

EMERALD MEDICAL CARE

1606 Tennessee Avenue
Lynn Haven, FL 32444
850-248-7925 Fax 850-248-7928

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, **Emerald Medical Care**, originates and maintains paper and/or 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 **Emerald Medical 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.

I wish to be contacted in the following manner (List / circle all that apply)

Home Phone/Cell phone _____ can/cannot leave message

Work Number _____ Can/Cannot leave message

Written Communication to: Home address / Work Address / Fax to: _____

Can give personal information to the following: Please list name/relationship to the patient and phone number:

Patient's Signature

Date

Witness

Date

(X) Copy of consent and Notice of Privacy Practices given to patient: ____ (initials of patient).

FOR OFFICE USE ONLY

() Consent received by _____ on _____

() Consent refused by patient, treatment refused as permitted.

() Consent added to the patient's medical record on _____.

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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 Emerald Medical 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

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PATIENT CONSENT TO OBTAIN PROTECTED HEALTH INFORMATION

I give my permission for all my current / previous healthcare providers to release my protected health information to Emerald Medical Care for the purpose of treatment. This includes (but is not limited to) hospital records, lab, X-rays, MRI's and office notes.

I understand that Emerald Medical Care will release my records to other healthcare providers who request them for the purpose of treatment.

These records may be faxed to: **850-248-7928**

If preferred, they may be mailed to: **1606 Tennessee Avenue, Lynn Haven, FL 32444.**

Printed Name: _____ DOB: _____

Signed: _____

Witness: _____

Date: _____

NEW PATIENT EVALUATION

Patient's Name _____
Last First Middle/Maiden

Date: _____

HISTORY OF PRESENT ILLNESS:

Location of problem: _____ Quality: _____
(normal vs. abnormal color, activity, etc)

Severity of problem: _____ Duration: _____
(how severe of pain) (how long have you had problem)

Timing: _____ Context: _____
(does pain occur at specific time) (where were you at onset of problem)

Associated signs and symptoms: _____

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

- | | | | |
|---------------------------|---------------------|-----------------|-----------------------|
| Headaches | Migraine Headaches | Hepatitis _____ | Anemia |
| Collagen Vascular Disease | High Blood Pressure | Osteoporosis | Bladder infections |
| Chronic Sinus Infection | Diabetes | Epilepsy | Glaucoma |
| Obstructive Sleep Apnea | Mumps | Red Measles | Hemorrhoids |
| Carpal Tunnel Syndrome | Rheumatic Fever | Scarlet Fever | Bronchitis |
| Seizures, Convulsions | Polio | Asthma | Thyroid disease |
| Kidney Disease | Encephalitis | Lupus | Mitral valve prolapse |
| Peptic Ulcer Disease | Nervous Breakdown | HIV/AIDS | Persistent cough |
| Rheumatoid Arthritis | Tuberculosis | Psychosis | Fibromyalgia |
| Gait Abnormality | Hiatal Hernia | Psoriasis | Obesity |
| Alcoholism | Pneumonia | Polymyositis | Heart Disease |
| Trigeminal Neuralgia | Substance Abuse | Shingles | Ulcer |
| Depression / Anxiety | Chronic Neck Pain | Low Back Pain | Stroke |
| Reiter's disease | Crohn's disease | Bipolar | Chicken pox |
| Cancer of the _____ | | | |
| Fracture of the _____ | | | |

PAST SURGICAL HISTORY:

Please list all previous surgeries _____

PRESENT MEDICATIONS: _____

****ALLERGIES** History of skin or adverse reaction to:** Please circle/list

DRUG ALLERGIES: Penicillin or other antibiotics, Morphine, Demerol, or other narcotics, Novocain or other anesthetics, Aspirin or other pain remedies, Tetanus or other serums, Iodine, Methiolate or other antiseptics, Latex, other

FOOD ALLERGIES: _____

ENVIRONMENTAL ALLERGIES: Dust, Mold, Other _____

IMMUNOLOGIC: Please circle: AIDS, Lupus, Immunologic disorders _____, None.

SOCIAL HISTORY: Please circle

Marital Status: Single Married Separated Divorced Widowed
Use of alcohol: Never Rarely Moderate Daily
Use of tobacco: Never Previously, but quit _____ Current packs per day _____
Use of drugs: Never Type/frequency _____
Excessive exposure at home or work to: Fumes Dust Solvents Airborne particles Noise

FAMILY HISTORY: Adopted: No family history known. Please list diseases/conditions.

Father _____
Mother _____
Siblings _____
Spouse _____
Children _____