PEA RIDGE FAMILY CARE CENTER
5553 HWY 90,
PACE FL, 32571
PHONE (850) 995-8811

DAVIS HWY FAMILY PRACTICE
5500 N DAVIS HWY STE # 2
PENSACOLA, FL 32503
(850) 475-0867

WOODBINE NIGHT CLINIC
5606 WOODBINE RD
PACE, FL 32571
(850) 995-606

Patient Name: _____ Date: _____
(Last, First, Middle Initial)

DOB: _____ SSN: _____

If patient is under 18 years of age or unable to comprehend responsible party:

Responsible Party's Name: _____
(Last, First, Middle Initial)

Relationship to Patient: _____

**Please read the new patient information provided for you in the folders and sign bellow acknowledging you have read and understand them.**

1 Consent To Treat/Privacy Act: I have read, understood and I agree

Signed: _____

2. HIPPA/NOTICE OF HEALTH INFORMATION PRACTICES

Signed: _____

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# PATIENT INFORMATION SHEET

NAME OF PATIENT_____
Last First M

Address_____City_____St_____Zip____

Home Phone_____Cell_____

Date of Birth_____Age_____Social Security Number_____

Marital Status: S M D W Sex M____F____

Email_____

Please check if information is the same as patient information_____

PARENT OR GUARDIAN NAME_____
Last First M

Address_____City_____St_____Zip____

Home Phone_____Cell_____

Date of Birth_____Age_____Social Security Number_____

Marital Status: S M D W Sex M____F____

PRIMARY INSURANCE INFORMATION

Primary Insurance_____

Name of insured_____Relationship_____

Date of Birth_____Social Security Number_____

Employer_____Phone_____

Adress_____City_____St_____Zip_____

SECONDARY INSURANCE INFORMATION

Primary Insurance_____

Name of insured_____Relationship_____

Date of Birth_____Social Security Number_____

Employer_____Phone_____

Adress_____City_____St_____Zip_____

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# CONSENT TO TREAT

## CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

**1. Patient Consent to Treat :**
I the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated and which are deemed necessary or advisable by the provider in the course of treatment.

**2. Patients Consent for use and Disclosure of Protected Health Information ("PHI") :**
I the undersigned patient, give my consent to the provider entities and its agents to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations. These individuals and entities can release, use, or disclose my PHI to other health care personnel including, but not limited to, physicians, certified registered nurse anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physician assistants, child life specialists, physical therapist, respiratory therapist, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities by persons as are deemed related to treatment payment and health care operations, as determined in the sole discretion of the provider, his/her practice group and their respective agents.

**3. Permission to Release Medical Records to Providers :**
If another provider who is involved with treatment, payment or health care operations relating to me requests records, I consent to the release of my medical record maintained by the provider to those other providers.

**4. Permission to Release Billing Information Over the Telephone :**
I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents or management company can disclose billing information to any person that calls the providers with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

**5. Permission to Call and Leave Voice Mail Messages :**
I agree that the provider, it's agents, or it's representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, health care operations and/or other information related to my treatment.

**6. Permission to discuss Protected Health Information With Third Persons :**

I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that is another person is with me, I have no objection to disclosure of my PHI to that person I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional or spiritual care, including, but not limited to family, friends, clergy, and patient advocates. I also agree that the provider, his/her practice(s), group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

**7. Permission to Discuss Protected Health Information Regarding Minors :**

I agree that the provider, his/her practice group, and their agents may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child PHI, and that I have no right to receive this information.

**8. Permission to discuss Protected Health Information With Public Agencies :**

I agree the provider, his/her practice group, and their agents may upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

**9. Acknowledge of Receipt of Notice of Privacy Practices :**

I acknowledge that I have received from this provider a copy of a separate document entitled, “Notice of Privacy Practices” which sets forth this provider privacy practices and my rights regarding privacy of my PHI.

NAME OF ENTITY**: PEA RIDGE FAMILY CARE CENTER INC.**

Patient Name: _____ Date: _____

Patient Signature: _____

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# NEW PATIENT TREATMENT AND PRESCRIPTION POLICY

1. I understand that this practice will not treat me for the following conditions with narcotics drugs:

   Chronic Pain (pain persisting for more than 90 days)

2. I understand that this practice will not prescribe me the following drugs or any drugs similar to them:

   **-OXYCONTIN**
   **-DILOTID**
   **-ROXICOTIN**
   **-LORTABS, LORACET**
   **-VICODIN**
   **-STADOL**
   **-XANAX**
   **-KLONOPIN**
   **-VALIUM**
   **-NORCO**
   **-LIBRIUM**
   **-TRANSENE**
   **-ATIVAN**
   **-SOMA**
   **-MS CONTIN**
   **-PERCOCET**
   **-PERCODAN**
   **-METHADONE**

   IF YOU DO NOT AGREE WITH THE ABOVE POLICY, PLEASE SEEK MEDICAL CARE AT SOME ONTHER FACILITY.

   AFTER READING THE ABOVE INFORMATION AND YOU STILL WANT TO BE SEEN By THE PROVIDER (PHYSICIAN OR PHYSICIAN ASSISTANT) PLEASE NOTE THE FOLLOWING CAREFULLY AND SIGN YOU CONSENT TO US.

   ALL MONEY PAID AT TIME OF CHECK – COPAYMENT – WILL BECOME NON-REFUNDABLE AND WE WILL BILL YOUR INSURANCE, ONCE THE PROVIDER HAS SEEN YOU.

   SIGNATURE:_____ DATE:_____

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**NAME: LAST: FIRST: DOB: ..**

**CONSENT FOR SERVICES NOT COVERED AND CHARGED TO INSURANCE :**
I understand that I am financially responsible for:-

and all OTHER services rendered to me or to the patient and agree to pay charge for such services; present and future, at the time services are provided.

Signature of Patient or Responsible Party _____

## HEALTH INSURANCE ASSIGNMENT AND RELEASE

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I, the undersigned, have insurance with

_____
(Name of Insurance Company)
and hereby assign all medical and/or surgical benefits to which I am entitled, private insurance, and any other health plan to _____M.D., I authorize the doctor or his agent to release all information necessary top secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of
Insured/Guardian_____Date_____

(MEDICARE ONLY) **MEDICARE AND MEDIGAP AUTHORIZATION**

I request that payment of authorized Medicare benefits and Medigap benefits, if applicable, be made either to me or to the physician providing service to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services, I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 0 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that the deductible, co-insurance, and non-covered services will be my full responsibility.

Signature of Beneficiary_____Date_____

**CONSENT OF TREATMENT:** I hereby grant authorization and consent for medical treatment and procedure for myself, or the patient, and understand that no guarantee or assurance has been made as to the results which may be obtained.

Signature of Patient/Guardian_____Date_____

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# NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Understanding Your Health Record/Information**

This notice describes the practices of Pea Ridge Family Care Center, Inc. (DBA: Pea Ridge Family Care Center, Davis Hwy Family Practice, and Woodbine Night Clinic) and that any physician with staff privileges with respect to your protected health information created while you are a patient at Pea Ridge Family Care, Affordable Medical physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition Pea Ridge Family Care/Affordable Medical and physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for the future care or treatment. This information, often referred to as your health or medical record, serves as a:

• Basis for planning your care and treatment;
• Means of communication among the many health professionals who contribute to our care;
• legal documents describing the care you received;
• means by which you or a third party payer can verify that services billed were actually provided;
• a tool in educating health professionals;
• a source of information for public health officials charged with improving the health of the nation;
• a source of data for facility planning and marketing;
• a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

• ensure its accuracy;
• better understand who, what, when, where, and why others may access your health information;
• make more informed decisions when authorizing disclosure to others. Your Health Information Rights Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you.

You have the right to:

• request a restriction on certain uses and disclosures of your information as provided by 45CFR164.522;
• obtain a paper copy of the notice of information practices upon request;
• inspect and copy your health record as provided for in 45 CFR164.524;
• amend your health record as provided in 45 CFR 164.526;
• obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528;
• request communications of your health information by alternative means or at alternative locations;
• revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities :**

This organization is required to:

• maintain the privacy of your health information;
• provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
• abide by the terms if this notice;
• notify you if we are unable to agree to a requested restriction;
• accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose our health information without your authorization, except as described in his notice.

**For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the Privacy Officers at Pea Ridge Family Care Center, Inc. (DBA: Pea Ridge Family Care Center, Davis Hwy Family Practice, and Woodbine Night Clinic) If you believe you privacy rights have been violated, you can file a complaint with Risk Management or with the Administration. There will be no retaliation for filing a complaint.

**Example of Disclosures**
**For Treatment and Health Operations**

We will use your health information for treatment.

**For example:** information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the action they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.

**For example:** A bill maybe sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for your regular health operations.

**For example:** Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in as effort to continually improve the quality and effectiveness of the healthcare and services we provide.

**Notification:** we may use or disclose to a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research:** we may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. In some cases, research will be conducted through a limited data set of personal health information that we maintain for research and quality improvement purposes which excludes patient names and other identifying information.

**Marketing:** We may contact you to provide appointment reminders or information about treatment, alternative or other health-related benefits and services that may be of interest to you.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Lawsuits and disputes:** If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a subpoena, discovery request, administrative order, or other lawful process by someone else involved in the dispute, in accordance with applicable law.

**Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with the laws relating to workers compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability: to report births or deaths; to report child or elderly abuse or neglect.

**Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agent thereof health information necessary for your health and the health and safety of other individuals.

**Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena, court order, warrant, summons or similar process.

**As required by law:** We will disclose health information about you when required to do so by federal, state, or local law.

**Health oversight activities:** we may disclose medical information to a health agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. Those activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Privacy Officer Numbers**
(850) 995-8811
(850) 475-0867
(850) 995-6068