

ANASTASIA FAMILY CARE

103 ANASTASIA BLVD. SAINT AUGUSTINE, FL 32080 (904) 825-4747

**PATIENT REGISTRATION
(PLEASE PRINT)**

NAME _____ **S / M / D / OTHER** **M / F**
(CIRCLE CORRECT RESPONSE) (MARITAL STATUS) (SEX)

SS# _____ **DATE OF BIRTH** ____/____/____ **AGE** _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

HOME PHONE# (____) _____ **LOCAL PHONE#** (____) _____

EMPLOYER _____ **WORK PHONE#**(____) _____ **EXT:** _____

DRIVERS LICENSE# _____ **STATE** _____

DO YOU HAVE A LIVING WILL? YES OR NO (CIRCLE RESPONSE)

NEXT OF KIN:

NAME: _____ **RELATIONSHIP** _____ **PHONE#**(____) _____

INSURANCE AND BILLING INFORMATION (CIRCLE TYPE OF PAYMENT)

CHECK -CASH-CREDIT CARD (VISA OR MASTER CARD OR DISCOVER OR AMERICAN EXPRESS) -INSURANCE

INSURANCE COMPANY: _____

POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____

POLICY HOLDER DATE OF BIRTH ____/____/____ **SS#** _____

INSURANCE ID# _____

******I UNDERSTAND THAT PAYMENT FOR SERVICE IS DUE AT TIME OF SERVICE******

I HEREBY REQUEST AND CONSENT TO MEDICAL TREATMENT AND EXAMINATION BY ANASTASIA FAMILY CARE.

PATIENT'S SIGNATURE _____ **DATE** _____

IF PATIENT IS A MINOR

PARENT / GUARDIAN SIGNATURE _____

RELATIONSHIP TO MINOR _____

PRINTED NAME _____ **DATE** _____

PATIENT NAME _____ **DOB** _____

PLEASE CHECK THE APPROPRIATE BOX IF YOU OR ANY OF YOUR BLOOD RELATIVES (LIST RELATIONSHIP OF THE RELATIVE) WHO HAS EVER HAD ANY OF THESE CONDITIONS:

| CONDITION | YOU | RELATIVE | CONDITION | YOU | RELATIVE |
|--------------------|-----|----------|-------------------|-----|----------|
| DIABETES | | | ANEMIA | | |
| HIGH BLOOD PRESURE | | | LEUKEMIA | | |
| STROKE | | | SICKLE CELL | | |
| HEART ATTACK | | | BLEEDING PROBLEMS | | |
| ASTHMA | | | STOMACH ULCER | | |
| MIGRAINE HEADACHES | | | GALLSTONES | | |
| CANCER | | | SEIZURES | | |
| EMPHYSEMA | | | TUBERCULOSIS | | |
| KIDNEY PROBLEMS | | | ALCOHOLISM | | |
| ARTHRITIS | | | SUICIDE | | |
| GLAUCOMA/EYE PROB. | | | DEPRESSION | | |
| SKIN RASH | | | MENTAL ILLNESS | | |
| OTHER | | | OTHER | | |

OPERATIONS/SURGERY/HOSPITALIZATIONS:

BLOOD TRANSFUSIONS:

MEDICATIONS: _____

ALLERGIES: (any reaction to any medication of any kind?)

If none, check here _____; if yes, please list below:

OCCUPATION/WORK HISTORY: Any exposure to pesticides, chemicals, or other hazards?

No _____ Yes _____ If yes, what kind _____

FAMILY HOUSEHOLD:

Who lives at home with you? _____

HABITS: Cigarettes: _____ Packs per day x _____ years; if quit, # of years _____.

Other tobacco products: _____

Drug Use: _____ Caffeine (coffee/colas): _____

Seat Belt use: No _____ Yes _____ Exercise: No _____ Yes _____, Method _____

OTHER:

PHARMACY:

Signature: _____ Date: _____

Patient/Parent/Guardian

PATIENT NAME _____ DOB _____

Where applicable, please indicate as to whether you have had the following tests done.

| NAME OF TEST | NO | YES | IF YES, PLEASE PROVIDE WHERE PERFORMED AND YEAR |
|---|----|-----|---|
| ELECTROCARDIOGRAM (EKG) | | | |
| STRESS TEST | | | |
| ULTRASOUND OF HEART (ECHOCARDIOGRAM) | | | |
| HOLTER (24-HOUR HEART MONITOR) | | | |
| LUNG FUNCTION TEST (PFT) | | | |
| CHEST X-RAY | | | |
| SIGMOIDOSCOPY | | | |
| STOOL CHECKS FOR OCCULT BLOOD | | | |
| BONE DENSITY STUDY | | | |
| LAB TESTS (INCLUDING CHOLESTEROL & BLOOD SUGAR) | | | |
| EYE EXAM | | | |
| PROSTATE EXAM (MEN) | | | |
| PAP SMEAR (WOMEN) | | | |
| MAMMOGRAM (WOMEN) | | | |
| PNEUMONIA VACCINE | | | |
| FLU VACCINE | | | |
| TETNUS | | | |
| HEPATITIS B VACCINE | | | |

DIABETIC: DATE OF LAST: HEMOGLOBIN A1C _____ EYE EXAM _____

DATE OF LAST FOOT EXAM: _____

FOR MEN ONLY: (CIRCLE RESPONSE)

DO YOU PERFORM TESTICULAR SELF-EXAM? YES NO

FOR WOMEN ONLY:

DO YOU PERFORM A MONTHLY BREAST SELF-EXAM? YES NO

CHILDHOOD IMMUNIZATIONS: SEE ATTACHED COPY/COPY REQUIRED _____

****PLEASE PROVIDE A COPY OF CHILD'S IMMUNIZATION RECORD FOR OUR FILES****

Signature _____
(Patient/Parent/Guardian)

Date: _____

PATIENT NAME _____ DOB _____

IT IS OUR 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 COPAYS, DEDUCTIBLES, AND NON- COVERED SERVICES AT THE TIME OF SERVICE.

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 THE FRONT OF THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THIS INFORMATION. A PHOTOSTATIC COPY OR OTHER REPRODUCTION OF THIS WILL BE AS VALID AS THE ORIGINAL.

DATE: _____ SIGNATURE: _____

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE ANASTASIA FAMILY CARE TO FURNISH MY INSURANCE COMPANIES, HOSPITALS, REFERRING OR CONSULTING PHYSICIANS AND BILLING AGENTS ALL INFORMATION WITH REGARD TO MY MEDICAL CARE.

DATE: _____ SIGNATURE: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ANASTASIA FAMILY CARE FOR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE.

DATE: _____ SIGNATURE: _____

ANASTASIA FAMILY CARE

NOTICE OF PRIVACY PRACTICES

This notice describes how certain information about **you** (the **Patient**) may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice please contact the office administrator at **(904) 825-4368**

1. Uses and disclosures for Treatment Payment, and Health Care Operations

Anastasia Family Care may use or disclose your Protected Health Information (**PHI**) for Treatment, Payment, and Health Care Operation purposes with your consent. To help clarify these terms, here are some definitions:

- **PHI** refers to information in your health record that could identify you.
- **TREATMENT** is when Anastasia Family Care provides, coordinates, or manages your health care and other services related to your health care. We may disclose certain information about our patients to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of them.

For example, a doctor treating a patient for a broken leg may need to know if he/she has diabetes because diabetes may slow the healing process.

- **PAYMENT** is when Anastasia Family Care obtains reimbursement for your healthcare. Example of payment is when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
- **HEALTHCARE OPERATIONS** are activities that relate to the performance and operation of our practice. Examples of how we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- **USE** applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **DISCLOSURE** applies to activities outside our office, such as releasing, transferring, or providing access to information about you to other parties.

2. Uses and Disclosures Requiring Authorization

Anastasia Family Care may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization: (2) If the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

3. Uses and Disclosures with Neither Consent nor Authorization

Anastasia Family Care may use or disclose PHI without your consent or authorization in the following circumstances:

- **CHILD ABUSE**: If we know, or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child’s welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **ADULT AND DOMESTIC ABUSE**: If we know, or have the reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **HEALTH OVERSIGHT ACTIVITIES:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspection, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.
- **JUDICIAL OR ADMINISTRATIVE PROCEEDINGS:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law and we will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
- **SERIOUS THREAT TO HEALTH OR SAFETY:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

4. Patient's Rights and Island Doctor's Duties

- **PATIENT'S RIGHTS:**
 - **RIGHT TO REQUEST RESTRICTIONS:** You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
 - **RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are being seen by Anastasia Family Care. Upon request, we will send bills to another address.
 - **RIGHT TO INSPECT AND COPY:** You have the right to inspect and/or obtain a copy of PHI in our health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.
 - **RIGHT TO AMEND:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
 - **RIGHT TO AN ACCOUNTING:** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.
 - **ISLAND DOCTOR'S DUTIES:**
 - We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
 - We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

5. Complaints

If you are concerned that we have violated your privacy rights or disagree with a decision we made about access to your records, you may file a written complaint with our practice or to the Secretary of the U.S. Department of Health and Human Services.

Patient Consent:

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE