Tampa
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Tampa, Florida 33625
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New Patient Registration Form

Today's Date		**Please Print**

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)					Name Normally Used (Nickname)
Address	Apt. No.	City	State	Zip	
E-mail	Home Phone	Work Phone	Cell Phone		
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No.	State Issued
Employer Name	Employer City	Employer State	How Did You Hear About Us?		

List anyone you authorize this office to share your medical information with (name and relationship to you)

Name _____ Relationship _____

Name _____ Relationship _____

permitted Contact Method (s) Circle ALL that Apply	it is ok to leave message on answering machine or voicemail?
☐Home ☐Cell ☐Work Phone ☐Email ☐Mail	☐Yes ☐No

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name (if patient a child) Name _____ DOB _____	Policy Holder's Social Security No.	
Secondary Insurance Company Name	Group No.	Insurance No.

Emergency Information

Person to notify in case of an Emergency

1. _____ Relationship to patient: _____Cell Phone: _____
2. _____ Relationship to patient: _____Cell Phone:_____
3. _____ Relationship to patient: _____Cell Phone:_____

Patient Medical History Form

Name: _____ DOB _____

PHYSICIAN (S) you were seeing previously _____ _____ _____

Other SPECIALISTS you currently see:

_____

_____

MEDICAL PROBLEMS (including present conditions):

_____

_____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take:

_____

_____

ALLERGIES TO MEDICATIONS (including reaction):

_____

_____

LIST SURGERIES YOU HAVE HAD (include year, surgeon, and hospital):

_____

_____

DESCRIBE HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital):

_____

_____

Have you had (Check the ones you have or had):

☐Migraines	☐Head injury	☐Memory trouble	☐Mental illness	☐Depression	☐Syncope
☐Vision Problems	☐Glaucoma	☐Sinus Problems	☐Dizziness	☐Haring Problems	☐Inner Ear Problems
☐Throat Problems	☐Gum Problems	☐Dental Problems	☐Endocrine Problems	☐Heart Problems	☐Hypertension
☐Gastritis	☐Gastric Ulcers	☐Esophageal Ulcers	☐Hemorrhoids	☐Abdominal Bloating	☐GI Bleed
☐Peripheral Vascular Disease	☐Blood Clots	☐Bleeding Problems	☐Lung Problems	☐Neuropathy	☐Seizures
☐Numbness on Extremities	☐Tingling on Extremities	☐Musculoskeletal conditions	☐Arthritis	☐History of Fractures	☐Bone Disease
☐Skin Problems	☐Kidney Stones	☐Gallbladder Stones	☐Hx of STD's	☐Bell Palsy	☐Shingles
☐Street Drug Addiction	☐Medication Drug Abuse	☐Alcoholism	☐Sexual abuse	☐Physical abuse	☐Joints Pain
Others:	Others:	Others:	Others:	Others:	Others:

Patient Medical History Form

Ethnicity (circle): Hispanic or Non-Hispanic Race:_____ Preferred Language(s):_____

Do you have a Living Will? ☐Yes ☐No If not, are you interested in having one? ☐Yes ☐No

Do/did you SMOKE? ☐**Yes** ☐**No** How much?_____packs/day # of years_____ Year you QUIT _____

When was the last time you tried to quit?_____ How many times have you tried to quit? _____

How have you been successful in quitting in the past? _____

Do/did you DRINK alcohol?_____ How much?_____ Drinks/week # of years _____

Year you QUIT_____ Previous or current problem with alcohol? _____ AA? _____

Do you or have you used (circle): heroin marijuana cocaine methamphetamine chewing tobacco diet pills

Do you have a history of prescription drug abuse or addiction? _____ If yes, which one(s)? _____

WOMEN Date of last normal period_____ # of pregnancies _____

Age at first period _____

# of live births_____ # of children living with you_____ # abortions/miscarriages _____

Problems with pregnancies (circle) pre-term labor toxemia diabetes high blood pressure other: _____

Birth control method _____

Date of last Pap_____ Result?_____ Done where? _____

Date of last mammogram_____ Result?_____ Done where? _____

Dou you have or had any bellow: (Check)

❒ Irregular Periods	❒ Severe Menstrual Cramps	❒ Heavy Periods	❒ Abnormal Mammogram	❒ Abnormal Pap Smear	❒ Breast Pain All the Time
❒ Pelvic pain	❒ Infertility	❒ Decreased Sexual Desire	❒ Painful Intercourse	❒ Vaginal Dryness	❒ Breast Discharge
❒ Vaginal Discharge	❒ Vaginal Odor	❒ Vaginal Itching	❒ Hot Flashes	❒ PMS	❒ Breast Lumps

Patient Medical History Form

ALL

Who in your *family* has/had (circle if cause of death and write age of death)?

Heart disease_____ genetic disorder_____ Diabetes_____

cancer (what type?) _____Thyroid disease_____alcoholism_____

Mental illness _____arthritis _____ Glaucoma _____asthma Allergies _____

stomach problems _____ Tuberculosis_____high blood pressure_____

Lung disease _____

List any other diseases that run in your family and specify your relationship to each family member listed.

_____
_____
_____

When was your last?

Tetanus shot _____ Flu shot_____ Pneumonia vaccine_____ Hepatitis vaccine_____

TB test_____ Colonoscopy_____ Chest x-ray_____ EKG_____

Who lives with you? _____

Do you have any children?_____ If yes, list their names, ages, and any major medical problems

_____

_____

_____

Where do/did you work? (Company Name and State) _____

What is or was your occupation? _____

What is the last grade in school you finished? _____

Anything else you would like us to know?

_____

Authorization to Release Medical Information

1. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ Lab Reports ☐ All Progress Notes ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records
☐ All Medication History
☐ Other: _____

SPECIAL AUTHORIZATION: Check applicable box (es) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature:_____Date: _____

2. **RECORDS FROM THE TIME PERIOD:** / / through / /

3. **PURPOSE OF DISCLOSURE: (**Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐Legal
☐ Personal ☐Workers' Compensation Claim ☐ Other: _____

4. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

5. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

6. The requestor may be provided with a copy of this authorization.

Patient/Guardian Name: _____ D/O/B: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Patient/Guardian Signature: _____ Date: _____

Patient Financial Responsibility

* As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill, please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your co-operation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Pinnacle Family Medicine offers a 50% discount for uninsured patients and this is payment is required at the time service is rendered.

If an account is not paid in full within 90 days, a **25% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a **$35.00 service fee** in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Pinnacle Family Medicine also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current **no-show fee is $45.00 for Medical Appointment and $100 for Diagnostic Appointments** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient Rights Regarding Medical Records**
- **Patient Financial Responsibility including collections, no-show policy**
- **Confidentiality and Privacy of Medical Records**

Patient Signature

Date

Scheduled Appointment Agreement

Your health care is important. WE ARE NOT AWARE of how your insurance company determines which services/labs are paid and which services/labs are not paid, or which are subject to coinsurance or deductible. Some pay only for illness codes, and some only for prevention codes, and some do not pay for a myriad of other factors. Our responsibility to the patient is to provide care and order labs based on your individual medical needs and current prevention guidelines and the standard of medical care. There are no medical guidelines to support "routine labs" ordered without a medical evaluation whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about coverage. There are many plans and their benefits change often we have no way of knowing what is current for you.

You may schedule an appointment as a WELL EXAM, PREVENTIVE CARE or ROUTINE EXAM. It will be billed as such to your insurance plan. Due to coding laws, we MUST bill your exam as Preventive Care. If during your visit you have ADDITIONAL CONCERNS or PROBLEMS that require a diagnosis and/or other treatment it would be considered a Problem Oriented Exam and you may incur additional office or lab charges. These charges and any from your Preventive Care Exam will be billed to your insurance company. You may want to keep your Well Exam separate from your Problem-Oriented Exam and we would be happy to schedule it that way for you.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate is "patient responsibility". Please DO NOT ASK US TO RE-BILL your insurance by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.

Laboratory services are provided by (LabCorp), Quest Laboratories, Property and/or Medical Diagnostic Laboratories and have no direct financial or other affiliation with **Horizon Multi-Specialty Clinic**. This means the laboratory work done is billed entirely by those individual companies. The services and billing remain the same regardless of whether you had those laboratory services done at Pinnacle Family Medicine or at an outside laboratory. The laboratory service, therefore, is offered as a convenience to our patients. If a billing question about laboratory service occurs, it is the responsibility of the patient to direct those questions to the laboratory billing department and please note that we will not change codes after the service is obtained.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility".

_____
Printed Name

_____
Signature

_____
Date

Patient Rights Regarding Medical Records

***All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms which will be provided upon request. All changes to preferred forms of communication must also be made in writing.**

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.

Right to Amend: If you believe that health information, we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care, we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any staff member.

Changes to This Notice

We reserve the right to change this notice and apply it to any past, present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy of our most current notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. You have the right to revoke this permission for any health information that has not yet been

Confidential and Privacy Medical Records Patient's Right

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information
The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI
The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

Patient/Guardian Signature _____ Date _____