Anne M. Lord, D.O., FACOOG

12650 World Plaza Lane, Bldg. 72, Ste.
2 Ft. Myers, FL 33907
P: (239) 656-9006 F: (239) 372-0269
E: info@Dranneallin.com

(Please Print Clearly)

Today's date:	PCP:

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 phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Email:

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

❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Google ❑ Billboard ❑Ad

Other family/ friends members seen here:

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 [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Patient Health History

Name: _____ **Date:** _____

Gender: M F Age: DOB: _____ **PCP:** _____

Drug Allergies: _____ **Current Concerns:** _____

_____ _____

Family History - Check All That Apply

Conditions	Father's side	Mother's side	Siblings
Heart Disease/ Heart Attack			
High Blood Pressure			
Stroke			
Anesthesia Complications			
Diabetes			
Epilepsy/ Seizures			
High Cholesterol			
Bleeding Disorder/ Blood Clots			
Kidney/ Liver Disease			
Asthma			
Thyroid Disease			
Cancer/ Type			
Drugs/ Alcoholism			
Mental Illness			

Current Prescriptions/ Medications (include non-Rx)

Medication	Dose	Frequency

Social History/ Habits

Substance	Type	Frequency	Date Quit
Tabacco			
Alcohol			
Cannibis/ Non Rx Drugs			
Exercise	1-3 d/wk	3-7 d/wk	None

Patient Medical History - (Please Circle)

Headache	Gall Bladder	Heart Attack/ Chest Pain/ Angina	Psychiatric Treatment
Prostate or Breast Disease	Rheumatic Fever	Menstrual Dysfunction	Seizures or Convulsions
Kidney Stones/ Disease	Heart Murmur/ Irregular Heart Beat	High Cholesterol	Hepatitis
Diabetes	HIV/ AIDS	Bleeding Disorder/ Clots	Depression
Asthma/ Pulmonary Disease	Sexually Transmitted Disease or HSV	Anemia	Nervousness or Anxiety
Cancer or Tumor	Pneumonia	Alcoholism	Drug Dependency
Ulcer/ GI Disorder	Goiter or Thyroid Problems	High Blood Pressure	Other (specify in notes)
Additional Notes:			

Patient Surgical History

Please list:

For Women Only

Last Pap:	**Abnormal Paps?**	**Abnormal Follow ups?**
# of Pregnancies:	**# of Deliveries:**	**# of Losses:**
Current Method of Birth Control:		**Age at Menopause:**
Date of Last Mammogram:	**Normal or Abnormal ?**	**Last Period:**
Date of Last Bone Density:	**Normal or Abnormal ?**	
Additional Notes:		

Anne M. Lord, D.O., FACOOG

12650 World Plaza Lane, Bldg. 72, Ste. 2
Ft. Myers, FL 33907
P: (239) 656-9006 F: (239) 372-0269
E: info@Dranneallin.com

Patient Name:_____

Date of Birth:_____

You may be contacted by Dr. Anne All In for appointments or exchange of clinical information, and you may be unavailable to answer your phone. In this event, does Dr. Anne All In have permission to leave a message on your voicemail/ email/ text?
YES ❑ **NO ❑**

Do you also give permission for pre and post images of your surgical or procedural site with Dr. Anne Lord / Clinical Associates & Staff to be utilized for purposes within the scope of the practice of Dr. Anne All In, including being part of your permanent record and transmitting images via email or an online secure portal between the practice and yourself?

YES ❑ **NO ❑**

Do you further give permission for your images to be used for educational/ teaching purposes or on the practice website "Before & After" section? **YES ❑** **NO ❑**

Do you give permission for certain clinically oriented professionals (i.e., Medical Students/ Residents, Medical-surgical company Reps, clinical personnel) to observe/ participate alongside of your Doctor? **YES ❑** **NO ❑**

We understand that from time to time, family members, care takers, etc. may have questions about your appointments, procedures, medications or test results. To protect the privacy of the patient, we are prohibited from speaking to anyone other than the patient about medical care. You may however, provide a name/s of individuals to whom we are able to speak with to disclose your information to.

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Patient Signature: _____ **Date:**_____

Anne M. Lord, D.O., FACOOG

12650 World Plaza Lane, Bldg. 72, Ste. 2
Ft. Myers, FL 33907
P: (239) 656.9006 F: (239) 372.0269
E: info@Dranneallin.com

PATIENT FINANCIAL POLICY

Thank you for selecting Dr. Anne Lord as your health care provider. Dr. Anne All In LLC payment and professional relationship policy is designed to provide the highest quality of health care without overbearing or time consuming hassles and constraints of an insurance based practice. The focus is purely on an optimal one-on-one relationship in a “direct patient care model”, which equals more time for you and superior outcomes.

"Self Pay Practice”

- By signing below you are responsible for full payment of services rendered to **Dr. Anne All In LLC**, and understand and acknowledge that any amount(s) which are designated as "patient responsibility" are payable at the time service is provided. You will be responsible for payment of all fees at the time of service. I further give permission for any representative of **Dr. Anne All In LLC** to charge my Credit Card for any deposit that may be required on my behalf for consultations or procedures. I also understand that I am subject to pay **$125 cancellation fee** if my scheduled visits are not canceled 24 hrs greater to my scheduled visit. Said deposit/ charges are **non-refundable. _____ (Initial)** I understand and agree that I am responsible and may be billed for any additional specimen testing, i.e. cytology, pathology, labs etc. I agree to assume any necessary fees involved in the collection of any remaining balance should I become delinquent. (The parent or guardian accompanying a minor is responsible for all expenses at the time of service). **_____ (Initial)**

- We will not submit any information/ codes or communicate with any insurance company/ Health saving account representative on your behalf. **_____(Initial)**

- We accept Visa, MasterCard, Debit Card, Cashiers checks, Traveler’s checks & Cash.

- In the event you have any questions regarding our bill or need assistance in making payment arrangements, billing department can be reached by calling (239)656.9006. Dr. Anne All In strives to meet personalized needs of our patients. Please understand that payment of your bill is part of your treatment and our professional relationship.

I have read the above Patient Financial Policy of Dr. Anne All In LLC and understand my financial responsibility as a patient.

Patient Signature_____ DOB:_____ DATE: _____

Anne M. Lord, D.O., FACOOG

12650 World Plaza Lane, Bldg. 72, Ste. 2
Ft. Myers, FL 33907
P: (239) 656.9006 F: (239) 372.0269
E: info@Dranneallin.com

Consent to Treat & Notice of Privacy Practices (HIPPA)

I authorize Dr. Anne Lord, or Clinical Associates at Dr. Anne All In to to perform a compete physical examination on me today, and for further related visits, within the office and surgical center. This is relevant to my clinical concerns and to assist the doctors and appointed staff in their clinical decision- making. **This Doctors' office is regulated pursuant to the rules of the Board of Osteopathic Medicine as set forth in Rule Chapter 64B15, F.A.C.**

Patient Signature_____ **DOB:**_____ **DATE:** _____

Print Name _____

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical data and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient's Signature_____ **DOB:**_____ **DATE:** _____

Print Name _____