PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____

SOCIAL SECURITY #: _____

ADDRESS 1: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

CONTACT INFORMATION

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT CELL PHONE: _____ RELATIONSHIP TO PATIENT: _____

PHARMACY

PHARMACY NAME: _____

PHARMACY LOCATION: _____

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Fred E. Clark in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA HOME TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE _____
- ☐ LEAVE CALL BACK NUMBER ONLY _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

Consent to medical care and treatment

I am being treated at ***ALLCARE CLINIC*** and I consent to all medical and surgical care, examinations and tests determine by my physician that are necessary for me. Though I expect the care given will meet customary standards. I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee of any individual associated with Physician Office is exposed to my blood or body fluids., I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

Consent to use of information

Electronic Health Records. I understand that the Physician Office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Physician Offices' sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.) I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The EHR will be accessible by Trinity Health credentialed physicians/practitioners as well as other individuals approved to access the HER for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with our HER system, I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to the physician Office's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as the Physician Office's participation in any health information exchange described in the physician Offices' Notice of Privacy Practices (NNP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

Acknowledgement of receipt of notice of privacy practices

I acknowledge that I have received or been offered a copy of physician's notice of privacy practices which provides information on how the physician office may use or disclose PHI for purposes of treatment, payment or health care operations.

Assignment of benefits

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

Financial Responsibility

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided, or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services render by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

Personal Valuables

I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office.

_____	_____
Patient Name (Print)	*Patient Date of Birth*

_____	_____	_____
Patient or Legal Representative (Signature)	*Date of Signature*	*Relationship of Legal Representative to Patient*

AllCare CLINIC

Reason for today's visit:_____

Review of Systems

Circle all that apply to you today:

General	Weight loss Weight gain Fatigue Fever	**Musculoskeletal**	Arthritis Muscle pain Join pain	**Hematologic**	Anemia Easy bruising Swollen glands
HEENT	Dizziness Headaches Changes in vision Eye pain Runny nose Hay fever Voice changes Post nasal drip Hearing problems Ear pain	**Psychiatric**	Memory Loss Depression Excessive stress Or anxiety	**Allergy**	Itching eyes Runny nose Sneezing
Respiratory	Cough Shortness of breath	**Skin**	Dryness Change in mole size Rash	**Urinary**	Awakening to urinate Burning Frequency Pain
Cardio	Chest pain High blood pressure Palpitations Swelling in legs	**Neurological**	Blackouts Fainting Dizziness Numbness	**Men's Health**	Sexual problems Worry of STI Discharge Pain
GI	Abdominal pain Nausea Changes in stool Vomiting Heartburn Constipation	**Endocrine**	Feeling too cold Feeling too hot Excessive urination Excessive thirst	**Women's Health**	Breast changes Changes to menstrual cycle Abnormal vaginal discharge Worry of STI Date last menses

Allergies

Are you allergic to any medications? Y N If yes, please list them below:

Medication	Severity (Mild, Moderate, Severe)& Symptoms

Medications

List all prescription and over the counter medications you are currently taking:

Medication	Dose	Frequency	Medication	Dose	Frequency

AllCare CLINIC

Family Medical History

List the health problems of family including all cancers, if deceased please list age of death:

Mother:	**Daughter:**
Father:	**Son:**
Sister:	**Grandmother:**
Brother:	**Grandfather:**

Personal Medical History

Do you have now, or have you ever had diseases or conditions of:
Circle all that apply

Hypoglycemia	Anemia	Anxiety	Arthritis
Asthma	BPH	Back problem	Breast cancer
Coronary artery disease	Heart failure (CHF)	COPD/emphysema	Cancer, please list type
High cholesterol	Dementia	Depression	Dermatitis
Diabetes	Seizures (Epilepsy)	GERD	Glaucoma
Gout	HIV	Headaches	Hepatitis
Hypertension	Heart attack (MI)	Migraine	Pneumonia
Renal stones	Stroke	Tuberculosis (TB)	Thyroid disease
Ulcer (GI)	Kidney disease	Abnormal heart beat	Liver disease

List any other medical conditions: _____

Social History

Do you drink alcohol?	Y	N	If yes, what kind and how many drinks per day?
Do you currently smoke?	Y	N	If yes, how many packs per week?
Former smoker?	Y	N	Date quit:

Surgical History

List surgical procedures you have had and year:

1.	4.
2.	5.
3.	6.

Hospitalizations (non-surgical) reason and year: _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to notify the doctor's office of any changes to my medical condition. I authorize the medical staff to perform any necessary services I may need and release information to others if necessary for my medical care.

_____

Print name **Patient Signature** **Date**

Billing & Insurance

AllCare Clinic is an independent clinic and will bill most insurance carriers in the area. Statements are sent monthly. All balances are due within thirty (30) days of the initial statement date unless prior arrangements have been made.

Accepted forms of payments are cash, personal checks, VISA, Mastercard, American Express and Discover. Credit card payments may be made in person or by telephone.

Our patient account representatives will gladly assist you with billing and financial questions. Patient account representatives are available by phone.

Phone number: (727) 800-9958

Monday-Friday

9a.m. to 4p.m.

Contracted Health Plans

AllCare Clinic is contracted with the following major health plans in the area. The terms of these health plans are subject to change. Please contact your insurance company for specific information regarding AllCare Clinic physician participation, coverage or benefits issues.

Aetna, Avmed, Blue Cross Blue Shield, Champ VA, Cigna, GEHA, ASGEHA, Humana, Medicare, Medicare Railroad, Liberty Health Share and Tricare for Life.

Know Your Benefits

Please understand that even though you are expecting insurance to pay for all or part of your medical treatment, you are responsible for your bill. It is wise to familiarize yourself with your insurance benefits. Your health plan mandates that you are financially responsible for payment of all co-pays, deductibles, non-covered services, and AllCare Clinic is contractually obligated to collect them. Please do not request that we adjust these from your account.

Patients who have a large deductible will be required to pay a minimum Eighty ($80) co pay at the time of service.

Cancellations/No Shows

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifteen ($15) fee: this will not be covered by your insurance company.

Labs

We send all patient labs to Quest Diagnostics. If your insurance requires you to use a specific lab, please let our staff know prior to your blood draw. Your insurance benefits are your responsibility. We can give you a script to take to the lab of your choice.

Your signature below signifies your understanding and willingness to comply with the policies of this office and insurance plan.

Patient or Responsible Party Signature_____**Date**_____

4401 4TH St N
Saint Petersburg, FL 33703
(727) 525-4401

Protected Health Information Release Form:

Patient Name: _____ Date: _____

(1) Concerning matters of my health, I give permission for Dr. Clark or a member of his staff to speak with:

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

Signature of patient: _____

Witness: _____