SEACOAST MEDICAL ASSOCIATES PA.

1801 S.E. Hillmoor Dr. Suite A102, Port St. Lucie, FL 34952
1713 US-441, Suite E, Okeechobee, FL. 34972
P: 772-249-2494 | F: 772-249-3113
EMAIL: SEACOASTMEDICAL@HEALTHCARE-MED.ORG

Name: _________________________________ Date of Birth: ____/____/_______

Age: ________ Social Security #: ________-______-________ Sex: _________

Marital Status: __Married __Divorced __Single __Widowed __Separated

Home phone: ( ) _______-________ Cell Phone: ( )_______-________

I give permission to leave phone and text messages regarding my medical care [ ] Y [ ] N

Email address: ____

Address: ____

City: _______________________ State: _____ Zip: ________________

Race: ____________________________________ Religion: ___________________

Primary Language: ________________________ Birth Country: _________________

Do you have a Power of Attorney? __Y __N Name of P.O.A: ___________________

Retired? Yes No Language Spoken: _________________________

Employer: ____

Business Address: ____

City: ____ State: _____

Zip: _______________

Primary Insurance Information

Insured Name: ________________________ Date of Birth: ___/___/______

Insurance Company: ____

Group #____________________ID#_________________________________

Address: ____

City: _______________________________________ State: _________

Zip: ________________

Secondary Insurance Information

Insured Name: ____________________________ Date of Birth:___/___/______

Insurance Company: ____

Group #_________________ ID#___________________________________

Address: ____

City: ______________________ State: ______ Zip: ________________

Contact in case of an emergency

Name: __________________________ Telephone #: _______-_____-_______

Pharmacy Name: ___________________ Telephone #: _______-_____-_______

Please read the following statements and confirm your agreement by signing below:

- I consent to treatment necessary for the care of the above-named patient.
- I consent to virtual visit (Telehealth)
- I allow fax transmittal of my medical records, if necessary.
- I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any medical services rendered.
- I certify the information given here is true and correct to the best of my knowledge.
- I will notify Seacoast Medical Associates PA. of any changes in my health status or in the above information.

Patient Signature: ____________________ Date:

Guardian Signature: ____________________ Date:

****Please provide your insurance card and Government issued ID.****

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PATIENT PERSONAL HISTORY & HEALTH ASSESSMENT **DATE:** ____________________

Patient Name: _________________________________ Date of Birth:

Allergies: Are you allergic to any medications? __YES __NO

If yes, please list the medications and the reaction you have to them.
Description:

Medications: Please list over the counter medications, doses and vitamins you take:

List each prescribed medication and dose and how often you take them:

Past Medical History/Diagnosis: Please check all that apply __

__Alcohol Overuse	__Dialysis	__Hepatitis	__Sickle cell anemia
__Allergies chronic	__Emphysema	__High blood pressure.	__Sleep disorder
__Anemia	__Epilepsy	__Intestinal polyps	__Stomach ulcers
__Asthma	__Frequent kidney/bladder infection		__Jaundice
__Stroke	__Bleeding tendency	__Frequent lung infection	
__Leukemia/Blood disorder		__Suicide attempt	__Cancer
__Gallbladder disease	__Measles/Mumps	__Thyroid Disease	__Chicken pox
__Goiter	__Migraine	__Tuberculosis	__Colitis
__Gout	__Nervous Breakdown	__Whopping cough	
__Congenital Heart Disease		__Hay Fever	
__Radiation treatment	__Depression	__Heart Attack	__Rheumatic Fever
__Diabetes	__Heart Disease	__Sexually transmitted disease	

Other:

____
____
____
____
____
____

Past Surgical/Hospitalization History-Please indicate approximate month/year:

____
____
____
____
____

Family Medical History-Please include significant pertinent medical history**:**

Mother:

____
____
____
____

Father:

____
____
____
____

Brother:

____
____
____
____

Sister:

____
____
____
____

Patient Name: ______________________________ Date of Birth:

Medical Equipment-Please check all that applies __:

__Cane __Walker __Wheel Chair __Catheter __Oxygen __Nebulizer __Glasses
__Hearing Aid

Social History:
Tobacco: __Y __N __None smoker __Quit ___ Years ago Years smoked: _____
Number of packs per day? _____

Alcohol: __Y __N How much do you drink: ____ per day ____per week ____per month

Drugs: __Cocaine __Marijuana Other: ___________________________

Marital Status**:** __Married __Widowed __Single __Divorced __Separated __Live Alone

Religious preference:
____

Health Maintenance:
Date of Last Colonoscopy: _____________________

Date of Bone Density: _________________________

Women only:
Pregnant __Yes __No
Date of Last Mammogram: _________________ Date of Last PAP Smear: _____________________

Immunizations-Most recent**:**
Tetanus______________________(Date) Pneumonia_________________(Date)

Flu Shot______________________(Date) Zostavax _______________ (Date)

Other________________________

Advance Directives:
A Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a living will? __Yes __No

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Patient Name: ___________________________ Date of Birth___/___/____

INSURANCE PAYMENT POLICY

We will accept your insurance assignment as soon as your coverage is verified by our office. As a courtesy to our patients, we will submit your claim forms and assist you in every way we can. You will be responsible for payment at the time services are rendered.

It must be fully understood that your contract is between you and your insurance company and that you are fully responsible for any amount due not paid by your insurance company.

Office policy regarding insurance payments:

1. If your deductible has not been met at the time of verification, you are responsible for the deductible amount when you visit our office.

2. You are responsible for the percentage of the amount due not paid by your insurance company at the time of your office visit(s).

3. <u>We do not guarantee that your insurance will pay for the services rendered.</u> Verification is not a guarantee of payment by your insurance company. We will make every reasonable attempt at the beginning of your care to obtain an approximate verification of your policy including the amount of the charge if your insurance company denies the claim or any part of the claim for any reason.

4. You must notify us of changes and updates to your insurance at least 24 hours prior to your appointment. Timely notification of changes will assist us in verifying that you have proper coverage and that the charges of your visit will be covered by your insurance company.

I have read, understood and agree with the Seacoast Medical Associates PA. Insurance Payment Policy

_______________________________ _______________________________
Patient / Guardian Signature Date Signed

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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 or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

Patient Initials

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 activities, employee review activities, 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.

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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this 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

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 for the purposes of treatment, payment or healthcare operations. 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.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend 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.

Patient Initials

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact 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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

By signing below, I acknowledge receipt of this Notice of Privacy Practices and I also understand that by refusing to sign this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

Release my health information to the following people:

1. ______________________________ Date of Birth: _____________

2. ______________________________ Date of Birth: _____________

3. ______________________________ Date of Birth: _____________

Patient Name: ____

Patient / Guardian Signature: ___________________________ Date: __________________

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RECEIPT OF NOTICE OF OFFICE AND PRIVACY PRACTICES

Written acknowledgement form

Patient Name: _____________________________________ Date of Birth: _____________

Guarantor Name: __________________________________ Date of Birth: ______________

1. I, ______________________________________ have read a Notice of Patient Privacy Practice.

2. I hereby authorize Seacoast Medical Associates PA. to obtain medical information that may be needed for my healthcare.

3. I authorize one or both of the following persons to make/cancel/or receive any information regarding my appointments.

4. Referrals to specialists may require up to 1 (one) weeks notice to be fulfilled, in case of an emergency the office will try to expedite this service.

5. Medications refills require a 48-72-hour notice. Antibiotics will not be called into a pharmacy without an appointment. Other medications that need refills will not be called in after business hours.

6. NO SHOW POLICY – There will be a $25.00 fee for missed appointments or cancellations with less than 24 hours notice. Patients that have a history of repeatedly ‘NO SHOWS’ may be subject to dismissal for ‘non-compliance’.

Patient / Guardian Signature: ___________________________ Date: ______________

Witness By: ___________________________ Date: ______________

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Print Patient's Full Name: ________________________ Date of Birth: ___________________

Social Security: _______________ Phone Number: ______________ Work Number: _____________

I ________________________, do hereby authorize _____________________. Phone number ______________________________ to release: DISCHARGE SUMMARY, HISTORY & PHYSICAL, PROGRESS NOTES, OPERATIVE NOTES, PATHOLOGICAL REPORTS, LABORATORY REPORTS, RADIOLOGY REPORTS, EKG/ECG/CARDIAC CATH, EMERGENCY REPORTS, AND/OR OTHER

__I DO __I DO NOT (please check one) authorize the release of information related to AIDS (acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

__REFERRAL TO SPECIALIST __INSURANCE __WORKER'S COMP
__CHANGE OF DOCTOR __LEGAL INVESTIGATION
__DISABILITY DETERMINATION __PERSONAL CONTINUING OF CARE
__ OTHER (PLEASE SPECIFY):

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from date of the signature. I understand that I may cancel this request with written notification but will NOT affect any information of cancellation. I understand that the information used or disclosed may be subjected to re-disclosure by the person or class of persons or facility receiving it and would then longer be protected by FEDERAL regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual or Guardian or Personal Representative: _________________

Today's Date: _______________

Seacoast Medical Associates

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Email: seacoastmedical@healthcare-med.org

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.	
Name *(last, first)*	
Birthdate *(MMM -DD-YYY)*	Gender ☐ Male ☐ Female

Patient Health Questionnaire (PHQ-2 & PHQ-9)

PHQ 2	
1. During the **past two weeks**, have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No
2. During the **past two weeks**, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes ☐ No
If the answer to both questions is No, the screen is negative for depression *(re-screen if indicated)*. If yes was selected for one or both questions, please consult appropriate discipline to complete the PHQ-9.	
Date *(MMM-DD-YYYY)*	Signature

PHQ 9				
Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ to indicate your answer)*	**Not at all** (score = 0)	**Several days** (score = 1)	**More than half the days** (score = 2)	**Nearly every day** (score = 3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
TOTAL				
TOTAL SCORE				

If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PHQ-9 Score	Meaning / Action
Less than 5	Patient not likely depressed, re-screen if affect changes. Communicate results to the team and to any referral sites.
Between 5-9	Watchful waiting - patient to be closely monitored and re-screened if needed. Communicate results to the team and any referral sites.
Greater than 9	Patient has screened positive and requires further assessment by a certified professional for diagnosis and treatment. Notify attending, consider consulting psychiatry or psychology. Communicate results to the team and any referral sites.

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Date *(MM-DD-YYY)*	Signature