Registration Form

Inclusive Care Group

Please complete the New Patient Registration Form and sign all required pages. Incomplete or unsigned forms may delay processing.

Email admin@inclusivecaregroup.com
Phone (727) 753-7787 Fax (833)471-3023

Personal information

Last Name

First Name

Name To Use

Address

Address Line 2

City State ZIP

Phone

Notifications ☐ Yes ☐ No

Email

☐ Not Provided

Date of Birth

Social Security Number

Sex at Birth ☐ Male ☐ Female ☐ Unknown

Pronouns

Sexual Orientation Gender Identity

Marital Status Language Race Ethnicity

Emergency Contact Full Name and Relationship

Emergency Contact Phone

Insurance information

Will you be using insurance?

☐ Self Pay

Insurance Name

Subscriber ID

Where did you hear about us?

☐ A friend or colleague ☐ Creative Loafing ☐ Website ☐ Google

☐ Watermark ☐ Social Media ☐ Current Patient Other

☐ Winter Pride ☐ Events

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Allergies & Medications

Food/Allergy	Medication	Allergic reaction

Current Medication Name	Dose	Times per day

Medical History

Please select all that apply.

- ☐ None
- ☐ AICD/Pacemaker
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding/Clotting Problems
- ☐ Cancer: _____
- ☐ Celiac Disease
- ☐ Chest Pain
- ☐ Cirrhosis of Liver
- ☐ Colon Polyps
- ☐ Connective Tissue Disorder
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease/Failure
- ☐ Lactose Intolerance
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Neurologic Disorders
- ☐ Pancreatitis
- ☐ Prostate Enlargement
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ TB (Tuberculosis)
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Other _____

_____

_____

_____

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Surgical/Procedural History

Please select all that apply.

		Date			Date
	None			Incisional Hernia Repair	
	Abdominoplasty/Tummy Tuck			Gallbladder Surgery	
	Appendectomy			Hemorrhoid Surgery	
	Back/Spinal Surgery			Hiatal Hernia Repair	
	Bariatric Surgery			Hysterectomy Surgery	
	Bladder Surgery			Inguinal Hernia Repair	
	Breast Surgery			Liver Biopsy	
	ERCP			Ovarian Surgery	
	Colon Resection			Prostate surgery	
	Colostomy/Ileostomy			Stomach/abdominal surgery	
	Colonoscopy			Stress Test	
	EGD			Thyroid surgery	
	Umbilical Hernia Repair			EUS	
	Pelvic Floor Surgery			Echocardiogram	
	Other:				

Additional information

Are you currently taking blood thinners or aspirin? ☐ Yes ☐ No

Are you currently on medication for weight loss? ☐ Yes ☐ No

Are you currently on medication for seizures? ☐ Yes ☐ No

Colonoscopy ☐ Yes ☐ No Date _____ Results ☐ Normal ☐ Abnormal

Mammogram ☐ Yes ☐ No Date _____ Results ☐ Normal ☐ Abnormal

Imaging studies completed _____ Imaging location _____ Date _____

Immunizations

Please select all that apply.

- ☐ Gardasil (HPV)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Influenza (Flu)
- ☐ COVID-19
- ☐ M-POX
- ☐ Tetanus/Booster
- ☐ Pneumonia/Pneumovax
- ☐ Shingles vaccine/Zostavax
- ☐ Bexsero/Meningococcal
- ☐ MMR (Mumps, Rubella, Measles)

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Lifestyle

Sexualy active? ☐ Yes ☐ No ☐ Defer

Protection _____

Sexual Partner ☐ Male ☐ Female ☐ Both

Do you participate in anal receptive intercourse?

☐ Yes ☐ No ☐ Defer

Have you ever had an Anal Pap Smear?

☐ Yes ☐ No Results ☐ Normal ☐ Abnormal

Have you ever had a Vaginal Pap Smear?

☐ Yes ☐ No Results ☐ Normal ☐ Abnormal

Have you traveled outside of the country in the last 30 days?

☐ Yes ☐ No If Yes, where? _____

Have you served in the military? ☐ Yes ☐ No

If Yes, how long? _____

Where you deployed? ☐ Yes ☐ No

If Yes, where? _____

Do you exercise regularly? ☐ Yes ☐ No

What Kind? _____ Duration? _____

How often? _____

Tobacco use ☐ Yes ☐ No Type: _____

How often? _____ How long? _____

Alcohol use ☐ Yes ☐ No Type: _____

How often? _____

Do you use recreational drugs? ☐ Yes ☐ No

What Kind? _____

Have you ever used needles to inject drugs? ☐ Yes ☐ No

How many hours, on average, do you sleep? _____

Family history

This section helps your provider understand potential health risks. Please answer what you know. Exact details are not required.

Has any immediate family member ever been diagnosed with any of the following? Check all that apply.

- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure (hypertension)
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Cancer (any type)
- ☐ Mental health condition
- ☐ Autoimmune disease
- ☐ Genetic or inherited condition

Other serious or chronic condition:

_____

_____

_____

If You Checked “Cancer”, please provide any details you know (optional):

Type of cancer: _____

Family member (e.g., mother, father, sibling): _____

Approximate age at diagnosis (if known): _____

Is there anything else about your family medical history that you think your provider should know?

_____

_____

_____

☐ I would like to review my family medical history in more detail with my provider.

Inclusive Care Group

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Review of systems

Please select all that apply.

CONSTITUTIONAL
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Diaphoresis
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

HENT
- ☐ Congestion
- ☐ Dental problem
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal drip
- ☐ Rhinorrhea
- ☐ Sinus pain
- ☐ Sinus pressure
- ☐ Sneezing
- ☐ Sore throat
- ☐ Tinnitus
- ☐ Trouble swallowing
- ☐ Voice change

EYES
- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Photophobia
- ☐ Visual disturbance

CARDIO
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

GI
- ☐ Abdominal distention
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

GU
- ☐ Difficulty swallowing
- ☐ Dysuria
- ☐ Enuresis
- ☐ Flank pain
- ☐ Frequency
- ☐ Genital sore
- ☐ Hematuria
- ☐ Penile discharge
- ☐ Penile pain
- ☐ Penile swelling
- ☐ Scrotal swelling
- ☐ Testicular pain
- ☐ Urgency
- ☐ Urine decreased
- ☐ Vaginal discharge
- ☐ Abnormal vaginal bleeding
- ☐ Breast pain discharge/lump

HEMATOLOGIC
- ☐ Adenopathy
- ☐ Bruises/Bleeds easily

MUSC
- ☐ Arthralgias
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Myalgias
- ☐ Neck pain
- ☐ Neck stiffness

SKIN
- ☐ Color change
- ☐ Pallor
- ☐ Rash
- ☐ Wound

ALLERGY/IMMUNO
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Immunocompromised

NEUROLOGICAL
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Polyuria

PSYCHIATRIC
- ☐ Agitation
- ☐ Behavior problems
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Dysphoric mood
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal ideation

RESPIRATORY
- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor
- ☐ Wheezing

Full Name _____ Signature _____ Date _____

Inclusive Care Group

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Privacy Practices & Patient Acknowledgment
HIPAA Notice

Inclusive Care Group (ICG) is committed to protecting the privacy and confidentiality of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable Florida law. We may use and disclose your health information for purposes of treatment, payment, healthcare operations, care coordination, and public health reporting as required by law. Access to your information is limited to authorized personnel only. We maintain administrative, technical, and physical safeguards to protect your privacy.

Patient Rights You have the right to:

- Access and request copies of your medical records
- Request corrections to your health information
- Request restrictions on certain disclosures where permitted
- Request confidential communications
- File a complaint without fear of retaliation

Electronic & Verbal Communication By receiving care at Inclusive Care Group, you acknowledge and agree that:

- Staff may contact you via phone, voicemail, text message, patient portal, or email for care-related communication
- Messages may include appointment reminders, lab results, care coordination, or billing notifications
- Absolute confidentiality cannot be guaranteed with electronic communication

You may request communication preferences or opt out of certain communication methods at any time.

HIPAA Acknowledgment I acknowledge that I have received and reviewed the Inclusive Care Group Notice of Privacy Practices. I understand my rights regarding my protected health information and how my information may be used and disclosed as permitted by law.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

Inclusive Care Group

Email admin@inclusivecaregroup.com
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Assignment of Benefits

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

I hereby assign all medical, dental and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical and dental plan, to issue payment check(s) directly to Inclusive Care Group for medical and dental services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Inclusive Care Group to:

1. Release any information necessary to insurance carriers regarding my illness and treatments;
2. Process insurance claims generated in the course of examination or treatment; and
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. I have requested medical services from Inclusive Care Group on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

Inclusive Care Group

Email admin@inclusivecaregroup.com
Phone (727) 753-7787 Fax (833)471-3023

Payment Agreement Policy and Insurance Release Form

Thank you for choosing Inclusive Care Group (ICG) as your provider of services. We appreciate the opportunity and privilege of participating in your care. With respect to payment of services, please review the following policies.

- Fees are charged for the professional services rendered. You, as the responsible party, accept complete financial responsibility for payment of all services provided.
- You are expected to pay all deductibles, co-pays, co-insurance amounts and non-covered services at the time of service. If you have a high deductible plan ($1000 or more) you are required to pay for services at the time of service until the deductible is met. ICG offers an automatic payment option for your convenience, please ask the office manager for details. We will bill your insurance company for all covered services.
- You are financially responsible for payment in full for any services that are denied as a non-covered service, not medically necessary, or if you failed to notify us of changes in insurance coverage, or if you did not obtain a referral or authorization as required by your insurance company.
- You are responsible for notifying ICG immediately of any changes in your insurance policy and for obtaining insurance related referrals and/or authorizations.
- If payment on a claim we submit is not received from Medicare, Medicaid, private insurance companies, or other third party payers within 90 days, you are responsible for payment of the balance in full at that time. If your insurance company makes a payment after 90 days, you will be issued a refund within 30 days of payment equal to the amount paid by the insurance company.
- If ICG is a not a participating provider (out of network) with your insurance company, you are responsible for payment in full at the time of service. We will submit a claim to your insurance company on your behalf. If your insurance company makes a payment on the claim, you will be issued a refund check within 30 days of receipt of payment equal to the amount paid by the insurance company.
- ICG may release patient information to third party payers and anyone assisting us in obtaining payment, including billing, coding, and collection agents and to the provider's attorneys and consultants.
- ICG reserves the right to discontinue services if you do not pay for your services.
- I understand that ICG cannot guarantee payment from participating insurance providers for services. Therefore, if my insurance carrier denies payment, I agree to be fully responsible for payment.
- I request that payment under my third party payer(s) be made directly to ICG and I authorize them to submit a claim to the third party payer(s) on my behalf. I understand and agree to ICG's policies as stated here.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

Inclusive Care Group

Email admin@inclusivecaregroup.com
Phone (727) 753-7787 Fax (833)471-3023

Practice Financial Policy

Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions that you may have and sign in the space provided. A copy will be provided to you upon request.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission We will submit your claims and assist you in any way we reasonably can 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. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. You or insurance benefit is a contract between you and your insurance company.

Referrals If you have an insurance plan with which we are contracted you need a referral authorization from your primary care physician. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Co- payments and Deductible All co-payments- Deductible & Co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Proof of Insurance All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim, or cancellation of appointment.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim, or cancellation of appointment.

Patient Statements If you have unpaid balance you will receive a statement by mail every two weeks. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to a collection agency for collections. All payments made go to the oldest outstanding balance.

PLEASE INITIAL

_____ **No show Fee** Cancel/reschedule your visits with 24 hours notice. At our discretion, a fee of $75 will be charged.

_____ **Late/same day reschedule** Fee At our discretion of $75 will be charged to showing up later than 10 min, or rescheduling on the same day. It is not guaranteed to be seen if you are 10 minutes late or more to your appointment.

Methods of Payment We accept payment by cash, Visa, MasterCard, American Express and Discover.

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Full Name _____ Signature _____ Date _____

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

Inclusive Care Group

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Consent To Provider Examination Of Pelvic Area

A pelvic examination is a series of tasks that include an examination of the vagina, cervix, uterus, fallopian, tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

A pelvic exam may include but is not limited to the following health care activities:

- Rectal examination during a pelvic examination
- Vaginal or Anal ultrasound
- Serial or discrete cervical exams

The risks and complications associated with a pelvic examination include, but are not limited to:

- Discomfort
- Bleeding
- Infection

The risks associated with failing or refusing to undergo a pelvic examination include:

- The inability to obtain a diagnosis and/or a delay in diagnosis of a medical condition;
- The inability of your health care provider to have the information needed to appropriately treat you.

By signing this consent, I_____ authorize and direct Inclusive Care Group and my treating provider as they deem necessary, together with nursing and medical personnel, and any students or residents of Inclusive Care Group who may be involved in my care, to perform a pelvic examination as described above. I have read or have had read to me the contents of this form.

☐ I do consent to having a pelvic exam on me while I am receiving care at Inclusive Care Group.

☐ I do NOT consent to a pelvic exam on me while I am receiving care at Inclusive Care Group.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

Inclusive Care Group

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Controlled Substances & Medication Policy Acknowledgment

Inclusive Care Group (ICG) prescribes medications in accordance with federal regulations, Florida law, and evidence-based medical standards. Controlled substances require heightened oversight to protect patient safety, staff, and the community.
Controlled Substances Prescribing Standards I understand and acknowledge that:

- Controlled substances are prescribed only when medically appropriate
- Prescriptions require a comprehensive clinical evaluation
- Identity verification and clinical documentation are mandatory
- A review of the Florida Prescription Drug Monitoring Program (E-FORCSE) is required
- Early refills, replacement prescriptions for lost or stolen medications, and dose increases are not guaranteed
- Requests made through front desk staff, messaging, or without an appointment will not be honored

Florida In-Person Requirement for Controlled Substances Inclusive Care Group complies fully with Florida state law and federal prescribing regulations. I understand that:

- Most controlled substances cannot be prescribed through telehealth alone
- An in-person medical evaluation is required before initiating, restarting, or continuing controlled substance prescriptions, unless a specific legal exception applies
- Telehealth visits may be used for follow-up care only when legally permitted and at the provider's discretion
- Requests for controlled substances made without an in-person visit will be denied

Attempts to pressure providers or staff to prescribe controlled substances outside of legal requirements may result in enforcement of the Inclusive Care Group Zero-Tolerance Policy, including possible dismissal from the practice.
Medication Boundaries I understand that I may not:

- Request new medications without a provider evaluation
- Request early refills without medical justification
- Request controlled substances via telehealth, messaging, or administrative staff
- Ask staff or providers to violate clinic policy or Florida law

Patient Responsibilities I agree to:

- Take medications only as prescribed
- Safeguard medications from loss, misuse, or diversion
- Communicate honestly with my provider
- Follow all Inclusive Care Group medication and safety policies

Substance Use Monitoring & Drug Screening Inclusive Care Group prioritizes patient safety and responsible prescribing. I understand and acknowledge that:

- We reserve the right to require drug or toxicology screening when prescribing or continuing controlled substances
- Screening may be requested when there is clinical concern for misuse, diversion, unsafe use, or non-adherence
- Testing may include urine, blood, or other medically appropriate screening methods
- Refusal to comply with the requested screening may result in declining to prescribe
- Screening results are used for clinical decision-making and patient safety, not punishment
- Failure to comply with medication monitoring requirements may result in discontinuation of controlled substance prescribing and/or dismissal from the practice.

Acknowledgment & Agreement By signing below, I confirm that I have read, understand, and agree to follow the Inclusive Care Group Controlled Substances & Medication Policy. I understand that violations may result in discontinuation of controlled substance prescribing and/or dismissal from the practice.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

Inclusive Care Group

Email admin@inclusivecaregroup.com
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Zero Tolerance Policy

At Inclusive Care Group, we are dedicated to providing a sanctuary of healing for all of our patients. To maintain a therapeutic environment, we enforce a strict Zero Tolerance Policy regarding any form of violence, harassment, or discrimination. This policy applies to all patients, visitors, staff, and contractors on these premises. Everyone has the right to receive or provide care without fear. We maintain a Zero Tolerance culture – meaning we do not just react to incidents; we proactively prevent them through continuous education and immediate intervention.

The following behaviors are strictly prohibited and will result in immediate action, up to and including removal from the practice and termination of the patient-provider relationship:

- Verbal Abuse: Shouting, swearing, or using offensive, derogatory, or discriminatory language (including homophobia, transphobia, biphobia, racism, or xenophobia).
- Targeted Harassment: Misgendering or "deadnaming" others with malicious intent, or making unwanted comments regarding a person's body, gender expression, or sexual orientation.
- Physical Aggression: Any form of physical contact that is threatening, harmful, or non-consensual.
- Sexual Misconduct: Inappropriate touching, sexual comments, or "boundary violations" between patients or toward staff.
- Intimidation: Making threats of harm (physical or professional) or using body language to block, corner, or intimidate others in waiting areas or exam rooms.

We are committed to a safe "shared space." If you witness another patient being harassed or feel unsafe due to another visitor's behavior. Report It Immediately: Notify any staff member. You do not need to intervene yourself.

Immediate Response, our staff is trained to de-escalate and, if necessary, escort the offending party from the building to protect the safety of other patients. Immediate Removal, individuals engaging in prohibited behavior will be asked to leave the premises immediately. Care Dismissal, serious or repeated violations may result in formal dismissal from the practice, in accordance with Florida medical board guidelines. We will involve local authorities if there is a threat of physical violence or illegal activity.

We believe that Safety is Healthcare. By entering this clinic, you agree to treat every person you encounter with the dignity and respect they deserve.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____