NEW PATIENT APPLICATION

Ronald Watson CRNA, APRN

Please be aware when you attend regular appointments your provider may change due to availability

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

Mailing Address:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Preferred Method of Communication:_____

Pharmacy:_____

Pharmacy Phone Number:_____

Emergency Contact and Relationship:_____

Emergency Contact Phone Number:_____

Primary Insurance and policy Number:_____

Secondary Insurance and Policy Number:_____

Patient Medical Information

Name:_____ Date of Birth:_____

Current Medical Concerns:_____

Current Medications

Prescription and non-prescription medications, vitamins, birth control, herbs and supplements

Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies or Reactions to Medications, Foods, or other Agents YES or NO

Please List Allergies: _____

Personal Medical History

Please circle yes or no to the following questions.

ADD/ADHD	**Yes**	**No**	**Blood Transfusion**	**Yes**	**No**
AIDS/HIV	**Yes**	**No**	**Breast Cancer**	**Yes**	**No**
Abuse/Domestic Violence	**Yes**	**No**	**Breast Problem**	**Yes**	**No**
Allergies/Hayfever	**Yes**	**No**	**COPD**	**Yes**	**No**
Anemia	**Yes**	**No**	**Cancer**	**Yes**	**No**
Anesthesia Complications	**Yes**	**No**	**Chicken Pox**	**Yes**	**No**
Anxiety Disorder	**Yes**	**No**	**Chronic Ear Infection**	**Yes**	**No**
Arthritis	**Yes**	**No**	**Congestive Heart Failure**	**Yes**	**No**
Asthma	**Yes**	**No**	**Constipation**	**Yes**	**No**
Autism Spectrum Disorder	**Yes**	**No**	**Coronary Artery Disease**	**Yes**	**No**
Bedwetting	**Yes**	**No**	**Depression**	**Yes**	**No**
Birth Defects	**Yes**	**No**	**Developmental Disorder**	**Yes**	**No**
Bladder/Kidney Problems	**Yes**	**No**	**Diabetes**	**Yes**	**No**
Blood Disease	**Yes**	**No**	**Difficulty Swallowing**	**Yes**	**No**

Diverticulitis	**Yes**	**No**	**Lung Disease**	**Yes**	**No**
Ear/Hearing Problems	**Yes**	**No**	**MRSA Exposure**	**Yes**	**No**
Eating Disorder	**Yes**	**No**	**Meniere's Disease**	**Yes**	**No**
Eczema	**Yes**	**No**	**Mental Disorder**	**Yes**	**No**
Fibromyalgia	**Yes**	**No**	**Muscle, Joint Problem**	**Yes**	**No**
GI Problems	**Yes**	**No**	**Obesity**	**Yes**	**No**
Gout	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**
Headaches	**Yes**	**No**	**Ovarian Cancer**	**Yes**	**No**
Heart Problems	**Yes**	**No**	**Polyps**	**Yes**	**No**
Hepatitis	**Yes**	**No**	**Pulmonary Embolism**	**Yes**	**No**
High Cholesterol	**Yes**	**No**	**Reflux/GERD**	**Yes**	**No**
Hospitalizations	**Yes**	**No**	**Seizures/Epilepsy**	**Yes**	**No**
Hypertension	**Yes**	**No**	**Stroke**	**Yes**	**No**
Infertility	**Yes**	**No**	**Thyroid Problems**	**Yes**	**No**
Kidney Disease	**Yes**	**No**	**Tuberculosis (TB)**	**Yes**	**No**
Kidney Stones	**Yes**	**No**	**Varicosities**	**Yes**	**No**
Liver Disease	**Yes**	**No**	**Vision/Eye Problem**	**Yes**	**No**

Prior Surgeries and Hospitalizations

(Please list all prior operations and hospitalizations if none please skip)

Past Surgical History (Indicate date if known.

List Surgeries:_____

_____

List Prior Hospitalizatin's: _____

_____

Family History

FATHER: Living or Deceased

MOTHER: Living or Deceased

How many sisters?_____

How many brothers?_____

Tobacco Use

(Please Circle)

I do not smoke I smoke but rarely I am an everyday smoker I quit smoking

How many packs do you smoke?_____ When did you quit?_____

How many years did you smoke?_____ Smokeless tobacco use? Yes or No

Are you interested in quitting? Yes or No

Alcohol Use
(Please Circle)

I never drink I socially drink I regularly drink

How many drinks per week?_____ When was the last time you drank?_____

Is your alcohol use a concern to you or others? Yes or No

Sexual History

Are you currently sexually active? Yes or No

Birth Control Method:_____

Have you ever had any sexually transmitted diseases (STD's)? Yes or No

Social History

Work: Employed Unemployed Retired Disabled

Occupation:_____

Marital Status: Married Single Divorced Domestic Partner

Education Level: Elementary High School Vocational College Graduate

Number of children_____

Who lives with you?_____

Financial/Insurance Agreement

Panhandle Rural Health and Primary Care (PRHPC) is pleased to file Insurance claims; however, the patient or guarantor is responsible for ALL services provided. Authorization or pre-certification of a procedure does not guarantee payment by your insurance company. Since insurance companies determine amount of payment after claims have been submitted, we cannot know in advance how much your insurance will pay.

Please initial each paragraph and sign below:

_____ I have provided PRHPC with the most current insurance information available

_____ I authorize PRHPC to release to my insurance carrier(s) or their representative, any information from my medical records needed to process insurance claims, I transfer PRHPC my rights to all payments from any insurance carrier(s) for services rendered, and authorize my insurance carrier(s) to make directly to PRHPC.

_____ I acknowledge my financial responsibility for payment for all services provided by Panhandle Rural Health and Primary Care (PRHPC). Including those services which my insurance may consider not covered, not medically necessary, or incidental to another procedure.

_____ I agree to pay charges promptly upon receipt of first bill. If I am experiencing financial hardship, I will request approval of a payment plan at time of service. I understand that unpaid bills may be turned over to collections agency 90 days after date of service.

_____ _____

Patient Signature Date

_____ _____

Witness/PRHPC Employee Signature Date

Notice of Privacy Practices
Health Insurance Portability Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

About us

In this notice, we use terms like "we", "us", or "our" to refer to Panhandle Rural Health and Primary Care Inc. and it's providers. We are a family based practice specializing in keeping you and your family in good health. This notice applies to Panhandle Rural Health and Primary Care Clinic.

What is "Protected Health Information" or "PHI"?

"Protected health information", or "PHI" for short, is information that identifies who you are and relates to your past, present, and future physical or mental health or conditions, the provision of health care to you, or past, present, or future payment for the provision of health care to you. PHI does not include your health information in your personal life.

Purpose of this notice

In the course of doing business, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practice and how we protect the confidentiality of our PHI. We are obligated to maintain the privacy of your PHI implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this notice about our legal obligations to maintain the privacy of your PHI. We must follow our notice that is currently in effect.

How we protect your PHI

We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established a training program that our employees must complete and update annually. We have also established a privacy officer, which has overall responsibility for developing, training, and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use, and disclosure.

Types of use and disclosure of PHI we may make without you authorization

Treatment; Payment Health Care Operations

Federal and state law allows us to use and disclose our PHI in order to provide health care services to you, as well as to bill and collect payments for the health care services provided to you by our physicians. For example, we may use your PHI to authorize referrals to specialists and to review the quality of care provided by your participating physician. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our physicians.

We may also use or disclose your PHI, for example, to recommend to you treatment alternative, to inform you about health-related benefits and services that we offer or to contact you to remind you of your appointments. We conduct these activities to provide health care to you and not as marketing.

Federal and state law also allows us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use our PHI in connection with population-based disease management programs. We may use or disclose your PHI to perform certain business functions to our business associates, who must also agree to safeguard your PHI as required by law.

We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law- In some circumstances, we are required by federal or state laws to disclose certain PHI to others, such as public agencies for various reasons.
2. For public health activities- Such as report about communicable diseases, defective medical devices to the FDA or work-related issues.
3. Report about child and other types of abuse, neglect, or domestic violence.
4. For health oversight activities-Such as reports to governmental agencies that are responsible for licensing physicians or other health care providers
5. For lawsuits and other legal disputes- In connection with court proceedings or proceedings before administrative agencies or to defend us or our participating physicians legal dispute.
6. For law enforcement purpose- Such as responding to a warrant or reporting a crime.
7. Reports to corners, medical examiners, or funeral directors- To assist them in performance of their legal duties.
8. For tissue or organ donation- To organ procurement or transplant organizations to assist them.
9. For research- To medical researchers with an approval of an institution review board (IRB) or privacy board that overseas studies on human subjects. Researchers are also required to safeguard our PHI.
10. To avert a serious threat to the health or safety of you or other members of the public.
11. For national security and intelligence/military activities- Such as protection of the President or foreign dignitaries.
12. In connection with services provided under workers' compensation law.

We may disclose your PHI, without your written authorization, to your family members or other persons if they are involved in your care or payment for this. We may also notify disaster relief organizations to assist them with their relief efforts. When you are a patient at a hospital or medical facility with which we are affiliated, we may create directory that includes your name, your location at the facility, your general condition and your religious affiliation. Information in this director may be disclosed to visitors and clergy. However, we must first provide your with an opportunity to agree to such disclosure. If you cannot agree or object because you are incapacitated or otherwise unavailable, we will use our professional judgement.

You as a parent can generally control your minor child's PHI. In some cases, however, we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission.

Some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. However, even such PHI may be disclosed without your written authorization if required or permitted by law.

Authorization

All other uses and disclosures of your PHI must be made with your written authorization.

If you need an authorization form, we will send you one for you or your personal representative to complete. When you receive the form, please fill it out and send it to the following address:

Panhandle Rural Health and Primary Care
20274 W. Central Ave.
Blountstown, Florida 32424

You may also revoke or modify your authorization at any time by writing to us at the same address. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

Your right regarding your PHI

Access to your PHI

You have the right to review and copy your PHI we maintain. If you wish to access your PHI, please write to us. We will respond to your request and you when and where you can review your PHI in our possession within our normal business hours. If you would like a copy of the information we have please write to us at the same address If we provide you with a copy, we may charge a reasonable administrative fee for copying your PHI to the extent permitted applicable law. If we deny your request for review or copy your PHI, we will explain the reasoning in writing. If we do not have your PHI, but know who does we will tell you whom to contact.

Rights to Amend your PHI

You have the right to request amendments to your PHI. If you wish to have your PHI corrected or updated, please write to us and tell us what you want changed and why. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why. You may also send us an addendum that is no longer than 250 words in length for each item you believe is incorrect. Please clearly indicate that you want the addendum to be included in your PHI. We will attach your addendum to the record(s) of your PHI. Your amended PHI will be available for your review upon request.

Right to Receive an accounting of disclosure of your PHI

You have the right to request an accounting of certain disclosures that we make of your PHI. You can request an accounting by writing to us. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you. We will respond to your request within a responsible period of time but no later than 60 days after we receive you request.

Right to receive a copy of this notice
You have the right to request and receive a paper copy of notice.

Right to request restrictions
You have the right to request restrictions on how we use and disclose your PHI for our treatment, payment, and health care operations. All request must be made in writing. Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Please note that we are not required to accept your request for restrictions. Your PHI is critical for providing you with quality care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI and that additional restrictions may be harmful to your care.

Right to confidential communications
You have the right to request that we provide our PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternative means (e.g. sending by a sealed envelope, rather than a post card) or to an alternative address (e.g. calling you at a different telephone number or sending letter to you at your office address rather than your home address). We will accommodate any reasonable request, unless they are administratively too burdensome or prohibited by law.

Right to complain
We must follow the privacy practices set forth in this notice while in affect. If you have any questions about this notice, wish to exercise your rights, or file a complaint; please direct your inquiries to:

Panhandle Rural Health and Primary Care
20274 W. Central Ave.
Blountstown, Florida 32424

You may contact your health plan or the Idaho Medical Associatin with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filling a complaint against us.

Rights reserved
We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in this notice. We reserve the right to revise our privacy practice consistent with law and make them applicable to your entire PHI we maintain, regardless of when it was received or created. If we make material or important changes to our privacy practices, we will promptly revise our notice. Unless, law requires the changes, we will not implement material changes to our practices before we revise our notice. You may request updates to this notice at any time.
Effective date of notice 5/1/2020

Acknowledgement of Privacy Practice

We at Panhandle Rural Health and Primary Care are required by law to manage and provide individuals with the attached notice of our legal duties and privacy practices with respect to protected health information (PHI). We want our patients to know how your Protected Health Information (PHI) may be used and/or disclosed. Please sign this acknowledgement stating you received Panhandle Rural Health and Primary Care's Notice of Privacy Practices.

_____

Print Patient/Guardian/Legal Representative's Name

_____

Patient/Guardian/Legal Representative's Signature

_____

Date

Consent to Treatment

I hereby voluntarily consent to care from the encompassing route diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the providers at Panhandle Rural Health and Primary Care. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the Panhandle Rural Health and Primary Care providers and staff, as is necessary in the medical staff's judgement. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and /or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend this clinic.

Authorization to Release Information

I herby authorize Panhandle Rural Health and Primary Care to release any information acquired in the course of my examination and treatment to any authorized agent for the purpose of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of the benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

Authorization to Access RX History Information

I herby authorize the Panhandle Rural Health and Primary Care staff to access historical prescription drug information.

_____

Signature of Parent/Guardian/Legal Representative

_____

Date

_____

Signature of PRHPC Personnel

HIPPA Authorization for Use or Disclosure of Health Information

This form is for use when such authorization is required, and complies with the health insurance portability act of 1996 (HIPPA) Privacy standards.

Print Patient Name:_____

DOB:_____

I authorize Panhandle Rural Health and Primary Care to get my medical records.

Name and Number of Doctor where your records are coming from:

To use or disclose the following health information: (check one)

_____ All of my health information.

_____ My health information relating to the following treatment condition:

_____

_____ My health information from the last two years.

The above party may disclose this health information to the following recipient:

Panhandle Rural Health and Primary Care
20274 W. Central Ave
Blountstown, Florida 32424
Phone: 850-353-7689
Fax: 833-974-2185

_____
Signature of Parent/Guardian/Legal Representative

HIPAA Medical Information Release

Due to FEDERAL GUIDELINES under HIPAA we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to family members, caregivers and friends you have designated, about you or your minor child's PROTECTED HEALTH INFORMATION. This would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, mail, or e-mail as needed for your care to only those identified below. POWERS OF ATTORNEY WOULD BE LISTED SEPARATELY.

I _____, give authorization to the following individuals listed below to discuss my medical care with you and your staff on my behalf.

Names:	**DOB:**	**Phone Number:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any health information that you do not want to be given out please list below:

_____
_____
_____

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed.

Signature:_____ Relationship (if minor)_____ Date:_____

Witness:_____ Date:_____

Sign here if you DO NOT wish to have your medical care discussed with anyone but yourself.

Signature:_____ Date:_____

Witness:_____ Date:_____