Physicians' Primary Care OF SOUTHWEST FLORIDA

# Adult Medicine Patient Registration

## NEW PATIENT INFORMATION

| FIRST NAME | MI | LAST |
|---|---|---|
| | | |

| ADDRESS | APT/UNIT | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

| DOB | SSN | BIRTH SEX | GENDER IDENTITY: [ ] M [ ] F |
|---|---|---|---|
| _____/_______/_________ | ________-_____-_______ | [ ] M [ ] F | [ ] Non-Binary [ ] Other____________________ |

| HOME PHONE: | CELL PHONE: | PREFERRED LANGUAGE: |
|---|---|---|
| ______-_______-____________ | ______-_______-____________ | |

E-MAIL:

EMPLOYMENT: [ ] Employed [ ] Retired [ ] Not Employed [ ] Self Employed [ ] Military Duty [ ] Stay-At-Home Parent

EMPLOYER:_________________________________

PHONE: __________________________________

| RACE | | ETHNICITY | MARTIAL STATUS |
|---|---|---|---|
| [ ] Asian | [ ] African American or Black | [ ] Hispanic/Latino | [ ] Single |
| [ ] American Indian | [ ] Native Hawaiian | [ ] Not Hispanic/Latino | [ ] Married |
| [ ] Alaskan Native | [ ] White | [ ] Declined | [ ] Widowed |
| [ ] African American | [ ] Other____________________ | | [ ] Divorced |
| [ ] Other Pacific Islander | [ ] Declined | | [ ] Declined |

***HOW DID YOU HEAR ABOUT US?*** [ ] Social Media [ ] Internet [ ] Billboard [ ] Ins. Company [ ] Referral__________________________________

PRIMARY CARE PROVIDER

| EMERGENCY CONTACT NAME | PHONE | RELATIONSHIP TO PATIENT |
|---|---|---|
| | ______-_______-____________ | |

## INSURANCE INFORMATION

| PRIMARY INSURANCE | RELATIONSHIP TO INSURED<br>[ ] Self [ ] Dependent | *PROVIDE NAME & DOB OF PRIMARY CARD HOLDER*<br>NAME:________________________________<br>DOB:_________________________________ |
|---|---|---|
| **SECONDARY INSURANCE** | **RELATIONSHIP TO INSURED**<br>[ ] Self [ ] Dependent | *PROVIDE NAME & DOB OF PRIMARY CARD HOLDER*<br>NAME:________________________________<br>DOB:_________________________________ |

## FINANCIAL RESPONSIBILITY
*If patient is a minor financial responsibility must be completed entirely*

| RESPONSBILITY PARTY NAME [ ] Self | RELATIONSHIP TO PATIENT | SSN | DOB |
|---|---|---|---|
| | | | |

| PHONE NUMBER | ADDRESS |
|---|---|
| | |

# Adult Medicine Financial Policy

**Patient Name:** ____________________________________________ **Patient DOB:** ____________________

**Payment in full is due and expected at the time of service. The parent or caregiver bringing in the patient for service will be financially responsible for all charges, as payment is required at the time services are rendered.**

**Insurance:** Your health insurance policy is a contract between you and your insurance company. Physicians' Primary Care of SWFL will file claims to any insurance carrier with whom we are participating providers. Co-payments, deductibles, and co-insurance are due at time of service. Nonpayment at the time of service will result in a $30.00 service fee.

I am providing the correct insurance to Physicians' Primary Care of SWFL for billing on my behalf, if the Insurance information is incorrect or the primary care as of this date, **I WILL BE RESPONSIBLE FOR PAYMENT OF THE ENTIRE VISIT AND SUBMISSION OF ALL CHARGES TO THE CORRECT INSURANCE PLAN.**

**Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility, it may not always be possible to know a head of time if any non-covered services will be done.**

**Out of Network:** If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, outstanding balances must be paid prior to the visit.

**Self -Pay:** If you have no insurance, payment for an office visit is to be paid at the time of the visit.

**Outstanding accounts**: I acknowledge Physicians' Primary Care of SWFL may utilize a collection agency to collect any unpaid balances. I understand that I will be responsible for any collection agency fees in addition to any account balance.

A $35 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

**For Medicare Patients:** LIFETIME AUTHORIZATION/MEDICARE CERTIFICATION I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurance.

I ________________________________________ have read and understand Physicians' Primary Care of SWFL financial policy as outlined above and give Physicians' Primary Care of SWFL permission to bill my insurance carrier and myself for any patient responsibility that I am responsible for.

______________________________________________________

**Print Name**

____________________________________________________ ____________________________

**Signature of Patient or Representative** **Date**

Physicians' Primary Care OF SOUTHWEST FLORIDA

# Patient Consents

**Patient Name:** ______________________________ **Patient DOB:** ____________________

## Consent for Transfer of Biological Specimen

Florida law (Section 817.5655) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third parity without the express consent of such person. During the course of your care at Physicians' Primary Care of SWFL, it may be medically necessary to suggest testing or examination of your DNA to support a diagnosis or suggested treatment. <u>This would be discussed with you by your healthcare provider and a mutual decision to test would be made</u>. After the analysis has been performed and the sample is no longer needed, it will be stored as medical wasted and then transferred to a third party for disposal in accordance with all local, state and federal requirements. It may also be the case that a biological specimen (such as blood, urine, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing you consent to the transfer of any and all biological specimens collected by or deposited with Physicians' Primary Care of SWFL to a third party as set forth above. **This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.**

## Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained, for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   a. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

______________________________

**Print Name**

______________________________ ____________________

**Signature of Patient or Parent/Guardian** **Date**

# Patient Authorization for Use and Disclosure of Protected Health Information

**Patient Name:** ________________________________________ **Patient DOB:** ____________________

**Please CHECK one of the following:**

______ I give my permission to Physicians' Primary Care of SWFL (PPC) to disclose my protected health information and patient medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have Power of Attorney on behalf of myself.

NAME: ___________________________________________ RELATIONSHIP: _________________

NAME: ___________________________________________ RELATIONSHIP: _________________

NAME: ___________________________________________ RELATIONSHIP: _________________

NAME: ___________________________________________ RELATIONSHIP: _________________

## OR

______ I request that all my Protected Health Information and/or Medical Record Information be disclosed to **ME ONLY.**

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In addition, the Patient agrees that PPC may disclose the following type of information, contained in the Patients medical records *(Please initial the appropriate categories that you choose to disclose listed below.):*

______ HIV/AIDS Information

______ Mental Health Information

______ Substance Abuse Information

______ Sexually Transmitted Disease Information

______ If Patient is under the age of eighteen (18), Pregnancy Information

May we leave test results on any of the following: *(Please initial the device(s) of your choice):*

______ Home voicemail

______ Cellular Phone Voicemail

______ Work Voicemail

*At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to PPC in writing.*

___________________________________________________
**Print Name**

___________________________________________________ ________________________
**Signature of Patient or Representative** **Date**

## ***This form is only authorized for 1 year from the date above.***

Physicians' Primary Care OF SOUTHWEST FLORIDA

# Advanced Directive Questionnaire

**Patient Name:** ________________________________________ **Patient DOB:** ____________________

**DON'T LOSE YOUR RIGHT TO DECIDE**

You cannot remove all uncertainty about your future healthcare needs; however, by having an advance directive you can have the peace of mind that comes from making your wishes known in advance.

**Declaration to Decline Life-Prolonging Procedures**

**[ ]** I have a Living Will

**[ ]** I do **NOT** have a Living Will

**Health Care Surrogate**

**[ ]** I have designated a Health Care Surrogate

**[ ]** I do **NOT** designate a Health Care Surrogate

**Durable Power of Attorney**

**[ ]** I have appointed a Durable Power of Attorney for Health Care decisions

**[ ]** I have **NOT** appointed a Durable Power of Attorney for Health Care decisions

_______________________________________________

**Print Name**

_______________________________________________ ___________________________

**Signature of Patient or Representative** **Date**

Physicians' Primary Care OF SOUTHWEST FLORIDA

# Patient Agreement Conditions

**Patient Name:** ______________________________________________ **Patient DOB:** ____________________

**The following is a list of informational reminders that will help you facilitate services from us.**

- You will be asked for a valid photo ID to scan into our computer system, if any changes occur please update us as necessary. Additionally, a valid photo ID will need to be presented when picking up any prescription.
- We require 48-hour advance notice of refill requests in order that we may properly record them and contact the pharmacy. The most efficient and accurate way to request a refill is to contact your pharmacy, they will let us know exactly what you need so we can process the request quickly.
- Please be advised that some of our healthcare providers utilize virtual scribes during your visits to enhance documentation accuracy and streamline the care process. Rest assured, your privacy and confidentiality remain our top priorities. If you have any concerns or questions, feel free to discuss them with your healthcare provider
- Physicians' Primary Care of SWFL is part of a Health Information Exchange (HIE) which allows us to access and share your medical records seamlessly between hospitals, specialties and other healthcare providers. Your privacy remains top priority, and all information is handled securely and in accordance with strict HIPAA privacy standards. If you wish to OPT-OUT of the HIE and prefer not to have your records accessed or shared to the HIE, please see a member of our staff to sign a form and be removed

## Cancellation/No-Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

In order to be respectful of the medical needs of other patients, please be courteous and notify us promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance, and calling early in the day is appreciated. Appointments are in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel appointments, please call 239-574-1988 (Cape Coral) or 239-482-1010 (Fort Myers and Lehigh)

Late cancellations (less than 24 hours) will be considered as a "no-show".

### Policy

A failure to present at the time of a scheduled appointment will be recorded in your patient chart as a "no-show". Each patient is allowed two "no-shows" within a 12-month period without penalty. A third "no-show" in a 12-month period will result in discharge from our practice.

______________________________________________
**Print Name**

______________________________________________ ________________________
**Signature of Patient or Representative** **Date**

Physicians' Primary Care
OF SOUTHWEST FLORIDA

# Patient History
*Adult Medicine*

**Patient Name:** ______________________________ **Patient DOB:** ____________________

## MEDICAL PROBLEMS
**Please check or list *current* medical problems**

[ ] Diabetes [ ] HYPERthyroid [ ] HYPOthyroid [ ] Emphysema [ ] Atrial Fibrillation [ ] High Cholesterol

[ ] GERD [ ] Arthritis [ ] Hypertension

**Other**

**Past Medical Problems**

## HOSPITALIZATIONS/SURGERIES
**Please check or list *all hospitalizations/Surgeries***

| Procedure | Date | Procedure | Date |
|---|---|---|---|
| [ ] Cholecystectomy (Gallbladder) | | [ ] Appendectomy (Appendix) | |
| [ ] Rotator Cuff Repair (Right or Left) | | [ ] Hernia Repair | |
| [ ] C-Section | | [ ] Coronary Artery Bypass Graft (CABG) | |
| [ ] Knee Replacement (Right or Left) | | [ ] Tonsillectomy | |
| [ ] Back Surgery | | [ ] Hysterectomy (Total or Partial) | |
| [ ] Hip Replacement (Right or Left) | | [ ] Other: | |

## ALLERGIES
**[ ] No Known Allergies**

| ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |
| | |

## MEDICATIONS
**List all medications that you are taking.**
***(Including non-prescription medications)***

| Medication Name | Dosage | Times Daily |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Physicians' Primary Care OF SOUTHWEST FLORIDA

# Patient History

*Adult Medicine*

**Patient Name:** ______________________________________________ **Patient DOB:** ________________________

| HEALTH MAINTENANCE SCREENING TEST HISTORY | | |
|---|---|---|
| **Screening** | **Most Recent Date** | **Abnormal Results?** |
| [ ] Cholesterol | | [ ] Yes [ ] No [ ] Unknown |
| [ ] Colonoscopy/FBOT | | [ ] Yes [ ] No [ ] Unknown |
| [ ] Mammogram | | [ ] Yes [ ] No [ ] Unknown |
| [ ] Bone Density | | [ ] Yes [ ] No [ ] Unknown |
| [ ] *Female Patient:* PAP Smear | | [ ] Yes [ ] No [ ] Unknown |
| [ ] *Male Patient:* Last PSA | | [ ] Yes [ ] No [ ] Unknown |

| VACCINATION HISTORY: | | | |
|---|---|---|---|
| **Vaccination** | **Most Recent Date** | **Vaccination** | **Most Recent Date** |
| [ ] Pneumococcal | | [ ] Shingle | |
| [ ] COVID Shot | | [ ] Gardasil (HPV) | |
| [ ] Influenza (Flu) | | [ ] TB Test | |
| [ ] Tetanus | | [ ] TB Result | |

**FAMILY MEDICAL HISTORY**

[ ] No Significant Family History is known

| Check All that APPLY | Alcohol/Drug Abuse | Asthma | Cancer (Type:_____) | COPD | Depression/Anxiety | Bipolar/Suicidal | Diabetes | Early Death | Heart Disease | High Cholesterol | High Blood Pressure | Kidney Disease | Stroke | Thyroid Disease | Migraines | Other:_____ | Other:_____ | Other:_____ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | | | | |
| Child(ren) | | | | | | | | | | | | | | | | | | |
| (M) Grandmother | | | | | | | | | | | | | | | | | | |
| (M) Grandfather | | | | | | | | | | | | | | | | | | |
| (P) Grandmother | | | | | | | | | | | | | | | | | | |
| (P) Grandfather | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | |

Physicians' Primary Care OF SOUTHWEST FLORIDA

# Patient History

*Adult Medicine*

**Patient Name:** ______________________________ **Patient DOB:** ____________________

| Social History | Women ONLY: |
|---|---|
| Lived in SW FL how long? Originally From? | Age when periods began? |
| Are you a permanent or seasonal resident? | Number of Pregnancies? |
| Most recent primary occupation? | Number of live births? |
| Last grade completed? | Number of miscarriages? |
| Do you have a religious preference? | Have you had a hysterectomy? [ ] Y [ ] N |
| What are your hobbies or Interests? | Do you have your ovaries? [ ] Y [ ] N |
| Are you right or left handed? Ambidextrous? | Do you have your cervix? [ ] Y [ ] N |
| Do you exercise regularly? [ ] Y [ ] N | Are you still having periods? [ ] Y [ ] N |
| Do you drink caffeinated beverages? [ ] Y [ ] N | Are your periods regular? [ ] Y [ ] N |
| If yes, what is your usual drink and how many per day? | What are you using for contraception? |
| Do you drink alcohol?<br>If yes, how often and what kind? | Preform self breast exams? [ ] Y [ ] N |
| Have you used recreational drugs? [ ] Y [ ] N | Have you reached menopause? [ ] Y [ ] N<br>At what Age? |
| Do you smoke? [ ] Y [ ] N If yes, how many packs per day? | Any other special notes you would like to let your provider know? |
| How long have you been smoking? | |
| If you smoked in the past, when did you quit? | |
| Do you use a cane, walker, or wheelchair? | |

| Preferred Local Pharmacy | | |
|---|---|---|
| Pharmacy Name | Phone Number | Pharmacy Address or Cross Streets |
| | | |

| Preferred Mail Order Pharmacy | |
|---|---|
| Pharmacy Name | Phone Number |
| | |