

First Coast Family Medicine, PA

Terry D. Hashey, DO, MHSE, DABFM - Medical Director

Today's Date _____

Soc Sec # _____

Patient's Full Name _____

Address/City/Zip _____

MAY WE LEAVE YOU A BRIEF MESSAGE AT ONE 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 I may be charged for appointments not canceled 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

NOTICE OF PRIVACY POLICIES FOR FIRST COAST FAMILY MEDICINE, PA

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Introduction

At First Coast Family Medicine, PA, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 1, 2007, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit First Coast Family Medicine, PA; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,

- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of First Coast Family Medicine, PA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.526.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

First Coast Family Medicine, PA is required to:

- Maintain the privacy of your health information,
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of the Notice currently in effect,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the Practice's Privacy Officer, Ms. Simpson at (904) 538-0950.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues, financial matters and any call pertaining to my clinical care. We may mail to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompanies the patient into the exam room, it is considered implied consent that a disclosure of the patient medical data is acceptable.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or

other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. State law requires the reporting of certain types of cancer to the Florida Cancer Data System. Under HIPAA, covered entities may disclose protected health information to these registries without the individual informed consent of each patient pursuant to the "public health" exception to HIPAA general disclosure rule. A log of these releases will be maintained.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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

<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Allergies <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Brain Injury <input type="checkbox"/> Breast Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> COPD <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Eye Problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack	<input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High/Low Blood Sugar <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Problems <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Premenstrual Syndrome <input type="checkbox"/> PTSD <input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Sinus Problems <input type="checkbox"/> Sleep Difficulties <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tobacco Use <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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Your Surgical History

<input type="checkbox"/> Appendectomy <input type="checkbox"/> Back Surgery <input type="checkbox"/> Brain Surgery <input type="checkbox"/> Breast Surgery <input type="checkbox"/> C-section <input type="checkbox"/> Colon Surgery	<input type="checkbox"/> Eye Surgery <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Hernia Surgery <input type="checkbox"/> Joint Surgery <input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Lung Surgery <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Surgery <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Tonsilectomy <input type="checkbox"/> Vasectomy	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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When was your last: Dental Exam _____ Eye Exam _____ Colonoscopy _____

<p>For Our Female Patients</p> <p>First Period _____</p> <p>Last Period _____</p> <p>Periods Are</p> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Menopausal	<p>Last Pap Test _____</p> <p># Pregnancies _____</p> <p>Miscarriages/Abortions _____</p> <p># of Children _____</p>	<p>Last Mammogram _____</p>
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Family History (Please list who in your family is / was affected)

<input type="checkbox"/> Asthma _____ <input type="checkbox"/> Back Problems _____ <input type="checkbox"/> Brain Injury _____ <input type="checkbox"/> Cancer _____ Type of Cancer _____ <input type="checkbox"/> Chemotherapy _____ <input type="checkbox"/> COPD _____ <input type="checkbox"/> Depression _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Emphysema _____ <input type="checkbox"/> Eye Problems _____ <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> Heart Attack _____	<input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> High Blood Sugar _____ <input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> Liver Disease _____ <input type="checkbox"/> Lung Problems _____ <input type="checkbox"/> Menstrual Problems _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Tuberculosis _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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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

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

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

Preferred Pharmacy: Costco CVS Ossi's Publix Sam's Walgreen's Walmart Winn-Dixie
 Other _____

What Street/Road is it on? _____