First Coast Family Medicine, PA

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Today's Date_____ **Soc Sec #**_____

Patient's Full Name_____

Address/City/Zip_____

_____

MAY WE LEAVE YOU A BRIEF MESSAGE AT ANY OF THE CONTACT NUMBERS BELOW? WHICH ONES?

Home Phone_____ **Cellular Phone**_____

Work Phone_____ **Sex**_____ **Birth Date**_____

Marital Status_____ **Occupation**_____

Employer_____

Employer Address/City/Zip_____

E-Mail_____

Spouse's/Parent's Name_____ **Birth Date**_____

Occupation_____ **Employer**_____

In case of emergency, call_____

Phone_____ **Relationship to you**_____

Who suggested you contact me?_____

May I contact him/her to acknowledge their kind recommendation? ☐YES ☐NO

Do you want this office to file insurance claims for you? ☐YES ☐NO
If Yes, please complete this section and allow us to make copies of your insurance cards.

Primary Insurance _____ **Policyholder**_____

Policy/ID #_____ **Group #**_____

Claims Address_____

_____

Secondary Insurance_____ **Policyholder**_____

Policy/ID #_____ **Group #**_____

Claims Address_____

_____

First Coast Family Medicine, PA

9191 RG Skinner Parkway Suite 603
Jacksonville, FL 32256
(904) 538-0950
(904) 538-0952 (fax)

AUTHORIZATION TO TREAT

I authorize the staff of First Coast Family Medicine, PA to provide me with medical treatment. I will inform the staff of First Coast Family Medicine, PA if I have any concerns about my healthcare.

I am the parent/legal guardian of _____. I authorize the staff of First Coast Family Medicine, PA to treat my son / daughter / legal ward named above.

PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by First Coast Family Medicine, PA. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the physician agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by myself or my dependent. I understand that this office has a no-show policy and I may be charged $25 for any appointments I miss that are not cancelled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by First Coast Family Medicine, PA, in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize First Coast Family Medicine, PA, to release to my insurance company and/or insurance plan management company information required for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by First Coast Family Medicine, PA. I also authorize First Coast Family Medicine, PA, to release the information necessary to secure full payment of my account through other parties, such as a collection agency or court of law, if my account becomes delinquent.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my insurance company and/or insurance plan management company to pay First Coast Family Medicine, PA, such amount as may be payable to me pursuant to the provisions of my contract.

I agree to promptly notify the staff of First Coast Family Medicine, PA of any changes in my personal information or insurance coverage.

Date_____ Signature_____

A copy of this form is as valid as the original.

FIRST COAST FAMILY MEDICINE, PA

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Acknowledgment of Receipt of Privacy Notice for First Coast Family Medicine, PA

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____

Signature of Patient or Legal Representative

Request for an *Exception* to the disclosure rules regarding the Release of Protected Health Information (PHI)

❑ Exception for Disclosure (Individuals or means where by P.H.I. may be released)

I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information.

Individual's Name (Please Print) *Relationship to Patient* *Phone Number(s)*

_____

_____

_____

Request for *Restriction* regarding the Release of Protected Health Information (PHI)

❑ Restriction for the disclosure of Protected Health Information (PHI)
(Individuals or means where by P.H.I. cannot be disclosed.) Please be specific in your request:

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Date of Request

For Practice Use Only:

_____ _____

Signature of Employee receiving request Date Received

Request for restriction/exception has been ❑ Approved ❑ Denied

Reason for denial: _____

_____ _____

Signature of Privacy Officer Date

First Coast Family Medicine, PA

Information for Your Physician

Name_____ **Date**_____

☐Referring or ☐Previous Physician_____ Phone_____

Allergies_____

What is the reason for your visit today? _____

_____

What other concerns would you like to discuss today?_____

_____

Vaccines (Include Year)
Tetanus _____
Other_____

Pneumonia _____
Hepatitis B _____
Other_____

Meningitis _____
Shingles_____
Other_____

Your Past Medical History – Please include how long you have had this condition

☐ADD/ADHD	☐COPD	☐Hepatitis	☐Sinus Problems
☐Allergies	☐Chronic Pain	☐High Blood Pressure	☐Sleep Difficulties
☐Anxiety	☐Depression	☐High/Low Blood Sugar	☐Stroke
☐Arthritis	☐Diabetes	☐Kidney Disease	☐Tuberculosis
☐Asthma	☐Emphysema	☐Liver Disease	☐Tobacco Use
☐Back Problems	☐Eye Problems	☐Lung Problems	☐Urinary Tract Infections
☐Brain Injury	☐Glaucoma	☐Menstrual Problems	
☐Breast Disease	☐Headaches	☐Premenstrual Syndrome	☐_____
☐Cancer	☐Heart Disease	☐PTSD	
☐Chemotherapy	☐Heart Attack	☐Radiation Therapy	☐_____

Your Surgical History

☐Appendectomy	☐Eye Surgery	☐Lung Surgery	☐_____
☐Back Surgery	☐Gall Bladder	☐Pacemaker	
☐Brain Surgery	☐Heart Surgery	☐Prostate Surgery	☐_____
☐Breast Surgery	☐Hernia Surgery	☐Skin Lesions	
☐C-section	☐Joint Surgery	☐Tonsillectomy	☐_____
☐Colon Surgery	☐Hysterectomy	☐Vasectomy	

When was your last: Dental Exam_____ Eye Exam_____ Colonoscopy_____

For Our Female Patients First Period_____ Last Period_____ Periods Are ☐Regular ☐Irregular ☐Menopausal	Last Pap Test_____ # Pregnancies_____ Are / Could you be pregnant now? Miscarriages/Abortions_____ # of Children_____	What form of birth control do you use? _____ Last Mammogram_____ Are you breastfeeding now?_____

Continued on next page

Family History (Please list who in your family is / was affected)

□Asthma_____	□Heart Disease_____
□Back Problems_____	□Hepatitis_____
□Brain Injury_____	□High Blood Pressure_____
□Cancer_____	□High Blood Sugar_____
Type of Cancer_____	□Kidney Disease _____
□Chemotherapy_____	□Liver Disease_____
□COPD_____	□Lung Problems_____
□Depression_____	□Menstrual Problems_____
□Diabetes _____	□Mental Illness_____
□Emphysema_____	□Stroke_____
□Eye Problems_____	□Substance Abuse_____
□Glaucoma_____	□Tuberculosis_____
□Heart Attack_____	□_____

Social History

Do you have a Living Will or Advanced Directive? □ Yes □ No Religious Preference_____

Race or Nationality of Parents_____ What is your primary language?_____

What type of work do you do?_____

How often do you exercise? ☐ Frequently ☐ Infrequently ☐ Sedentary Type of exercise?_____

Tobacco

☐ Never ☐ Quit ☐ Smoke/Dip _____ packs/day

Alcohol

☐ Never ☐ Quit ☐ Drink _____ alcoholic beverages/day

_____ alcoholic beverages/week

Current Medications – Include Prescriptions, Vitamins and Over the Counter Items

Name of Medicine	Strength	How often do you take it	Who prescribed it

Pharmacy: ☐Costco ☐CVS ☐Ossi's ☐Publix ☐Sam's ☐Target ☐Walgreen's ☐Walmart ☐Winn-Dixie ☐Other_____

What Street/Road is it on? _____

First Coast Family Medicine

9191 RG Skinner Parkway * Suite 603
Jacksonville, FL 32256
(904) 538-0950

HIPAA Notice of Privacy Practices

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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protect health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes

- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with Nicole Dayhoff, our HIPAA Compliance Officer in person or by phone at 904-538-0950.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.