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 Employee Wellness, P.A. 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: _____

MEDICAL HISTORY

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:

<u>Smoking</u>

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: _____

EMPLOYEE WELLNESS, P.A.
Michele F. Libman, M.D. | Kristin Washington, APRN - DNP

1050 SE Monterey Rd. Suite 101 Stuart, FL 34994 | p. **772-872-7304** | f. **772-872-7305**

ACKNOWLEDGEMENT OF RECEIPT OF
Notice of Privacy Practices & Consent for Contact Form

I have received a copy of the Employee Wellness Notice of Privacy Practices**:** ☐ **YES** ☐ **NO**

If we attempt to contact you and do not reach you, please indicate if and where we may leave a message:

Home Phone: (_____) _____

Cell Phone: (_____) _____

Work Phone: (_____) _____

E-mail: _____@_____

Other: _____

☐ **Patient portal** *(must sign patient portal authorization)*

☐ **NEVER** leave any medical information for me; simply ask me to call back

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It is ok to discuss medical information regarding me with:

My husband/wife/partner: _____
Print Name, Relationship

My power of Attorney: _____
Print Name, Relationship

Other: _____
Print Name, Relationship

_____
Patient Name (print)

_____ _____
Patient Signature Date

EMPLOYEE WELLNESS, P.A.
Michele F. Libman, M.D. | Kristin Washington, ARNP - DNP

1050 SE Monterey Rd. Suite 101 Stuart, FL 34994 | p. **772-872-7304** | f. **772-872-7305**

Notice of Privacy Practices

Our Duties As They Relate to Your Protected Health Information (PHI)

Our records about you contain health information that is very personal. The confidentiality of this personal information is protected by federal and state law. We have a duty to safeguard your Protected Health Information (PHI) which includes individually identifiable information about:

Your past, present, or future health or condition
Provision of health care to you
Payment for the health care considered PHI

We are required to:
Safeguard the privacy of your PHI,
Give you this Notice which describes our privacy practices,
Explain how, when and why we may use or disclose your PHI

Except in very specific circumstances, we must use or disclose only the minimum PHI that is necessary to accomplish the reason for the use or disclosure.

We must follow the privacy practices described in this Notice; however, we reserve the right to change the terms of this Notice at any time and to make the new Notice provisions effective for all protected health information that we receive, disclose or maintain. Should our Notice change, we will post a new Notice at this location, and you may request a copy of the new Notice. You may also obtain a copy from the Employee Wellness, P.A. website: www.employeewell.com

Why We May Need to Use or Disclose Your PHI:

We use or disclose PHI for a variety of reasons. For some of these uses or disclosures, we must have your written authorization. For some, the law permits us to make some uses or disclosures without your authorization. Generally these uses or disclosures are related to treatment, payment, or health care operations.
Some examples of these uses or disclosures are:

For Treatment: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team.

To Obtain Payment: We may use or disclose your PHI in order to bill and collect payment for your health care services.

For Health Care Operations: We may use or disclose your PHI in the course of operating Employee Wellness, P.A. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.

To Remind You of Appointments: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

Uses and Disclosures For Which We Require Your Authorization (consent):

When the use or disclosure goes beyond treatment, payment, or health care operations, we are required to have your written authorization. There are some exceptions to this rule, and they are listed below.

Authorizations can be revoked by you at any time to stop future uses or disclosures, except where we have already used or disclosed your PHI in reliance upon your authorization.

Uses and Disclosures For Which We Do Not Require Your Authorization:

The law permits us to use or disclose your PHI *without written authorization* in the following circumstances:

When a Law Requires Disclosure: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or in response to a court order, or to a law enforcement official. We must also disclose PHI to authorities who monitor our compliance with these privacy requirements.

For Public Health Activities: We may disclose PHI when we are required to collect information about diseases or injuries, or to report vital statistics to a public health authority.

For health oversight activities: We may disclose PHI for health oversight activities such as audits; inspections; civil or criminal investigations or actions.

Relating to decedents: We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors.

For organ, eye or tissue donations purposes: We may disclose PHI to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

For research purposes: In certain circumstances, and under supervision of a privacy board or institutional review board, we may disclose PHI for research purposes.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or others persons who can reasonably prevent or lessen the threat of harm.

For specialized government functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

For workers' compensation: We may disclose PHI to comply with workers' compensation laws.

Uses or Disclosures For Which You Must Be Given An Opportunity To Object:

Sometimes we may disclose your PHI if we have told you that we are going to use or disclose your information and you did not object.
Some examples are:

Patient directories: Your name, location, general condition, and religious affiliation may be put into our patient directory for use by clergy and callers or visitors who ask for you by name.

To family, friends, or others involved in your care: We may share with these people information directly related to your family's friend's or other person's involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

If there is an emergency situation and we do not have time to allow you to object to the disclosure, we may still disclose your PHI if you have previously given your permission and disclosure is determined to be in your best interests. If we do this, you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

Your Rights As They Relate to Your Protected Health Information (PHI)

You have the following rights relating to your PHI:

To request restrictions on uses or disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use or disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses or disclosures that are required by law.

To choose how we contact you: You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days for PHI we keep on-site, within 60 days for PHI that is not kept on-site. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is:

Correct and complete;
Not created by us or not part of our records; or,
Not permitted to be disclosed.

A denial will state the reasons for denial. It will also explain your rights to have your request, our denial, and any statement in
response that you provide, added to your PHI.
If we approve the request for amendment, we will change the PHI and inform you, as well as tell others who need to know about the change in the PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released, except for instances of disclosure that were made for treatment, for payment, for health care operations, to you, per a written authorization, for national security or intelligence purposes, to correctional institutions or law enforcement officials, or for the facility directory. The list also will not include any disclosures made before April 14, 2003.

We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

To receive a copy of this notice: You have a right to receive a paper copy of this Notice or an electronic copy by email upon request.

How to Complain about our Privacy Practices

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with Privacy Officer

Contact Person for Additional Information, or to Submit a Complaint

If you have questions about this Notice, need additional information, or have any complaints about our privacy practices, please contact:

Melisa Majorossy-Ionno - 1050 SE Monterey Rd. Stuart, FL 34994 p. 772.872.7304

V. Effective Date. This Notice is effective on 12/21/09

PATIENT PORTAL AUTHORIZATION

Authorization to disclose health information via electronic transmission

Patient Name: _____

E-mail: _____

Date of Birth: _____ / _____ / _____

By signing this form, I authorize **EMPLOYEE WELLNESS, P.A.** to communicate via a personal, secured access Patient Portal with me for my medical care and treatment. Employee Wellness, P.A. 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 Employee Wellness, P.A. 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. EMPLOYEE WELLNESS, P.A. will not be liable for information lost or misdirected due to technical errors or failures.
- EMPLOYEE WELLNESS, P.A. 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 EMPLOYEE WELLNESS, P.A..
- 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 EMPLOYEE WELLNESS, P.A. 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