WELCOME TO OUR OFFICE

PATIENT INFORMATION

Demographics

Last Name: _____ First Name: _____Age: _____

Date of Birth: _____ Social Security: _____

Sex: Male / Female Race: _____ Primary Language Spoken: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Employer Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Pharmacy Information

☐ **CVS** ☐ **Publix** ☐ **Target** ☐ **Sam's Club** ☐ **Walgreens** ☐ **Winn Dixie** ☐ **Wal-Mart**

☐ **Other _____**

Pharmacy Phone: _____ Address: _____

I, _____ here by authorize the medical staff of Professional Health Care of Pinellas, Inc. to render medical services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that I am ultimately responsible for full payment of my treatment and care. My insurance policy is a contract between Professional Health Care of Pinellas and my insurance company(s). Professional Health Care of Pinellas will file my claim. I am required to provide the most correct and updated information about my insurance and will be responsible for any charges incurred if information provided is not correct or updated. **Patients are responsible for the payment of all co-pays, coinsurances, deductibles, procedures, treatments and explanations of any services not covered. Payment is due at the time services are rendered. Insurance companies will only pay for services that it determines to be "reasonable and medically necessary" under the Insurance Companies standards. Insurance companies may deny payment for services that they deem are screenings or not meeting medical necessity guidelines per the local coverage determinations. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.**

Professional Health Care of Pinellas cannot waive co-payments or bill on your behalf. For your convenience we accept cash, check and most major credit cards.

X _____ Date: _____

Patient Signature

PATIENT CASE HISTORY

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Chief complaint/Reason for visit: _____

Duration of Present Condition: _____

Medication Allergies

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, what medication(s) _____

What is your reaction to this medication? _____

Past Medical History

☐ High Blood Pressure ☐ Diabetes Mellitus ☐ Bleeding Problems ☐ Hepatitis / HIV ☐ Skin Cancer

Previous Surgery

Type	Date
_____	_____
_____	_____

Social History

Do you smoke? ☐ **Yes** ☐ **No** **If so how many pack(s) per day?** _____

Have you ever smoked ☐ **Yes** ☐ **No**

Family History (Please list)

_____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please check off all that apply or select NONE if none apply

Patient Name: _____ **Date:** _____

Patient Name: _____ **Date:** _____

Eyes
- ☐ Visual Problems
- ☐ Blurry Vision
- ☐ Red Eyes
- ☐ **NONE**
- ☐ Other _____

Ears
- ☐ Hearing Problems
- ☐ Ringing In Ears
- ☐ Discharge
- ☐ **NONE**
- ☐ Other _____

Throat
- ☐ Swallowing Difficulty
- ☐ Frequent Sore Throats
- ☐ Speech Problems
- ☐ **NONE**
- ☐ Other _____

Oral
- ☐ Dental Problems
- ☐ Tongue Problems
- ☐ Canker Sores
- ☐ **NONE**
- ☐ Other _____

Neck
- ☐ Swollen Glands
- ☐ Thyroid Problems
- ☐ **NONE**
- ☐ Other _____

Chest
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ **NONE**
- ☐ Other _____

Heart
- ☐ Murmurs
- ☐ Pace Maker
- ☐ Palpitations
- ☐ Valve Problems
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Angina
- ☐ **NONE**
- ☐ Other _____

Intestinal
- ☐ Colitis
- ☐ Ulcer Gastritis
- ☐ Barrett's Esophagus
- ☐ Polyps
- ☐ Constipation
- ☐ **NONE**
- ☐ Other _____

Urinary
- ☐ Urinary Problems
- ☐ Frequency
- ☐ Burning
- ☐ Kidney Stones
- ☐ **NONE**
- ☐ Other _____

GYN
- ☐ Pregnant
- ☐ Breast Feeding
- ☐ Last Menstrual Period _____
- ☐ **NONE**
- ☐ Other _____

Spine
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Scoliosis
- ☐ Herniated Disc
- ☐ Sciatica
- ☐ **NONE**
- ☐ Other _____

Upper Extremity
- ☐ Pain In Arm
- ☐ Carpal Tunnel
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ **NONE**
- ☐ Other _____

Lower Extremity
- ☐ Pain in Legs
- ☐ Pain in Knees
- ☐ Pain in Hips
- ☐ Ankle Pain
- ☐ Tingling
- ☐ **NONE**
- ☐ Other _____

Systemic
- ☐ Weight Loss
- ☐ Fever
- ☐ Night Sweats
- ☐ Trouble Sleeping
- ☐ Loss of Energy
- ☐ Arthritis
- ☐ **NONE**
- ☐ Other _____

Neurological
- ☐ Headache
- ☐ Convulsions / Seizures
- ☐ Fainting
- ☐ ADD
- ☐ Stroke
- ☐ **NONE**
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Stress/Excess Worry
- ☐ Drug / Alcohol Issues
- ☐ **NONE**
- ☐ Other _____

Professional Health Care of Pinellas, Inc.

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated there under, as amended from time to time (collectively) referred to as "HIPAA".

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Professional Health Care of Pinellas, Inc. will not condition treatment, payment, enrollment in a health plan or eligibility for benefits, as applicable, on your providing authorization for the requested use of disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that ***Professional Health Care of Pinellas, Inc.*** may use or disclose your personal health care information to other medical professionals relating to your treatment, payment, or health care options.

Further by signing this authorization you acknowledge that you have been provided a copy of, have read and understand Professional Health Care of Pinellas, Inc.'s "*Notice of Patient Privacy Practices"* containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While, ***Professional Health Care of Pinellas, Inc.*** has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from ***Professional Health Care of Pinellas, Inc.*** at any of its offices, on our website, or by sending a written request with return address to 1839 Central Avenue, St. Petersburg, FL 33713, or 5500 MLK St. N. St. Petersburg, FL 33703 or 8133 54th Avenue N. St. Petersburg, FL 33709, depending on your primary care office. In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your Protected Health Information (PHI) in the designated record set maintained by ***Professional Health Care of Pinellas, Inc.*** for as long as the Protected Health Information (PHI) is maintained in the designated record set.

You have the right to revoke this authorization, in writing; at any time, except to the extent that ***Professional Health Care of Pinellas, Inc.*** has taken action in reliance on it. A revocation is effective upon receipt by ***Professional Health Care of Pinellas, Inc.*** of a written request to revoke and a copy of the executed authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of ***Professional Health Care of Pinellas, Inc.*** or (d) seven years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA. Professional Health Care of Pinellas, Inc. will provide you with a copy of this signed authorization, if requested.

Professional Health Care of Pinellas, Inc.

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Professional Health Care of Pinellas, Inc. originates, maintains paper and electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatments, any plans for future care or treatment and payment for the services or treatments we've provided. We use this information to:

- Plan your care and treatment
- Communicate with other healthcare professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment or healthcare.

To request from other healthcare entities or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies or individual(s) for payment of our services or treatments provided to you.

To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, email or with a household family member.

[ ] Please check here if you do not want us to leave messages on your answering machine.

[ ] Please check here if you do not want us to leave messages with a household family member.

[ ] Please check here if you do not want us to leave messages on your mobile voice mail.

[ ] Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.

To discuss your healthcare or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments. Please list by name and relationship the persons with whom we may share this information:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You have the right to request a copy of our "*Notice of Patient Privacy Practices"* prior to signing this authorization for a more complete description of health information uses and disclosures.
I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print) _____ Date: _____
Signature: _____
Printed Name of Guardian or Representative_____ Date_____
*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ]
RELATIONSHIP_____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____
Acknowledged and agreed to by:

Patient: _____ _____
Signature Printed Name

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse requires specific authorization.

You have the right to request a copy of our "Notice of Patient Privacy Practices" prior to signing this authorization for a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

AUTHORIZATION

I hereby authorize _____
(Physician/Healthcare Facility)
To release information on _____(Patient's Name)
_____(Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:
_____
Name
_____
Address
_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose:

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV, Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____

_____

_____

PHC
OF PINELLAS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initials)
Psychiatric/Mental Health _____ (initials)
Tests for Antibodies to HIV _____ (initials)
Genetic Information _____ (initials)

DURATION

This authorization shall be effective immediately and remain in effect for one year _____.
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of the authorization shall be considered effective and valid as the original.
I have the right to change or revoke this authorization, in writing, at any time.
I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative of patient

Relationship if other than self

_____ _____
Patient's Name (PRINT)

Date

_____ _____
Patient's Social Security Number

Patient's Date of Birth

_____ _____
Witness Name

Witness Signature

CENTRAL OFFICE	MLK OFFICE	5 – TOWNS OFFICE
1839 Central Avenue St. Petersburg, FL 33713 Ph: 727.322.1054 Fax: 727.322.2725	5500 Dr. MLK St. N. St. Petersburg, FL 33703 Ph: 727.525.5500 Fax: 727.522.2574	8133 54TH Ave N. St. Petersburg, FL Ph: 727.541.4458 Fax:727.546.6663