CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Welcome

Welcome to our practice! Our goal is to provide the highest level of care possible in a timely manner. In order for us to reach this goal with each of our patients, we have established the following guidelines.

1. Patients are seen by appointment. We are unable to see "walk-ins", but we will make every effort to schedule urgent or acute illnesses the same day or the next day, if at all possible.
2. For prescription refills, please allow 24 hours for the prescription to be called into the pharmacy.
3. We will be happy to file your insurance for you. Because of our contracts with insurance companies, we are required to collect your co-pay or coinsurance at the time of check in.
4. For patients with no insurance, payment in full is expected at the time of service.
5. We ask that you turn off all cell phones while in exam rooms.
6. All telephone messages will be handled by our medical staff. They will send messages to Dr. Christopher, and our medical staff will get back to you as soon as possible.
7. After three "no-shows", (where the patient has an appointment but does not attempt to notify our office that they will be unable to make the scheduled appointment), our office has the right to discharge the patient from the practice.
8. It is YOUR responsibility to notify our office of any changes or updates to any of the following information. Please advise us as soon as possible of any phone, address, status updates, etc.
9. Failure to disclose the use of any controlled substances (including medical marijuana) to our office may result in dismissal from the practice. Please be open and honest about all medications/activities/chemicals that pertain to you.
10. Due to high call volume, we encourage all patients to communicate using the Healow patient portal to ensure timely response to all non-emergent inquiries. Refills, results, referrals, and almost any medical questions can be address more quickly and efficiently using the patient portal. It also allows 24/7 access to your medical records, results, medications, and much more! Please ask us if you have any questions or need assistance.

We hope you will find your visit here pleasant and comfortable. We look forward to having a physician/patient relationship with you for many years to come.

Thank you,

Christopher MD and Associates

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Welcome

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home/Primary phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Email Address:						

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:
Previous Primary Care Physician:
Date of Last physical exam:

Race:	☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to answer

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			
Please indicate primary insurance			

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

		/ /			$
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CHRISTOPHER M.D. & ASSOCIATES131 E. REDSTONE AVE, SUITE 107CRESTVIEW, FL 32539 Ph: 850-682-6320 Fax: 850-682-6339 or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Health Maintenace Information:

Immunizations and Dates

☐ Influenza	☐ Hepatitis B	☐ MMR, Measles, Mumps, Rubella
☐ Pneumonia/Prevnar 13/ Pneumovax 23	☐ Shingles/Zoster	☐ Tdap, Tetanus, diphtheria, pertussis
☐ Covid Vaccine		

Allergies:	**Pharmacy:**
MEDICATIONS:	**MEDICATIONS: Anyone prescribed medical marijuana MUST provide the state issued card to our office staff!**

Other Physicians Seen:

Example: Dr. Smith Cardiology	

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Social History

Marital Status (circle one): Married Widowed Single Divorced Other:						
Children	☐ Yes	☐ No	How many children?			
Tobacco Use?	☐ Yes	☐ No	Quit Date	Type of Tobacco Used:		
Alcohol Use	☐ Yes	☐ No	Recreational Drug Use?	☐ Yes	☐ No?	Substances Used?
Living Will:			Power of Attorney:		Education Level: Occupation:	
Sexual History	Had sex in the last 12 months with:(circle one) Men Women Both			☐ Yes ☐ No	Use Protection?	
LMP:	Have you ever had an STD?		☐ Yes ☐ No	If yes, what STD?		
Do you experience Domestic Violence in your home?			☐ No	☐ Yes		

Health Maintenance

Last date of procedure (approx. if not certain)		
Mammogram		
PAP		
DEXA/Bone Scan		
Labs		
Colonoscopy		
Eye Exam		
Cardiac Stress Test		

Family History

Relationship	Known Health Issues	Approx. Date Deceased	Cause of Death
Mother			
Father			
Pat Gr Father			
Pat Gr Mother			
Mat Gr Father			
Mat Gr Mother			
Spouse			
Brothers/Sisters			
Children			

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Medical History-check all that apply	**Surgical History:** List all past surgeries
☐ Atrial Fibrillation	
☐ Anxiety/Depression	
☐ Asthma/COPD	
☐ Anemia	
☐ Cancer	
☐ Cough (persistent)	
☐ Heart Attack	
☐ Diabetes	
☐ Stroke	
☐ Urinary Incontinence	
☐ High Cholesterol	
☐ Hyper/Hypothyroidism	
☐ Gout	
☐ Gastritis/Ulcer	
☐ Muscle/Bone	
☐ Migraines	
☐ Mental Health	
☐ Osteoporosis	
☐ Osteoarthritis	
☐ Palpitations	
☐ Hypertension (High Blood Pressure)	
☐ Kidney Disease	
☐ Liver Disease	
☐ TIA (Transient Ischemic Attack)	
☐ Seizures	
☐ Sleep Apnea	
☐ Shortness of Breath	
☐ Other:	

STOP- Give all paperwork already completed to the front desk so we may process it in a timely fashion.

Communications Consent Form

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Please provide consent for any/all methods by which you would prefer us to communicate with you.

Home Telephone Number: _____

Cell Phone Number: _____
_____ **Consent to Text message use**

Work Telephone Number: _____

Email address: _____@_____

Other: (please specify preferences or means for which you would like to be contacted)
_____

Patient Name: _____

Patient Signature: _____

Date: _____

Designation of Personal Representative

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form, you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Designation Section

I, _____ (print name) hereby nominate the following person(s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Name	Phone Number	Relationship to patient

This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Christopher MD and Associates at 131 E Redstone Ave Ste 107, Crestview FL 32539. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____

Signature **Date**

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Privacy Practice

I. Your Protected Health information
II. Uses and Disclosures of Your Protected Information
III. Patient Privacy Rights
IV. Changes to this Notice
V. Complaints
VI. Legal Effect of this Notice

Detailed information is in the patient waiting room or at reception desk.

I acknowledge that I have read the Notice of Privacy Practices for Christopher MD and Associates.

Name: _____

Signature: _____ Date: _____

_____
Name of Personal Representative

_____

Relationship to Patient

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Results Notification Policy

We at Christopher MD and Associates strive to obtain all results in a timely fashion. You will be notified personally of all **abnormal** results by one of our nursing staff. If results are **normal**, we may send you electronic communication or release the results to the patient portal as soon as they are available.

If you have not received any communication in regard to results within a week of the test being performed, it is ultimately the patient's responsibility to contact the provider to obtain information about said results.

I, _____, accept and agree to the results protocols in place for Christopher MD and Associates. I understand it is my responsibility to follow up with the ordering physician regarding receiving timely results.

Signature: _____ Date: _____

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

CHRISTOPHER, MD. & ASSOCIATES

131 Redstone Avenue, Suite 107, Crestview, FL 32539
Ph: 850-682-6320 Fax: 850-682-6339

Authorization for Release of Information

Instructions: Fill in all blanks for required information and sign release

Patient: NAME: _____

Identification: DOB: _____
Parents/Previous Name: _____

Provider: NAME: _____
(MD releasing data) ADDRESS: _____

Information Requested:

- Complete Records/dates: _____ Purpose: _____
- Labs/Date: _____
- EKG/Date: _____
- H&P Date: _____
- Immunization Records: _____
- Radiology/Date: _____
- Other/Specifics: _____

Send Information to Christopher MD and Associates
131 E Redstone Ave Ste 107
Crestview FL 32539
850-682-6320 (p), 850-682-6339 (f)

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to: (check all that apply)

- Substance Abuse
- HIV or AIDS related testing and treatment
- Mental Health

This authorization is good for **one year from the date of signature.** I understand that I may revoke this authorization at any time by giving written notice to CMDA. I understand that I have the right to inspect t the information and data disclosed under proper notification and under appropriate conditions. This statement is made and the authorization is binding, controlling, and I understand that they take precedence over statements made in the CMDA Privacy Practices.

Signature of Patient/Legal Representative: _____

Date: _____ Relationship to patient: _____

CHRISTOPHER M.D. & ASSOCIATES

Name: _____ **DOB:** _____

Christopher MD and Associates
131 E Redstone Ave Ste 107
Crestview FL 32539
Open Monday to Thursday from 7:30 am to 4:30 pm
Open Fridays from 7:30 am to 12:00 pm

Phone: 850-682-6320
Ext 1- Nursing Questions
Ext 2- New Patients/Billing Questions
Ext 3-Refill Line (Voicemail Only)
Ext 4-Appointment Line
Ext 5-Emegency Line ONLY!
Fax: 850-682-6339

Please visit our website at **Christophermdonline.com.** There you can see details about our practice and access your patient portal via the Healow Link.

HEALOW INSTRUCTIONS FOR CELLULAR DEVICES

- ☐ In order to access the Healow app, you must have a smart phone.
- ☐ Download the Healow app or go to Healow.com
- ☐ Click the access your Health Record button and locate your doctor's office by typing in city/state/zip (Crestview, 32539, Christopher) Click Go.
- ☐ Select your practice from the list and enter your unique username and password that was provided to you. Usernames and passwords are case sensitive.
- ☐ Validate your identity by entering your date of birth OR phone number and click Next
- ☐ After validation, you must create a new password to replace the temporary password.
- ☐ Enter your new password to confirm the password.
- ☐ When your new password is confirmed, click Log in

HEALOW INSTRUCTIONS FOR COMPUTERS

- ☐ Go to chrstophermdonline.com
- ☐ Click the link at the top R hand of the page that says "Login to eClinicalWeb Portal"
- ☐ Enter your unique username and password that we have provided to you.
- ☐ Validate your identity by entering your date of birth OR phone number and click Next
- ☐ After validation, you must create a new password to replace the temporary password.
- ☐ Enter your new password 2 times to confirm the password.
- ☐ Select your security question and answer, click Agree.
- ☐ If you have read and accept the terms in the Practice Consent Form, click Agree
  When your new password is confirmed, click Log in.