PATIENT HEALTH QUESTIONNAIRE

Last Name: _____First Name: _____MI:_____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ St: _____Zip: _____

Cell#: _____Home #: _____Work#: _____

Which number is the best way to reach you? Cell_____ Home_____ Work_____

Email Address: _____

Preferred Pharmacy Name and #: _____

Emergency Contact Name:_____

Relationship To Patient:_____ Emergency Contact Phone #_____

How did you hear about us?_____ Marital Status:_____

PRIMARY INSURANCE:

Person Responsible for Account: _____
Last First MI

Relation to Patient_____ DOB:_____SS# _____

Address: _____Phone _____
(if different from patient)

City: _____State: _____Zip_____

Employer/Occupation: _____

Insurance Company _____

Subscriber # _____ Group #_____

SECONDARY INSURANCE:

(ONLY FILL IN IF YOU HAVE TRICARE OR MEDICARE AS PRIMARY)

Subscriber Name_____
Last First MI

Relation to Patient _____ DOB: _____SS#:_____

Address (if different from patient)_____Phone # _____

Insurance Company: _____

Subscriber # _____Group #_____

NEW GOVERNMENT GUIDELINES TO MEET HI-TECH USAGE OF ELECTRONIC MEDICAL RECORDS

Fountain Family Medicine

Patient Name: _____

DOB: _____

Please check one of the following:

RACE:

____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ White
____ Other Specific Islander
____ More Than One Race
____ Refused to Report/Unspecified

ETHNICITY:

____ Hispanic or Latino
____ Not Hispanic or Latino
____ Refused to Report/Unspecified

LANGUAGE:

____ English
____ Spanish
____ Other

Please provide e-mail address for educational updates:

E-mail Address: _____

Fountain Family Medicine

11701-32 San Jose Blvd Suite 103, Jacksonville, Fl 32223
Phone (904)262-9075 Fax (904)262-9076
www.fountainfamilymedicine.com

COMMUNICATION RELEASE FORM

I hereby give permission to the office staff at **Fountain Family Medicine** to notify me by telephone of the following: (check all that apply)

Yes _____ No_____ Appointment reminder, either by personal message or recorded message.

Yes_____ No_____ A message to call the office for test results

Yes_____ No_____ Talk to anyone listed below regarding my health condition, test results (normal or abnormal), and medical history.

The individual(s) listed below are authorized to receive the above information on my behalf:

_____

_____

I understand this form is intended to guard my privacy and is a release of general medical information.

_____ _____
Patient Signature (Responsible Party) Date

_____ _____
Witness Signature Date

FOUNTAIN FAMILY MEDICINE

As a patient you have certain rights and responsibilities. We recognize that a respectful relationship between the healthcare provider and the patient is the foundation for proper medical care.

CONSENT FOR TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and course of treatment, the administration of all local anesthetic and or blocks and any and all medication and technical procedures which in the judgment of the Healthcare Provider attending and consulting may be considered necessary or advisable to treat.

FINANCIAL RESPONSIBILITY AND OFFICE POLICIES

Fountain Family Medicine requires that all patients update their personal information on a yearly basis. We must have on file a copy of your Insurance Card and Driver's License. If changes have been made with your insurance company, home address, phone numbers, employer etc. please update this information upon your arrival to our office.

Payment is due at the time services are rendered. We accept Cash, Check, Visa, MasterCard, Discover and American Express. There is a $30.00 charge for Returned Checks.

If you are covered by Medicare, Tricare, BCBS, Aetna, Cigna, United Healthcare, Humana or any other Managed Health Care Plans that we are contracted with, we will file your insurance claim directly for reimbursement as a courtesy to you.

You are responsible for any **Co-Payment, Deductible, Co-Insurance and Non-Covered Services** at the time of your visit. **Co-Payments** for office visits cover only the visit with the Doctor. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information.

You have selected Fountain Family Medicine as your Primary Care Provider. It is your responsibility to notify your Insurance Company of this fact.

NO SHOW – LATE CANCELLATION FEE

If you do not arrive for your scheduled appointment and the appointment was not cancelled or rescheduled at least **Twenty Four (24) Hours** prior to the appointment a **$50.00 Fee** will be charged to your account. _____ **(Please Initial)**

In the event that your Insurance Company does not pay the **Full Balance** within Ninety (90) days, we will notify you so you may contact your Insurance Company. Please remember that payment responsibility rests with you, the patient. You should not rely on your Physician's Staff to know the details of your Health Care Plan. We work with many different Health Care Plans and are not familiar with the details of any one plan. They are all different. Be sure you are familiar with your Health Care Plan and know your **COVERED AND NON-COVERED SERVICES.**

ALL SELF PAY PATIENTS ARE EXPECTED TO PAY FOR SERVICES IN FULL AT THE TIME THAT SERVICES ARE RENDERED

UNACCOMPANIED MINORS UNDER AGE 18

Before being seen by the Physician the parents or guardians of unaccompanied minors must provide written permission for treatment.

MEDICATION REFILL POLICY

Please call for refill requests at least three (3) days prior to running out of medications as it may take up to 3 business days to process your refill request. Prescribing of **NEW MEDICATIONS** will require an office visit. If you are requesting an **ANTIBIOTIC** an office visit is required. If you are requesting pain medication an office visit is required. We do not call in medication after hours or on the weekends.

Registration Form

REFERRALS

Please allow three (3) to five (5) days for all referrals. **NEW REFERRALS** will require an office visit.

FORMS

There is a **$35.00** charge to fill out **PHYSICAL FORMS** if a visit is not required by the Physician**.** All forms require three (3) to four (4) days for completion. **DISABILITY AND FMLA FORMS REQUIRE A VISIT TO COMPLETE.**

MEDICAL RECORDS

Record Release Forms are required before any Medical Records can be released to the Patient, Physician or Health Care Facility. There is a copy charge for all Medical Records released to Patients. There is a charge of $1.00 per page for the first twenty-five (25) pages and $0.25 for each additional page. We will release Medical Records to another Physician at No Charge.

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

I authorize Fountain Family Medicine to release or receive all medical information to all of my Insurance Carriers or other third party payor's as may be required or requested for the processing of claims or other insurance purposes.

I have received a copy of the Privacy Act (HIPAA) _____ (Please Initial)

ACKNOWLEDGEMENT

I have read and understand the above Financial and Office Policies and I authorize the Assignment Of Benefits as well as the Release and Receipt of Medical Information as stated above.

Signature_____ Date_____

Patient's Name:_____ **DOB:**_____

Allergies to Medications

Medication	Reaction

Preventive Health History

Check if you have had any of the following and provide date (month and year) and/or results.

	Date	Results
☐ Colonoscopy	_____	_____
☐ Cardiac Stress Test	_____	_____
☐ Mammogram	_____	_____
☐ Bone Density	_____	_____
☐ Pelvic and Pap	_____	_____
☐ Cholesterol Screening	_____	_____

	Date
☐ **Vaccines**	
☐ Tetanus (Td or Tdap)	_____
☐ Pneumonia	_____
☐ Zostavax (Shingles)	_____
☐ Hepatitis B	_____
☐ Influenza (flu)	_____

Family History

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister
Breast Cancer								
Colon Cancer								
Diabetes								
Heart Attack								
High Blood Pressure								
High Cholesterol								
Lung Cancer								
Prostate Cancer								
Skin Cancers								
Stroke								
Other (Please Specify)								

If your mother, father, brothers or sisters are deceased, please list their age at the time of death and the cause:

_____

_____

Your Health History (Check if you have had any of the following)

☐ Abnormal Heart Rhythm	☐ Chronic Pain	☐ Heartburn / GERD	☐ Obesity
☐ Allergies/Seasonal/Environmental	☐ Chronic Kidney Disease	☐ Heart Failure	☐ Osteoporosis
☐ Anemia	☐ Depression	☐ Heart Murmur	☐ Peripheral Vascular Disease
☐ Anxiety/Stress	☐ Diabetes	☐ Hepatitis	☐ Seizures / Epilepsy
☐ Asthma	☐ Diverticulitis	☐ High Blood Pressure	☐ Sleep Apnea
☐ Arthritis	☐ Emphysema / COPD	☐ High Cholesterol	☐ Stomach Ulcers
☐ Atrial Fibrillation	☐ Gallbladder Disease	☐ HIV / AIDS	☐ Stroke
☐ Back Pain	☐ Gout	☐ IBS	☐ Thyroid Disease
☐ Colitis or Crohn's Disease	☐ Headaches / Migraines	☐ Kidney Failure	
☐ Cancer (any type)	☐ Heart Attack	☐ Kidney Stones	

Accidents - Trauma

Have you ever had a severe accident?

_____

Do you have any metal pins or plates in your body?

_____

Please list any other doctors that are currently assisting in your care and their specialty.

_____
_____
_____

Past Surgical History

Date	Surgery	Date	Surgery

Please List Any Additional Medical Information

_____
_____
_____

Health Habits History

Do you now or have you ever smoked? No: ___ Yes: ____
If yes: How long have/did you smoked? _____ How many packs per day? _____
Did you quit? No: ___ Yes: ___ **If yes**: What year did you quit? _____
How many alcoholic beverages do you drink per week? _____
How many days per week do you exercise? _____
Do you follow a healthy diet? No:___ Yes:____
What type of diet do you follow? (well-balanced, low carb, low fat, etc.) _____

Ob / Gyn History

Number of pregnancies: ___ Number of full term babies: ___ Number of premature babies: ___

Number of abortions or miscarriages: ___ Number of living children: ___

List ALL Prescription Medications, Vitamins, and Herbal Supplements

Medication	Dose	Frequency

Do you have an advance directive or a living will? _____

If yes, please supply the office with a copy to be placed in your chart.

Systems Review

Please check each item "yes" or "no" as they are related to your health.

Constitutional	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever or Sweats	☐	☐
Headache	☐	☐

Eyes	Yes	No
Glasses/Contacts	☐	☐
Cataracts	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐

Ears, Nose, Throat	Yes	No
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Pain	☐	☐
Nasal Congestion	☐	☐
Frequent Sore Throats	☐	☐
Hoarseness	☐	☐

Cardiovascular	Yes	No
Chest Pain	☐	☐
Palpitations	☐	☐
Fainting Spells	☐	☐
Dizziness	☐	☐
Difficulty Lying Flat	☐	☐
Swelling in Legs	☐	☐
Cramps/Coldness in Legs	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐

Gastrointestinal	Yes	No
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficulty Swallowing	☐	☐
Abdominal Pain	☐	☐
Black Stools	☐	☐

Genitourinary	Yes	No
Frequent Urination	☐	☐
Difficult Urination	☐	☐
Burning on Urination	☐	☐
Nighttime Frequency	☐	☐
Blood in Urine	☐	☐
Abnormal Discharge	☐	☐
Genital Skin Lesions	☐	☐

Endocrine	Yes	No
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐
Weight Gain	☐	☐
Sexual Dysfunction	☐	☐

Lymph/Immune	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
Hay Fever/Allergies	☐	☐

Musculoskeletal	Yes	No
Joint Pain/Swelling	☐	☐
Back Pain	☐	☐
Muscle Pain	☐	☐

Skin	Yes	No
Rash/Sores	☐	☐
Abnormal Moles	☐	☐
Abnormal Masses	☐	☐

Neurological	Yes	No
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

Psychiatric	Yes	No
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐
Anxiety/Depression	☐	☐

Females Only	Yes	No
Heavy/Irregular Periods	☐	☐
Vaginal Discharge	☐	☐
Infertility	☐	☐
Hot Flashes	☐	☐

Please explain or comment on any *Yes* response if you feel more details are needed.

_____

_____

_____

_____

Fountain
Family Medicine

11701-32 San Jose Blvd Suite 103, Jacksonville, Fl 32223
Phone (904)262-9075 Fax (904)262-9076
www.fountainfamilymedicine.com

Rights and Responsibilities of Patients

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 the 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:

PATIENT RIGHTS

- 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 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, physical 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 the purposes of experimental research and to give his or her consent of 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 serves him or her and to the appropriate state licensing agency.
- A patient has the right to appropriate assessment and management of pain

PATIENT RESPONSIBILITIES

- A patient is responsible for providing the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illness, 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. The patient is responsible for notifying the health care provider or health care facility if they are unable to keep appointment
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instruction

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

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Registration Form

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal Program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form whether electronically, on paper or orally are kept properly confidential. This Act gives you, the Patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. This includes the coordination or management of your health care with a third party for treatment purposes. An example of this would be referral to a specialist or diagnostic facility
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute re-identified information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and service that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a **Written Request** to the Privacy Office:

- The right to request restrictions on certain uses and disclosures of protected health, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. To inspect and copy your protected health information **you must submit a written request. If you request a copy of your information we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.**
- The right to amend your protected health information. However, we may deny your request for an amendment. Requests for amendment **must be in writing** and must be directed to our Privacy Officer. In this written request you must also provide a reason to support the requested amendments.
- The right to receive an accounting of disclosures of protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations and which take place after April 14, 2003. The request **must be in writing.**
- The right to obtain a paper copy of this notice from us at your first date of service.
- The right to provide us a written acknowledgement that you have received a copy of this Notice of Privacy Practices.

We are required by law to maintain the Privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with us at the address below or with the Department of Health & Human Services – Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington D.C., 20201
(202)619-0257 or Toll Free 877-696-6775

Registration Form