



Nation's Best Family Health Care – Lynn Haven
817 Ohio Avenue
Lynn Haven, FL 32444
Phone: 850-481-1101
Fax: 850-441-3748

Nation's Best Family Health Care - PCB
7504 McElvey Drive
Panama City Beach, FL 32408
Office visit date: _____

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **SSN:** _____

Parent or Guardian (for minor child): _____

Address: _____

STREET ADDRESS, CITY, STATE, ZIP CODE

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____

Would you like online access to the Patient Portal? **Yes** **No**
(the patient portal allows you access to your medical records, appointment scheduling, contacting us, etc.)

SEX: Male Female **Marital Status?** _____

Race: Asian / Native Hawaiian-Pacific / Black –African American/ White / Hispanic/ Other race/Decline to Report

Ethnicity: Hispanic – Latino/Not Hispanic / Decline to report

How did you hear about us? _____

EMPLOYMENT INFORMATION:

Patient's Employer: _____

Spouse's Name: _____ **Contact Phone:** _____

Do you have insurance? Yes No If yes, please complete the following:

INSURANCE INFORMATION:

1. PRIMARY: _____ POLICY NUMBER: _____

(address)

Policyholder Name: _____ Policyholder DOB: _____

2. SECONDARY: _____ POLICY NUMBER: _____

(address)

Policyholder Name: _____ Policyholder DOB: _____

3. TERTIARY: _____ POLICY NUMBER: _____

(address)

Policyholder Name: _____ Policyholder DOB: _____

FINANCIAL RESPONSIBILITY

Patient Name: _____

Responsible Party: _____ Relation to patient: _____

Address: _____

_____ Phone Number: _____

AUTHORIZATION TO FILE INSURANCE

MEDICARE/TRICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorized any holder of medical information to include psychiatric and or psychological, HIV/AIDS, or other information about me to release these to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician (s) to submit a claim to the carrier for payment. I understand that I am personally responsible for my medical bills and will pay my deductible and or co-pays.

SIGNATURE OF PATIENT OR GUARDIAN OF MINOR DATE

INSURANCE LIFETIME AUTHORIZATION

I authorize any holder of medical information to include psychiatry, HIV/AIDS, or other information about me to release same to any insurance carrier for the purpose of obtaining payment of services rendered by the physician (s) of this medical group practice. This includes but is not limited to hospital or medical services companies, insurance companies, workman's compensation carriers, veteran's administration or welfare. I understand that I am financially responsible for my medical bills regardless of insurance coverage. Any insurance coverage that has not been paid within 45 days will become my responsibility to pay.

SIGNATURE OF PATIENT OR GUARDIAN OF MINOR DATE

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to benefits of any type arising out of any insurance insuring the patient or any other party liable to patient, such benefits are hereby assigned to Nation's Best Family Health Care for application to the patient's bill. The undersigned and or patient are responsible for charges not covered by this assignment.

SIGNATURE OF PATIENT OR PATIENT'S GUARDIAN DATE



Payment Policy

Thank you for choosing Nation's Best Family Health Care as your primary care provider. We are committed to providing you with quality and affordable health care. Please read our payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We accept most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information at the time of your visit, you will be responsible for your visit for that day or will need to reschedule.
5. **Claims submission.** We are contracted with a billing company who will submit your claims and assist you in any way they reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you do not notify us in a timely manner that your insurance has changed, the time to file the claim may be expired and thus the balance will be your responsibility.
7. **Nonpayment.** If your account is over 45 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise discussed. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and charge a \$50 fee for doing so. You and your immediate family members *may* be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** If you need to change your appointment, please call our office within 24 hours of your scheduled appointment. Our policy is to excuse the first missed appointment. The second missed appointment will be charged \$50. If you cancel your appt the same day as your appointment you will be charged a \$25 cancellation fee. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. If you miss more than two appointments in a row, this is grounds for dismissal from our practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

**PATIENT CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(HIPAA)**

I understand that as part of my healthcare, Nation's Best Family Health Care, originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information and uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Nation's Best Family Health Care is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Personally, I wish to be contacted in the following manner (List / circle all that apply and please number the order of your preference 1-3)

_____ Home Phone/Cell phone _____ Can/Cannot leave message

_____ Text Message/Email _____

_____ Work Number _____ Can/Cannot leave message

Written Communication to: Home address /Email/ Fax to: _____

I authorize Nation's Best Family Health Care to give personal information to the following people: Please list name/relationship to the patient and phone number:

Patient's Signature _____ Date

Witness _____ Date

Would you like a copy of this form? Please initial _____ yes _____ no

Prescription History Consent

I give my consent to Nation's Best Family Health Care to obtain my prescription history from external sources.

Patient of Authorized Person's Signature: _____ Date: _____

**SUMMARY OF THE FLORIDA PATIENT’S BILL
OF RIGHTS AND RESPONSIBILITIES**

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider’s or health care facility’s right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider’s instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

History.—s. 1, ch. 91-127; s. 65, ch. 92-289; s. 656, ch. 95-148; s. 21, ch. 98-89; s. 178, ch. 98-166; s. 64, ch. 99-397; s. 7, ch. 2001-53; s. 2, ch. 2001-116; s. 3, ch. 2004-297; s. 12, ch. 2006-261; s. 3, ch. 2008-47; s. 2, ch. 2011-112; s. 1, ch. 2011-122.

¹Note.—The word “of” was substituted for the “or” by the editors.

For more information on the Florida Patient Bill of Rights: <http://www.flsenate.gov/laws/statutes/2011/381.026>

Would you like a copy of the Florida bill of rights? YES NO

Please sign below acknowledging you have been offered a copy of the Florida Patient’s Bill of Rights.

Patient Signature

Date

Witness

Date

Name: _____ D.O.B: _____ Date: _____

INITIAL PATIENT INTAKE FORM:

Briefly describe what brings you to our clinic today? (Primary concern first)

IF YOU HAVE TAKEN MEDICATIONS THAT ARE CONTROLLED SUBSTANCES (SUBOXONE/HYDROCODONE/TRAMADOL/XANAX/VALIUM, ETC.), PLEASE LIST THEM BELOW WITH THE PRESCRIBING PROVIDER AND THE PHARMACY YOU USE:

NAME OF MEDICATION	DOSE	FREQUENCY	PRESCRIBER	PHARMACY

CURRENT MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING: (or attach a copy of your medication list)

NAME OF MEDICATION	DOSE	FREQUENCY	REASON	PRESCRIBER

PRIOR SCREENING TESTS **WHEN?** **ABNORMAL?**

Pap Smear (Women > 21 y/o)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mammograms (Women > 40 y/o)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy (Men/Women > 50 y/o)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate Screening (Men > 50 y/o)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Density Scan		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Stress Test		
Lung Function Test		

PRIOR IMMUNIZATIONS

<input type="checkbox"/> Flu	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> MMR	<input type="checkbox"/> PPD (Tuberculosis screen)
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Shingles	<input type="checkbox"/> Gardasil (HPV)
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Tetanus w/ pertussis		

PAST MEDICAL HISTORY: Please check any previous medical conditions you have had.

<input type="checkbox"/> Alcoholism/substance abuse	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Osteoporosis / Osteopenia
<input type="checkbox"/> Allergies/Chronic Sinusitis	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Psoriasis/Eczema
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Psychosis/Schizophrenia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatoid Disease
<input type="checkbox"/> Arthritis / Joint Pain	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Shingles
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Heart Disease/Prior Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Crohn's disease / Ulcerative Colitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Chronic Knee Pain	<input type="checkbox"/> Hiatal Hernia/GERD	<input type="checkbox"/> Other Medical Conditions:
<input type="checkbox"/> Chronic Low Back Pain	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Chronic Neck Pain	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Chronic Shoulder Pain	<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> COPD/chronic bronchitis	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Depression / Anxiety	<input type="checkbox"/> Lupus/Autoimmune disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obstructive Sleep Apnea	

*****Allergies*****

History of skin or adverse reaction to: (Please circle/list)

Are you sensitive or allergic to foods, drugs, or environmental substances? (Rash, anaphylaxis, etc.)

ANTIBIOTICS: _____

PAIN MEDICATION: _____

ANTISEPTICS (Iodine, etc.): _____

TAPE/SUBSTANCE (latex, silk tape, etc.): _____

IMMUNIZATIONS: _____

FOOD ALLERGIES: _____

ENVIRONMENTAL ALLERGIES: Dust, Mold, Other: _____

Hospitalizations/Surgical History

Ever Been Hospitalized or Any Prior Surgeries?

Family History

Family Member	Status	DOB	Age (yrs.)	Notes (cancer, heart disease, etc.)
Father				
Mother				
Paternal Grand Father				
Paternal Grand Mother				
Maternal Grand Father				
Maternal Grand Mother				
Brother				
Brother				
Sister				
Sister				
Son				
Son				
Daughter				
Daughter				

Social History:

Social Info	Yes / No	Details
Tobacco use / Have you ever used tobacco?		
Alcohol / Do you drink alcohol?		
Drugs / Any use of drugs in the last 3 years?		

Do you have any significant cultural or religious beliefs pertaining to your health care? Yes No

Do you have Advanced Directives? Yes No Don't Know

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

0. Not At All
1. Several Days
2. More Than Half the Days
3. Nearly Every Day

Feeling down, depressed, or hopeless

0. Not At All
1. Several Days
2. More Than Half the Days
3. Nearly Every Day

Review of Symptoms

Please check any recurring symptoms related to your visit today

<u>General</u> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue	<u>Respiratory / Chest</u> <input type="checkbox"/> Chest congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty/Pain breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Pain	<u>Hematology</u> <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Easy bruisability	<u>Musculoskeletal</u> <input type="checkbox"/> Weakness <input type="checkbox"/> Muscle stiffness <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness
<u>Allergy</u> <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Itching <input type="checkbox"/> Sneezing	<u>Cardiac</u> <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath with exertion <input type="checkbox"/> Shortness of breath with sleeping flat	<u>Breast</u> <input type="checkbox"/> Lump <input type="checkbox"/> Discharge <input type="checkbox"/> Tenderness <input type="checkbox"/> Pain	<u>Vascular</u> <input type="checkbox"/> Pain in legs after exertion <input type="checkbox"/> Swelling of legs
<u>Ear, Nose, Throat</u> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Discharge <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sore throat <input type="checkbox"/> Swollen glands <input type="checkbox"/> Blocked ear	<u>Gastrointestinal</u> <input type="checkbox"/> Appetite changes <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Black, tarry stools	<u>Men Only</u> <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Scrotal mass <input type="checkbox"/> Lesion <input type="checkbox"/> Discharge	<u>Skin</u> <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Itching
<u>EYES</u> <input type="checkbox"/> Sensitivity <input type="checkbox"/> Change in vision <input type="checkbox"/> Double Vision/Blurred Vision <input type="checkbox"/> Pain <input type="checkbox"/> Redness	<u>Endocrine</u> <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Constant thirst <input type="checkbox"/> Constant hunger	<u>Urinary</u> <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Difficulty in starting the stream <input type="checkbox"/> Incontinence <input type="checkbox"/> Pain/Burning with urination <input type="checkbox"/> Blood in urine	<u>Neurologic</u> <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Headache <input type="checkbox"/> Fainting <input type="checkbox"/> Tremors <input type="checkbox"/> Loss of memory <input type="checkbox"/> Unsteadiness/Difficulty walking <input type="checkbox"/> Dizziness

OTHER PROVIDERS OR SPECIALISTS INVOLVED IN YOUR CARE:

SPECIALTY	PROVIDER NAME	APPROXIMATE DATE OF LAST VISIT
CARDIOLOGY		
HEMATOLOGY/ONCOLOGY		
ENDOCRINOLOGY		
GYNECOLOGY		
NEPHROLOGY		
PAIN MANAGEMENT		
PSYCHIATRY/COUNSELING		
GENERAL SURGERY		
ORTHOPEDIC SURGERY		
VASCULAR SURGERY		