Southern Breeze Healthcare
Family Medicine Allergy Immunology Pulmonology
Gary P. Bullard, PA-C
4566 E. Hwy 20, Suite 105
Niceville, FL 32578
Ph#: 850-279-4543 Fax#: 850-279-4827

Patient Registration Form

Today's Date____/_____/_____

Patient Name:_____,_____ Birth Date:___/___/____ Sex: M / F
(Last) (First)

Address:_____
(Street) (City/State/Zip)

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Email:_____

(Circle One) Married/Single/Divorced/Widowed/Minor Social Security #_____-_____-_____

Contact Preference: (Home Ph / Cell Ph / Email / US Mail) Preferred Pharmacy_____

Employer:_____ Employer Phone Number:(_____)_____-_____

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact Number:_____

Guarantor: (If different from patient)_____ Relationship:_____

Birth Date:___ /___/____ Address:_____
(Street) (City/State/Zip)

Insurance Information

Primary Insurance:_____ Member ID:_____Group#:_____

Patient Relationship to Subscriber:_____

Secondary Insurance:_____ Member ID:_____Group#:_____

Patient Relationship to Subscriber:_____

Designation for Release of Information

I permit the staff at Southern Breeze Healthcare to discuss my protected health information, in person or by telephone with the person named below. This includes the ability to make, cancel, or reschedule appointments on my behalf and assist me in making payments or inquiring about my billing account.

Name:_____ Relationship:_____

I authorize the release of any medical information necessary to process my claims to my insurance company, and request payment of benefits to Southern Breeze Healthcare, P.A. I acknowledge that I am financially responsible for payment whether or not services are covered by insurance. All information provided above is true to the best of my knowledge.

Signature:_____ Date:____/_____/_____

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Patient's Name:_____ Date of Birth:_____/_____/_____

Preferred Lab:_____

Present Problem

What is the reason for your visit today?_____

Do you have a chief complaint/concern?_____

When did the problem begin and how often does it occur?_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

Medication and Allergy Review

Medication/Supplement	Dosage/Frequency	Medication/Supplement	Dosage/Frequency
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Allergy	Reaction
1.	
2.	
3.	

Social History

Exercise: None/Mild/Vigorous	Alcohol Intake: Yes/No Drinks Per Week:_____	Tobacco Usage: Yes/No How Long?_____ Year Quit____ Packs Per Day?_____
Immunization: Current/Opt Out Last Date Administered:	Current/Past Usage of Recreational Drugs: Yes/No	Do you have pets? Y/N What kind?

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Patient's Name:_____ Date of Birth:____/____/_____

What other providers do you currently see?_____,_____

What other Primary Care Providers have you seen?_____,_____

Past Medical History

What other Primary Care Providers have you seen in the past?_____

Date of Last: (if applicable) 1.Eye Exam:___/___/____ 2.Dental Exam:___/____/___ 3.PSA____/____/____

4.Colonoscopy:____/_____/____ 5.Pap:_____/____/____ 6.Mammogram:____/____/____

Please list Any Hospitalizations/Surgeries and Year:

1.	4.
2.	5.
3.	6.

Family Health History

	Mother	Father	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Siblings	Children
Age								
Alive Y/N								
Allergies/Hay Fever								
Asthma								
Cancer								
Food Allergies								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Immunodeficiency								
Other:								

Southern Breeze Healthcare, PA

Patient Name: _____ Initial ROS provided by the patient on ___/___/20___

Check If You Have The Following:								ADOLESCENT Male (Ages 11-17) ROS	
GENERAL		Swelling to arms/legs		TICs		Developmental delays			
Growth concerns		Hypertension		**ENDOCRINOLOGY**		Hyperactive			
Difficulty Sleeping		Hyperlipidemia		Hypothyroidism		ADHD			
Fatigue		**GASTROENTEROLOGY**		Flushing		**PERFERRED LABORATORY**			
Headaches		Appetite changes		Diabetes		Location:			
Involuntary wt gain		Bowel habit changes		Excessive sweating					
Difficulty losing wt		Heartburn/reflux		Excessive thirst					
Involuntary wt loss		Abdominal pain		Temperature Intolerance		**PREFERRED PHARMACY**			
Difficulty gaining wt		Bloating		Adrenal/endo problems		Location:			
Fever		Nausea		**HEMATOLOGY/LYMPH**					
ENT		Vomiting		Bleed easily					
Ear pressure		Malabsorbtion		Bruise easily					
Ear pain		Food Allergies		Swollen lymph nodes		**NOTES:**			
Sore throat		Difficulty swallowing		Anemia					
Sinus pressure		**UROLOGY**		Vitamin deficiencies					
Sinus pain		Burning/painful urination		**IMMUNE SYSTEM**					
Runny nose		Frequency		Immune deficiencies					
Sneezing		Leakage		Frequent infections					
Nasal congestion		Difficulty urinating		IVIG/SQIG infusions					
Nose bleeds		**MALE REPRODUCTIVE**		**RHEUMATOLOGY**					
Hearing loss		Circumsided		Juvenile RA					
Mouth/tooth pain		Testicular masses		Lupus					
Problems smelling		Teticular pain		Psoriatic Arthritis					
Vocal hoarseness		Penis discharge/pain		Fibromyalgia					
OPTHALMOLOGY		Sexually active		Connective tissue disorders					
Watery eyes		Self exam		**MUSCULOSKELETAL**					
Itchy eyes		**DERMATOLOGY**		Muscle Pain					
Red eyes		Itching		Muscle spasms					
Dry eyes		Rashes		Muscle weakness					
Blurred vision		Hives/urticaria		Joint pain					
Vision loss		Dry skin		Neck pain					
Allergy shiners		Eczema/atopic dermatitis		Back pain					
Painful eyes		Lumps/bumps		Chronic pain					
Glasses/contacts		Boils		**PSYCHOLOGY**					
RESPIRATORY		Acne		Anxiety					
SOB at rest		Hair loss		Stress					
SOB with activity		Hair thinning		Depression					
Wheezing		New/changing moles/lesions		Behavioral issues					
Cough		**NEUROLOGY**		Anger/irritable					
Chest congestion		Neuropathy		Suicidal idealtions					
Smoke/vape		Numbness to arms/legs		Homicidal idealations					
Asthma		Dizziness		Confusion/brain fog					
CARDIOLOGY		Recent loss of consciousness		Problems concentrating					
Chest pain		Seizures		Problems organizing					
Palpitations		Tremors		Learning delays					

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Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your healthcare provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative:_____

Printed Name of Patient or Personal Representative:_____

Relationship to Patient:_____

Date:___/____/____

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Your Rights and Responsibilities as a Patient of Southern Breeze Healthcare

* To courtesy, respect, dignity, and timely, responsive attention to your needs.

* To receive information from your HealthCare Provider and to have the opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their Provider will offer guidance about what they consider the optimal course of action for the patient based on the Physician's objective professional judgment.

* To ask questions about your health status or recommended treatment when you do not fully understand what has been described and to have their questions answered.

* To tell your HealthCare Provider everything you know about your illness/condition. To include all medications/supplements.

* To make decisions about the care the Physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.

* To accept the consequences if you refuse to follow your healthcare professionals recommendations.

* To have the Provider and other staff respect the patient's privacy and confidentiality.

* To obtain copies or summaries of your medical records.

* To obtain a second opinion.

* To be advised of any conflicts of interest your Provider may have with respect to your care.

* To continuity of care. Patients should be able to expect that your provider will cooperate in coordinating medically indicated care with other health care professionals, and that the Provider will not discontinue treating them when further treatment is medically indicated, without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

* Case discussion, consultation, examination, and treatment are considered confidential and will be conducted discreetly.

Patient Signature:_____ Date:_____/_____/_____

Printed Name:_____

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NEW PATIENT AGREEMENT

Please initial alongside each item *of* information as acl‹nowledgement and understanding of the policies/expectations listed.

1._____**Appointment time:** I am expected to arrive 10 minutes prior to my appointed time.

2._____**Co-payment:** I will pay my *co-pay* by cash, check or credit/debit card before leaving the clinic.

3._____**No insurance:** If I have no insurance, full payment is due on the day of the office visit.

4._____**Late for appointment:** If I am more than 15 minutes late for my scheduled appointment, I understand that I may have to wait until P.A.-C Gary Bullard can work me into the schedule. (We will make every effort to do so or reschedule for a later date).

5._____**No-show appointment:** There will be a $50.00 fee which is NOT part of a co-pay and is NOT billed to my insurance.

6._____**Controlled substance medication:** Due to continued efforts to decrease the amount of controlled substances circulated by the general public for recreational purposes, both the state of Florida and the DEA have strict controlled substances laws. All patients requiring regular controlled substance prescriptions (for pain, sleep, narcolepsy, anxiety and attention deficit disorders) are required to sign a controlled substance informed consent and are subject to periodic urine drug screen testing.

_____ _____

Patient Name and Date Staff Member and Date

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NOTICE OF PRIVACY PRACTICES

Effective date: 1 July 2014

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our office in a visible location, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact a member of your medical team.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including, but not limited to our Providers and nurses, may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your health information:

1.Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury of illness or medical surveillance.

2.Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. These activities can include investigations, inspections, audits, surveys, licensure & disciplinary actions; civil, administrative and criminal procedures/actions; other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use or disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has

(A) The use or disclosure involves no more than minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health or safety or the health/safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12.Workers' compensation. Our practice may release your PHI for workers' compensation/similar programs.

E. **Your rights regarding your PHI:**

You have the following rights regarding PHI that we maintain about you:

1.Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to: **Gary Bullard, P. A. C at 4566 Highway 20 East, Ste 105, Niceville, FL 32578,** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to**: Gary Bullard , P..A. C. at 4566 Highway 20 East, Ste 105, Niceville, FL 32578**. Your request must describe in a clear and concise fashion.

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Gary Bullard, P.A. C at 4566 Highway 20 East, Ste 105, Niceville, FL 32578** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Gary Bullard, P.A. C at 4566 Highway 20 East, Ste 105, Niceville, FL 32578.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not

5. Accounting of disclosures. All our patients have the right to request an accounting of disclosures. An accounting of disclosure is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the Provider sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: **Gary Bullard, P.A.C at 4566 Highway 20 East, Ste 105, Niceville, FL 32578**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of these privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact any member of the medical team.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Gary Bullard ,P.A. C at 4566 Highway 20 East, Ste 105, Niceville, FL 32578**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact a member of the medical team.

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NOTICE OF PRIVACY PRACTICES
Patient Acknowledgement of Understanding

I have received this practice's Notice of Privacy Practices. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made of this Practice. The Notice includes:

*A statement that this Practice is required by law to maintain the privacy of protected health information.
*A statement that this Practice is required to abide by the terms of the Notice currently in effect.
*Types of uses and disclosures that this Practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
*A description of the other purposes of which this Practice is permitted or required to use or disclose protected health information without my written consent or authorization.
*A description of uses and disclosures that are prohibited or materially limited by law.
*A description of other uses and disclosures will be made only with my written authorization and that I may revoke such authorization.
*My individual rights with respect to protected health information and a brief description of how I exercise these rights in relation to:

The right to complain to this Practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
The right to request restrictions on certain uses and disclosures of my protected health information, and that this Practice is not required to agree to a requested restriction.
The right to receive confidential communications of protected health information.
The right to inspect and copy protected health information.
The right to amend protected health information.
The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of the Notice of Privacy Practices upon request.

*This Practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this Practice's current Notice of Privacy Practices on request.

Patient/Guardian Name (Print):_____

Signature:_____

Relationship to Patient:_____

Date:_____/_____/_____