CONSENT TO TREAT

I, the undersigned, voluntarily give consent to Medical Center Affiliates professional to provide and perform such medical/diagnosis/minor surgical treatment (s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in this office.

_____ _____ ___ / ___ / _____

Patient Printed Name Date Date of Birth

_____

Signature of Patient/Legal Representative

……..

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received/reviewed a copy of Medical Center Affiliates' Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date _____ Initials _____ Reason _____

Authorization and Assignment

I hereby authorize Medical Center Affiliates practice to release any medical information necessary to process all claims for reimbursement on my behalf: I authorize payment to be made directly to Medical Center Affiliates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover insures. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above names entity. I understand that I am financially responsible for all charges if. they are not covered by my insurance. In the event of default, I agree to pay all cost of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative Date

NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

What is HIPAA and how does the Privacy Rule affect you? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to comply with the regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information? Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment and /or that identifies you as an individual.

What is the Notice of Privacy Practice? Our official Notice of Privacy Practice is posted in our reception area and informs our patients about their rights surrounding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained or retained by our practice. We may update our Notice of Privacy Practices at any time. Our Notice of Privacy Practice will be posted in our reception area and you may ask for a copy at any time.

The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information:

- Treatment
- Payment
- Treatment Options
- Health-related benefits and services
- Appointment Reminders
- Health Care Operations
- Disclosures required by law
- Release of information to Family/Friends

The following categories describe unique situation in which we may disclose your individually Identifiable Health Information:

Public Health Risks
Lawsuits and Similar Activities
Organ and Tissue Donation
Military
Worker's Compensation
Research
Health Oversight Committees
Deceased Patients
Serious Threats to Health or Safety
National Security Inmates
Law Enforcement

What are your rights concerning your Individually Identifiable Health Information? You have rights regarding the Individually Identifiable Health Information that we maintain about you. The policies and procedures for the following circumstances are listed in our Notice of Privacy Practices:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

I have read the short notice provided by Physician Care Centers and have been informed of how to obtain more information regarding the practice's Notice of Privacy.

_____ _____
Signature Date

_____ _____
Print Name Date

PATIENT SELF-DETERMINATION QUESTIONNAIRE

YOUR RIGHT TO DECIDE

PATIENT NAME: _____ **DOB** _____

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures

☐ I have made a Living Will

☐ I do NOT have a Living Will

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have NOT designated 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

If you have a living will and/or an assigned health care surrogate, we will gladly make a copy of your documents and place it in your chart.

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____ Phone: _____

Name: _____ Phone: _____

III. Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL": ☐ Check here to indicate that this statement was read.

IV. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

☐ **Yes** ☐ **No**

V. Please print the phone number you want to receive calls about your appointments _____

☐ I am fully aware that a cell phone is not a secure and private line.

Signature Patient/legal Representative: _____ **Date:** _____

PHYSICIAN CARE CENTERS

PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

Name *(Last, First, M.I.):* ☐ M ☐ F			**DOB:**
Address:			**SOC.SEC #:**
City:	**State:**	**Zip Code:**	**Phone: ( )**
Email:			
Employer:		**Employer Phone:**	
Nearest Relative:	**Relationship:**	**Address:**	
City:	**State:**	**Zip Code:**	**Phone :( )**	**Work: ( )**
Date of last physical exam:	**Previous or referring doctor:**		**Phone ( )**

PERSONAL HEALTH HISTORY *(CHECK IF YOU USE OR HAVE ANY OF THE FOLLOWING)*

Medical Equipment:	☐ Cane	☐ Oxygen	☐ Catheter	☐ Walker	Do you use:	
	☐ Wheelchair	☐ Nebulizer			Glasses_____	Hearing Aid_____
Social History of:	☐ Alcohol		☐ Other			
	☐ Smoking					
	☐ Drugs		RELIGION:			
Marital Status:	Married ☐	Widowed ☐	Single ☐	Divorced ☐	Separated ☐	Live Alone ☐
Immunizations and dates:	☐ Tetanus		☐ Pneumonia			
	☐ Hepatitis		☐ Chickenpox			
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*			

FAMILY HISTORY	ALIVE	DEAD	AGE	CAUSE OF DEATH
MOTHER				
FATHER				
BROTHER				
SISTER				

CHECK IF YOU HAVE/HAD ANY OF THE FOLLOWING ILLNESSESS. (*IF UNSURE, LEAVE BLANK*)

	Yes	No	Any Relative		Yes	No	Any Relative		Yes	No	Any Relative
Alcohol Overuse				Epilepsy				Radiation Treatment			
Allergies				Frequent Kidney/Bladder Infections				Rheumatic Fever			
Anemia				Gallbladder Disease				Sexually Transmitted D.			
Arthritis				Goiter				Sickle Cell Anemia			
Asthma				Gout				Stomach Ulcers			
Bleeding Tendency				Hay Fever				Stroke			
Cancer				Heart Attack				Suicide Attempt			
Chicken Pox				Intestinal Polyps				Thyroid			
Colitis				Jaundice				Tuberculosis			
Congenital Heart Disease				Leukemia				Whooping Cough			
Depression				Measles				Other			
Diabetes				Migraine							
Dialysis				Mumps							
Emphysema				Nervous Breakdown							

OPERATIONS: *List and indicate approximate year*		
Year	Reason	
HOSPITALIZATIONS: *Other than operations, especially in the last year*		
Year	Reason	
SERIOUS INJURIES: *Other than above*		

MEDICATIONS: (*Check if take any of the following)*					
Asthma wheezing medication	☐	Insulin or Diabetic pills	☐	Weight-reducing pills	☐
Aspirin, Bufferin, Anacin, Tylenol or other	☐	Anemia medicine	☐	Blood thinners or Coumadin	☐
Blood Pressure Pills	☐	Laxatives	☐	Dilantin	☐
Cortisone, Prednisone	☐	Motrin, Advil, Ibuprofen	☐	Diuretics, water pills	☐
Cough Medicine	☐	Sleeping Pills, Tranquilizer	☐	Antibiotics	☐
Digitalis or Heart Medicine	☐	Thyroid Medicine	☐	Phenobarbital/barbiturates	☐
Hormones	☐	Stomach/Digestive Medicine	☐	Vitamins	☐

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

PHYSICIAN CARE CENTERS

Patient Name: **DATE**:

REVIEW OF SYSTEMS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
General	Do you usually fell persistently tired or worn out?	☐ Yes	☐ No
	Have you recently been drinking more water or fluids?	☐ Yes	☐ No
	Has there been any unusual weight gain or loss recently?	☐ Yes	☐ No
Cardiovascular	Do you have pain, tightness or pressure in the front or back of your chest?	☐ Yes	☐ No
	Do you have any swelling of your feet or ankles?	☐ Yes	☐ No
	Have you been told your electrocardiogram was abnormal?	☐ Yes	☐ No
	Does your heart ever beat fast or irregularly?	☐ Yes	☐ No
	Do you have cramps in the calf muscles when you walk?	☐ Yes	☐ No
	Do your fingers or toes ever get cold, become numb, or get very white or bluish?	☐ Yes	☐ No
Central Nervous System	Do you have frequent or severe headaches?	☐ Yes	☐ No
	Do you often have spells of dizziness, faintness or hotheadedness?	☐ Yes	☐ No
	Do you sometimes lose the ability to speak?	☐ Yes	☐ No
	Have you recently fainted, blacked out, lost consciousness?	☐ Yes	☐ No
	Do you have trouble remembering recent events?	☐ Yes	☐ No
	Do you ever have convulsions or fits?	☐ Yes	☐ No
	Have you ever wanted to commit suicide?	☐ Yes	☐ No
	Do you ever hear voices or see people when no one is around?	☐ Yes	☐ No
EYES	Have you had any pain in your eyes?	☐ Yes	☐ No
	Have you had Glaucoma?	☐ Yes	☐ No
	Have you had blurry vision?	☐ Yes	☐ No
	Have you had halo around lights?	☐ Yes	☐ No
	Have you had change in vision?	☐ Yes	☐ No
	Have you had cataracts or implants?	☐ Yes	☐ No
	Do you wear glasses?	☐ Yes	☐ No
	When did you last see an eye doctor?		
ENT	Do you have any trouble hearing?	☐ Yes	☐ No
	Any trouble ringing or buzzing in your ears?	☐ Yes	☐ No
	Do you have earaches or discharge from your ears?	☐ Yes	☐ No
	Do you have frequent or severe nose bleeds?	☐ Yes	☐ No
	Do you have persistent hoarseness?	☐ Yes	☐ No
	Do you have bleeding gums?	☐ Yes	☐ No
	Do you use a hearing aid?	☐ Yes	☐ No

Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Have you ever had a blood transfusion?	☐ Yes	☐ No

Authorization to Release Information

Patient Name: _____ DOB: _____ Phone: _____

Address:_____

I Authorize copies of my Medical Records to be released as stated below:

RELEASE RECORDS FROM:	RELEASE RECORDS TO: **PCC MEDICAL HOLDINGS**
Doctor/Office:	PCC Location:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone:	Phone:
Fax:	Fax:

A.) I authorize release of information for:

_____ Medical Care *(physicians, etc.)* _____ Personal Use _____ Other: *(Attorney, Insurance, Employer, etc.)*

B.) I authorize release of my *(refer to **section C**, if applicable)* _____ Entire Medical Record

-OR-

Medical Records for the specific treatment dates from: _____ to _____

C.) I authorize release of the following **additional** portions of my medical record:
***(initial** beside each area to also be included in release)*

_____ Mental Health _____ Substance Abuse _____ HIV/AIDS _____ Communicable Disease

I understand that this authorization shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

Should my case require review by a governing agency or another medical professional actively involved _in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical professional for review.

_____ _____
Patient/legal representative Date

_____ _____
Relationship to Patient Witness Date

NOTICE: The information has been disclosed to you from records whose confidentiality bas been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization is NOT sufficient for this purpose.

PHYSICIAN CARE CENTERS

Billing Demographics Sheet

Location: _____ Physician: _____

Patient Name: _____ Date:_____

Date of Birth: _____ Social Security #: _____

Home Street Address:_____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Marital Status: ____ Single ____ Married ____ Widow ____ Divorced

Employer _____ Work Phone _____

Emergency Contact - *(Not Living With You)*

Name: _____ Phone: _____

Relationship: _____

Insurance Information

Primary Insurance: _____ Phone: _____

Mailing Address:_____

ID Number: _____ Policy Number: _____

Subscribers Name: _____ Group Number: _____

Date of Birth: _____Social Security:_____

Employer: _____

Secondary Insurance: _____ Phone: _____

Mailing Address: _____

ID Number: _____ Policy Number: _____

Signature of Patient or Responsible Party for Payment: _____

Print Name of Patient or Responsible Party for Payment: _____

Office Use:

ATTACH A COPY OF THE FRONT AND BACK OF ALL INSURANCE & IDENTIFICATION CARDS