Additional Use Of Information

Appointment Reminders/Phone Calls:

Your health information and/or demographic information (address, phone number, etc.) may be used by our staff to return calls to the patient and to communicate with other doctors' offices and/or medical facilities. In addition, your demographic information may be used by our staff to remind you of future appointments or any necessary change that may need to be made regarding your appointment.

Appointment reminders may be transmitted to me by any or all of the following: (initial all that apply):

_____ Email to the following address: ***Email is our preferred appointment reminder method.**

Email Address: _____

_____Text message:

Cell Phone Number: _____Cell Phone Carrier (required): _____

Information Of Treatment:

Your health information may be used to send you information on treatment and management of your medical condition that you may find pertinent and interesting.

_____Telephone messages may be left on my answering machine

Individual Rights

You have certain rights under the federal privacy standards. They include but are not limited to:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communication concerning your medical condition and treatment.
- The right to inspect copies of your protected health information.
- The right to receive accounting of how and to whom your protected health information has been disclosed.
- The right to be informed of any breach of your protected PHI.
- The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. In addition, we also are required to abide by the privacy and practices outlined in this notice.*

_____ _____

Signature Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA RULE 164.508

(You May Refuse to Sign This Authorization)

I, _____, (hereafter "individual") hereby authorize **NORTH FLORIDA MEDICAL CLINIC**, (hereafter collectively referred to as "you") to use and disclose, in form or format, a copy of records concerning Individual, to:

_____

(hereinafter "recipients") for the purpose of:

_____.

I specifically authorize you to use and disclose the following types of super-confidential information (initial where appropriate):

_____ HIV records (including HIV test results) and sexually transmitted diseases
_____ Alcohol and substance abuse diagnosis and treatment records
_____ Psychotherapy records
_____ Tuberculosis
_____ All hospital records
_____ All of the above

I specifically authorize you to use and disclose the following Protected Health Information. Please initial one or more of the following, if applicable:

_____ Written Medical Records
_____ X-rays/MRI/CT
_____ Billing records
_____ Prescription records
_____ Other (specify in detail) _____
_____ All of the above

I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law; that this Authorization remains effective until the following date (_____); the following event (_____); or until you actually receive a signed revocation or until the records retention period required under federal and Florida law has expired, whichever first occurs; that I have been given an opportunity to ask questions; that I have received a copy of the signed Authorization; that I may inspect a copy of my protected health information to be disclosed under this Authorization; that you have not conditioned provision of services to or treatment of me upon receipt of this signed Authorization; and that I may refuse to sign this Authorization.

My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided on this form. If the purpose of this Authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, you reserve the right to deny treatment associated with such research. If the purpose of this Authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed. I understand that I may revoke this Authorization at any time by notifying you in writing, except to extent that action has been taken in reliance on this Authorization; or if this Authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy or the policy itself.

_____ _____

Patient Date

North Florida Medical Clinic

1361 13th Ave South, Suite 150
Jacksonville Beach, FL 32250
Office: (904) 242-7177 Electronic Fax: 1-888-990-1419

Kevin M Holthaus M.D.
David M. Johnson, M.D.
Stacey Williams, MSN, APRN, FNP-BC Laura M. Triola, DNP, APRN, FNP-BC

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize North Florida Medical Clinic to ( ) release or ( ) obtain the following medical records.

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____

Reason for Request: Please Check One

_____ Moving ____ Transferring Doctor _____ Insurance/Work Purposes

If transferring doctors, please list reason why _____

Please ( ) Send them to OR ( ) obtain them from the following address:

Name of Physician/Institution: _____

Address: _____

City, State, Zip: _____

Phone Number: ( )_____ Fax: ( )_____

This consent includes authorization to FAX my medical records that may contain information concerning: HIV, drug or alcohol abuse, venereal disease or psychiatric care. I further agree that North Florida Medical Clinic, it's physicians, employees or designated representatives shall not be held liable in any manner for furnishing or having obtained such information.

This authorization shall expire 90 days from date of request.

_____ _____

Patient's Signature ** Parent or Guardian if Minor

_____

Date of Request

If the patient is a minor, mentally incompetent, or deceased, the next of kin, legal guardian or executor of the estate may sign.

North Florida Medical Clinic
Patient Registration Information

Patient Information	
Last Name:	First Name: MI:
Address:	Maiden Name:
City: State: Zip:	Date of Birth:
Home Phone:	Work Phone:
Cell Phone:	Social Security #:
Gender: Male Female (circle one)	Drivers License #:
Marital Status: M S D W (circle one)	Occupation:
	Email:

Guarantor Information:	
Last Name:	First Name: MI:
Address:	Maiden Name:
City: State: Zip:	Date of Birth:
Home Phone:	Work Phone:
Cell Phone:	Social Security #:
Gender: Male Female (circle one)	Drivers License #:
Marital Status: M S D W (circle one)	Occupation:

Other Information:	
Please list a friend or relative not living with you.	
Last Name:	First Name: MI:
Address:	City: State: Zip:
Home Phone:	Cell Phone:

Insurance Information (Primary)	**Insurance Information (Secondary)**
Name:	Name:
ID#:	ID#:
Group#:	Group#:
Phone#:	Phone#:
Mailing Address:	Mailing Address:
Effective Date:	Effective Date:
Policy Holder:	Policy Holder:

HMO Information ONLY	
PCP Co-payment:	
Effective Date:	
PCP:	
PCP Phone#:	
Authorization Requirements:	

Who may we thank for referring you?	
Name:	Phone#:
Address:	City: State: Zip:

North Florida Medical Clinic
1361 13th Ave. South, Suite 150
Jacksonville Beach, FL 32250
Phone (904) 242-7177 Fax (904) 242-7433
Kevin M. Holthaus M.D.
David M. Johnson, M.D.
Stacey Williams,MSN, APRN, FNP-BC
Laura Triola, DNP, ARNP, FNP

HISTORY AND PHYSICAL

NAME: _____ SS#: _____ DATE: _____

ADDRESS: _____ OCCUPATION: _____

PHONE (HOME) _____ (WORK) _____ DOB: _____ AGE: _____

CHIEF COMPLAINT: _____

DRUG ALLERGIES

_____
_____
_____
_____
_____
_____

CURRENT MEDS

_____
_____
_____
_____
_____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
HEART DISEASE:	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE:	☐	☐	☐	☐	☐	☐
STROKE:	☐	☐	☐	☐	☐	☐
CANCER:	☐	☐	☐	☐	☐	☐
DIABETES:	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS:	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER:	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE:	☐	☐	☐	☐	☐	☐
THYROID DISEASE:	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS:	☐	☐	☐	☐	☐	☐
OSTEOPORSIS:	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

WOMEN ONLY: PREGNANT? [ ] YES [ ] NO PLANNING PREGNACY? [ ] YES [ ] NO

MEDICAL HISTORY

☐ HEADACHE: _____
☐ SHORTNESS OF BREATH: _____
☐ HEART PALPITATONS: _____
☐ HEART MURMUR: _____
☐ CHEST PAIN: _____
☐ DIZZINESS / FAINTING: _____
☐ PERIPHERAL VASCULAR DISEASE: _____
☐ ALLERGIES / HAY FEVER: _____
☐ ASTHMA: _____
☐ BRONCHITIS: _____
☐ PNEUMONIA: _____
☐ ULCER: _____
☐ GI DISORDER: _____

☐ LACTOSE INTOLERENT: _____
☐ GALLBADDER DISEASE: _____
☐ PROSTATE DISEASE: _____
☐ BOWEL IRREGULARITY: _____
☐ INCOTINENCE: _____
☐ SEXUAL/MENSTRUAL DYSFUNCTION: _____
☐ VENEREAL DISEASE: _____
☐ FREQUENT INFECTIONS: _____
☐ HEPATITIS: _____
☐ ANEMIA: _____
☐ ARTHRITIS: _____
☐ OSTEOPOROSIS: _____
☐ NERVOUSNESS: _____

☐ DEPRESSION: _____
☐ GOUT: _____
☐ SCARLET FEVER: _____
☐ CHRONIC RASHES: _____
☐ RHEUMATIC FEVER: _____
☐ MUMPS: _____
☐ MEASLES: _____
☐ RUBELLA: _____
☐ POLIO: _____
☐ DIPHTHERIA: _____
☐ TETANUS: _____
☐ OTHER: _____
☐ OTHER: _____

HABITS

☐ SMOKE: PACKS DAILY _____
HOW LONG _____
INTERESTED IN STOPPING? _____
☐ EXERCISE ROUTINE _____
☐ DIET: _____
☐ CONTACT WITH BLOOD/BODILY FLUID AT WORK ____

☐ COFFEE: CUPS DAILY _____
OTHER CAFFEINE _____
☐ ALCOHOL: TYPE _____
AMOUNT _____
SALT INTAKE _____
FAT INTAKE _____

☐ SLEEP: DIFFICULTY FALLING ASLEEP _____
CONTINUITY DISTURBANCES _____
SNORING _____
EARLY MORNING AWAKENING _____
DAYTIME DROWSINESS _____
OTHER _____

North Florida Medical Clinic
Authorizations and Assignment of Benefits

Payment at Time of Service

It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file your insurance. However YOU are responsible for all co-pays, deductibles, and non-covered services at the time of service.

Date:_____ Signature:_____
(Patient, Parent, or Legal Representative)

Patient Statement

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided on this form is true and correct to the best of my knowledge. I will notify North Florida Medical Clinic of any changes in this information. A photocopy or other reproduction of this will be valid as the original.

Date:_____ Signature:_____
(Patient, Parent, or Legal Representative)

Authorization to Release Information

I hereby authorize North Florida Medical Clinic to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents all information with regard to my medical care.

Date:_____ Signature:_____
(Patient, Parent, or Legal Representative)

Authorization for Assignment of Benefits

I hereby authorize payment directly to North Florida Medical Clinic for medical benefits, if any, otherwise payable to me under the terms of my insurance.

Date:_____ Signature:_____
(Patient, Parent, or Legal Representative)

Office Policy For No-Show Appointment

I am aware I will be charged an administrative fee of $50.00 for any appointment made by or for myself that is not canceled **24 hours Prior to the Appointment Time**.

Date:_____ Signature:_____

North Florida Medical Clinic

PF-100 Notice of Privacy Protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to the other healthcare professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For examples, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of North Florida Medical Clinic. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities may promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's Public Health Department.

Other Uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Photograph Consent. I Further consent that photographs may be taken of me or parts of my body by the physician or staff and may be modified or retouched by the physician at his discretion. The photographs shall be used for medical records and, if, in the opinion of my physician, medical research, education or science will benefit from their use, if published in medical journals or medical books I shall not be identified by name and reasonable steps shall be taken to preserve any identity.

_____ _____

Signature of Patient Date