



PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME WITH FORMS FILLED OUT, INS AND PHOTO ID CARD

Today's Date _____ Soc Sec # _____

Patient's Full Name: _____ DOB: _____ Gender: F / M

Address: _____ City: _____ State: _____ Zip: _____

May we leave you a brief message on any of the numbers listed below? If so which ones?

Home Phone (_____) _____ YES NO Work Phone (_____) _____ YES NO

Cell Phone (_____) _____ YES NO Email Address: _____

What is your preferred method of contact? Please circle one: Home phone – Work Phone – Cell phone - Email

Marital Status: Single Married Divorced Race: (Optional) Black White Asian Hispanic Other

What is your primary language? _____

Employer _____ Occupation: _____

Responsible Party Name: _____ DOB: _____ Relationship: _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone(_____) _____

INSURANCE INFORMATION Primary Insurance Company

Primary Insurance _____ Policy holder _____

DOB of Primary policy holder: _____ Relationship to you: _____

Policy/ID # _____ Group # _____

Claims Address _____

Secondary Insurance _____ Policy holder _____

DOB of Primary policy holder: _____ Relationship to you: _____

Policy/ID # _____ Group # _____

Claims Address _____

FIRST COAST FAMILY MEDICINE, PA

9130 RG Skinner Parkway, Jacksonville, FL 32256

(904) 538-0950, (904) 538-0952 (fax)

AUTHORIZATION TO TREAT AND OBTAIN MEDICATION AND MEDICAL HISTORY

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 give permission to my healthcare provider to share my medication & medical history with my pharmacy, my health plans, and my other healthcare providers. As well as retrieve my medication and medical history from other health care facilities/providers.

_____ Please Initial

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. I have read First Coast Family Medicine’s Financial Policy and agree to abide by it.

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

Date: _____

Patient Name: _____ Date of Birth: _____

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 whereby 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 whereby P.H.I. cannot be disclosed.) Please be specific in your request:

Signature of Patient or Legal Representative

Signature Date

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

Information for Your Physician

Name _____

Date _____

Referring or Previous Physician _____

Phone _____

Other Physicians/Providers- Please provide their NAME, SPECIALTY, and PHONE NUMBER:

Allergies: _____

What is the reason for your visit today?

What other concerns would you like to discuss today?

Past Medical History (Check all that Apply)

<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Allergies (Runny Nose) <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Brain Injury <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Pain <input type="checkbox"/> COPD / Emphysema <input type="checkbox"/> Depression <input type="checkbox"/> Blind <input type="checkbox"/> Deaf Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Blood Sugar Problem	Heart Problems <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> AICD <input type="checkbox"/> Atrial Septal Defect <input type="checkbox"/> Heart Attack (Yr.) _____ <input type="checkbox"/> Heart Failure <input type="checkbox"/> Heart Stents <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Murmur <input type="checkbox"/> Pacemaker <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Hepatitis <input type="checkbox"/> Sleep Difficulties <input type="checkbox"/> Smoking	<input type="checkbox"/> Stroke (Year?) _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Illegal Drug Use <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Alcoholism <input type="checkbox"/> Headaches <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Premenstrual Syndrome <input type="checkbox"/> PTSD <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> _____ <input type="checkbox"/> _____	Cancer (type) <input type="checkbox"/> Bladder <input type="checkbox"/> Bone <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Colon <input type="checkbox"/> Esophagus <input type="checkbox"/> Kidney <input type="checkbox"/> Ovarian <input type="checkbox"/> Melanoma <input type="checkbox"/> Lung <input type="checkbox"/> Prostate <input type="checkbox"/> Skin <input type="checkbox"/> Stomach <input type="checkbox"/> Thyroid <input type="checkbox"/> Other _____
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When was your last: Eye Exam _____ Colonoscopy _____

Vaccines (Include Month / Year):

Pneumonia _____ **Meningitis** _____ **Tetanus** _____ **Hepatitis B** _____ **Shingles** _____

May we upload your vaccine records to the Florida shot registry? YES NO

Patient Name: _____ Date of Birth: _____

Your Surgical History

<input type="checkbox"/> Appendectomy <input type="checkbox"/> Back Surgery <input type="checkbox"/> Brain Surgery <input type="checkbox"/> Carotid Artery <input type="checkbox"/> Cataract surgery <input type="checkbox"/> Eye Surgery <input type="checkbox"/> C-section Breast Surgery <input type="checkbox"/> Augmentation <input type="checkbox"/> Biopsy <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Reduction <input type="checkbox"/> Mastectomy	<input type="checkbox"/> Gall Bladder <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Gastric Sleeve <input type="checkbox"/> Hernia Surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia Repair Heart <input type="checkbox"/> Heart Bypass <input type="checkbox"/> Pacemaker <input type="checkbox"/> Valve Replacement <input type="checkbox"/> Defibrillator <input type="checkbox"/> Heart Stents <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Colon Surgery <input type="checkbox"/> Lung Surgery <input type="checkbox"/> Prostatectomy <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Splenectomy <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> (partial) <input type="checkbox"/> (whole) <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Transplant (which organs) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Joint Replacement <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other Hysterectomy <input type="checkbox"/> Abdominal <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervix present? <input type="checkbox"/> Ovaries present? Other Surgeries: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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Family History (Please list who in your family is/was affected)

Alcoholism _____ Asthma _____ Cancer _____ Type of Cancer _____ Drug Abuse _____ Addiction _____ COPD _____ Depression _____ Diabetes _____ Emphysema _____ Glaucoma _____	Heart Disease _____ Hepatitis _____ High Blood Pressure _____ High Cholesterol _____ Kidney Disease _____ Liver Disease _____ Menstrual Problems _____ Mental Illness _____ Stroke _____ Thyroid Disease _____ Tuberculosis _____
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Social History

Who is your Primary Caregiver? Mom Dad Son Daughter Grandparents None Other

Where do you live? House Apartment Nursing Home Mobile Home Homeless Other

Do you have a Living Will or Advanced Directive? Yes No May we keep a copy on file? Yes No

For Our Female Patients

First Period _____ Last Period _____ Periods Are <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Menopausal	# Pregnancies _____ Are you pregnant now? Y/N _____ Miscarriages/Abortions _____ # of Living Children _____	Last Pap Test _____ Last Mammogram _____ Last Bone Density _____ What birth control do you use? _____ Are you breastfeeding now? _____
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What is your Religious Preference? _____

Patient Name: _____ Date of Birth: _____

What is your highest level of Education?

Less than High School High School Grad Some College College Grad Post Graduate

What is your employment status?

Fulltime Part time Retired Unemployed Student

What is your occupation (if retired what was your occupation)? _____

If a student, where do you go to school? _____ What is your Major? _____

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

Tobacco Use Never Quit Smoke/Dip _____ packs/day

Alcohol Use Never Quit Drink ___ Alcoholic beverages/day ___ beverages/week

How do you best learn? Visual Hearing Demonstration

Current Medications

Include Prescriptions, Vitamins, Herbal Supplements or Over the Counter Items

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

Preferred Pharmacy _____ **Phone Number:** _____

First Coast Family Medicine



Terry D. Hashey, DO, MHSE, FAAFP
9130 RG Skinner Parkway
Jacksonville FL, 32256

Phone: (904) 538-0950 Fax: (904) 538-0952

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ DOB: _____, authorize First Coast Family Medicine, PA, to obtain and release medical and/or social information for treatment purposes. I understand that this may include drug, alcohol, mental health, and psychiatric records.

Name of Physician/Facility: _____

Address/City/State: _____

Phone: _____ Fax: _____

Office Notes/H&P
Medication List
EKG/Stress Test
Radiology Reports
Colonoscopy
Other: _____

Diagnostic Procedures
Discharge Summary
Pathology Results
Lab Results
Mammogram
Other: _____

[] All Current Records or Specific dates: _____

I hereby give specific authorization for release of information regarding:

HIV Information _____
Drug/Alcohol Information _____
Mental Health/Psychiatric _____

Signature: _____ Date: _____

Relationship to patient: _____

For Questions and records coordination, please ask for Patient Records Department. Please fax records to the provided fax number. 904-538-0952

A copy of this form is as valid as the original. Unless otherwise noted or revoked, this authorization.

Will expire 12 months from the date of the signature listed above.

The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of treatment at 45 CFR 164.501.

Shared drive/FCFM General/2023 New patient forms updated 2023-10-05.

FIRST COAST FAMILY MEDICINE, PA

9130 RG Skinner Parkway Suite 603, Jacksonville, FL 32256 - (904) 538-0950, (904) 538-0952 (fax)

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 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.

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 or 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 Monica B Steinmetz, 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.

Shared/registration forms/2016 NOTICE OF PRIVACY PRACTICES.docx