CHRISTOPHER M.D. & ASSOCIATES

Office: Christopher MD and Associates

Address: 131 East Redstone Ave Suite# 107
Crestview, FL 32539

Hours: Open Monday to Thursday from 7:30am to 4:30pm
Open Fridays from 7:30am to 12:00pm
Closed on Saturday to Sunday and Holidays

Website: Christophermdonline.com

Phone: 850-682-6320
Ext 1- Appointments
Ext 2- New Patients/Billing Questions
Ext 3- Refill Line (Voicemail Only)
Ext 4- Nursing Line
Ext 5- Physician/Hospital Line

Fax: 850-682-6339

Practice Code: DHBJAA

Healow Health Portal

Instructions for Cellular Devices

- In order to access the Healow app, you must have a smart phone (Android, iPhone, etc.).
- Download the Healow app.
- Click the access your Health record button and locate your doctor's office by typing in the Provider's Name and Zip code (Christopher, 32539) then click Go.
- Select your practice from the list provided (Christopher MD and Associates).
- Validate your identity by entering your date of birth, name, or phone number and click Next.
- After validation, you must create a new password.
- Enter the new password to confirm, click Log In.
- You must have a lock on your phone in order to access your Healow portal.
- Once password is confirmed you may set up a 6 digit pin number for easy log in for the future.

Instructions for Computers

- Go to christophermdonline.com
- Click the link at the top right hand of the page that says "Login to eClinicalWeb Portal".
- Enter Practice Code: DHBJAA
- Validate your identity by entering your date of birth, name, or phone number and click Next.
- After validation, you must create a new password.
- Enter the new password 2 times to confirm.
- 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.

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(Please print clearly and give your insurance cards to the Receptionist)

Name: _____ DOB: _____ Date: _____

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Prefix/ Suffix:
Is this your legal name? Yes / No	If not, what is your legal name?	Former Name:	Birth Date: / /
Age:	Marital Status: Single / Married / Divorced / Separated / Widowed	Sex: Male / Female	Social Security Number:
P.O. Box:	Street Address:	City:	State:
Zip Code:	Email Address:		
Occupation:	Employer:		Employer Phone Number:
Referred to Clinic by (Circle One):	Friend / Family / Location / Online / Insurance / Hospital / Other Doctor / Other:_____	Do you have other family members seen here: Yes / No	If Yes, then Who? _____
Date of Last Physical Exam:	Previous Primary Care Physician:	Race (Circle One): American Indian / Asian / Alaska Native / Caucasian / African American /	Native Hawaiian / Pacific Islander / Unknown / Decline to answer

IN CASE OF EMERGENCY

Name of local friend or relative (NOT living at the same address):	Relationship to the 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. & ASSOCIATES 131 EAST REDSTONE AVE, SUITE 107 CRESTVIEW, FL 32539 Phone: 850-682-6320 Fax: 850-682-6339 or insurance company to release any information required to process my claims.

_____ _____

Patient/ Guardian Signature Date

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(Please Print Clearly)

INSURANCE INFORMATION

Person Responsible for bill:	Birth Date: / /	Address (if different):	
Is the Responsible person a patient here? Yes / No	Is this Patient covered by Insurance? Yes / No	Cell Phone No.:	Home Phone No.:
Occupation:	Employer Address:		Employer Phone No.:
Primary Insurance:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Birth Date:
	Group No.:	Policy No.:	Co-Payment:
Patient's Relationship to Subscriber (Circle One):	Self / Spouse / Child / Other		
Secondary Insurance:	Subscriber's Name:	Subscriber's SSN	Subscriber's Birth Date:
	Group No.:	Policy No.:	Co-Payment:
Patient's Relationship to Subscriber (Circle One):	Self / Spouse / Child / Other		

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 and at the receptionist desk.

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

_____ _____

Name of Patient Date

_____ _____

Signature Relationship to Patient

_____

Name of Personal Representative

CHRISTOPHER M.D. & ASSOCIATES

(Please Print Clearly)

RESULTS NOTIFICATION POLICY

We at Christopher M.D. 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 M.D. and Associates. I understand it is my responsibility to follow up with the ordering physician regarding receiving timely results.

_____ _____

Signature Date

COMMUNICATIONS CONSENT

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

Home Phone Number: _____ Email: _____

Cell Phone Number: _____ Consent to Receive Text Message: (Circle One)

Work Phone Number: _____ Yes / No

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

_____ _____

Patient's Name Date

_____

Patient's Signature

CHRISTOPHER M.D. & ASSOCIATES

(Please Print Clearly)

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Insurance Portability and Accountability Act (HIPAA) 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 or persons as your personal representative(s). 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, _____, 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.

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

Name	Phone Number	Relationship to the Patient

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 M.D. 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

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(Please Print Clearly)

Health Maintenance Information

Name: _____ DOB: _____

Immunizations and Dates:

○ Influenza	○ Hepatitis B	○ Measles, Mumps, & Rubella
○ Pneumovax23/ Pneumovax20/ Prevnar13	○ Shingrix	○ Tetanus, Diptheria, & Pertussis
	○ COVID Pfizer/ Moderna/J&J	

Other Physicians Seen:

Example: Dr. Smith Cardiology in Destin, FL 850-123-4567	

Pharmacy:	
Allergies:	
Medications:	**Note: If you are prescribed medical marijuana you MUST provide the state issued card to the receptionist.**
Please include name, dosage, and frequency of all prescribed and OTC medications to include supplements	

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(Please Print Clearly)

Name: _____ DOB: _____

Social History:

Marital Status:	Married	Single Divorced	Widowed Other:
Children:	Yes No	How many children?	
Education Level:		Occupation:	
Living Will:	Yes No	Power of Attorney: If answered Yes, who?	Yes No _____
Tobacco Use: (Cigarettes, Snuff, Vaping, Chewing tobacco, etc.)	Yes No Former	Start Date: Quit Date:	○ ½ PPD ○ 1 PPD ○ 2 PPD ○ Over 3 PPD ○ Socially < 1 cig/day ○ Other:
Alcohol Use:	Yes No	Do you drink alcohol: ○ Daily ○ Weekly ○ Monthly ○ Yearly	How many drinks per occasion: ○ 1-2 ○ 3-4 ○ 5-6 ○ 7 or more
Recreational Drug Use:	Yes No Former	Substances Used?	Quit Date:
Have you had sexual intercourse in the last 12 months:	Yes No	If Yes, have you had sex with (circle one): Men Women Both	Did you use protection?
Have you ever had a Sexually Transmitted Infection (STI)?	Yes No	If Yes, what STI?	Do you experience Domestic Violence in your home? Yes No

	Date of last procedure and where it was completed
Eye Exam	
Pap Smear	
Mammogram	
Colonoscopy	
DEXA Scan	
Cardiac Stress Test	
Labs	

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(Please Print Clearly)

Name: _____ DOB: _____

Medical History:

○ Atrial Fibrillation	○ Anxiety	○ Asthma
○ Cancer	○ COPD	○ Cough (Persistent)
○ Gastritis/ Ulcer	○ Gout	○ Heart Attack
○ High Blood Pressure	○ Hyper/Hypothyroidism	○ Kidney Disease
○ Seizures	○ Sleep Apnea	○ Stroke
○ Osteoporosis	○ Arthritis	○ Urinary Incontinence
○ Anemia	○ Diabetes	○ High Cholesterol
○ Liver Disease	○ Migraines	○ Depression
○ Others:		

Surgical History:

Approx. Date	Procedure Name

Family History:

Relationship	Date Deceased	Health Issues	Cause of Death
Father			
Mother			
Pat Gr Father			
Pat Gr Mother			
Mat Gr Father			
Mat Gr Mother			
Spouse			
Siblings			
Children			

CHRISTOPHER M.D. & ASSOCIATES

131 East Redstone Ave, Suite 107, Crestview, FL 32539

Ph: 850-682-6320 Fax: 850-682-6339 or 850-682-6303

Authorization for Release of Information

Patient Name: _____

Date of Birth (DOB): _____

Previous/Alias/Maiden Name(s): _____

Provider Name: _____

(MD releasing data) Phone and Address: _____

Information Requested:

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

Send Information to: **Christopher MD and Associates**

131 E Redstone Ave Suite# 107

Crestview, FL 32539

(P) 850-682-6320 (F) 850-682-6303

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 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: _____