DIAGNOSTIC CLINIC
MEDICAL GROUP
Your Home for Comprehensive Care

Thank you for choosing Diagnostic Clinic for your healthcare needs.

We have scheduled time prior to your first appointment to complete a brief, new patient registration. Please have your Driver's License or State ID card available. We will also need to make a copy of your insurance card (or cards) to ensure accurate billing. Completing the questions below will speed the registration process.

Patient's Name: First _____ MI ____Last_____.

Contact phone #_____**cell or home** **Emergency phone#**_____

What is your Social Security Number? ___ ___ ___ - ___ ___ - ___ ___ ___ ___
(We use your SSN to prevent fraud and account duplication).

What is your marital status? SINGLE MARRIED DIVORCED WIDOWED OTHER

Who is your current employer? _____ **Phone:** (____)_____-_____
UNEMPLOYED CHILD STUDENT RETIRED DISABLED

What is your race? ASIAN, WHITE, AFRICAN AMERICAN, AMERICAN INDIAN/ALASKA NATIVE, HAWAIIAN or PACIFIC ISLANDER, DECLINE

How would you describe your ethnicity? HISPANIC/LATINO or SPANISH ORIGIN, NOT HISPANIC/LATINO or SPANISH ORIGIN, DECLINE.

What is your primary language? _____

E-mail Address? _____.

Is the Patient the primary policy holder on the insurance plan? YES _____ NO _____

If no, please provide us with the following information on the primary policy holder:

What is their name? First _____ M.I. ____Last _____

What is their date of birth? (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Who is their employer? _____

Name of Primary Care Physician, if not in the Diagnostic Clinic?_____

Clinic #: _____

Date of Birth: _____

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

Diagnostic Clinic is committed to protecting the privacy and security of your health information. With your written permission, Diagnostic Clinic staff may disclose (discuss) your health information with family members, other relatives, or other person(s) you identify below, when the health information is directly relevant to that person's involvement with your care. I understand that such identified person(s) will not have access to my written health records.

I, _____, authorize the release of verbal health information regarding my treatment and care to the following individuals.

Name	Relationship	Contact Number(s)

This form may be revoked at any time upon my written request to the Diagnostic Clinic. If I refuse to sign this form, my information will not be released verbally except as required by law. I agree to hold the Diagnostic Clinic harmless and release them from any liability for any claims or actions, which may occur as a result of the release of information. We will not condition treatment on the completion of the form.

Signature: _____ Date: _____

Print Name: _____

If Signed by Representative, Description of Relationship to Patient and Authority: _____

Acknowledgement of Receipt of Notice of Privacy Practices

The Diagnostic Clinic Medical Group, PA reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that the Notice of Privacy Practices is posted on Diagnostic Clinic's website at www.DC-FL.com and I will be provided with a paper copy upon request.

Signature of Patient _____ Date _____

Print Name of Patient _____

Signature of Patient Representative _____ Date _____

Print Name of Patient Representative _____ Relationship to Patient: _____

rev. 9.15.19

OFFICE USE ONLY -- SCAN THIS SIDE ONLY

DIAGNOSTIC CLINIC MEDICAL GROUP

Name_____

I. Consent to Treatment

I consent to the examinations, treatments and procedures that may be performed during my affiliation with Diagnostic Clinic. If I am the representative/responsible party for another person or a minor, I also provide such authorization. This will include radiological examinations, laboratory procedures, medical and non-invasive treatments or procedures, or other medical or medicallyrelated services rendered to the patient under the general and special instructions of the physicians or allied health provider(s) of Diagnostic Clinic. Additional informed consent may be required for certain procedures.

II. Code of Conduct

I have read and understand DCMG Organizations **Patient Code of Conduct.** Requirements: In an effort to provide and maintain a safe and healthy environment for employees, visitors, patients and other occupants I have been informed that unacceptable, disruptive behaviors and/or communications (mail, telephonic, electronic, voicemail) of any form will not be tolerated and/or permitted within DCMG facilities. The following behaviors are prohibited and will be resolved as indicated through proper public law enforcement assistance; destruction of property, verbal or gesturing threats and/or implications of violence, possession of any/all weapons, cursing/profanity, physical assault or threats and/or other derogatory verbal or non verbal remarks. No hostile communication or gestures regarding an individuals' race, ethnicity, language or sexuality is permitted within DCMG facilities. Appropriate attire and shoes must be worn at all times. Inappropriate exhibition, exposure and/or nudity will not be tolerated and violators will be removed from the premises.

III.Lifetime Authorization – Medicare Certification for Payment

I certify that the information given by me in applying for payment under Titles XVIII of the Social Security Act (i.e., Medicare) is accurate and correct. I authorize any holder of medical or other information about myself, or the patient I represent to release to the Social Security Administration or its intermediaries or carriers any information or documentation needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my or the represented patient's behalf. I hereby assign the benefits payable for physician services to the physician or organization furnishing the services, and hereby authorize suchphysician or organization to submit a claim to Medicare for payment.

IV. Assignment of Insurance or Third Party Benefits

I authorize direct payment to Diagnostic Clinic of any insurance, managed care, self-insured plan, or other third party benefits or state disability benefits otherwise payable to or on behalf of myself or the patient for services rendered, and assign to Diagnostic Clinic, for application to patient's account, all such benefits, payable at a rate not to exceed Diagnostic Clinic's regular rates and charges. I understand that I, or the patient I represent, will remain responsible for all charges or applicable co-payments not covered in whole or in part by the payor, subject to applicable law.

V. Financial Responsibility Agreement

By signing this agreement, whether as a patient, representative, or guarantor, I fully understand, acknowledge, andagree to each of the following:

- I will be fully financially responsible for any and all services rendered by Diagnostic Clinic and its staff, whether coveredor not covered by insurance, an employee benefit program, Medicare, Medicaid, or HMO.
- I agree to pay any additional account balances in full at the time of billing statement receipt.
- I agree to pay any additional account balances in full at the time of my next visit even if I have not yet receiveda billing statement.
- I certify that I have read the foregoing, and I am the patient, guarantor, or the patient's representative duly authorized to execute this Agreement and accept its terms.

_____	_____	_____
Signature of Patient/Guarantor/Representative	**Relationship if not self**	**Date**

DIAGNOSTIC CLINIC MEDICAL GROUP

Consent to Receive Communications via E-mail, Telephone Calls, Text Messages and Postcards

Name _____ **Date of Birth** _____ **MRN#** _____

I give my express consent to receive communications from DCMG via e-mails, telephone calls to my cell phone or landline (including voicemail messages on these lines), text messages, and/or postcards at the telephone number(s) and/or address that are listed below, or at such updated address/phone number(s) that I may provide to DCMG. Such communications may include, but are not limited to:

- written or verbal messages reminding me of my appointments;
- information about my account balances or other billing or payment information;
- preventative care recommendations;
- instructions on how to electronically access my summary of care record following my evaluations; and
- reminders regarding DCMG policies and procedures and patient satisfaction surveys.

I expressly acknowledge and agree that this consent includes communications that may contain Protected Health Information, including information about my diagnosis, medications, laboratory test results and other treatment related information. I realize that at any time I may opt out of receiving communications from DCMG through the channels described above by following the opt out directions contained in the texts, verbal automated messages and/or by calling DCMG.

By selecting this consent, you authorize DCMG to release Protected Health Information to you in the manner described above and agree that you are solely responsible and liable for the confidentiality and security of the street or email address or telephone numbers (cell and/or landline) you provide, the security of the devices upon which you view or otherwise access the Protected Health Information, and the risks inherent in using electronic communications, including risks that these communications can be intercepted, altered, forwarded or used without authorization or detection. You have the right to designate a different email address or telephone number at any time, and you should do so if you believe that the address/telephone number you are providing today is no longer secure or valid. You understand that failing to update your e-mail address/telephone number may result in a delay or failure of notification of important information and/or the possible release of Protected Health Information to an unintended recipient.

I understand that DCMG does not charge for providing the communications described above to its patients, but I am responsible for any costs or expenses associated with the maintenance or operation of my e-mail or telephone accounts including, without limitation, text messaging fees that may be charged by my wireless carrier.

First and Last Name _____ Email Address _____

Cell Phone Number _____ Landline Number _____

Address _____

Signature _____ Date _____

☐ I DECLINE, I DO NOT WISH TO RECEIVE THE ABOVE DESCRIBED COMMUNICATIONS.

I certify that I have read the foregoing agreement and I accept its terms. I certify that if I am signing this agreement as the personal representative of the patient, I am legally authorized to also accept its terms on behalf of the patient.

_____	_____	_____
Signature of Patient Guarantor/Representative	Relationship	Date

DIAGNOSTIC CLINIC

NOTICE OF PRIVACY PRACTICES
FOR DIAGNOSTIC CLINIC MEDICAL GROUP, INC.
(the "Provider")

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.

This Notice describes the privacy policies of the Provider, and applies to the physicians, health care professionals, employees, staff and other personnel who provide services at the Provider. The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by the terms of this notice. We may share your information for purposes of treatment, and as necessary for payment and operations activities as described below.

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It is intended to describe the policies that protect medical information relating to your past, present and future medical conditions, health care treatment, and payment for that treatment (called "Protected Health Information" or "PHI"). It does not apply to information that could not reasonably be used to identify you.

OUR LEGAL DUTIES

- We are required by law to take reasonable steps to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.
- We are required to maintain reasonable and appropriate administrative, technical and physical safeguards for protecting e-PHI.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

We may use your PHI, or disclose your PHI to others, for a number of different reasons. This notice describes the categories of reasons for using or disclosing your information. For each category, we have provided a brief explanation, and in many cases have provided examples. The examples given do not include all of the specific ways we may use or disclose your PHI. However, any time we use or disclose your PHI, it will be for one of the categories of listed below.

Treatment. We will use your health information to provide you with medical care and services. This means that our employees and staff and others who work under our direct control may read your health information to learn about your medical condition and use it to make decisions about your care. For instance, a medical assistant may read your medical chart in order to care for you properly. We will also give your information to others who need it in order to provide you with medical treatment or services. For instance, we may send your doctor the results of laboratory tests or x-rays we perform.

Payment. We will use your health information, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your health information to

prepare a bill. And we may send that bill, and any health information it contains, to your insurance company. We may also disclose some of your health information to companies with whom we contract for payment-related services. We may give information about you to a health plan that pays for your benefits. We will not use or disclose more information for payment purposes than is necessary.

Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our Staff. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. For example, we may disclose your health information to a company that assists us with quality assurance. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

To Business Associates. We may hire third parties that may need your PHI to perform certain services on our behalf. These third parties are our "Business Associates". Business Associates must protect any PHI they receive from, or create and maintain on our behalf.

Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object. We may also disclose to your personal representatives who have authority to act on your behalf (for example, to parents of minors or to someone with a power of attorney).

Public Health Oversight. We may disclose your health information to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; licensure or disciplinary actions (for example, to investigate complaints against health care providers); inspections; and other activities necessary for appropriate oversight of government programs (for example, to investigate Medicaid fraud).

To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by Medicare or Medicaid.

Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

For Lawsuits and Disputes. We may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. We may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if we have received adequate assurances that the information to be disclosed will be protected.

Specialized Purposes. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ,

eye, or tissue donation); or for national security and intelligence purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance). We may disclose PHI to organizations engaged in emergency and disaster relief efforts.

To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Research. We may disclose your health information in connection with medical research projects if allowed under federal and state laws and rules. We may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

Information to Patients. We may use your health information to provide you with additional information. This may include sending you appointment reminders. This may also include giving you information about treatment options or other health-related services that we provide.

YOUR RIGHTS

Authorization. We will ask for your written authorization if we plan to use or disclose your health information for reasons not covered in this notice, including but not limited to uses and disclosures relating to psychotherapy notes, marketing activities, and any sale of your PHI. If you authorize us to use or disclose your health information, you have the right to revoke the authorization at any time. If you want to revoke an authorization, send a written notice to the Privacy Official listed at the end of this notice. You may not revoke an authorization to the extent that we have already given out your information or taken other action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. You must make this request in writing. We will consider your request, but we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

Right to Request Restrictions for Self-Pay Procedures. You have a right to request that we not disclose PHI to health plans because you paid for services or items out of pocket and in full. However, you should be aware that if you choose to use a medical expense reimbursement/flexible spending account (FSA) or a health savings account (HSA) to pay for the health care items or services that you wish to have restricted, those plans will still require you to provide the necessary substantiation of the expenses in order to receive reimbursement.

Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail. If you want us to communicate with you in a special way, you will need to give us details about how to contact you, including a valid alternative address. You also will need to give us information as to how payment will be handled. We may ask you to explain how disclosure of all or part of your health information could put you in danger. We may choose to honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

Access to and Copies of Health Information. You have a right to access certain PHI that we have in our records, which is limited to the medical and billing records, and any other information about you that is used in whole or part to make decisions about you (the "Designated Record Set"). To the extent PHI in your Designated Record Set is maintained electronically, you have a right to request an electronic copy of those records. We may charge a reasonable, cost-based fee for copying, mailing, and transmitting the records, and the cost of any specific media you request, to the extent allowed by state and federal law.

To ask to inspect your records, or to receive a copy, send a written request to the Privacy Official listed at the end of this notice. We also have an authorization form for release of information available on our website. Your request should specifically list the information you want copied. We may deny you access to certain information, such as if we believe it may endanger you or someone else, in which case we will also explain how you may appeal the decision.

Amend Health Information. You have the right to request us to amend health information about you in your Designated Record Set which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your PHI to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must request this list in writing. You must tell us the time period you want the list to cover, which may not exceed the most recent six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures incident to a permitted use or disclosure; disclosures as part of a limited data set; disclosures to your family members, other relatives, or friends who are involved in your care or who otherwise need to be notified of your location, general condition, or death; disclosures for national security purposes; certain disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you or your representatives.

Right to Notification of Breach of Unsecured PHI. We will comply with the requirements of HIPAA and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if we or a business associate discover a breach of unsecured PHI.

State Rights More Stringent Than HIPAA. In certain instances, protections afforded to PHI under applicable state law may be more stringent than those provided by HIPAA and we will not disclose this PHI without your authorization, unless required or permitted by law.

Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the privacy official listed at the end of this notice.

Complaints. You have a right to complain if you think your privacy has been violated. We encourage you to contact our Privacy Official if you have a complaint, or question how your PHI is being used or disclosed. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

OUR RIGHT TO CHANGE THIS NOTICE.

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. We will post the new notice in our office, and make copies available upon request. The new notice will include an effective date. A copy of the latest version of this notice will also be maintained on our website.

CONTACT THE PRIVACY OFFICER FOR MORE INFORMATION

If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at:

HIPAA Privacy Official
Diagnostic Clinic Medical Group, Inc.
1301 Second Avenue SW
Largo, Florida 33770
727-581-8767, Ext. 2512

Website: www.dc-fl.com

DIAGNOSTIC CLINIC

Financial Policies of Diagnostic Clinic

Thank you for entrusting Diagnostic Clinic to serve your health care needs ! Please review our financial policies carefully.

Should you have any questions, please allow us to assist you by:

- ***Calling Patient Financial Services at 833-428-5283***

How should I prepare for a visit?
- Plan to arrive at least 20 minutes prior to your visit for check in and registration.
- Be prepared to present your up to date insurance card(s) at every visit.
- Have a means of paying for any balance that is the patient's responsibility (including co-pays, deductibles, or previous account balances).

Who is financially responsible for my bill ?
- Most patients have health insurance but this is a contract between you and your insurer.
- We are pleased to file claims with your insurance company but **you** are personally financially responsible for health care services provided to you by Diagnostic Clinic and its staff.

If I Have Insurance, Why Do I Have a Bill?
- Diagnostic Clinic will make an effort to advise you about services we provide for which you may be financially responsible.
- However, it is possible that your insurance will not cover all services recommended.
- Additionally, even when covered, we cannot guarantee that you will not have significant personal financial responsibility due to deductibles, co-payments, and co-insurance.

When am I supposed to pay my bill?
- Payment of out-of-pocket expenses is expected at time of service, including:

  - Deductibles
  - Co-payments
  - Co-insurance (the part of your bill that is patient responsibility)
  - Payment for services not covered by your insurance

- Be prepared to make co-payments prior to your visit.
- Additionally, we may request payment of deductibles, co-payments, and / or co-insurance for expensive testing ***prior to scheduling.***

How do I know if my services will be covered by insurance?
- All services are recommended based on medical need (not insurance coverage).
- We will attempt to verify your insurance eligibility, benefits coverage, and even pre-certify services when necessary. We will try to make you aware of our findings.
- If you have any questions about insurance coverage, please get them answered ***BEFORE*** having services provided

What if I don't have insurance or my coverage cannot be verified?

A deposit will be collected ***prior*** to services being provided if you are:
- Not insured or insurance eligibility cannot be verified
- Insured by a plan that does not list Diagnostic Clinic as a participating provider

Can a patient be released from Diagnostic Clinic for non-payment?

- Yes, your account could be restricted until paid. Also, possible termination can occur.
- All balances not paid within 90 days may be placed with an outside collection agency.
- Patients who have accounts placed with a collection agency are severed.
- Reinstatement is sometimes possible but you must speak with a representative in Patient Financial Services (833-428-5283).

What if I "bounce" a check intended to pay my bill at Diagnostic Clinic?

- This is a serious issue because we have no way of knowing if it is unintentional or the result of check fraud.
- Returned checks are subject to a $25.00 charge.
- If you receive notification of a returned check, you must contact us immediately.
- If we have not been contacted by you within 14 days, we will notify the legal authorities regarding the occurrence.

A Word about Preventive Visits, Routine Physical Exams, and Testing

- This has been an ongoing source of confusion and we want to improve your understanding of this situation.
- The "yearly physical" or "preventive medicine visit" is covered by some insurance plans, but not by all (it is NOT covered by Medicare).
- Medicare only pays for an initial preventive physical exam upon initial enrollment (after meeting the deductible).
- Healthcare providers are ***required by law*** to accurately list the reason for a visit.
- If the purpose of your visit is for a yearly physical, the doctor must list the visit as "preventive medicine." If your insurance does not cover it, you will be fully responsible for payment.
- If during a routine physical exam, your provider also evaluates a known chronic medical condition or new medical complaint, we also have to list this as a separate reason for the visit. Not surprisingly, this may result in another charge.
- This is a part of the classification method developed by the federal government that we are ***required by law*** to follow.
- Our health care providers are sensitive to financial concerns. However, they base their medical decisions on what is best for you without consideration of insurance coverage. Therefore, please consider their advice and recommendations carefully.

Should you have any questions, please allow us to assist you by:

- ***Calling Patient Financial Services at 833-428-5283***

TO ALL PATIENTS AND IN COMPLIANCE WITH FLORIDA STATUTE 408.810(5)(b):

To report a complaint regarding the services you receive, please call toll-free (1-800-962-2873).

To report abuse, neglect, or exploitation, please call toll-free (1-888-419-3456)

To report suspected Medicaid Fraud, please call toll-free (1-866-966-7226)

DIAGNOSTIC CLINIC MEDICAL GROUP

Largo: 1301 2nd Avenue SW, Largo, FL 33770
Countryside: 3131 N. McMullen Booth Rd., Clearwater, FL 33761
St. Petersburg: 6776 54th Ave N, St Petersburg, FL. 33709
St. Petersburg: 630 Pasadena Ave S., St Petersburg, FL. 33707

YOUR NAME: _____ **DATE:** _____

CLINIC # _____

NAME OF YOUR PHARMACY: _____

PHONE # _____

ADDRESS _____

PLEASE LIST ALL MEDICATIONS INCLUDING PRESCRIBED, OVER THE COUNTER, VITAMINS, AND HERBAL REMEDIES:

Medication Name	Dosage	How Taken
Example: Lasix	*40 mg*	*Once in morning*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Any known allergies? _____

_____

_____

DIAGNOSTIC CLINIC
MEDICAL GROUP

No Show and Cancellation Policy

Dear Patient:

Diagnostic Clinic Medical Group providers strive to provide excellent medical care for all of our patients. In order to meet your medical needs and provide access for those who need appointments, we ask each of our patients to give 24-hour notice for any cancellation requests.

We will confirm ALL appointments 48 hours prior to your appointment. You can also review your upcoming appointments on our patient portal. **IF** you are unable to keep any of your appointments, there are (3) ways to cancel:

- Use our patient portal to send a message to our office to cancel your appointment. We can also contact you to reschedule your appointment.
- Call our 24 hours cancellation line **727-585-3797**
- Call our office at **727-584-7706**

Any patient who has a missed appointment (no show), our staff will reach out to you by phone and attempt to reschedule your appointment. If we are unable to reach you, a letter will be sent reminding you of the missed appointment asking you to call and reschedule.

Patients who have missed (no showed) for (3) appointments are subject to termination from the practice or entire facility.

Thank you for choosing Diagnostic Medical Group as your health care provider!