Welcome to the Practice

Dear New Patient,

Thank you for making an appointment with me. I look forward to assisting you with your healthcare needs. Please arrive a few minutes early for your initial appointment. The first consultation requires approximately 1 hour and 15 minutes. Because substantial time is reserved for your visit, please provide at least 48 hours' notice whenever possible if you need to cancel or reschedule.

Please complete the enclosed health questionnaire as thoroughly as possible. This information allows me to create your chart and devote more of the visit to your present illness and specific concerns. Medical problems can be complex, and a complete history is important. Please bring any relevant X-rays, MRI studies, bone-density tests, and laboratory results.

A secure patient portal and smartphone app are available for communication with the practice. Through the portal, you may view personal health information, review downloaded laboratory results and statements, and request appointments and prescription refills. Please provide your email address so your account can be web-enabled.

Before your first appointment, please send a copy of the front and back of your insurance card(s) and a photo ID. Updated copies are also needed whenever your insurance changes. Documents may be texted to 772-206-2262 or emailed to the address below. If you do not have insurance, or the practice is not credentialed with your plan, cash visits may be available.

Cash-pay visit fees must be received before the scheduled appointment time. Copayments, coinsurance, and other amounts due at the time of service must also be paid as required. Outstanding balances should be paid promptly and generally must be resolved before another appointment unless a prior payment arrangement has been approved.

Sincerely,

Lindsey R. Bennett, FNP-BC

Lindsey R. Bennett, FNP-BC, PA

New Patient Information

Please complete every applicable field. Write N/A when an item does not apply.

Patient & Contact Information

Patient name: _____	Date of birth: _____	Age: _____
Mailing address: _____	Email: _____	City/State/ZIP: _____
Home phone: _____	Cell phone: _____	Work phone: _____
Sex: _____ Marital status: _____	Social Security no.: _____	Language: _____ Race: _____
Ethnicity: ☐ Hispanic ☐ Non-Hispanic		
Primary care physician: _____	Phone: _____	
Referring physician: _____	Phone: _____	
Pharmacy name: _____	Phone: _____	
Emergency contact: _____	Phone: _____	Relationship: _____

Insurance Information

Primary insurance: _____	Insured's name: _____	Insured DOB: _____
Secondary insurance: _____	Insured's name: _____	Insured DOB: _____

Current Medications - Include Vitamins, Supplements & OTC Medications

Medication	Dose	How often taken	Start date	Stop date

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Lindsey R. Bennett, FNP-BC, PA

Medical History

Current Medical Problems - Check All That Apply

☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Polymyalgia rheumatica (PMR)
☐ Psoriatic arthritis
☐ Osteoporosis
☐ Spinal stenosis
☐ Rotator tendinitis / tear
☐ Bursitis
☐ Fibromyalgia
☐ Lupus
☐ Prostate problems
☐ Bladder problems: _____
☐ Kidney problems
☐ Sjogren's syndrome: _____
☐ Last bone density test: _____
☐ Broken bone(s): _____
☐ High blood pressure
☐ Diabetes
☐ Heart disease: _____
☐ Heart attack
☐ Atrial fibrillation
☐ High cholesterol
☐ Emphysema / asthma
☐ Reflux / GERD
☐ Stomach/GI problems: _____
☐ Depression
☐ Thyroid disorder
☐ History of tuberculosis
☐ PPD positive
☐ Cancer, type: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____

Medication Allergies

Medication	Type of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries

Type of surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Lindsey R. Bennett, FNP-BC, PA

Family & Social History

Family Medical History

Family member	Year of birth	RA	Osteoporosis	Diabetes	Hypertension	Heart disease	Other
Father	_____	☐	☐	☐	☐	☐	☐
Mother	_____	☐	☐	☐	☐	☐	☐
Paternal grandfather	_____	☐	☐	☐	☐	☐	☐
Paternal grandmother	_____	☐	☐	☐	☐	☐	☐
Maternal grandfather	_____	☐	☐	☐	☐	☐	☐
Maternal grandmother	_____	☐	☐	☐	☐	☐	☐
Siblings	_____	☐	☐	☐	☐	☐	☐
Children	_____	☐	☐	☐	☐	☐	☐
Other/unknown	_____	☐	☐	☐	☐	☐	☐

Social History / Habits

Smoking: _____ packs/day ☐ Non-smoker ☐ Quit smoking in _____

Alcohol use: ☐ Yes (drinks/week: _____) ☐ No

Marital status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Occupation: _____ ☐ Retired

Exercise: ☐ Regularly ☐ Rarely ☐ Do not exercise Type: _____

☐ Traveled outside the United States within the past three months

Recreational drug use - Type: _____ ☐ Never

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Lindsey R. Bennett, FNP-BC, PA

Review of Symptoms

Please check symptoms you have experienced recently.

EAR / NOSE / THROAT
- ☐ Scalp tenderness
- ☐ Dry mouth
- ☐ Hair loss
- ☐ Postnasal drip
- ☐ Thrush
- ☐ Jaw pain
- ☐ Oral sores
- ☐ Sore throat
- ☐ Cold
- ☐ Cough
- ☐ Coughing blood
- ☐ Nosebleed
- ☐ Change in voice

RESPIRATORY
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Congestion

EYES
- ☐ Decreased vision
- ☐ Red eyes
- ☐ Blurry vision
- ☐ Vision loss
- ☐ Dry eyes
- ☐ Seasonal eye symptoms

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Hives
- ☐ Raynaud's
- ☐ Skin cancers
- ☐ Wound
- ☐ Bruising
- ☐ Psoriasis
- ☐ Sun sensitivity
- ☐ Shingles
- ☐ Rosacea
- ☐ Eczema

UROLOGY
- ☐ Burning
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Increased frequency
- ☐ Leaking
- ☐ Recurrent UTI
- ☐ Nocturia

CARDIOLOGY
- ☐ Chest pain
- ☐ Palpitations
- ☐ Leg swelling
- ☐ Dizziness
- ☐ Passing out

ENDOCRINE
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance

GASTROENTEROLOGY
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Bloating/belching
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Blood in stool
- ☐ Black tarry stool

PSYCHOLOGY
- ☐ Depression
- ☐ High stress level
- ☐ Sleep problems
- ☐ Suicidal thinking
- ☐ Eating disorder
- ☐ Panic attacks
- ☐ Grief

MUSCULOSKELETAL
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Back pain
- ☐ Neck pain

BLOOD / LYMPH
- ☐ Swollen glands
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Fevers
- ☐ Easy bruising

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Malaise
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of appetite
- ☐ Insomnia

NEUROLOGY
- ☐ Headache
- ☐ Tingling/numbness
- ☐ Weakness
- ☐ Gait difficulties
- ☐ Tremors/shaking
- ☐ Restless legs
- ☐ Peripheral neuropathy
- ☐ Memory loss
- ☐ Seizures

ALLERGY
- ☐ Runny nose
- ☐ Scratchy throat
- ☐ Itchy eyes
- ☐ Ear fullness
- ☐ Sinus fullness
- ☐ Stuffy nose

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Lindsey R. Bennett, FNP-BC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: _____ Name of person, physician, or facility	FAX: _____

By signing this authorization, I authorize Lindsey R. Bennett, FNP-BC to use and/or disclose certain protected health information (PHI) about me from the person, physician, or facility identified above.

Please fax the following individually identifiable health information to Lindsey R. Bennett, FNP at 888-498-4434:

1. **All pertinent information**
2. **Office notes**
3. **Laboratory results**
4. **X-ray and imaging results**
5. **Bone density results**

The information will be used or disclosed for continuity of medical care.

This authorization will expire on: _____

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Lindsey R. Bennett, FNP-BC. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address shown below.

_____ _____
Signature of Patient or Legal Guardian | Date Signed

_____ _____
Print Name of Patient or Legal Guardian | Date of Birth of Patient

Lindsey R. Bennett, FNP-BC, PA

Patient Responsibilities, Treatment Monitoring & Continuity of Care Policy

This policy supports safe, coordinated rheumatology care.

Patient Name: _____ DOB:_____

Purpose and Shared Responsibilities

Rheumatologic care is a collaborative process. The provider is responsible for recommending and managing medically appropriate care; patients are responsible for participating in the follow-up and monitoring needed to make that care safe. Individual circumstances and reasonable delays will be considered.

Required Follow-Up and Monitoring

Patients receiving ongoing care are expected to attend follow-up visits at recommended intervals; complete requested laboratory tests, imaging, and other monitoring within the recommended time frame; maintain appropriate follow-up while receiving medications from this practice; report significant adverse effects, hospitalizations, new diagnoses, medication changes, or rheumatology treatment received elsewhere; and respond to reasonable requests for information or reassessment needed for safe treatment.

Why Monitoring Is Medically Necessary

Many medications used for rheumatologic disease - including DMARDs, biologic therapies, immunosuppressive medications, and other prescription therapies - require surveillance for changes in blood counts, liver or kidney function, infection risk, medication toxicity, and other complications. Follow-up is also needed to assess disease activity, treatment response, dosing, and whether treatment benefits continue to outweigh risks.

Medication Refills When Monitoring Is Overdue

Refills depend on appropriate clinical follow-up and completion of required safety monitoring. If follow-up or testing is overdue, refills may be limited, delayed, or withheld when continued prescribing would not be medically appropriate. A prior prescription does not create an obligation to continue prescribing indefinitely without reassessment and monitoring.

Repeated or Prolonged Failure to Complete Monitoring

An isolated scheduling problem, unavoidable delay, or other reasonable circumstance will be considered individually. However, repeated or prolonged failure to complete required testing, attend recommended follow-up, or otherwise participate in monitoring necessary for safe treatment may make continued specialty management unsafe and may result in discharge from the practice.

Continuity and Termination Requirements

Any termination of an active treatment relationship will be handled in accordance with applicable professional, legal, notice, records-access, and continuity-of-care requirements. This policy is patient-safety focused and is not punitive.

Second Opinions and Transfer of Ongoing Rheumatology Care

Patients may seek a second opinion. A consultation or referral for additional expertise does not, by itself, constitute a transfer of care when this practice remains responsible for ongoing rheumatology management and the consultant's recommendations return here for consideration. A transfer of ongoing care is different. If a patient independently establishes ongoing management with another rheumatologist - including medication prescribing, treatment changes, or monitoring - continuity of the plan established by this practice may be interrupted. For safety and clarity, one rheumatology provider should generally be responsible for ongoing medication decisions, monitoring, refills, and treatment changes.

Effect of an Independently Modified Plan of Care

When another rheumatology provider assumes management and modifies, discontinues, or replaces a treatment plan, this practice is not obligated to resume the prior plan, reverse another provider's decisions, or assume responsibility for care delivered elsewhere. Medications previously prescribed here will not automatically be restarted.

Patient Responsibilities Policy – Continued

Patient Name: _____ DOB:_____

Requests to Return After Transfer of Care

A request to return after transferring ongoing rheumatology care elsewhere will be treated as a request to re-establish care, not as a routine follow-up. Each request will be reviewed individually, and acceptance is not automatic or guaranteed. Considerations may include clinical needs, prior participation in follow-up and monitoring, the circumstances and duration of the transfer, outside records, and the practice's ability and capacity to provide safe ongoing care.

If Reaccepted

The patient may be required to provide complete records from intervening rheumatology providers; complete updated laboratory tests, imaging, or other evaluation; undergo reassessment of diagnoses, medications, treatment response, and current clinical status; and attend a new, extended, or re-establishment visit. A new plan may be developed based on current circumstances.

Communication and Administrative Expectations

To support timely specialty care, patients should use designated non-emergency communication methods; provide complete information; keep contact, pharmacy, and insurance information current; and allow reasonable time for messages, refills, records, prior authorizations, and forms. Requests requiring medical assessment, treatment decisions, extensive review, or documentation may require an appointment. Portal messages and routine communications are not emergency services.

Prior Authorizations and Forms

The practice will make reasonable efforts to submit medically appropriate prior authorizations and forms. Approval, coverage, timing, and payer decisions cannot be guaranteed. Forms must be within the provider's scope and supported by the record, and may require an appointment or fee when permitted. Missing information may delay completion.

Questions and Individual Circumstances

Patients are encouraged to ask questions and promptly report barriers to recommended care. Relevant medical, access, and personal circumstances will be considered while maintaining the standards needed for safe prescribing and specialty management.

Consent to Treatment, Privacy & Financial Responsibility

Patient Name: _____ DOB:_____

I give consent for necessary medical treatment for the above-named patient for whom I am legally responsible. This consent includes medical care provided today and at subsequent appointments.

Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of the Practice are entitled to the greatest degree of privacy possible. Release of medical information to an insurance carrier, entities directly associated with Lindsey R. Bennett, FNP-BC, PA, the primary care provider, and/or referral physician in connection with treatment is authorized. The Practice will strive to ensure that patient information is used only for authorized purposes. No other disclosures will be made without written authorization from the patient or guardian. Patients may review their medical files upon reasonable written notice during normal business hours and may submit comments.

Assignment of Benefits

I hereby assign to the Practice all payments and/or insurance benefits for services rendered. I agree to complete additional forms required by my insurance plan for assignment of benefits. I authorize the Practice to release medical information necessary to obtain payment. I understand that I am financially responsible for amounts not covered by my insurance plan.

Financial Responsibility

In consideration of services provided, I am directly and primarily responsible for charges incurred for services and procedures rendered by the Practice. It is my responsibility to know and understand my insurance policy. I am responsible for applicable deductibles, copayments, or coinsurance before services are provided. I understand these amounts cannot be waived where prohibited by law. Any estimate is based on anticipated insurance payment and is not a guarantee. I remain responsible for balances exceeding the estimate. Payment is not contingent on insurance, settlement, judgment, or treatment results. The Practice does not refund payment for services rendered and will file insurance claims as a courtesy. If my insurer does not pay timely for any reason, I am responsible for prompt payment. A balance unpaid after the third billing statement may be referred for collection. SHOULD MY ACCOUNT BE REFERRED TO A COLLECTION AGENCY OR ATTORNEY, I WILL PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE.

Payment Timing and Outstanding Balances

Cash-pay patients must pay the applicable visit fee before the scheduled appointment time. If payment has not been received, the appointment will need to be rescheduled. If you are unable to make payment before your appointment, please notify the Practice as early as possible - preferably at least 24 hours before the appointment - so the visit can be rescheduled and any applicable late-cancellation or no-show fee may be avoided.

Patient balances are expected to be paid promptly after a statement is received. To keep accounts current and avoid interruptions in scheduling, outstanding balances generally must be paid before the patient can be seen for another non-emergency appointment, unless the Practice has approved a payment arrangement in advance. Patients who need to discuss a balance or payment arrangement are encouraged to contact the Practice promptly.

Payment Processing Surcharge Policy

To maintain the quality of care while managing rising operational costs, a processing surcharge will be applied to transactions made using credit cards. This surcharge reflects fees charged by payment processors and will not exceed the actual cost incurred by the Practice to accept the card payment.

Patients may avoid this surcharge by choosing an available no-fee payment method, such as cash, check, or Zelle.

Thank you for your understanding and support, which help the Practice keep services accessible and sustainable.

Authorization for Treatment / Release of Information

In connection with medical services I receive from the above-named provider or provider's group, I authorize the provider and/or group/associate to disclose information concerning my medical condition and treatment (including, but not limited to, specially protected information concerning sexually transmitted diseases, mental health, chemical dependence, or similar information), including applicable hospital and medical records, to:

Any third-party payer covering medical services for the patient;

Other healthcare professionals and institutions involved in delivering healthcare;

The proponent of a legally sufficient subpoena, or in response to a court order;

Employees and agents of the Practice, to the degree necessary to facilitate healthcare services and payment;

Pharmacies; and

As otherwise required by law.

The Practice will take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I have read and understand this authorization. I have been given access to the provider's privacy notice and had an opportunity to place special restrictions upon this consent. Requests for restrictions must be submitted in writing and reviewed and approved by the Privacy Officer. I also authorize disclosure of personal health information to the individuals listed below and via answering machine.

Name: _____	Relationship: _____
Name: _____	Relationship: _____

Patient Responsibilities and Policy Acknowledgment

I acknowledge that I am responsible for attending recommended appointments and follow-up visits and for completing provider-ordered laboratory tests, imaging, and other monitoring. I understand that these requirements support safe treatment and that medication refills may be limited, delayed, or withheld when required follow-up or monitoring is overdue.

I acknowledge that I have received, read, and understand the Patient Responsibilities, Treatment Monitoring & Continuity of Care Policy, Consent to Treatment, Privacy & Financial Responsibility, and Authorization for Treatment / Release of Information included in this packet and have had an opportunity to ask questions.

I understand that repeated or prolonged failure to complete medically necessary monitoring may result in discharge subject to applicable continuity-of-care requirements.

I understand that the Practice requires 24-hour notice to cancel an appointment and that failure to follow the no-show policy may result in a $50 charge per occurrence, payable before a future appointment.

This consent is valid from the date executed until revoked in writing by the patient.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Arbitration Agreement for Health Care Services

IMPORTANT: By entering into this agreement, the parties are giving up their constitutional and statutory rights to have any dispute involving healthcare services decided before a judge or jury and are instead accepting mandatory and binding arbitration.

Whereas, on this _____ day of _____, 20____, the undersigned patient or the patient's legal representative has entered into this agreement with Lindsey R. Bennett, FNP-BC, PA to arbitrate any dispute involving the rendition of healthcare services by Lindsey R. Bennett, FNP-BC, PA and its providers, employees, agents, partners and assigns (collectively, the "health care provider") and has agreed to the following terms and conditions.

Article 1. Full Consideration for This Agreement.

The undersigned parties agree that this agreement has been made for full consideration, including their mutual desire to have any healthcare service dispute or controversy resolved in a fair and expeditious manner by mandatory and binding arbitration.

Article 2. Health Care Services Are Arbitrable.

The undersigned parties agree that any and all issues involving healthcare services rendered by the health care provider, including but not limited to any dispute or controversy involving malpractice or negligence in diagnosis, treatment, or care of the patient, are arbitrable issues that shall be submitted to mandatory and binding arbitration as provided in this agreement. The parties further agree that disputes or controversies involving healthcare services rendered before execution of this agreement are also arbitrable and shall be submitted to mandatory and binding arbitration.

Article 3. Agreement to Arbitrate Disputes Under Rules of the American Arbitration Association.

Any dispute or controversy involving healthcare services provided by the health care provider to the patient shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and Supplementary Procedures for Large, Complex Disputes. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction.

Article 4. Notice of Demand to Arbitrate.

A party shall give written notice demanding arbitration of a controversy or dispute involving healthcare services provided to the patient. The notice shall specify the allegations or issues and appoint an arbitrator. Within 20 days after receiving the written demand, the responding party may name an arbitrator; failure to do so within that period will be considered consent to the claimant's appointed arbitrator. If the responding party appoints an arbitrator, the two arbitrators shall select a third arbitrator within 20 days. If they cannot agree, the American Arbitration Association shall select the third arbitrator, who will chair the panel. Within a reasonable time after accepting appointment, each arbitrator shall provide an oath or undertaking of impartiality. Any arbitrator appointed shall have experience and knowledge of healthcare-service issues.

Article 5. Discovery.

Consistent with expedited arbitration, each party shall promptly provide, upon written request, copies of documents relevant to any claim or counterclaim. The chair of the arbitration panel (or the arbitrator if only one serves) will determine disputes regarding discovery, relevance, or scope. Discovery shall be completed within 60 days after appointment of the final arbitrator. The arbitrator(s) may order depositions deemed relevant and appropriate. Depositions are limited to three per party, must be held within 30 days of a request, and may be expanded only with permission of the chair for good cause. Each deposition is limited to three hours. Objections are reserved for the hearing except objections based on privilege or proprietary or confidential information.

Article 6. Location of Arbitration.

The place of arbitration shall be within 50 miles of the offices of the health care provider.

Article 7. Patient's Right to Cancel Arbitration Agreement.

The patient has a right to rescind this agreement by written notice to the healthcare provider within one (1) calendar week after this agreement has been signed and executed. The patient may rescind by writing "cancelled" on the face of one copy of the agreement, signing beneath that word, and mailing the copy by certified mail, return receipt requested, to the healthcare provider within that one-week period.

Article 8. Arbitration Is Exclusive Remedy.

With respect to any dispute or controversy made subject to arbitration under this agreement, no suit at law or in equity based on that dispute or controversy shall be instituted by either party, except to enforce the arbitrator's award.

Arbitration Agreement - Continued

Article 9. General Provisions.

A. This agreement shall be governed by and interpreted in accordance with the laws of the State of Florida.

B. This agreement shall bind each party's assigns, heirs, personal representatives, and assigns. The parties intend that it bind all parties whose claims may arise from or relate to treatment or healthcare services provided by the healthcare provider, including a spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to the claim.

C. The substantially prevailing party shall be entitled to reasonable attorney fees. The arbitrator(s) shall award the substantially prevailing party, if any, all costs and fees, including reasonable pre-award expenses, arbitrator fees, administrative fees, travel expenses, out-of-pocket expenses such as copying and telephone, court costs, witness fees, and attorney fees.

D. Except as required by law, neither a party nor an arbitrator may disclose the existence, content, or results of arbitration without both parties' prior written consent.

E. Damages awardable at arbitration are limited to those available under Florida law.

Both parties acknowledge that they have constitutional and statutory rights to have disputes involving healthcare services decided before a judge or jury and instead accept mandatory and binding arbitration to resolve any dispute.

Lindsey R. Bennett, FNP-BC, PA

Dated this ____ day of _____, 20____	By: _____
	Lindsey R. Bennett, FNP-BC
Dated this ____ day of _____, 20____	Patient or Patient's Legal Representative:
	By: _____
	Printed name: _____