

THOMAS E. LANGLEY MEDICAL CENTER PRIVACY STATEMENT

PRIVACY PRACTICES: 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.

Treatment is the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another.

Example: A copy of your most recent lab work may be sent to a specialist that we refer you to.

Payment is the activities undertaken to obtain reimbursement for the provision of healthcare under the health plan; obtain or provide reimbursement for the provision of healthcare; and determination of eligibility or coverage and adjudication of claims; risk adjustment; billing; claims management; collection activities; obtaining payment; related healthcare data processing; review of services with respect to medical necessity; appropriateness of care; justification of charges; utilization review activities; and disclosure to consumer reporting agencies relating to collection of reimbursement.

Example: Supporting documentation from your chart may be released to your insurance company to support a claim made.

Healthcare Operations means performing any activities related to covered functions, including: conduction quality assessment; reviewing competence or qualification of healthcare professionals; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

Example: A consultant may review your medical record for appropriate documentation.

You have a right to:

- Restrict disclosures to individuals who may be involved in your care or payment related to your care
- Receive confidential communication
- Inspect and copy protected health information about yourself
- Request an amendment to your medical record
- Request an accounting of disclosures

For further information contact this facility's Compliance Officer.

Patient/Parent/Guardian Signature

Date

By signing above I acknowledge that I have received a copy of the Privacy Statement.

THOMAS E. LANGLEY MEDICAL CENTER
1425 S. US Hwy 301, Sumterville, FL 33585

PATIENT/GUARANTOR AGREEMENT

PATIENT'S

LEGAL NAME: _____ ID #: _____

- I. **RELEASE OF INFORMATION:** The Thomas E. Langley Medical Center (TELMC) may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to TELMC for all or part of TELMC's charges, including but not limited to hospital or medical service companies, Worker's Compensation carriers, Veteran's Administration, welfare or the patient's employer. Information may also be released to the person or organization referring the patient to TELMC.
- II. **PHYSICIAN INSURANCE ASSIGNMENT:** I, the below named subscriber, hereby authorize payment directly to Thomas E. Langley Medical Center for any medical, dental and/or psychiatric benefits herein specified and otherwise payable to me for their services, as described but not to exceed the reasonable and customary charge for these services.
- III. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she shall hereby be individually obligated to pay the account of Thomas E. Langley Medical Center in accordance with the regular rates and terms of TELMC. The undersigned also agrees to be liable for all expenses incurred in the collection of this account, including but not limited to, all reasonable attorney fees and all costs.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to a fine and imprisonment under Federal Law.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE INFORMATION EXPLAINED AND FULLY UNDERSTANDS THE ABOVE AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT, AS PATIENT'S GENERAL AGENT, TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Date: _____, 20_____

Patient

TELMC Witness: _____

Patient's Representative
SS# _____ DOB _____

TELMC Witness: _____

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION and LIFETIME MEDICARE B SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare and request payment of medical insurance benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original, as long as I receive services at Thomas E. Langley Medical Center. I understand that I am responsible for my co-insurance amount on Medicare coverable services. I further understand that the Part B deductible does not apply to FQHC services; however, should I receive services that are non-covered under FQHC, I will be responsible for the part B deductible.

I have completed a copy of the Medicare Secondary Payor (MSP) Questionnaire.

Date

Signature

Relationship to Patient

Thomas E. Langley Medical Center
1425 S. US Hwy 301 • Sumterville, FL 33585
(352) 793-5900 • Fax (352) 793-9558

PERMISSION FOR TREATMENT

I, _____, voluntarily
(Please Print)

request examination and /or treatment for: ___ Myself or ___ Minor Child or ___ Ward,
whose name is: _____
(Please Print)

by the personnel at Langley Medical Center. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of TLMC. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees or TLMC concerning my diagnosis and treatment.

I authorize Langley Medical Center to release medical information to my insurance carrier(s) for the purpose of paying my bill and to release medical information to another physician or hospital to which I might be referred.

I certify that the information given to Langley Medical Center is the truth, to the best of my knowledge.

Patient Signature

Signature of Parent or Guardian for Minor
Or Mentally Incompetent

Relationship to Patient: _____

Address, if other than Patient's: _____

WITNESS: _____ Date: _____
(Langley Medical Center Personnel)

**THOMAS E. LANGLEY MEDICAL CENTER
1425 S. US HWY 301, SUMTERVILLE, FL 33585
352-793-5900 • 888-298-5510**

**Identification of Migrant and Seasonal
Farm-workers**

In the past 2 years

- A) Has anyone in your family worked in agricultural labor?
_____ Yes _____ No
- B) Has over half of your family wages (income) come from fieldwork?
_____ Yes _____ No
- C) Has anyone in your family moved from this area, in search of
fieldwork, to another county or state?
_____ Yes _____ No
- D) Has your family lived in this area and only worked during the
Harvest Season?
_____ Yes _____ No

Patient/Parent/Guardian Signature

Identificación Para Trabajadores De Agricultura

En Los Ultimos 2 Años

- A) Alguien de tu familia trabaja en Agricultura?
_____ Si _____ No
- B) Mas de la mitad de las ganancias de su familia vienen del trabajo
de Agricultura?
_____ Si _____ No
- C) Alguien de su familia se ha mudado de este lugar, para otro condado o estado?
_____ Si _____ No
- D) Su familia ha vivido en el mismo lugar y solamente ha trabajado durante la
epoca de recoger frutas y vegetales?
_____ Si _____ No

Firma del Paciente/Padre's/Guardian

Thomas E. Langley Medical Center

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352-793-5900 • 888-298-5510 • 352-793-9558 Fax

APPOINTMENTS AT THOMAS LANGLEY MEDICAL CENTER

Medical services are available Monday through Friday 8:00am to 5:00pm. Dental Services are available Monday through Friday 7:30am to 6:00pm. Our Walk-In Clinic is open Saturday 8am to 2pm.

Routine medical services are provided by appointment. If you live in Sumter County, call: (352) 793-5900. If you are outside the county, our toll free number is (888) 298-5510.

If you are in need of urgent medical care, our Walk-In Clinic is available on a walk-in basis. With the exception of medical emergencies, Walk-In patients are served on a first come, first served basis.

To make a dental appointment, let the operator know you need a dental appointment and your call will be transferred directly to the dental office. Dental emergencies are handled as space is available.

Your appointment time is time set aside for **YOU** to meet with your provider. The amount of time set aside was based on your needs.

- You are expected to arrive 15 minutes before your appointment. Every effort will be made to see you on time. If you are more than 10 minutes late, your provider **may** not be able to see you. You may then be seen in the Walk-In Clinic, or by another provider, depending on the urgency of your need and available time.
- If you cannot keep your appointment, it is important to let us know 24-48 hours in advance. We can then use the time to serve someone else. This makes good use of your provider's time and makes it easier for everyone to get an appointment when they need it.
- If you miss your appointment, your prescription may not be refilled until you come in for your next appointment.
- **Patients with three (3) missed appointments in twelve (12) consecutive months may be subject to discharge.**

Following the appointment policy and procedure will help us to serve you better. Thank you for your assistance.

I have read, and understand, the above information.

Patient signature

Date