Nation's Best Family Health Care
625 W. Baldwin Road, Suite C Panama City, FL 32405
Phone: 850-481-1101
Fax: 850-640-3949

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. **PLEASE INITITAL EACH NUMBER.**

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 non-covered 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, social security number and current valid insurance to provide proof of insurance. If you choose not to provide us with any of these, we are not obligated to file your insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. ________
5. **Claims submission.** Our billing department 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. ________
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 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. These charges will be your responsibility and billed directly to you. If you cancel your appointment the same day of your appointment you will be charged $25. 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.

[1]Note.—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)		□ Yes □ No
Mammograms (Women > 40 y/o)		□ Yes □ No
Colonoscopy (Men/Women > 50 y/o)		□ Yes □ No
Prostate Screening (Men > 50 y/o)		□ Yes □ No
Bone Density Scan		□ Yes □ No
Cardiac Stress Test		
Lung Function Test		

PRIOR IMMUNIZATIONS

□ Flu	□ Hepatitis A	□ MMR	□ PPD (Tuberculosis screen)
□ Pneumonia	□ Hepatitis B	□ Shingles	□ Gardasil (HPV)
□ Tetanus	□ Tetanus w/ pertussis		

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

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

General	**Respiratory / Chest**	**Hematology**	**Musculoskeletal**
___Fever ___Chills ___Fatigue	___Chest congestion ___Wheezing ___Difficulty/Pain breathing ___Shortness of breath ___Cough ___Coughing up blood ___Pain	___Prolonged bleeding ___Easy bruisability	___Weakness ___Muscle stiffness ___Joint pain ___Joint stiffness
Allergy ___Cough ___Congestion ___Itching ___Sneezing	**Cardiac** ___Palpitations ___Shortness of breath with exertion ___Shortness of breath with sleeping flat	**Breast** ___Lump ___Discharge ___Tenderness ___Pain	**Vascular** ___Pain in legs after exertion ___Swelling of legs
Ear, Nose, Throat ___Nose bleeds ___Sinus problems ___Discharge ___Ringing in ears ___Sore throat ___Swollen glands ___Blocked ear	**Gastrointestinal** ___Appetite changes ___Nausea ___Constipation ___Diarrhea ___Heartburn ___Vomiting ___Abdominal pain ___Vomiting blood ___Black, tarry stools	**Men Only** ___Erectile dysfunction ___Scrotal mass ___Lesion ___Discharge	**Skin** ___Hives ___Rash ___Itching
EYES ___Sensitivity ___Change in vision ___Double Vision/Blurred Vision ___Pain ___Redness	**Endocrine** ___Heat intolerance ___Cold intolerance ___ Constant thirst ___ Constant hunger	**Urinary** ___Frequency ___Urgency ___Difficulty in starting the stream ___Incontinence ___Pain/Burning with urination ___Blood in urine	**Neurologic** ___Numbness/Tingling ___Headache ___Fainting ___Tremors ___Loss of memory ___Unsteadiness/Difficulty walking ___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		

Patient's name ____ Date of birth ___ ______/________/________

Social Security Number ___________-________-___________ Telephone number (________) _______-___________

Please release my medical records **from**:

<table>
<tr>
<td>☐ Nation's Best Family Health Care
625 W. Baldwin Road Suite C
Panama City, FL 32405
FAX: 850-640-3949</td>
<td>☐ Name of provider: ____

Provider's address: ____

____

Provider's Fax Number: ________________________________</td>
</tr>
</table>

TO:

<table>
<tr>
<td>☐ Nation's Best Family Health Care
625 W. Baldwin Road Suite C
Panama City, FL 32405
FAX: 850-640-3949</td>
<td>☐ Name of provider: ____

Provider's address: ____

____

Provider's Fax Number: ________________________________</td>
</tr>
</table>

Please release:

□ All records/labs from past two years
□ Records from the past (time period) ___________________
□ Labs/diagnostic testing (time period) ___________________
□ ____

I request that health information regarding my care and treatment be released as set forth on this form. In accordance with The Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I understand that signing this authorization is voluntary.
2. This authorization may include disclosure of information relating to Alcohol and drug abuse, mental health treatment, and CONFIDENTIAL HIV related information.
3. This authorization will expire 90 days after the date signed.

____ Date: ______________________________
Patient's Signature

____Date:______________________________
Witness Signature

625 W. Baldwin Road Suite C
Panama City, FL 32405
850-481-1101 Fax: 850-640-3949