Patient Registration

	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient:
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone:
Work Phone:	Emergency Contact Information
Mobile Phone	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone:
Patient email:	
Required by government mandate [although you may refuse]:	Employer information
Language:	Employer:
Race:	Address
Ethnicity:	Phone:
Marital Status:	
Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:
Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Member ID: Group #:	Member ID: Group #:
Last Name	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name :
Address:	Address:
City: State Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

FAVORITE PHARMACY

Name: _____ **Address:** _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:_____	Meningococcus	Date:_____
Flu Shot	Date:_____	MMR *(Measles, Mumps, Rubella)*	Date:_____
Gardasil/HPV	Date:_____	Pneumonia	Date:_____
Hepatitis A	Date:_____	Tdap *(Tetanus and pertussis)*	Date:_____
Hepatitis B	Date:_____	Tetanus	Date:_____
		Zostavax *(Shingles)*	Date:_____

Date of last colonoscopy: _____
Results of colonoscopy: _____
Date of last physical exam:_____
Last vision screening: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal
Last Mammogram Date _____ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
Cesarean sections If yes, then number: _____

Bleeding between periods
Heavy periods
Extreme menstrual pain
Vaginal itching, burning, or discharge
Wake in the night to go to the bathroom
Hot flashes
Breast lump or nipple discharge
Painful intercourse
Sexually active
Current sexual partner is Female Male
Do you use condoms Yes No
Other Birth control method used:__ _____
Interested in being screened for STD's _____

PAST MEDICAL HISTORY

Please check all that apply:

[] Anxiety Disorder
[] Arthritis
[] Asthma
[] Bleeding Disorder
[] Blood Clots (or DVT)
[] Cancer
[] Coronary Artery Disease
[] Claustrophobic
[] Diabetes – Insulin
[] Diabetes – Non-Insulin
[] Dialysis
[] Diverticulitis
[] Fibromyalgia
[] Gout
[] Has Pacemaker
[] Heart Attack
[] Heart Murmur
[] Hiatal Hernia or Reflux Disease
[] HIV or AIDS
[] High Cholesterol
[] High Blood Pressure
[] Overactive Thyroid
[] Kidney Disease
[] Kidney Stones
[] Leg/Foot Ulcers
[] Liver Disease
[] Osteoporosis
[] Polio
[] Pulmonary Embolism
[] Reflux or Ulcers
[] Stroke
[] Tuberculosis
[] Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Grandmother (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Grandfather (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease

Father	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Mother	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease
Other:	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic Heart disease Hypertension Osteoporosis Stroke disease

SOCIAL HISTORY

Education Less than 8th grade
High school
2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Exercise Level None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Caffeine None Occasional
Moderate Heavy
# of cups/cans per day?
____

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
Yes No

If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks/day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____
_

Please add any other information about your health that you would like your provider to know here:

_____ _____

Parent, Guardian, or Caregiver Signature

Financial Responsibility

I understand and accept that I will be financially responsible for all deductibles, co-payments, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment at least 24 hours prior to my appointment a $25 dollar fee will be charged. If my insurance requires a referral to receive medical care, I understand it is my responsibility to provide such a referral. If my referral is determined to be invalid by my insurance carrier, I understand I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to Palm Beach Family Medicine, LLC all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the physician and/or representative(s) to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions when manual or electronic.

Patient signature _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name Date of Birth Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with **Florida** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Palm Beach Family Medicine, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Palm Beach Family Medicine, LLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Palm Beach Family Medicine, LLC.
3. I have the right to revoke this authorization at any time by writing to Palm Beach Family Medicine, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE PALM BEACH FAMILY MEDICINE, LCC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law Date

Relationship to Patient Interpreter, if utilized

Witness Signature

HIPAA Privacy and Release of Information Authorization

Patient Name: _____
Patient DOB: _____

I, _____ hereby authorize Palm Beach Family Medicine, LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient Printed Name Date

_____

Patient Signature

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:

Relationship: _____ _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify): _____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization

_____

Date

I have received a copy of Florida's Patient's Bill of Rights and Responsibilities.

Print Name

Signature

Date

Patient Consent of Receive text and/or phone messages

Do we have permission to leave the following information on your home answering machine or voice mail?

Medical information; i.e. Lab results _____ Yes _____ No

Do we have permission to text you the following information?

Medical information; i.e. Lab results _____ Yes _____No

Do we have permission to leave the following information on your cell voice mail?

Medical information; i.e. Lab results _____Yes _____No

_____

Patient Printed Name Date

_____

Patient Signature

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS:**

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. **TERMINATION OF THE E-MAIL RELATIONSHIP**

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of _____ at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between _____ and staff and _____.
(Healthcare provider's name) *(Patient's name)*

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the ***patient/legal representative*** *(circle one)* fully understands what I have explained.

_____
Healthcare Provider Signature/Date/Time

_____ copy given to patient _____ original placed in chart
initial initial

Palm Beach Family Medicine

Emily Harrison, MD

1447 Medical Park Blvd, Ste 405

Wellington, FL 33414

(P) 561-377-7131

(F) 866-219-0330

Transfer of Patient Medical Records

Dear Doctor: _____

Medical Center Name and Address: _____

_____

Phone/Fax: _____

Re: (Patient Name): _____

Date of Birth: _____

Patient's Address: _____

The above patient is now a patient of Emily Harrison, MD and requires that **all** his/ her medical records are forwarded to the above address. If you are able to send the records electronically please do so. Thank you.

I understand the information in my health record may include information relating to sexually transmitted disease and other reportable disease, AIDS/HIV. It may also include psychiatric or mental health services, and treatment for alcohol and drug abuse. I have the right to revoke this authorization at any time by contacting Emily Harrison, MD in writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment. I understand I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. I understand this authorization will expire one year from the date below.

Signature: _____ Date: _____