to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and Insurance claim form submission. Under penalty of perjury, I declare that I have read the forgoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature ____ Date: _________________________

Witness Signature (CFM Employee) ____________________________ Date: _________________________

Cooper Family Medical
Request for protected health information/ patient authorization for release of records

Patient name ________________________________ Date of birth ___________________________

Social security number__________________________ Patient phone number ___________________

Requested dates please circle one:

Most recent, last year, last 3 years, or specific dates ________________

Request information from: ____

____

____

____

Release information to:
Cooper Family Medical 5123 Fourth Avenue Circle E. Bradenton, FL 34208
Phone: 941-744-5510 Fax: 941-744-5166

Purpose of the Disclosure- Please circle one:
Insurance, legal, continuing care, personal, other (specify): ______________________

Specific description of the information to be disclosed:

___ Hospital records ___ Pathology reports ___ Therapy records ___ Radiology report

___ EKG ___ Mammogram ___ OV note ___ Lab results

___ Orders ___ Other (Specify):
____

Specific information to ***NOT*** be disclosed:
____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by the Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department. I understand that my revocation is not effective to the extent that the persons or the organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.
I hereby authorize this medical facility and/or HealthMark Group to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.
I hereby release this medical facility and/or HealthMark Group from any liability which may result from this disclosure of confidential medical information, or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 180 days from the date signed.
This information may include Medical, Surgical, Psychiatric, Substance Abuse, and HIV/Aids information. I authorize that this information may be faxed when applicable.

Signature ____ Date ____________________

Patient representative signature and authority to sign _______________________________________

Date ____________________

Witness ____ Date ____________________

Patient Care Contract:

The team at Cooper Family Medical works hard to give you the best possible care while you are a patient at our office. In order to have the best information to do this, we need certain key details that give us the best information to manage your health. Regular annual wellness visits performed each year with routine lab work is a valuable insight into your current health. Additionally, preventative screenings are critical to catching early diagnoses to ensure the best possible outcomes. We encourage you to discuss any concerns you may have about these events and any other health related items at any visit with your provider.

We understand that every now and again you may be unable to follow through with the needed items to manage your health. We encourage you to complete these tests as soon as you are able to do so. Without this information, we are limited in our ability to properly care for you as a patient. If at any time we feel that the lack of information impedes our ability to safely take care of you, we will reach out to discuss. Routine failure to complete these valuable tests may result in dismissal from the practice in extreme cases. Please feel free to discuss your concerns with your provider on your next visit if you have any questions about why these tests are needed.

We are so grateful that you chose Cooper Family Medical for your care and hope to have you as a patient for many years to come. Thank you!

By signing below, you acknowledge the information above has been communicated to you as a patient of Cooper Family Medical.

______________________________	______________________
Patient Name /DOB	Date
______________________________	______________________
CFM Witness	Date