CONFIDENTIAL PERSONALINFORMATION

Full Legal Name:_____ Date of Birth:_____ Age:_____
Preferred Name:_____ Ethnicity:_____ Language:_____ Gender: ☐Male ☐Female
Address:_____
E-mail address:_____ SS #:_____
Home #:_____ Cell #:_____ Work #:_____
Occupation:_____ ☐Full-time ☐Part-time ☐Student ☐Retired ☐Other:_____
Employer/School:_____
Address:_____
Emergency Contact:_____ Phone #:_____

Insurance Information – Please present current copy of Insurance card.
Insurance Company:_____
Name insured:_____ Date of birth:_____
Policy #:_____ Group #:_____
Secondary insurance:_____

Motor Vehicle Accident (MVA)
Date of MVA:_____ State MVA occurred:_____ Claim submitted: ☐ Yes ☐ No – Pip coverage: ☐ Yes ☐ No
Insurance company:_____ Claim number:_____
Adjuster name:_____ Adjuster phone:_____
Attorney name:_____ Attorney phone:_____

Primary Physician:_____ Phone:_____
For which condition(s)_____
Specialist:_____ Phone:_____
For which condition(s)_____

Pharmacy:_____ Phone:_____
Address:_____

Please be aware that e-mail is not secure communication and that discussion of medical care will become part of medical record.
What is the best way to communicate with you between office visits? ☐E-mail ☐Home ☐Work ☐Cell ☐Other:_____
Is there any place you do NOT want me to leave a message?_____
May your doctor send you educational and promotional materials such as newsletters via e-mail? ☐Yes ☐No May your doctor discuss your private medical information with you via e-mail? ☐Yes ☐No

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient_____ Today's Date_____

Name:_____ Date:_____

ALLERGIES (drugs, food, or environmental substances)

Substance: Reaction:

MEDICATION CURRENTLY TAKEN: MEDICATION PREVIOUSLY TAKEN:

IMMUNIZATION HISTORY

SURGICAL HISTORY: List procedures and dates

HOSPITALIZATIONS, IMAGING & TEST HISTORY with DATES

SUPPLEMENTS (herbs, vitamins & OTC)

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

CHIEF COMPLAINTS: Primary concern first.

_____ _____

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY: Indicate whether you have had any of the following diseases.

☐Cancer	☐Diabetes	☐Allergies	☐Epilepsy
☐High blood pressure	☐Heart disease	☐Asthma	☐Stroke
☐Anemia	☐Kidney disease	☐Tuberculosis	☐Glaucoma
☐Arthritis	☐Liver disease	☐Pneumonia	☐Mental illness
☐Back injury	☐Diverticulitis	☐COPD	☐Alzheimer'sdisease

Any other diseases: Not listed above.

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HEALTH HISTORY: Indicate whether a family member has **ANY** disease(s). See prompts above.

Relationship	Name	Age if living	Age at death	Disease(s)
Father				
Mother				
Brother(s)				
Sister(s)				
Paternal grandparents				
Maternal Grandparents				
Children				

FINANCIAL POLICIES

1. Unless prior arrangement is made, full payment is due at the time of service.

   Your payment options are: cash, check, or credit/debit cards. We accept Visa, Master Card, Discover, or American Express.

2. Insurance Billing

   If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the non-guaranteed information they provide to us.

   You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).

   If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.

   Insurance companies may reimburse differently than the information they initially provide to us.

   You are responsible for and will be billed for any resulting unpaid balance.

3. Missed Appointments/Late Cancellations

   All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, you will be charged based on the provider for the missed appointment. Missed appointment charges are subject to change. If you have any questions regarding the missed appointment fee per provider, please contact the staff at (727) 498-8898.

   Medical New Patient missed appointment fee: $100.00
   Medical Follow-up missed appointment fee: $ 50.00

4. Past Due Accounts

   Accounts greater than 30 days past due will be charge a $10 administrative fee.

   Accounts greater than 90 days overdue will be sent to a collections agency.

These policies are subject to change withoutnotice.

I have read, understood and agree to the policies described above:

Print Name: _____

Signature: _____ Date: _____

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted in the office and you may obtain one at any time. This Notice goes into effect July 01, 2013.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to our office. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact the office. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to the office and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to the office staff. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact our office at (727) 498-8898 to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with the DHHS or us.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print)_____

Patient/Guardian Signature_____ Date_____

Relationship to Patient (if other than self):_____

Note: If a legal representative is signing this acknowledgement, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray Results ___Medications
___Lab Tests/Results _____ Summary of Medical Record ___Care Plan
___ Other (specify): _____

Patient Name: _____
Date of Birth: _____

Information to be given to:

Name: _____
Relationship: _____
Address: _____
Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):
□ (specify expiration date or event)
□ NO EXPIRATION DATE

_____ _____
Signature: Date: