First Coast Family Medicine

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

Today's Date_____ Soc Sec #_____

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

Address: _____City: _____ State: _____ Zip: _____

May we leave a brief message or call you 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: _____

Marital Status: Single Married Divorced Partner Widowed Separated

Race
□ American Indian or Alaska Native
□ Black or African American
□ Asian
□ Declined to Specify
□ Other Race
□ White

Ethnicity
□ Hispanic or Latino Ethnicity
□ Not Hispanic or Latino
□ Declined to Specify

What is your primary language? _____ Translator Required: _____Yes _____No

Responsible Party Name: _____ DOB: _____ Relationship: _____

Employment: ___Full-time ___Part-time ___Not Employed ___Self-employed ___Retired ___Student ____Active Military ____Veteran

Occupation Current or Past: _____How did you hear about us? _____

EMERGENCY CONTACT:

Name_____ Relationship_____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone(_____)_____

Name_____ Relationship_____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone(_____)_____

NSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Name:	**Name:**
Insured Name:	**Insured Name:**
Policy Number:	**Policy Number:**
Relation to Insured:	**Relation to Insured:**

Name_____ Date_____

First Coast Family Medicine, PA

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.

_____ Please Initial

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.

_____ Please Initial

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.

Name_____ Date_____

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. I understand that I have the right to review the NOTICE before signing this consent. FCFM has afforded me sufficient time to review this NOTICE and has answered any questions that I have to my satisfaction. I also understand that FCFM cannot use or disclose my individually identifiable health information other than as specified on the NOTICE. I also understand, however, the FCFM reserves the right to change its notice, and the practices detailed there in prospectively (for uses and disclosures occurring after the revision) if it posts a copy of the revised notice in a prominent space in the medical center(s).

I understand that I do not have to consent to the use of disclosure of my individual identifiable health information for treatment, payment, and health care operations, but that if I do not consent, FCFM may refuse to provide me health care services unless applicable state or federal law requires FCFM to provide such services.
I understand that I have the right to request restriction as to the method of communications to me.

_____
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_____DateReceived_____

Request for restriction/exception has been __ Approved __Denied Reason for Denial: _____

_____ _____
Signature of Privacy Officer Date

Name_____ Date_____

PATIENT MEDICAL, FAMILY, SOCIAL HISTORY

Please fill out the following sections as completely and accurately as possible so that we may provide you with the best quality of care. This information is collected to identify conditions that may affect your health, functioning, and/or quality of life, and so that we may connect you to resources which may provide support.

Please List Referring or Previous Physicians below

Physician: _____Specialty: _____Phone_____

Physician: _____Specialty: _____Phone_____

Physician: _____Specialty: _____Phone_____

List Allergies and reactions:

_____

_____

What is the reason for your visit today? _____

_____

What other concerns would you like to discuss today? _____

_____

PAST MEDICAL HISTORY- (Do you have/had any of the following?)

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

For Our Female Patients

Date of last period: _____Age your periods began: _____Your Periods are: __Regular __Irregular

 # Pregnancies: _____ Miscarriages/Abortions _____ # of Living Children_____ Are you pregnant now? ____

Last Pap Test: _____ Last Mammogram _____ Last Bone Density_____

If you stopped having periods: Age of menopause _____ What birth control do you use? _____

Name_____ Date_____

YOUR SURGICAL HISTORY

☐ Appendectomy ☐ Back Surgery ☐ Brain Surgery ☐ Carotid Artery ☐ Cataract surgery ☐ Eye Surgery ☐ C-section **Breast Surgery** ☐ Augmentation ☐ Biopsy ☐ Lumpectomy ☐ Reduction ☐ Mastectomy	☐ Gall Bladder ☐ Gastric Bypass ☐ Gastric Sleeve ☐ Hernia Surgery ☐ Hemorrhoidectomy ☐ Hernia Repair **Heart** ☐ Heart Bypass ☐ Pacemaker ☐ Valve Replacement ☐ Defibrillator ☐ Heart Stents ☐ _____ ☐ _____ ☐ _____	☐ Colon Surgery ☐ Lung Surgery ☐ Prostatectomy ☐ Skin Lesions ☐ Splenectomy ☐ Thyroidectomy ☐ (partial) ☐ (whole) ☐ Tonsillectomy ☐ Tubal Ligation ☐ Vasectomy ☐ Transplant (which organs) ☐ _____ ☐ _____ ☐ _____	**Joint Replacement** ☐ Hip ☐ Knee ☐ Other **Hysterectomy** ☐ Abdominal ☐ Vaginal ☐ Cervix present? ☐ Ovaries present? Other Surgeries: ☐ _____ ☐ _____ ☐ _____

When was your last: Eye Exam_____ Colonoscopy_____

Previous Hospitalizations, which hospital, and Dates: _____

_____

Vaccines (Include Month / Year):

Pneumonia _____ Meningitis_____ Tetanus_____ Hepatitis B_____ Shingles _____

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

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

*Mother, Father, **Paternal** Grandmother/Grandfather, Aunt, Uncle, **Maternal** Grandmother/Grandfather, Aunt Uncle, Children*

Alcoholism_____	Heart Disease_____
Asthma_____	Hepatitis_____
Cancer_____	High Blood Pressure_____
Type of Cancer_____	High Cholesterol _____
Drug Abuse_____	Kidney Disease _____
Addiction_____	Liver Disease_____
COPD_____	Menstrual Problems_____
Depression_____	Mental Illness_____
Diabetes _____	Stroke_____
Emphysema_____	Thyroid Disease _____
Glaucoma_____	Tuberculosis_____

What is your Religious Preference? _____

Patient Name: _____ Date of Birth: _____

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

What is your highest level of Education?
□Less than High School □High School Grad □Some College □College □Grad □Post Graduate

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	Diagnostic Procedures
Medication List	Discharge Summary
EKG/Stress Test	Pathology Results
Radiology Reports	Lab Results
Colonoscopy	Mammogram
Other: _____	Other: _____

☐ **All Current Records or Specific dates: _____**

By initialing I am giving 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 the 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.

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 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 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