**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 2:00 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. 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](http://www.johnlittellmd.com) and clicking the portal link. 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.

**Dermatology Services are also available in our office.**

**Financial and Office Policies:**

Payment is expected at the time of service. Co-pays, co-insurance, deductibles, all due at the time of service. You are responsible to know and understand what your insurance plan will or will not cover. We ask that you reschedule your appointment if you are unable to pay your financial responsibility at the time of service, including past balances. We will assess a $35 service fee for any returned checks from the bank. Past due balances are due prior to making another appointment.

**Canceled or Missed Appointments:**

If you need to cancel an appointment, contact us at least **24 HOURS PRIOR** to your appointment time, if you contact us after that time there will be a **$50 FEE** assessed to your account. If you miss an appointment and do not call you will have a **$50 FEE** billed to you.

**WE USE AUTOMATED & ELECTRONIC SYSTEMS FOR APPOINTMENT REMINDERS.**

You authorize our agents to contact you using any contact information you provide to us including e-mail addresses and wireless phone numbers.

I agree to the above terms of John T. Littell, M.D. and Associates, I am responsible for any balances due on my account.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADULT MEDICAL HISTORY**

Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_Marital History: \_\_\_Single

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_ \_\_\_ Married \_\_\_\_#Years

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_ \_\_\_ Divorced \_\_\_#Years

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_ \_\_\_Widowed

Religious Preference (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Grade Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or Degree Obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: \_\_\_\_\_#of Years Packs/Day: \_\_\_\_\_\_\_\_ Quit Date \_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use: \_\_\_\_\_\_Never \_\_\_\_\_Occasional \_\_\_\_\_\_\_ Weekends \_\_\_\_\_\_\_ Daily

Caffeine Use # per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired \_\_\_\_\_\_\_ Homemaker \_\_\_\_\_\_\_\_

Types of work done: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FEMALES, PLEASE COMPLETE**

Number of: \_\_\_\_\_Pregnancies \_\_\_\_\_Abortions \_\_\_\_\_\_Miscarriages \_\_\_\_\_\_Live births

Date of Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it: \_\_\_\_\_Normal \_\_\_\_\_Abnormal

Date of last Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_ Was it: \_\_\_\_\_\_Normal \_\_\_\_\_Abnormal

**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

Preferred 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PARENT/GUARDIAN (if patient is a minor)**

Mothers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fathers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INSURANCE 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 #: \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Name Date Signature

**HIPAA PRIVACY AUTHORIZATION FORM**

*Consent to the Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations*

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.

Authorization for release of PHI covering the period of healthcare (check one)

\_\_\_\_\_\_ From (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

\_\_\_\_\_\_ All past, present and future periods.

I hereby authorize the release of PHI as follows (check one)

\_\_\_\_\_\_ My complete health record (including records relating to mental health care, communicable diseases, HIV/AIDS, and the treatment of alcohol/drug abuse

OR

\_\_\_\_\_\_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):

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that the person 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.

This authorization shall be in force effective nine (9) months after my death or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date or event) at which time this authorization expires.

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.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date Signature

*Privacy Policy available upon request.*

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**PREVIOUS PCP, SPECIALIST OR FACILITY THAT WE NEED RECORDS FROM**

* I authorize the following person(s) and/or organization(s) to release my PHI:

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I authorize this information to be released to:

John T. Littell, M.D. & Associates

300 Park Place Blvd.

Kissimmee, FL 34741

Phone: 407-343-1711 Fax: 407-343-1611

* Specific description of the PHI that I authorize for disclosure:

**NO CD’S OR ZIP DRIVES PLEASE**

* Specific description of the purpose for each use or disclosure:

AT THE REQUEST OF THE INDIVIDUAL

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 revoked by the recipient and destroyed. I may cancel this authorization in writing at any time.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS# \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship or Authority of Personal Representative (if applicable)