Story Family Medicine

...your health is *Our Story*

NEW PATIENT APPOINTMENTS

About Our Doctor and his Practice:

As a Medical Practice, we strive to bring back the personal experience of having an *Old-Fashioned Family Physician*. Our office keeps appointments available for urgent visits & same day appointments for Concierge Patients along with Direct Patient access regarding phone calls after hours and on the weekend, home visits are offered in case of an emergency.

A few reminders regarding your upcoming

New Patient Appointment:

- Please complete your New Patient Paperwork, 2 days before your scheduled appointment with us. If your paperwork cannot be completed within this time, your appointment will have to be re-scheduled. If you need to cancel or reschedule your appointment, please do so within 2 hours,if possible, we cannot reschedule your New Patient Appointment if there has been a No-Show.
- Complete all sections of Paperwork **(Dates of Tests are Necessary)**
- Provide us with a current Government-Issued Photo ID and Health Insurance Card. This is re uired and must be present to check in.

NOW INTRODUCING

The Concierge Health & Medicine Experience

Only $600 Annually

JOIN TODAY!

Thank you for your interest in Story Family Medicine

Our Practice Location: 18308 Murdock Circle Unit 101 Port Charlotte FL 33948

Main Telephone: 941-875-9059 Facsimile: 941-206-2066

Elevating Your Healthcare Experience – A Personalized Approach

Dear Valued Patient,

I am pleased to share an exciting enhancement to our practice designed to offer unparalleled accessibility, personalized attention, and tailored medical care that aligns with your unique needs. In recognition of the diverse preferences of our patients, we are introducing a hybrid model that seamlessly integrates traditional primary care with the exclusive benefits of concierge medicine. This approach ensures that whether you choose standard insurance-based care or opt for a more customized healthcare experience, you receive the highest level of medical attention and support. For those seeking an elevated level of care, our concierge services provide: I am proud to announce my new and enhanced Membership Program the ***Concierge Health and Medicine Experience Membership.***

✓ ***Priority Scheduling***—same-day or next-day appointments for timely medical attention

✓ ***Extended Consultations***—unhurried, in-depth discussions focused on your well-being

✓ ***24/7 Direct Access***—reach me via phone, email, or text whenever needed

✓ If necessary, ***Weekend Availability***—flexible scheduling to accommodate your lifestyle

✓ As needed ***after-hours Home Visits***—personalized medical care in the comfort of your home

Proactive Wellness Planning—comprehensive strategies for long-term health prevention. Receive ***a Customized Lifestyle Program with on going modifications.*** This program includes features such as: *Meal Planning, Diet & Nutrition, Education & Counseling, Exercise & Self Care Routine*. My program features Chronic Conditions such as *Depression, Weight loss, Diabetes, Hypertension and Cardiovascular Health* just to name a few.

This dual approach allows you to select the level of care that best serves your *health journey*. Whether you remain within our traditional model or embrace ***a New Enhanced Way*** to receive on-going accessibility and bespoke care, I am committed to delivering thoughtful, patient-centered healthcare tailored to your needs. Should you wish to explore my new enhanced ***Concierge Health and Medicine Experience***, I welcome the opportunity to answer your questions. Simply reply to this email or contact Rebekah my Concierge Coordinator & Patient Resource Director at (941)-875-9059, and we will be happy to assist you in finding the ideal fit for your healthcare goals.

With warmest regards,

r urtis Story

STORY FAMILY MEDICINE
NEW PATIENT REGISTRATION FORM

Today's Date: _____

Name: _____ Date of Birth: __/__/____ Height: ____
Last First M
Status: ☐ Married ☐ Single ☐ Widowed ☐ Child ☐ Other **Gender** ☐ Female ☐ Male ☐ Other: _____
Social Security# _____ **Religion:** _____ **Ethnicity:** _____
Phone (Home) _____ **Cell:** _____ **Email Address**: _____
Address: _____ Is this a seasonal residence? ☐ yes ☐ no
City, State and Zip Code Are you a Full-Time Resident of Florida? ☐ yes ☐ no
Occupation Status: ☐ Working ☐ Retired ☐ Unemployed ☐ On Medical Leave ☐ Disabled ☐ Other ☐ Declined to Specify

In Case of an Emergency

Name: _____ **Relation** ☐ Spouse Mother ☐ Father ☐ Grandparent ☐ Friend ☐ Other: _____
Phone: _____ Is it okay to contact this person in case of an emergency? ☐ Yes ☐ No

Advanced Care Directives, Medical Wishes or Other Preferences

*Do you have a living will? ☐ Yes ☐ No ☐ n/a
*Are you an organ donor? ☐ Yes ☐ No ☐ n/a
*Do you have a DNR? ☐ Yes ☐ No ☐ n/a
*Do you have a Power of Attorney? ☐ Yes ☐ No

If you have a Power of Attorney or a Health Care Surrogate, please list them below.
Name: _____ Relationship _____ Phone Number _____
Are we able to disclose Medical Information with them? ☐ YES ☐ No

Health Insurance Information

Do you have Health Insurance? ☐ Yes ☐ No (Relationship to Insured) ☐ Self ☐ Dependant
Primary Insurance _____ Policy# _____
Plan Type ☐ HMO ☐ PPO ☐ Medicare ☐ Federal ☐ Veteran ☐ Disability ☐ Other _____
Secondary Plan: _____ Policy# _____ Is this a Medicare Plan? ☐ Yes ☐ No
Do you have Medicaid? ☐ Yes ☐ No (Please Advise: We are Out-of Network with Medicaid)

Health and Social History

Have you ever smoked/used tobacco products? ☐ Yes ☐ No (If Former smoker, when did you Quit?) _____
Do you currently smoke? ☐ Yes ☐ No (If you currently smoke, how many a day or week?) _____
Do you drink alcohol? ☐ Yes ☐ No (If yes, how often): _____ Currently use recreational drugs? ☐ Yes ☐ No
Do exercise regularly? ☐ Yes ☐ No (If yes, how often): _____ What type of exercise? _____
Nutritional Diets: ☐ Diabetic Diet ☐ Low Sodium ☐ Low Fat ☐ Low Cholesterol ☐ Other: _____
Do you have drug, environment or food allergies? ☐ Yes ☐ No (If yes, please list type and reactions)
_____

Major Medical Events and History

Complications to Medical Treatments ☐ Yes ☐ No _____
Hospital Admissions or Emergency Care? ☐ Yes ☐ No _____

PAST SURGERIES/OPERATIONS

Type of Operation	Date
_____	_____
_____	_____
_____	_____
_____	_____

OTHER PROVIDERS/ SPECIALISTS

Provider Name	Specialty Type
_____	
_____	
_____	

☐ No Other Providers

LIST OF PREFERENCES

Hospital _____
Pharmacy _____
Laboratory _____
Imaging _____

Do you have any health concerns that need further clarification? ☐ Yes ☐ No (If yes, please explain)
_____
How did you hear about Dr. Story? _____

Current Medical Conditions

Patient Name: _____

- ☐ Anemia
- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Abnormality
- ☐ Blood Deficiency
- ☐ Cancer: _____
- ☐ Chronic Back Pain
- ☐ Congestive Heart Failure
- ☐ Colitis/IBS
- ☐ COPD
- ☐ CoronaryAtherosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Erectile Dysfunction
- ☐ Headaches
- ☐ Hypertension
- ☐ Hypothyroid
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Arrhythmia
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ GERD
- ☐ GOUT
- ☐ Glaucoma
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Muscle Weakness
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Ulcers
- ☐ Implantable Device
- ☐ Pacemaker Status
- ☐ ID# _____
- ☐ Unsteady Balance
- ☐ Urinary Incontinence
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

☐ **NO MEDICAL HISTORY**

FAMILY HISTORY

	Mother	Father	Sibling	Other	
Heart Condition	☐	☐	☐	☐	_____ (Please specify) _____
Heart Attack/Stroke	☐	☐	☐	☐	_____
Alcoholism	☐	☐	☐	☐	_____
Breast Cancer	☐	☐	☐	☐	_____
Colon Cancer	☐	☐	☐	☐	_____
Other Cancer	☐	☐	☐	☐	_____ (Please specify type of Cancer) _____
Depression	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Lung Conditions	☐	☐	☐	☐	_____
Thyroid Issues	☐	☐	☐	☐	_____

☐ **No Family History**

☐ **Unknown Family History**

LIST OF MEDICATIONS

☐ **NO CURRENT MEDICATIONS**

_____	mg	x daily	_____	mg	x daily
_____	mg	x daily	_____	mg	x daily
_____	mg	x daily	_____	mg	x daily
_____	mg	x daily	_____	mg	x daily

PROCEDURES & TESTING

☐ **NO TESTING COMPLETED**

DIAGNOSTIC TESTS:

- Colonoscopy: _____
- Bone Density: _____
- Mammogram: _____
- Chest Xray: _____
- EKG: _____
- Echo: _____
- Stress Test: _____
- Other: _____

IMMUNIZATIONS:

- Flu Vaccine: _____
- Co-vid 19: _____
- Pneumonia 23: _____
- Prevnar 13 : _____
- TDap/Tetanus: _____
- Shingles Vaccine: _____
- MMR: _____
- Other: _____

EXAMS:

- Last Labs: _____
- Health Physical: _____
- Breast Exam: _____
- Prostate Exam: _____
- Pap Smear: _____
- Eye Exam: _____
- Foot Exam: _____
- Other: _____

REVIEW OF NEW OR EXISTING SYMPTOMS

☐ **NO CURRENT COMPLAINTS**

Eyes:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Worsening Sight

Ears & Hearing:
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Wax Buildup

Head & Neck:
- ☐ Headaches
- ☐ Dizziness
- ☐ Lightheaded
- ☐ Memory Loss

GI:
- ☐ Difficulty Swallowing
- ☐ Nausea/ Vomiting
- ☐ Stomach Pain
- ☐ Loss of Appetite
- ☐ Diarrhea
- ☐ Constipation

Urinary:
- ☐ Burning
- ☐ Frequent Urination
- ☐ Difficulty Urinating
- ☐ Incontinence
- ☐ Hesitancy

Oral:
- ☐ Dry Mouth
- ☐ Loss of Taste

Nose & Throat:
- ☐ Sneezing
- ☐ Nose Bleeds
- ☐ Runny Nose
- ☐ Sinus Issues
- ☐ Sore Throat

Respiratory:
- ☐ Asthma
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiac:
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Irregular Heartbeat

Muscle/Bones/Joints:
- ☐ Back Pain
- ☐ Sore/Achy Muscles
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Foot Pain
- ☐ GOUT
- ☐ Leg Pain

Neurological:
- ☐ Confusion
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors/Shaking
- ☐ Poor Balance
- ☐ Poor Coordination

Skin:
- ☐ Rash/Hives
- ☐ Itching
- ☐ Bruising
- ☐ Abnormal Growth

General Mood:
- ☐ Anxiety
- ☐ Depression
- ☐ Stressors
- ☐ Mood Changes

Patient Consent Form

I, _____ **(Print Name)** have carefully read and fully understand the information provided to me below with regards to informed consent, and have had all my questions answered.

_____ Today's Date: _____

Patient Signature

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

GENERAL CONSENT

Consent for Medical Treatment. I give consent to Story Family Medicine and its staff, (collectively, the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well-being, or the health and well-being of the patient for whom I am legally authorized to provide such consent.

CANCELLATION AND NO-SHOW POLICY

Office Visits are reserved by appointment only. We understand that situations may arise that cause schedule conflicts or delays. If you cannot keep your appointment, please notify us within 24 hours or a charge of $30.00 may result and billed to your account. I acknowledge and understand the Story Family Medicine (Cancellation and No-Show Policy). If a scheduled appointment is missed 3 times within a year, a full charge of 150.00 will be required before re-scheduling and reserving another appointment.

HIPAA-CONSENT TO TREAT AND DISCLOSURE OF HEALTH INFORMATION

TO PROVIDE TREATMENT: We will use your HPI within the office to provide you medical care. This may include administrative, clinical and office procedures designed to optimize scheduling/coordination of care between the physician and/or other clinical, lab, imaging centers, pharmacies and/or other health care providers involved with your care.

TO OBTAIN PAYMENT: We will use your HPI with an invoice, used to collect payment for the treatment you receive here. HPI will be used on your insurance forms sent by mail or electronically.

PATIENT COMMUNICATIONS: Phone calls, text messages and emails may be used to remind you of an upcoming appointment or other situations that may be necessary. We also may use other electronic methods to contact you such as online medical record accounts, postcards, letters, statements, etc. These methods of communications help optimize our office workflow and are necessary to provide care.

ABUSE OF NEGLECT: We may notify government or other agencies if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make their disclosure only when we are compelled by our ethic judgement, specially required, authorized by law or with patient's agreement and request.

PUBLIC HEALTH/NATIONAL SECURITY: We may be required to disclose to federal/ military officials or other authorities, if HPI is necessary to complete an investigation related to public health or national security. HPI is important to the government if they believe that public safety could benefit from, control or prevent an epidemic.

FOR LAW ENFORCEMENT: As permitted/required by State/Federal Law, disclosure of HPI may be necessary under certain circumstances, if warranted. Whether being a victim of a crime or reporting a crime. We will revoke access, at any time to also protect the patient, unless there is a warrant in place or consent given from the patient directly.

TELEMEDICINE SERVICES: This may be offered as an alternative service which involve the use of audio, live video (like Skype, Zoom, Etc, for the purpose of providing medical care. A potential risk of telemedicine is that your specific concerns may still necessitate a face-to-face session as part of your medical treatment such as Sick Visits. Virtual communications involving medical documentation will be necessary to provide proper documentation.

I understand the (HIPPA Consent to Treat/Disclosure of Health Information PAGE 1)

_____ Today's Date: _____

PATIENT SIGNATURE

OTHER AUTHORIZATIONS

Chronic Care Management (CCM). If deemed appropriate by practice provider, I consent to receive Chronic Care Management (CCM) services from Story Family Medicine. I understand that I can stop CCM services at any time. I understand that CCM services include 24/7 access to a member of my care team. I understand that CCM services include a comprehensive care plan. I understand that CCM services include oversight of my medication regimen.

Advanced Primary Care Management (APCM). If deemed appropriate by practice provider, I consent to receive Advanced Primary Care Management (APCM) services from Story Family Medicine, which includes comprehensive care coordination, proactive monitoring of my chronic conditions, and 24/7 access to my care team. I understand that only one provider can furnish APCM services per calendar month, I have the right to stop these services at any time, and cost sharing may apply.

NARCOTIC PRESCRIBING AND MEDICATION ADHERENCE POLICY Scheduling an appointment does not guarantee that you will be prescribed narcotics or other medications. Some medications may provide therapeutic relief, though they have more risks than benefits. The patient must disclose all medications that they are using as well as any illicit drugs. If deemed medically necessary, blood work and/or a urine drug test might be required before prescribing medication. Medical Records from the former prescriber will be required.

To the best of my knowledge, the answers and information provided are true and correct. I acknowledge and understand the (Narcotic Prescribing/Medication Adherence Policy), I agree to the terms stated above.
PATIENT INITIALS: _____

FINANCIAL RESPONSIBILITY

Authorization of Payment of Insurance Benefits. I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment of the service rendered to me.

Signature on File (For Medicare patients). I certify that the information given to me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the Practice for services provided by the Practice.

Financial Agreement. I agree to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that, to the extent permitted by law, where insurance or other third-party benefits are insufficient, I will be responsible for the payment of any deductibles, copayments, coinsurance or other fees required by insurer or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer or other benefit plan/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I understand that there will be a charge for all returned checks.

IF YOU DO NOT HAVE HEALTH INSURANCE- For self-pay patients, we offer discounted rates, though require payment in full at the time of your office visit. It is $150.00 per visit or you can sign up for our Concierge Membership. The total fee is $600.00 annually. Total collection of the fee must be made first before an arrangement can be made between the practice and the patient. We accept Cash, Visa, Mastercard, American Express. We cannot accept a check for payments more than $50.00. There is a charge for return checks of $30.00.

HIPAA Privacy and Release of Information Authorization (EMERGENCY CONTACT)

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

In addition to the above, I hereby give authorization for protected health information to be shared with the following individual(s) or organization(s) noted in the list below:

_____	_____	_____
NAME OF INDIVIDUAL	SPECIFY RELATIONSHIP	CONTACT CELL PHONE

I understand the (HIPPA Consent to Treat/Disclosure of Health Information PAGE 2)

_____ Today's Date: _____
PATIENT SIGNATURE

MEDICAL RECORD RELEASE

URGENT REQUEST ☐ YES ☐ NO

Date Needed by: _____

Fax Records to: 941.206.2066

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zipcode _____

_____/_____/_____ Date of Birth _____ Daytime Phone _____ Previous Names _____

2) AUTHORIZES

Name of Healthcare Provider/Agency or Facility _____ tele# _____

Address _____ fax # _____

3) TO DISCLOSE TO:

Dr. Curtis Story MD of Story Family Medicine — Name of Healthcare Provider — 941.875.9059 tele

18308 Murdock Circle Unit 101 Port Charlotte, FL 33948 — Address — 941.206.2066 fax

DELIVERY OPTIONS: ☐ Self Pick up ☐ Fax ☐ Mail to: _____

To be picked up by, I hereby authorize: _____ above) _____ (Photo ID required)

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ (month/year) to _____ (month/year)

(If left blank, information from the past (2) years will be disclosed)

5) INFORMATION TO BE DISCLOSED:

☐ All medical records related to (specify condition, treatment, etc.): _____

☐ All billing records related to (specify condition, treatment, etc.): _____

☐ Radiology films/images (specify test): _____

☐ Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: _____

7) PURPOSE (Check all that apply - (Copy fees may apply) ☐ Further Medical Care ☐ Legal Investigation /Action ☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. If you have issues receiving your records or information or need assistance in filing a civil rights or health information privacy complaint, please email OCR at OCRMail@hhs.gov or call 1-800-368-1019 for more information.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

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For Office Use Only: ☐ Yes ☐ No Completed by: _____ Date Released: __/__/_____

Signature/ID verified *Name /Title*

___#of ☐ Pages

___#of ☐ CD(s)

SEND COORESPONDENSE TO:

18308 Murdock Circle Unit 101 Port Charlotte, Florida 33948

telephone: 941.875.9059 facsimile 941.206.2066

visit our website at https://www.storyfamilymedicine.com/