Patient Registration Form

Date: ____ /____ /________ Marital Status: Single Married Divorced Separated Widowed

Last Name: ______________________________ First Name: _________________________ M.I.: _________

Maiden Name: ___________________________ Birth Date: ____ /____ /_______ Age: _________

Male Female Social Security Number: ____

Street Address: ____

City: ____________________________________ State: ________________ Zip Code: _________________

Home Phone: (______) ________ - ___________ Cell Phone: (______) ________ - ___________

Work Phone: (______) ________ - ___________ Email: _____________________@__________________

Referred by: ____

Ethnicity: (please select) Hispanic/Latino Not Hispanic/Latino Decline

Race: (please select) White Hispanic Black/African American American Indian/Alaskan Native

Asian Native Hawaiian/Pacific Islander **Preferred Language:** ____________________________

Preferred Local Pharmacy: ____

Mail Away Pharmacy: ____

ALL INSURANCE AND SELF PAY PATIENTS: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT'S ACCOUNT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS PAYMENTS; HOWEVER, IF INSURANCE IS DENIED OR INSURANCE INFORMATION IS NOT RECEIVED AT THE TIME OF SERVICE, THE PATIENT/GUARDIAN IS RESPONSIBLE FOR ALL APPLICABLE FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO-PAY CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADANCE WITH OUR OFFICE MANAGER.

If visit is to be submitted to an insurance company, please read and initial the following: I request that payment of authorized Medicare/or other Insurance Carrier of benefits be made either to me or on my behalf to Treasure Coast Primary Care for any services furnished to me by that party. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of medical or other information about me, to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical Insurance benefits to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S. C3801-3212 provides penalties for withholding this information).

Insurance Information

(Please make sure that the front desk has scanned in a copy of your photo ID and insurance card)

Subscriber's Name: ___________________________________ Date of Birth: ____ /____ /________

Relationship to patient: ____________________________ Phone Number: (______) _______-__________

Please indicate primary insurance: ____

Please list secondary insurance if applicable: ____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance that is left over. I also authorize Treasure Coast Primary Care to release any information required to process my claims.

Patient Signature: _______________________________________ Date: ______________________

Guardian Signature: ______________________________________ Date: ______________________

Welcome to our practice today. Please let our front desk know if you have had a name, phone number, or address change since your last visit. We can also print a list of your medications to review before going into the exam room. This can help prepare you for any refills that you might need today.

Are you here for your annual well visit today? YES NO

(please see the bottom of this page for more information on wellness exams)

If you chose yes, please know that most insurances cover one well physical per year, at no cost to you. If you are sick or are having pain of any kind, please let the front desk know and we can change today to a sick visit. We can take care of this for you today and reschedule your well exam to a later date. Please note that your sick visit may add a copay charge for today, according to your insurance policy.

Have you had any testing done since your last visit, such as bloodwork, X-rays, Ultrasound, Colonoscopy?

YES NO

Please let us know when and where you had the testing and fill out a medical release form, if necessary:

____

Have you been to the hospital since your last visit here? YES NO

If you were at a hospital other than Martin Memorial, please sign a medical release form for us.

Did you bring any forms with you today that need to be filled out by the provider? YES NO

If so, please give them to the front desk, so that they can be reviewed by the provider, prior to your visit.

Do you require a work or school absence note for your visit today? YES NO

If you have any of the following, please give them to the nurse so that she can scan them into your chart and return the originals to you:

Blood Pressure Log Blood Glucose Log

Medical Records *(test results or visit notes from other providers)*

****A wellness exam is defined as a preventative exam. Insurance companies prevent us from billing a wellness and a diagnostic visit on the same day. This is for your protection as your insurance carrier may deny one of these visits and forward the financial responsibility to you. This does not prevent you from requesting refills of any maintenance medications; however, we ask that you please schedule a separate appointment, on a different day, if you have any new concerns or other ongoing health problems that need more attention. Should your wellness exam turn into a diagnostic or problem-oriented visit, we may bill accordingly and reschedule your wellness visit****

Name: ______________________ Signature: ________________________ Date: __________

New Patient Medical History Form

First Name: ________________________ Last Name: _________________ Date of Birth: ____/____/______

Reason for today's visit:

____

____

Allergies: PENICILLIN SULFA ASPIRIN IBUPROFEN IODINE Others:

____

____

Current Medications:

Name	**Dosage**	**How many do you take & how many times per day**
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____
_____________________	___________	____

Past Medical History: (Please mark any conditions that you have had or have)

Abnormal EKG	Anemia	Asthma	Breast Lump
Cancer: ___________	Coronary Artery Disease	Depression	Diabetes Type I or II
High Cholesterol	Emphysema	Heart Attack	Hepatitis (type: _______)
High Blood Pressure	Hyperthyroidism	Hypothyroidism	Kidney Disease or Stones
Mental Illness	Migraines	Osteoarthritis	Osteoporosis
Seizures	Stomach Ulcer	Stroke	Tuberculosis

Please list any others or clarification of anything circled above:

____
____
____

Surgical History:

Have you ever had surgery? YES NO

If yes, please list the surgery and the date below. If you are not sure of the date, please give approximation.

Date **Surgery**

____
____
____
____
____
____
____
____

Family History:

If any of your close family members (grandparents, parents, siblings, children, aunts, and uncles) have had any of the conditions listed below. **Please be sure to list if the member is paternal or maternal when necessary**.

Cancer (list type, if known): ____

Diabetes (list type, if known): ____

Heart Disease/High Blood Pressure: ____

Stroke: ____

Thyroid Disease: ____

Mental Health History: ____

Health Habits:

Smoking

Have you ever smoked? Never Former Current

If yes, how many years have you smoked or did you smoke? __________ If you did quit, what year? _______

Former or current smokers, please answer the amount: ______________ packs per day

Caffeine

Do you drink caffeinated beverages? YES NO Decaffeinated Only

Coffee: How many on average per day __________ week __________

Tea: How many on average per day __________ week __________

Soda: How many on average per day __________ week __________

Alcohol

Do you drink alcoholic beverages? YES NO Former Alcoholic

If yes, what beverage do you typically drink? _____________________________

How many on average per day __________ or week __________ or month __________

Exercise

Never 1 x week 2-3 x week 4-5 x weekDaily

Preferred exercise routine: ____

Substance Abuse

Do you have any history of substance abuse? YES NO

If yes, please list the substance(s): ____

Mental Health

Do you have any history of mental illness? YES NO

If yes, please list the illness(s): ____

Communicable Disease

Do you have any history of communicable diseases? YES NO

(this would include STD's, hepatitis, tuberculosis, etc…) If yes, please list the disease(s) below:

____

Patient Signature: ____Date: ____________________

TREASURE COAST Primary Care

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PREVENTATIVE MEDICAL QUESTIONNAIRE

PATIENT AUTHORIZATION AND NOTICE

____ ____________

Patient Name Date of Birth

ANSWER THE QUESTIONS AS ACCURATELY AS POSSIBLE
Please help us keep your chart up to date by letting us know which of the following you have had and the dates. If you are not sure of the date, please give an estimate. **If a question is not clear, please ask one of our staff to explain it.**

MEDICAL EXAMS/TESTS:

Colonoscopy	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Endoscopy	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Exercise Stress Test	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Nuclear Stress Test	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Stress Echo	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Echocardiogram	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Carotid Doppler	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Aortic Ultrasound	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Bone Density Scan	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Mammogram	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Pap Smear	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Sleep Study	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Chest X-ray	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Dental Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Eye Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Dermatology Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Urology Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
EKG	☐ YES	☐ NO			DATE: __________
Flu Shot	☐ YES	☐ NO			DATE: __________
Pneumonia Shot	☐ YES	☐ NO			DATE: __________
Tetanus Shot	☐ YES	☐ NO			DATE: __________
Shingles Vaccine	☐ YES	☐ NO			DATE: __________

HIPAA Medical Release Form

Health Insurance Portability and Accountability Act – Privacy Form

ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES & PERMISSION TO SHARE HEALTH INFORMATION

____

Patient Name (please print)

I understand that my medical records are protected by federal law and that the information can only be released as per the Health Information Privacy and Portability Act. *(A copy is available upon request at the front desk)*

☐ All Forms ☐ Electronic copy or web-based portal ONLY ☐ Hard Copy ONLY

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize **Treasure Coast Primary Care** to disclose my protected health information to the following individual(s):

Name	Email	Phone/Fax
__________	__________	__________
__________	__________	__________

I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTIFICATION OF PHYSICIANS

I hereby authorize **Treasure Coast Primary Care** to disclose my protected health information to the following physician(s):

Physician Name or Practice	Email	Phone/Fax
__________	__________	__________
__________	__________	__________

I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTICE OF VOICEMAIL AND MESSAGES

Voice messages may be left on the phone number(s) provided: ☐ YES ☐ NO

This includes lab results, medications or any other pertinent information about your health care and health records.

RESTRICTIONS ON THE USE & DISCLOSURE OF YOUR HEALTH INFORMATION

I understand that I may request certain restrictions on the use and disclosure of my health information.

I REQUEST THE FOLLOWING RESTRICTIONS:

☐ Mental Health Records

☐ Communicable diseases including, but not limited to, HIV/AIDS, Alcohol/Drug abuse, Genetic information

☐ Other (Specify) ____

____________________________________ ____________________

Signature of Patient Date

I understand that I can revoke this authorization to share my health data at any time by submitting a request in writing to: ***TREASURE COAST PRIMARY CARE***

TREASURE COAST
Primary Care

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POLICIES & TERMS

AKNOWLEDGMENT OF RECEIPT OF FINANCIAL & OFFICE POLICIES

PATIENT AUTHORIZATION AND NOTICE

APPOINTMENTS: ***(including ultrasounds/stress tests)***
I have read and understand that Treasure Coast Primary Care requires a **cancellation notice at least 24 hours in advance** when I'm unable to keep an appointment. If a cancellation notice is not provided at least 24 hours prior to my appointment time or I DO NOT SHOW, I am aware there is **A $50.00 FEE** per occurrence. I also am aware if I incur this fee, it must be paid in full prior to being seen at my next appointment. If you are more than **15 minutes late** for your appointment, you will be considered a no show and will have to reschedule your appointment. Broken appointments prevent others from receiving medical care.
New patients who do not show for their first appointment may not be rescheduled. Multiple cancellations or missed appointments in any 12 month period will result in dismissal from the practice. **(*Initial*_______)**

PHONE CALLS:
We will make every effort to return your call as soon as possible. Phone calls received after to 2:00p.m. will be returned the following business day. **(*Initial*_______)**

MEDICATION REFILLS:
We recommend that you keep a two (2) week supply of all medications on hand at all times. Please call our office and request a refill when you have one (1) weeks supply left, as it may take up to three (3) business days to process the request. This is especially important during hurricane season and around the holidays. **(*Initial*_______)**

OFFICE HOURS:
Primary Care hours are 8:00am to 5pm Monday thru Friday and Saturday 9:00am to 1:00pm. Our Urgent Care locations are available Monday thru Friday from 8:00am to 6:00pm and 8:00am to 2:00pm Saturday and Sunday. **(*Initial*_______)**

REFERRALS:
We encourage you to be aware of your insurance policy. If you have a HMO or PPO plan that requires referrals, we remind you that ALL non-emergent referrals can take 5-7 business days to process. We are unable to authorize any referral without evaluation for a problem. Please do not call and request referrals by phone. **(*Initial*_______)**

LAB AND X-RAY RESULTS POLICY:
We call our patients regarding every lab or x-ray result. If you have not heard from us by a week from the date of your lab test or x-ray, please give us a call. **(*Initial*_______)**

It is our pleasure to serve you. Your comments and suggestions are welcome.

____ ____

Patient Name (print) Patient Signature

TREASURE COAST
Primary Care

Medical Records Custodian Office
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www.**tcprimarycare.com** | Secure Fax: **772-403-2379**

MEDICAL RECORDS RELEASE

The following patient requested that their records be released as listed below.

RE: PATIENT: ______________________________ DOB: ______ / ______ / ________

SSN: ____________________ DATES NEEDED: ______________________________ ☐ ALL

RELEASE RECORDS FROM: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________ FAX: ____________________

RELEASE RECORDS TO: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________ FAX: ____________________

Health Information to be disclosed upon the request of the person named above.

☐ **Disclose my complete health record**
(Including but not limited to diagnoses, lab tests, prognosis, treatment and billing for ALL conditions)

☐ **Disclose my health record as above <u>BUT DO NOT INCLUDE</u>**

- ☐ Mental Health ☐ Alcohol/Drug Treatment
- ☐ Communicable Diseases (including HIV & AIDS)
- ☐ Other (please specify) ______________________________

FOR THE PURPOSE OF CONTINUITY OF CARE UNLESS OTHERWISE NOTED: ____________________

Pursuant to Florida Law, the records may be used only for the purpose provided and to whom requested. Any information may not be disclosed to any other person without the specific written consent of the undersigned. Changes are in compliance with Florida Law. I understand I may revoke this consent at any time before the information has been released.

______________________________ ____________________
Name of the Individual Giving this Authorization (print) Date of Birth

______________________________ ____________________
Signature of the Individual Giving this Authorization Date

Witness: ______________________________ Date: ____________________

TREASURE COAST
Primary Care

PATIENT PORTAL AUTHORIZATION

Authorization to disclose health information via electronic transmission

Patient Name: ____

E-mail: ____

Date of Birth: ___________ / ___________ / ______________

By signing this form, I authorize **Treasure Coast Primary Care / Treasure Coast Urgent Care** to communicate via a personal, secured access Patient Portal with me for my medical care and treatment. Treasure Coast Urgent Care will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers of Treasure Urgent Care as a result of the communications:

- **My Personal Health Information**
- **Electronic Displays of Radiological Images (X-rays)**
- **Laboratory Test Results / Pathology Reports**
- **Other Diagnostic Testing**

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this authorization.

- Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- Portal Messages received by us can be forwarded, printed and/or read, and stored by our staff members.
- We advise caution when communicating highly sensitive or personal information via Portal messages.*(i.e. HIV status, mental illness, chemical dependency, and workers compensation issues)*
- Clinically relevant messages and responses will be documented in your medical record. Treasure Coast Urgent Care will not be liable for information lost or misdirected due to technical errors or failures.
- Treasure Coast Urgent Care does not own or have any interest in the Portal website. Our EMR software provides the Portal as a secure conduit in which communication with our data base is managed.
- I understand that I may revoke this authorization at any time in writing to Treasure Coast Urgent Care.
- I understand that if I revoke this authorization, it will not apply to any information already released.

I understand that I may refuse to sign this authorization and understand that Treasure Coast Urgent Care cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

____   _________________________

Patient or legal guardian signature   Date

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PATIENT PORTAL PROCESS/INFORMATION

INFORMATION

At **Treasure Coast Primary Care** we offer HIPAA compliant electronic access to your patient record. This is a convenient way for you to have quick and anytime access to your medical care and treatment you receive at the clinic. This secure portal is offered to you through EMD's, the electronic health record program that is used by **Treasure Coast Primary Care**.

First, you will need to sign a portal authorization form
This is available via our website at www.tcprimarycare.com under Resources >Patient Forms. Under the tab 'Portal Authorization' click on the form to fill out in Google Chrome or other PDF viewer. You may also obtain a copy in any of our office locations.

Second, you will be emailed a registration link
Follow the directions in the email to complete the registration process. You can yuse your email address as your user name and create a password of your choice. We recommend 6-8 characters and the use of at least one capital and number.

Once completed, you will have HIPAA compliant access to your health history including medication history, secure email directly with your provider and you'll be able to request copies of your labs, make appointments, and order some medication refills. **Please treat this login information as you would any confidential login.**

TYPES OF COMMUNICATION AVAILABLE TO YOU VIA THE PORTAL:

- Send/receive messages to/from clinic staff including directly to/from your provider
- Receive lab or diagnostic test results
- Request a physician referral
- Request an appointment
- Request a refill of your medication(s)
- You can also view/update your current medication list, demographic information, and login information

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Authorization for Credit Card Use

All information will remain confidential.
You must contact us to change/cancel this authorization.

Name on Card: ____

Billing Address: ____

____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx

Credit Card Number: ____

Expiration Date: ____

Card Identification Number (CVC): __________ (last 3 digits located on the back of the credit card)

No Show Appointments Fee: $ 50.00 (USD)

Virtual Visits (Tele-Medicine) Appointment Fee: $ 40.00 (USD)

I authorize **TREASURE COAST PRIMARY CARE** to charge the credit card listed above for all Virtual Visit Fees (Tele-Medicine) that I schedule with a Provider and NO SHOW fees for any virtual or in-office visit for which I fail to show or fail to give at least 24hrs advance notice. I agree to pay for the purchase(s) in accordance with the issuing bank cardholder agreement.

Cardholder Authorization – Please Sign and Date

Signature: ____

Date: ____

Print Name: ____