Bliss Specialty Healthcare

Phone (352)205-9149 | FAX (866) 341-7847

Dear Patient,

Welcome to the Bliss Specialty Healthcare (BSH) initiative, a new way of managing your health care! Bliss specialty Healthcare is a model of care designed to improve the coordination of your health care with an emphasis on your all-around well-being.

I invite you to continue working with me in this new model of care. I will work with other health care providers to take care of you. As your care team, we will involve you in decisions about your health and health care, and thus be able to develop a stronger relationship with you.

Our main concern is about the range of the patient's whole health, we are responsible for coordinating care across the healthcare setting.

I look forward to working with you on the path to a healthier you!

Sincerely,

Kingsley D. Aliu, M.D.
Bliss Specialty Healthcare

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Patient Portal Consent Form

Patient Portal is a secure online source of confidential medical information for patients. This gives patients a convenient 24-hour access to personal health information, from anywhere with an Internet connection. Using a secure username and password, patients can:

- Access personal health information
- Request refills for prescriptions
- Review results for Labs/Tests
- Correspond with our staff and providers regarding your care

I agree to the following:

1. I will abide by all terms and conditions of Bliss specialty Healthcare Patient Portal.
2. Bliss Specialty Healthcare is not responsible for any breach of information caused by patient misuse.
3. I understand that my activities within the Patient Portal will become part of my medical record.

I understand the following:

1. For medical emergencies, dial 911. The Patient Portal is NOT to be used for urgent needs.
2. All communication is sent to the nursing staff, not directly to the provider. You will receive a response within 24-48 hours.
3. The Patient Portal is NOT a substitute for office visits with your provider and prescription requests for medications not currently being prescribed will NOT be honored.

I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal.

☐ I DECLINE access to the Patient Portal ☐ I would like access to the Patient Portal

Patient Name: _____ DOB: _____/_____/_____
Secure Email Address: _____
Patient Signature: _____ Date: _____
Relationship if representative: _____

For office use only Portal Invite Sent by_____ on _____

BLISS SPECIALTY HEALTHCARE

AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at aliu@blissspecialtyhealthcare.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at www.blissspecialtyhealthcare.com and that I may request a paper copy at my provider reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ Email: _____

➔ Signature: _____ Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Name and Relationship of Person Signing, if not Patient: _____

Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.

Bliss Specialty Healthcare Group

Patient Enrollment Form

Patient Information: Please use full legal name.

☐ *M* ☐ *F*

First Name: _____ Last Name: _____ M.I. _____

☐ *Skill SNF* ☐ *Assisted Living*
☐ *In-Home* ☐ *Independent Living*

Date of Birth: _____/_____/_____ Social Security #: _____

Community and Room #: _____ City/State: _____

Race/Ethnicity: *Choose one or more*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: _____ Country of Origin: _____ ☐ Interpreter Services Needed

Insurance:

Medicare ID #:_____ (If on Medicare, ID ***required*** for enrollment.)

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Prescription Drug Coverage Name: _____ Plan ID #: _____

Personal Representative (Healthcare Decision Maker): Provide copy of Health Care Directive and/or Guardianship Paperwork.

☐ Self; I make my own medical decisions and have no Medical Power of Attorney or Health Care Directive.

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Billing Contact:

☐ Same as Healthcare Decision Maker ☐ Self

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Your Healthcare Information:

Drug allergies and specific reactions: _____

Current diagnoses: _____

Code status: ☐ Full code ☐ Do Not Resuscitate (DNR) ☐ Other (Please include paperwork, if applicable.)

Family History (siblings or parents; check all that apply): ☐ Alzheimer's/Dementia ☐ Heart Disease ☐ Diabetes
☐ Hypertension ☐ Depression/Mental Health Conditions ☐ Cancer (Type): _____
☐ Other: _____

Bliss Specialty Healthcare Group

Authorization for Release of Health Information

Patient Information: Please use full legal name.

First Name: _____ Last Name: _____ M.I. _____ Date of Birth: _____/_____/_____

Community and Room #: _____

***Release Information From (Required):**

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Information To:

Bliss Specialty Healthcare
6388 Silver Star Road Ste 2-H
Orlando, FL 32818

FAX: 866-341-7847 **PHONE: 407-704-1771**

***Information To Be Released (Required):** Indicate ONLY the information that you are authorizing to be released.

☐ Notes from **four** most recent provider visits ☐ Labs and imaging within last two years

☐ Hospital discharges within **last two years** ☐ Other: _____

By law, you must specifically request the following information for it to be released:

Chemical dependency program: ☐ Yes ☐ No Behavioral health notes: ☐ Yes ☐ No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bliss Specialty Healthcare Group. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bliss Specialty Healthcare Group before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent does not expire unless I write in a specific expiration date here: _____.

_____ _____

Patient or Legal Representative Signature ***Date***

_____

Legal Representative Printed Name and Authority to sign for patient *(i.e. Health Care Directive, Medical POA; must include documentation)*

Fax completed forms to: 866-341-7847

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Medical Questionnaire

Name: _____ Date: _____
Home Address: _____
Phone: _____ D.O.B: _____ Age: _____ SS#: _____
Circle the highest year of education: 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 1 2 3 4
Elementary H.S. College Post- Grad
What is your marital status? Single Married Divorced Widowed
Reason for visit: _____
Are you under a health care provider's care for any condition? YES ___ NO ___
If yes, what is the health care provider's name: _____
Last date seen by provider: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR GENERAL HEALTH

How would you rate your general health: Excellent___ Good___ Fair___ Poor___?

PAST MAJOR ILLNESSES:

Lung Disease	Date: _____	Neurological Problems	Date: _____
Heart Disease	Date: _____	Gallbladder Disease	Date: _____
Kidney Disease	Date: _____	Epilepsy / Seizures	Date: _____
Tuberculosis	Date: _____	Migraine / Headaches	Date: _____
Blood Disorder	Date: _____	Blood Transfusion	Date: _____
Diabetes	Date: _____	Anxiety / Depression	Date: _____
Stroke / TIA	Date: _____	High Blood Pressure	Date: _____
Swelling	Date: _____	Parkinson's Disease	Date: _____
Glaucoma	Date: _____	Colitis / Bowel Disease	Date: _____
Cataracts	Date: _____	Seasonal Allergies	Date: _____
Gallbladder Disease	Date: _____	Loss of Consciousness	Date: _____

Epilepsy / Seizures Date: _____

Thyroid Problems Date: _____

Migraine / Headaches Date: _____

SURGERIES:

Appendectomy YES___ NO___ DATE_____

Cholecystectomy YES___ NO___ DATE_____

Hysterectomy YES___ NO___ DATE_____

Cataract Surgery YES___ NO___ DATE_____

Heart Surgery YES___ NO___ DATE_____

Heart Catheterization YES___ NO___ DATE_____

Hip surgery YES___ NO___ DATE_____

Other Surgeries not mentioned above:

_____

_____

Broken Bones:

_____

_____

Hospitalizations:

_____

_____

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FAMILY HISTORY:
Parents: Mother living ___deceased___ age and cause of death _____
Father living ___deceased___ age and cause of death _____
Siblings: Number living ___ Number Deceased___
Children: Number living ___ Number Deceased___ Do you have family in the local area? YES___ NO___

Any family history of the following:
Cancer If so, who _____
Depression If so, who _____
Diabetes If so, who _____
Heart Disease If so, who _____
Stroke If so, who _____
Dementia/Senility If so, who _____
Have any of your friends or relatives pass away recently?
If so, who and when _____

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PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR RECENT HEALTH STATUS:

When was your last Mammogram? YEAR____ Not applicable__

When was your last pelvic exam or Pap Smear? YEAR____ Not applicable__

When was your last Prostate exam? YEAR____ Not applicable__

When was your last hearing exam? YEAR____ Not applicable__

When was your last bone density exam? YEAR____ Not applicable__

When was your last eye exam? YEAR____

When was your last dental exam and cleaning? YEAR____

When was your last Colonoscopy? YEAR____

When was your last Pneumococcal Immunization? YES___ NO___ Date_____

Have you had a flu shot this season? YES___ NO___ Date_____

Have you had a Tetanus Immunization? YES___ NO___ Date_____

Do you exercise regularly? YES___ NO___

Do you smoke or have you ever smoked? YES___ NO___
If so, how many years? _____ How many packs a day? _____
Do you still smoke? _____ When did you quit? _____

Do you drink alcohol? YES___ NO___
- Social_____
- Occasional_____
- Daily_____

How many glasses a day? ____

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PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ACTIVIES OF DAILY LIVING:

Can you handle your own personal care (Toileting, Eating, Walking, Dressing, Bathing)?
YES___ NO___ SOME___
Do you do your own cooking? YES___ NO___
Do you do your own cleaning? YES___ NO___
Do you do your own shopping? YES___ NO___
Do you handle your own finances? YES___ NO___ Do you handle your own medications? YES___ NO___ If you answered no to any of these questions, who does these things for you?

_____

Do you use the phone to call family, friends or for emergencies? YES___ NO___ Do you drive? YES___ NO___
If so, have you had any accidents or near accidents in the last two years? YES___ NO___
Have you ever gotten lost? YES___ NO___

PLEASE INDICATE IF YOU ARE HAVING PROBLEMS WITH ANY OF THE FOLLOWING:

Dizziness YES___NO___ Comments _____
Blurred Vision YES___NO___ Comments _____
Headaches YES___NO___ Comments _____ Swelling YES___NO___ Comments _____
Chest Pain YES___NO___ Comments _____
Insomnia YES___NO___ Comments _____
Sexual Function YES___NO___ Comments _____
Memory Loss YES___NO___ Comments _____
Easily Fatigued YES___NO___ Comments _____
Recent Fall YES___NO___ Comments _____
Painful/Burning Urination YES___NO___ Comments _____
Diarrhea/Constipation YES___NO___ Comments _____
Indigestion/Heartburn YES___NO___ Comments _____
Weight loss/ Weight gain YES___NO___ Comments _____
Muscle or Joint Pain YES___NO___ Comments _____
Anxiety/ Depression YES___NO___ Comments _____
Recent appetite changes YES___NO___ Comments _____
Shortness of Breath YES___NO___ Comments _____ Cough YES___NO___ Comments _____

Name: _____

Current Medication List

Medication Name	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

PLEASE MAKE SURE TO BRING YOUR MEDICATION BOTTLES THE DAY OF YOUR 1st APPOINTMENT WITH US.

THANK YOU!