Primary Care Associates

PATIENT INFORMATION			
First Name	Middle Name	Last Name	Gender ☐ Male ☐ Female
Street Address	City, State, Zip		Email Address *(required)*
Date of Birth / /	SSN - -	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widow(er)	
Home Phone - -	Cell Phone - -	Work Phone - -	
What is your preferred method of contact? ☐ Home Phone ☐ Cell Phone ☐ E-Mail ☐Mail			
Employer ☐ Check here if retired		Occupation	Referred by
Emergency Contact	Contact Phone - -	Relationship to Patient ☐ Spouse ☐ Child ☐ Sibling ☐ Parent ☐ Friend	
Race ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Other: _____ ☐ Unreported/Refused			
Preferred Language	Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unreported/Refused		

FINANCIALLY RESPONSIBLE		
Primary Insurance Carrier Name	Date of Birth - -	SSN of Primary Carrier
Relationship of Financial party to patient: ☐ Self ☐ Spouse ☐ Parent ☐Guardian		

PHARMACY REFILL POLICY

Prescriptions: Please mark your calendar one week prior to your prescription running out to call if a refill is needed. Before requesting a refill for a current prescription, please call your pharmacy to see if you have refills left one the original prescription. If there are no refills, you may call and leave a message on the Medical Assistance's voicemail. The providers or Medical Assistance process refill request at the endo of the day after they have finished seeing patient or within 24 hours of notice. In order to enable us to process your request please call and leave a message before 3:00pm that day to allow us sufficient time. Please be patient and check with the pharmacy, repeat phone calls only delays the process from being completed.

Pharmacy Name:

Phone Number:

Address:

CONSENT FOR TREATMENT

I hereby voluntarily consent to the rending of care, including treatment, administration of anesthesia and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of ***Primary Care Associates*** and it is the responsibility of the staff to carry out instruction of the physicians.

Patient's Signature:

MEDICAL HISTORY

□ ANEMIA	□ DIVERTICULITIS	□ HEPATITIS/LIVER	□ SUICIDE ATTEMPT
□ ASTHMA	□ EMPHYSEMA / COPD	□ HIGH CHOLESTEROL	□ THYROID PROBLEMS
□ ANXIETY	□ EPILEPSY / SEIZURES	□ BLOOD PRESSURE	□ OTHER: _____
□ CANCER: _____	□ GERD / PEPTIC ULCERS	□ KIDNEY PROBLEMS	_____
□ DIABETES TYPE I / II	□ GOUT	□ PNEUMONIS	□ OTHER:_____
□ DEPRESSION	□ HEART DIEASES / MI	□ STROKE / TIA	_____

SURGERIES:	HOSPITALIZATIONS:
□ CHECK HERE IF NO SURGERY HISTORY	□ CHECK HERE IF NO HOSPITAL HISTORY
□ APPENDECTOMY □ C-SECTION # _____ □ GALLBLADDER REMOVAL □ GASTRIC BYPASS / BANDING □ HERNIA REPAIR: _____ □ HYSTERECTOMY (PARTIAL / TOTAL) □ ORTHO SURGERY: _____ □ TONSILLECTOMY □ OTHER: _____ □ OTHER: _____	_____ _____ _____ _____

FAMILY HISTORY

□ CHECK HERE IS UNKNOWN OR ADOPTED

DAUGHTER:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
FATHER:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
SON:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
SPOUSE:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
MOTHER:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
PATERNAL GF:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
PATERNAL GM:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
MATERNAL GF:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
MATERNAL GM:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK
OTHER:	□ CANCER	□ DIABETES	□ HYPERTENSION	□ HEART DISEASE	□ LIPIDS	□ UNK

SIBLING? NO / **YES** → NUMBER OF SIBLING(S): _____ SISTER(S) _____ BROTHER(S)

CHILD? NO/ **YES** → NUMBER OF CHILDREN: _____ DAUGHTER(S) _____ SON(S)

SOCIAL HISTORY

MARTIAL STATUS	SINGLE	MARRIED	SEPERATED	DIVORCED	WIDOWED
RELATIONSHIP	HAPPY	SATISFIED	AVERAGE	NOT HAPPY	UNSTABLE
STRESS LEVEL	NONE	MILD	MODERATE	HIGH	VERY HIGH
ALCHOL USE	NONE	SOCIALLY	WITH DINNER	HABITUALLY	QUIT: _____YR
TOBACCO USE	NEVER	QUIT#____YR AGO	CURRENT# _____PER DAY FOR # YEARS: _____		
AEROBIC EXERCISE	NONE	OCCASIONALLY	1-2 TIMES WEEK	3-4 TIMES WEEK	5-6 TIMES WEEK
STRENGTH TRAINING	NONE	OCCASIONALLY	1-2 TIMES WEEK	3-4 TIMES WEEK	5-6 TIMES WEEK
VEGETABLE INTAKE	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
FRUIT INTAKE	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
MEAT INTAKE	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
FAST FOOD	NEVER	1-2 TIMES A WEEK	3-4 TIMES A WEEK	1-2 X A MONTH	3-4 X A MONTH

REVIEW OF SYMTOMS

Please check any symptoms that you experience. For any checks, please provide a brief description.

CONSTITUTIONAL	GASTROINTESTINAL
☐ WEIGHT LOSS / GAIN - HOW MANY POUNDS? ____	☐ ABDOMINAL PAIN
☐ WEAKNESS	☐ BLOATING / GAS
☐ LOSS OF APPETITE	☐ BLOOD IN STOOL
☐ FEVER / CHILLS	☐ CONSTIPATION # OF BOWEL MOVEMENTS: _____
☐ EXCESS FATIGUE - HOW LONG? _____	☐ DIARRHEA
☐ INSOMNIA / LIGHT SLEEP	☐ HEARTBURN
ALLERGIES	☐ DIFFICULTIES SWALLOWING
☐ ITCHY EYES	☐ RECTAL BLEEDING
☐ RUNNY NOSE	**HEMATOLOGY / LYMNHATICS**
☐ SINSUS CONGESTION - SEASONAL? YES / NO	☐ EASY BRUISING
☐ SCRATCHY THROAT	☐ SWOLLEN GLANDS
EYES / EAR / NOSE / THROAT	**DERMATOLOGY**
☐ BLURRY VISION	☐ RASH
☐ EYE DRAINAGE	☐ DRY SKIN
☐ LOSS OF VISION - OPHTHALMOLOGY EVAL?	☐ ACNE
☐ HEADACHES / MIGRAINES	☐ WRINKLES
☐ COUGH	☐ ITCHING
☐ SORE THROAT / HOARSENESS	☐ PIGMENTATION / SCARRING
☐ GERD	☐ EXCESSIVE / ABNORMAL HAIR GROWTH
☐ RINGING IN EARS	**PSYCHOLOGY**
☐ HEARING LOSS	☐ DEPRESSED
CARDIOVASCULAR	☐ FEELING ON EDGE / STRESSED
☐ CHEST PAIN: HISTORY OF MI or HEART DISEASE	☐ NERVOUSNESS
☐ PALPITATION	☐ THOUGHTS OF SUICIDE (ATTEMPTED? YES / NO)
☐ DIZZINESS	☐ ANXIOUS
☐ LEG SWELLING	**ENDOCRINE**
☐ PAIN IN LEGS WHILE WALKING	☐ INTOLERANCE TO COLD / HOT
RESPIRATORY	☐ EXCESSIVE THIRST #_____GLASSES OF FLUIDS DAY
☐ SHORTNESS OF BREATH	☐ HAIR LOSS
☐ WHEEZING	☐ SWEATING
☐ COUGHING	☐ CHANGE IN APPETITE
☐ PAINFUL BREATHING	**UROLOGY**
MUSCULOSKELETAL	☐ FREQUENCY – HOW OFTEN PER DAY _____
☐ MUSCLE or JOINT PAIN	☐ BLOOD IN URINE
☐ STIFFNESS	☐ DIFFICULTY or PAINFUL URINATING
☐ LOSS OF RANGE MOTION	☐ INCONTINENCE
☐ MUSCLE CRAMPS	☐ CHANGES IN URINARY STRENGTH
NEUROLOGY	**HORMONAL**
☐ LOSS OF MEMORY	☐ DECREASED LIBIDO
☐ NUMBNESS / TINGLING	☐ DIFFICULTY WITH EJACULATION / ERCTILE
☐ PARALYSIS	☐ ABNORMAL VAGINAL BLEEDING - MENOPAUSAL YES/NO
☐ GAIT ABNORMALITY	☐ HOT FLASHES
☐ CONCENTRATION	☐ PRE-MENSTRUAL SYMPTOMS
☐ SEIZURES	☐ VAGINAL DRYNESS
☐ DIZZINESS / FAINTING	☐ BREAST PAIN / DISCHARGE / LUMP

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also, list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How Often You Take the Medication	Reason Your Taking:

ALLERGIES TO MEDICATIONS ☐ CHECK HERE IF NO ALLERGIES	
Name the Drug	Reaction You Had

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ***0*** **+** _____ **+** _____ **+** _____

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PATIENT SIGNATURE:_____

NEW PATIENT PREVENTIVE QUESTIONS

NAME: _____DOB: _____ DATE: _____

COLON SCREENINGS

Have you had a colonoscopy: _____ YES _____ NO; If yes, please answer the following:

Date of procedure _____ MD or facility: _____

Results: _____

DIABETIC EYE EXAM

Are you diabetic: _____YES _____ NO: If yes, please answer the following:

When was your last eye exam? _____ Where? _____

Results: _____

VACCINATIONS

Have you had a flu vaccine this season: _____YES _____ NO; If yes, date?: _____

Have you ever had a pneumonia vaccine: _____ YES ____ NO: If yes, what year?: _____

RHEUMATOID ARTHRITIS

Have you ever been told you have Rheumatoid Arthritis: _____YES _____NO: If yes:

What medication was prescribed?: _____MD?: _____

OSTEOPOROSIS

Have you ever been diagnosed with Osteoporosis?: _____YES _____NO: If yes:

What medications was prescribed?: _____

Have you had a bone fracture within the last 2 years?: _____ YES _____ NO; If yes:

Which bone?: _____MD?: _____

FEMALES ONLY:

When was your last mammogram?: _____ Results?: _____
Where did you go for your mammogram?: _____
When was your last papsmear?: _____ MD?: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I, _____DOB _____ voluntarily consent to authorize my health care provider

PRIMARY CARE ASSOCIATES

Dr. _____

The following records:
The type and amount of information to be used or disclosed is as follows:

☐ Consultation Reports	☐ Medication List	☐ General Health Records
☐ Psychiatry/Mental Health	☐ Laboratory Results	☐ Physicals
☐ Discharge	☐ Problem List	☐ Diagnostic Tests
☐ Entire Record	☐ Other	

_____

_____

I understand that the information in my general health records may include information regarding to: Drug/Alcohol Abuse STI/STD's, HIV/AIDS, Behavioral or Mental Health and Genetics.

I understand that this information shall be in effect 365 days (l year) following the date of signature.
However, I may revoke at any time this authorization by giving oral or written notice to the medical office.
A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical Records have been released, the medical office cannot retrieve them and has not control over the use of already released copies.
I hereby release Primary Care Associates from any and all liability which may arise as a result of my authorized release of records.
Should my case require review by a governing agency or another medical profession actively in my care to make a final determination, it is my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Facility/Practice requesting records from: _____

_____
(Please print your previous or requested physician name & number above.)

Please send the following medical records listed above to:

PRIMARY CARE ASSOCIATES
1545 SE Palm Court
Stuart, FL 34994
PH: 772-283-2086 F": 561-619-8497

Patient Signature (or legal rep):_____Date:_____

Relationship to patient_____Witness:_____

NAME: _____ DATE: _____

PATIENT SELF-DETERMINATION QUESTIONNAIRE YOUR RIGHT TO DECIDE.

While you cannot removal all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- **DECLARATION TO DECLINE LIFE-PROLONGING PROCEDURES**
  - I have made a Living Will
  - I do NOT have a Living Will
- **HEALTH CARE SURROGATE**
  - I have designated a Health Care Surrogate
  - I have NOT designated a Health Care Surrogate
- **DURABLE POWER OF ATTORNEY**
  - I have appointed a Durable Power of Attorney for Heath Care Decisions
  - I have NOT appointed a Durable Power of Attorney for Heath Care Decisions

If you have a living will and/ or an assigned health care surrogate, we will gladly make a copy of your documents and place it in your chart.

Please list below the family members or significant others whom we may inform about your medical condition in **ONLY IN AN EMERGENCY SITUATION.**

NAME: _____ PHONE# _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____ RELATIONSHIP: _____

PATIENT / GUARDIAN / POA - SIGNATURE: _____

PATIENT AGREEMENT / CONSENT TO LEAVE PHONE MESSAGES

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES – HIPPA

_____ (initials) I hereby acknowledge that I have access to a copy of the Notice of Privacy Practices of Primary Care Associates, PA which is available for me at this and subsequent visits to read and understand. I understand that under the Health Insurance Portability and Accountability Act of 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 & direct my treatment and follow up among the multiple health providers involved in my treatment
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications

I understand that as part of my health care, Primary Care Associates, PA may need to reach me by phone.

_____ (initials) I **DO** authorize Primary Care Associates to leave a message on my:

□ Home phone
□ Cell phone
□ Work phone

Regarding laboratory / test results and imaging studies.

However, I understand that sensitive information and/or results that will require medication follow-up of discussion will require that I make an appointment with the provider.

□ I DO NOT authorize Primary Care Associates to leave message on my phone (home, cell, work) regarding any type of testing results. I will accept the responsibility of making an appointment with the provider to obtain the results.

□ I hereby give consent to my health care provider to discuss or release my private health care information to (i.e. spouse, parent, care-taker, family member):

NAME: _____ PHONE# _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____ RELATIONSHIP: _____

PATIENT / GUARDIAN SIGNATURE: _____

PATIENT CONTRACT

This CONTRACT confirms your responsibilities and informs you about our Practice Polices.

After Hours

_____ (*initials*) For all emergences, call 911 or proceed to the nearest ER facility. *The after-hours phone service is **NOT** for prescription refills or routine questions.* Prescription refills and routine questions are handled during normal business hours.

Laboratory / Test Results and Imaging Studies

_____ (*initials*) Lab work results will be available to you at your physical and/or follow up visit. ***Please note, all blood work done through our office requires an office visit.*** It will be **your responsibility** that your personal information is updated at time of visit. If you have not heard from our office within 3 business days after completing your blood work or any diagnostic test. **PLEASE CALL THE OFFICE**. It is **your responsibility** to contact Primary Care Associates for your results. It is our policy that ***sensitive information (i.e. HIV, STD), abnormal results, and tests that need follow-up or discussion will require an appointment with the physician.***

Patient Portal

_____ (*initials*) I am aware that by providing my doctor's office with my current email, I will have access to my secure medical chart via the patient portal. I will be able to access my appointment request or reminders, prescription refills, non-urgent medical questions, lab results and more.

Electronic Prescribing

_____ (*initials*) ***Primary Care Associates*** is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to provide the best possible treatment. I give ***Primary Care Associates*** permission to request and use my prescribing medication history from other healthcare providers.

Late and Missed Appointments

_____ (*initials*) In fairness to other patients who are waiting to receive scheduled appointments, I agree to arrive timely to my appointment and/or provide a full 24-hours' notice if I am unable to keep my appointment. I understand that missed appointments with less than 24-hours' notice may incur a fee of **$35** for ***Primary Care Associates***. Repeated missed appointments will not be tolerated.

Release of Information

_____(*initials*) My physician and authorized staff may disclose all or part of the patient's records to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient of physician(s) charges, including but not limited to, insurance companies, worker's compensation carries, auto insurance carries, attorney, welfare funds, or the patient's employer.

Fee for Service

_____ (*initials*) I agree to pay my account at the time service is rendered or will make financial arrangements satisfactory to ***Primary Care Associates*** for payment. If my account is sent to an attorney for collections, I agree to pay collection expenses and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any liable to the patient, is hereby assigned to ***Primary Care associates.*** If co-payment and/or deductibles are designed by my insurance company or health plan, I agree to pay them to ***Primary Care Associates.*** However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Non-Covered Services

_____ (*initials*) I understand that ***Primary Care Associates***, contract with health care services plans (i.e. HMOs, PPOs) which specifically state services which are "covered" by the health care services plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care services plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the plan furnished to the patient; and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with ***Primary Care Associates***, to obtain necessary health care services authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service.

Credit Card Polices for Co-Pays, Deductibles, Co-Insurance, and Other Balances

_____ (*initials*) I understand I am responsible for payment of services at the time they are rendered and for any unpaid balances in the event of third party or insurance claims. We gladly accept cash or credit cards. ***An Updated and current insurance card will be requested of you each time at check in.*** If you have an outstanding balance after your insurance claim has been processed, it is your responsibility to pay the outstanding amount. You will receive a confirmation of the charge along with a billing statement explaining the reason for your remaining balance. I understand that this in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment. I understand that failure to pay any outstanding balances may result in additional fees id sent to collections.

Assignment of Benefits

_____ (*initials*) I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to ***Primary Care Associates.*** I understand that ***Primary Care Associates*** contracts with multiple but not all health care service plans. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by ***Primary Care Associates*** if I belong to a plan that does not contract with ***Primary Care Associates*** Medicare Assignment of Benefits (Medicare Patient's ONLY).

_____ (*initials*) I request that payment of authorized Medicare benefits be made on behalf to ***Primary Care Associates*** for services furnished me by ***Primary Care Associates.*** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ***Primary Care Associates*** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Medigap (Medicare Patients ONLY)

_____ (*initials*) I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ***Primary Care Associates*** if possible or otherwise to me.

Patient's Signature: _____ Date: _____