

North Florida Medical Clinic

Patient Registration Information

Patient Information:

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ SSN: _____ Birth Gender: _____
Address: _____
City: _____ State: _____ zip: _____
Primary contact number: _____ (cell, home, work)
Alternate number: _____ (cell, home, work)
Email address: _____
Marital Status: S M W O (circle one) Spouse/partner name: _____
Emergency contact: (Please list friend or relative not living with you):
Name: _____ Phone: _____
Relationship to patient: _____

Insurance Information:

Primary Insurance: _____ ID #: _____
Group #: _____ Phone number: _____
Policy Holder name: _____ D.O.B.: _____
Relationship to patient: _____

Secondary Insurance: _____ ID #: _____
Group #: _____ Phone number: _____
Policy Holder name: _____ D.O.B.: _____
Relationship to patient: _____

Pharmacy:

Name: _____ Phone: _____
Address: _____

Provider List:

Prior Primary Care Provider: _____ Phone: _____

Please list all other providers you currently see and their specialty:

History and Physical

Name: _____ DOB: _____ Date: _____

Occupation: _____ Risk of contact with bodily fluids: Y / N

Drug allergies: _____

Family History (Diagnosis/age when diagnosed/alive or deceased)

Mother: _____

Father: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Sibling (specify): _____

Child (specify): _____

Aunt/Uncle (specify): _____

Medications:

Surgical History (Date): _____

Social history

Tobacco Use (if yes how long?)	
Caffeine(frequency/quantity)	
Alcohol (frequency/quantity)	
Exercise (frequency)	

Women (date of last):

Last menstrual cycle: _____ Previous pregnancy: _____ Last PAP smear: _____

Mammogram: _____ DEXA bone density: _____ Birth control method: _____

Screenings (date of last):

Colonoscopy: _____ Lab work: _____ PSA (if applicable): _____

Pertinent medical history (i.e. high blood pressure, diabetes, high cholesterol) _____

North Florida Medical Clinic
Authorizations and Assignment of Benefits

Payment at Time of Service

_____ It is our office policy that payments are due at the time of service. If we have a contract with your insurance company,
(initial) we will file your insurance. However YOU are responsible for all co-pays, deductibles, and non-covered services at the
(initial) time of visit.

Patient Statement

_____ I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my
(initial) Account. I certify that the information provided on this form is true and correct to the best of my knowledge. I will
(initial) notify North Florida Medical Clinic of any changes in this information. A photocopy or other reproduction of this
(initial) will be valid as the original.

Authorization to Release Information

_____ I hereby authorize North Florida Medical Clinic to furnish my insurance companies, hospitals, referring or consulting
(initial) physicians and billing agents all information with regard to my medical care

Authorization for Assignment of Benefits

_____ I hereby authorize payment directly to North Florida Medical Clinic for medical benefits, if any, otherwise payable to
(initial) me under the terms of my insurance

Office Policy for No Show Appointment

_____ I am aware I will be charged an administrative fee of \$50.00 for any appointment made by or for myself that is not
(initial) cancelled **24 hours prior to the appointment time**

Additional Use of Information

Your health and/or demographic information may be used by our staff to return calls to the patient and communicate with other medical facilities as needed. In addition, our staff will use the following methods to contact you for appt reminders:

Email: _____ It is ok to email this address _____ (initial)

Cell Phone _____ It is ok to text _____ (initial) call _____ (initial) this number for appt reminders

You may leave message regarding my healthcare on the above contact methods _____ (initial)

I authorize the use of audio and/or visual components for all telehealth appointments _____ (initial)

Individual Rights

You have certain rights under the federal privacy standards. They include but are not limited to:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communication concerning your medical condition and treatment
- The right to inspect copies of your protected health information
- The right to receive accounting of how and to whom your protected health information has been disclosed
- The right to be informed of any breach of your protected PHI
- The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. In addition, we also are required to abide by the privacy and practices outlined in this notice.

Date: _____ Patient Name: _____ Signature: _____

North Florida Medical Clinic

PF-100 Notice of Privacy Protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE READ CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to the other healthcare professions for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of North Florida Medical Clinic. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's Public Health Department

Other uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Photograph Consent. I further consent that photographs may be taken of me or parts of my body by my physician or staff and may be modified or retouched by the physician at his discretion. The photographs shall be used for medical records. If it is the opinion of my physician that medical research, education, or science will benefit from their use, the photographs may be published in medical journals or medical books. In the instance that the photographs are published, I shall not be identified by name and reasonable steps shall be taken to preserve patient's identity.

I have read the above fully

Date: _____ Patient Name: _____ Signature: _____

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION UNDER HIPAA RULE 164.508
(You May Refuse to Sign This Authorization)**

I, _____, (hereafter "individual") hereby authorize **NORTH FLORIDA MEDICAL CLINIC**, (hereafter collectively referred to as "you") to use and disclose, in form or format, a copy of records concerning Individual, to:

_____ (hereinafter "recipients") for the purpose of:

I specifically authorize you to use and disclose the following types of super-confidential information (initial where appropriate):

- _____ HIV records (including HIV test results) and sexually transmitted diseases
- _____ Alcohol and substance abuse diagnosis and treatment records
- _____ Psychotherapy records
- _____ Tuberculosis
- _____ All hospital records
- _____ All of the above

I specifically authorize you to use and disclose the following Protected Health Information. Please initial one or more of the following, if applicable:

- _____ Written Medical Records
- _____ X-rays/MRI/CT
- _____ Billing records
- _____ Prescription records
- _____ Other (specify in detail) _____
- _____ All of the above

I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law; that this Authorization remains effective until the following date (_____); the following event (_____); or until you actually receive a signed revocation or until the records retention period required under federal and Florida law has expired, whichever first occurs; that I have been given an opportunity to ask questions; that I have received a copy of the signed Authorization; that I may inspect a copy of my protected health information to be disclosed under this Authorization; that you have not conditioned provision of services to or treatment of me upon receipt of this signed Authorization; and that I may refuse to sign this Authorization.

My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided on this form. If the purpose of this Authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, you reserve the right to deny treatment associated with such research. If the purpose of this Authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed. I understand that I may revoke this Authorization at any time by notifying you in writing, except to extent that action has been taken in reliance on this Authorization; or if this Authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy or the policy itself.

Patient

Date

Kevin Holthaus, M.D.

North Florida Medical Clinic

David Johnson, M.D.

Stacey Williams, MSN, ARPN, FNP-BC

1361 13th Ave South Suite 150

Laura Triola, DNP, APRN, FNP-BC

Jacksonville Beach, FL 32250

Phone: 904-242-7177 Fax: 904-242-7433

Informed Consent Agreement for Treatment with Controlled Substances

I, _____, have been diagnosed with _____.
(please print patient name) (write in condition being treated)

This diagnosis has been confirmed in consultation with _____ (Provider name).

The medication that I have been prescribed for treatment of my condition is _____.

I understand that there may be alternative treatments which include, _____.

The goal of my therapy is to reduce pain to a level that is tolerable and will allow me to improve my day-to-day functions. I understand that daily use of a controlled substance increases certain risks, which include, but are not limited to:

- Addiction, development of tolerance
- Breathing problems and dizziness
- Nausea, vomiting, and constipation
- Impaired judgement, sleepiness and confusion
- Impaired ability to operate machinery or drive motor vehicles
- Allergic reactions, overdose and possible fatal complications

I agree to the following guidelines and understand that if I do not follow these guidelines my treatment may be terminated

1. I will take this medication as prescribed by my provider. I will not vary the dose or interval without authorization from my provider
2. I will submit to initial/random urine/blood tests if requested by my provider to assess compliance
3. I will obtain above narcotic prescription(s) through North Florida Medical Clinic and fill all prescriptions at _____ (pharmacy) * In an acute emergency another provider may prescribe narcotic medications for me. If this occurs I will notify my primary care provider as soon as possible.
4. Due to potential of misuse, I know that I will be unable to obtain early refills or replacement of stolen medications. I also understand, refills will be made only during regular office hours.
5. I agree to see North Florida Medical Clinic for on-going case management and understand that I have to see the provider every 3-6 months, depending on the class of the controlled substance I am on, as long as I am taking the controlled substance medication.
6. I understand that there may be risks of allergic reactions, overdose and fatal complications such as myocardial infarctions and/or death
7. I understand I may have impaired ability to drive and release this office of any liability for my actions and/or responsibility for the safety of others while I am under the influence.

I have discussed the risks, benefits and alternatives to controlled substance treatment with my provider. I've had the opportunity to ask questions and received answers to those questions to my satisfaction

Patient Name: _____ Signature: _____ Date: _____