Patient Information

How did you hear about us?

☐Personal Referral ☐Insurance Company ☐Internet Search ☐Brandon Hospital ☐ZocDoc ☐Walk-In ☐Website ☐Other______

Last Name _______________ First Name _______________ MI _______

Mailing Address _______________ Apt # _______ City _______________ State _______ Zip Code _______

(______)_______________ Primary Phone
(______)_______________ Secondary Phone
(______)_______________ Work Phone

______/______/_______ Date of Birth
_______________ Social Security Number
Male / Female (circle one)
Marital Status: ☐M ☐S ☐D ☐W

_______________ Email Address

_______________ Local Pharmacy
(______)_______________ Local Pharmacy Number
_______________ Mail-Order Pharmacy
(_____)_______________ Mail-Order Pharmacy Number

IN CASE OF EMERGENCY:

_______________ Emergency Contact Name
_______________ Relationship to Patient
(______)_______________ Emergency Contact Number

Mailing Address _______________ Apt # _______ City _______________ State _______ Zip Code _______

Please review and sign below to provide consent:

☐I authorize Destiny Health Clinic to obtain all prescription history from any external source for the purposes of my treatment.

☐I authorize disclosure of necessary medical information to my insurance company to determine benefits payable to related services.

☐I give Destiny Health Clinic consent to perform medical treatment.

_______________ Patient/Representative Signature
_______________ Relationship
_______________ Date

Medications:

Medication	Dosage	Directions

Are you allergic to any medications? ____

Medical History:
Please list your medical diagnoses: ____

Preventative Services (please list dates):
☐I do not have preventative services history
Mammogram _________ Dexascan _________ Fasting Labs _________ PSA _________

Colonoscopy _________ FOBT ________ Eye Exam _________ Pap _________

Immunizations (please list dates):
☐I do no not have any immunization history

Hepatitis_______ Influenza________ Pneumococcal________ Shingles________ TDAP________

Surgeries and Hospitalizations (please list dates):	
Type/Reason	Date

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Family History (please list relationship):		
Bleeding Disorder ___________ Seizures _________________ Kidney Disease _______________ Migraines ___________________ Tuberculosis _________________	Cancer (type) ________________ Suicide _________________ Heart Attack __________________ Diabetes _________________ Other _________________	Dementia ___________________ COPD ___________________ Thyroid Disease _____________ Stroke ___________________

Social History:

Lifestyle:

Is there someone that lives in your residence? Y / N

If yes, list name and relationship ____

Type of residence: ☐House ☐Apartment ☐Mobile Home

Durable Medical Equipment? ☐Wheelchair ☐Oxygen ☐Walker ☐Cane ☐Nebulizer ☐CPAP/BIPAP

Do you require assistance with the following? ☐Bathing ☐Grooming ☐Toilet Needs

Do you drive yourself to your appointments? Y / N If no, who does? _____________________________

Personal Habits:

Do you drink alcohol? Y / N If yes, how often? ____

Have you ever used? ☐None ☐Marijuana ☐LSD ☐Heroin ☐Cocaine ☐Speed ☐Other __________

How much caffeine do you consume daily? ☐None ☐1-2 cups ☐3-4 cups ☐more than 4 cups

What is your occupation? ________________________ Do you have children? Y / N How many? ____

Do you have pets? Y/ N If yes, what kind? ____

Tobacco History:

Do you smoke? Y / N

If yes, how many cigarettes per day? ______________ If no, what year did you quit? _______________

Financial Responsibility Form

At Noorani Medical Center, we strive to give you the best possible care. In order to serve that purpose, it is important that you understand the process of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours.

- *If you have had any changes in your insurance coverage, you must notify us.*

COYPAYMENTS, CO-INSURANCES, AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Please understand that you will be expected to pay your co-payment for each date of service. You are also responsible for your deductible. Your deductible amount is determined by your individual contract with your insurance carrier. We may not have information about your deductible amount, or how much of it has been met. You will be responsible for finding out all information prior to your appointment with our office. During the course of your care, your provider may order labs or other diagnostic testing. These test orders are based on your provider's opinion of medical necessity. It is your responsibility to know your insurance coverage as it relates to the ordered tests before you have the testing performed.

SELF PAYMENT/SELF-PAY

All cash patients and patients without valid insurance information or active insurance coverage are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to your visit. Should you have insurance but are unable to provide valid information at the time of your visit, you will be expected to pay in full at time of service until your insurance information is on file.

____________________________________	_______/_______/_________
Patient/Representative Signature	Date of Birth
____________________________________	____________________
Relationship	Date

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Consent for Release of Confidential Medical Information

I, ______________________________, hereby authorize Destiny Health Clinic to release my healthcare information to the following:

1. ____ ________________________________
   Name of party authorized to receive information Relationship to patient

   ____
   Phone number of above-named person

2. ____ ________________________________
   Name of party authorized to receive information Relationship to patient

   ____
   Phone number of above-named person

I authorize the verbal release of information contained in my medical record via either telephone or face-to-face communications to the above-named individual(s). Unless otherwise indicated, my authorization includes the release of the following:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment
- Generic test results and/or related treatment.
- Other: ___________________________________

☐ By checking this box, I agree to allow messages containing personal health information on my answering machine. If this box is not checked, only brief, non-specific messages may be left.

This authorization shall remain in effect from the date signed until written revocation is received. I understand that I am under no obligation to sign this release and that it is my right to inspect all information disclosed, if I so request.

_________________________________ _______/_______/_________
Patient/Representative Signature Date of Birth

_________________________________ ____________________
Relationship Date

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PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow – up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice Privacy Practices.

I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_________________________________ _______/_______/_________

Patient/Representative Signature Date of Birth

_________________________________ ____________________

Relationship Date

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Consent for Treatment of Minor

We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. Please be advised, a minor child (under 18) will not be treated without a parent/ legal guardian present. Please sign the first authorization below to allow us to care for your child.

Patient Name: ____ DOB: ____________________

Authorization to Treat a Minor Patient When Accompanied by Parent/Legal Guardian

I, _________________________, authorize and consent to the above-named patient receiving medical, immunizations or other healthcare treatment as is considered necessary by Destiny Health Clinic.

__________________________ ____________
Parent/Guardian Signature Date