Morris Medical Center, P.A.

Dareld R. Morris II, D.O.
Keisha Miller DNP, FNP-BC
6800 Porto Fino Circle, Fort Myers, FL 33912 Phone (239) 418-0775 Fax (239) 418-0630
45 Bryan Ave., LaBelle, FL 33935 Phone (863) 675-3427 Fax (863) 675-3809

Thank you for choosing our practice to assist in your healthcare needs. We appreciate the confidence you and your personal physician have placed in us. Please read the following instructions and information and let us know immediately if you have any questions.

INSURANCE: Please bring your insurance cards so we can copy them for your chart. We will file your primary insurance claim for you. If your insurance requires prior authorization, please ensure it is taken care of before the day of your appointment as you cannot be seen without it and your appointment will have to be rescheduled.

PAYMENT: It is the policy of this office to advise patients that they are responsible for all bills incurred. Please be prepared to pay any copay or coinsurance amounts due at the time of service.

We accept cash, and most major credit cards. **Personal checks are only accepted if 1. You have been a patient at Morris Medical Center, for 1 year or more, 2. Your bank and the address on your check must be local.**

Financial Policy

We are committed to providing you with the best possible care. In order to achieve these goals we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered.

Returned checks and account balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize that:

Your insurance is a contract between you and your insurance company. We are not party to that contract.

We must emphasize that, as medical physicians, our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do a rise, we encourage you to contact us promptly for assistance in the management of your account.

If you any questions about the above information, PLEASE do not hesitate to ask us. We are here to help you.

Responsible Party (**print name**):_____

Responsible Party (**signature**):_____

Date: _____

Relationship to patient: Self Spouse Parent

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Last Name: _____First Name: _____ SEX: M F

If patient is a minor,

name of parent or guardian accompanying patient:_____

Relationship to patient:_____Phone # (if different): _____

Address:_____

City:_____State:_ _____Zip Code: _____

Home Phone _____Cell _____

Email: _____

Date of Birth:_____SS#:_____married single divorced widowed (circle one)

Referred by: ___ Fox Radio ___ Friend/relative ___ Insurance ___ Attorney ___ Other

Health Insurance:

Please circle:

BCBS Cigna Aetna Medicare or Auto Insurance

Id#: _____ Group # _____

Auto Insurance (if applicable)

Insurance Company name: _____

Claim # _____ Adjuster _____

Attorney name: _____ Phone: _____

Emergency Contact

Name _____ Relationship_____

Phone _____

Are we authorized to release your medical information to the listed emergency contact? Yes or No

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AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical or other information about me to release same to the insurance carrier for the purpose of payment of services.

I hereby authorize payment directly to my medical provider for all medical care benefits otherwise payable to me; this is not to be construed as an assignment of benefits unless the medical provider has a contractual agreement with the insurance company. I understand that I am responsible for any insurance deductibles and coinsurance, and I am financially responsible for my medical bills regardless of insurance coverage.

SIGNATURE_____ PATIENT'S SIGNATURE (OR PARENT IF MINOR)

MEDICARE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical provider(s) services to the medical provider(s) furnishing the services and authorize such medical provider(s) to submit a claim to Medicare for payment.

SIGNATURE_____ DATE_____
PATIENT'S SIGNATURE (OR PARENT IF MINOR)

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_____Date of Birth: _____

Please Check One of the Following:

_____ I REQUEST THAT ALL OF MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER FRIENDS OR FAMILY.

OR

_____ I GIVE MY PERMISSION TO THE EMPLOYEES OF Morris Medical Center, P.A. TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME: _____ RELATION _____

NAME: _____ RELATION _____

NAME: _____ RELATION _____

NAME: _____ RELATION _____

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Morris Medical Center, P.A would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is our policy to call you at any phone number you provide to us. Please let us know what type of message we may leave on your answering machine/voicemail by answering the following questions by circling **YES** or **NO**.

When we contact you by calling you at any telephone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? **YES** or **NO**

If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your telephone when we are contacting you to remind you of an appointment at our office.*****

I understand I may revoke or change this consent at any time by filling out another consent form to replace this one.

_____ _____

Patient/Guardian/or Legal Representative Signature Date

_____ _____

Printed Name if not signed by Patient Relationship

Internal Use Only: Please post the above information in the patient's off-bill comments.

Date Received:_____Posted By _____

DATE REVOKED/CHANGED_____

SIGNATURE_____ PATIENT'S SIGNATURE (OR PARENT IF MINOR)

DATE_____

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Notice of Privacy Practices

Effective April 14, 2003, all medical practices must follow certain guidelines as it pertains to the "Protected Health Information" (PHI) of their patients. PHI is defined as information about the patient, including demo- graphic information, that may identify the patient, and relates to the patient's past, present, or future physical or mental condition and related health care services.

This short form has been created to provide you an overview explaining how we will handle your PHI and actions you can take if you feel we have not handled your PHI properly. A more detailed explanation of this Notice of Privacy Practices is available on our website at www.swfna.com.

How we handle your Protected Health Information:

We will ask each patient to sign consent from allowing our office to use your PHI for three purposes only. Those purposes are for medical treatment, information required for payment of services rendered, and for conducting our operational activities. No other use of your PHI will occur without your written consent, unless it is to comply with state and federal laws.

_____ _____

Patient Signature Date

_____ _____

Staff /witness signature Date

Review of System

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐ Weakness ☐ Stroke ☐ Tremor ☐ Seizure ☐ Memory loss

- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT problems ☐ Ear pain ☐ Hearing loss ☐ Ear noises ☐ Nose bleed ☐ Sore throat ☐ Hoarseness ☐ Dental

- Cardiovascular ☐ Chest pain ☐ Chest pressure ☐ Shortness of breath ☐ Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood

- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Bloody stool ☐ Pain in stomach ☐ Ulcers ☐ Hepatitis
- Genitourinary ☐ Painful urination ☐ Frequent urination ☐ Bloody urine ☐ Kidney stone ☐ Incontinence ☐ Loss of libido ☐ Sexual difficulty ☐ Infection

- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Compression fracture ☐ Head injury ☐ Neck injury

  ☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus☐Spina bifida

  ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis
- Women only ☐ Irregular periods ☐Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps ☐ Vaginal discharge

  ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram _____
- Men only ☐Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty starting urination
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts

  ☐ Suicidal ideation ☐ Homicidal ☐Hallucination ☐ Psychosis ☐ Other _____

Past Medical History

- Heart ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐Valvular disease ☐ Aneurysm ☐ High cholesterol

  ☐Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other _____
- Lungs ☐Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other _
- Gastrointestinal ☐ Ulcer ☐ Reflux☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other ___
- Kidney ☐ Failure ☐ Stones☐ Dialysis (When)_____☐ Other _____
- Endocrine ☐ Diabetes ☐ Hypothyrodism ☐ Hyperthyroidism ☐ Other _____
- Neuro ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia

  ☐ Seizures ☐ Parkinson's ☐Other _____
- Psychiatric ☐ Depression ☐Bipolar☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other ___
- Bone/Muscular ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other _____
- Cancer ☐ _____
- Other ☐ _____

Past Surgery History

_____

_____

Allergies

•Latex ☐ No ☐ Yes Reaction_____• Contrast (Dye) ☐ No ☐ Yes Reaction _____

Allergic to any medication(s) _____

Current Medications

_____

_____

_____

_____

Significant Family History (Cancer, hypertension, diabetes, depression, back pain…)

- Father side _____
- Mother side _____
- Siblings _____

Social History

- Tobacco: ☐ Never ☐ Quit in_____ ☐ Currently___pack per day
- Alcohol : ☐ Never ☐ Rarely ☐ Moderate ☐ Daily_____
- Use of drugs: ☐ Never ☐ Occasionally ☐ Frequently, Type/frequency _____
- Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
- Family status: Living with

  _____

- Occupation:

  _____

- Disability: ☐ No ☐ Yes (Type) _____
- Litigation (Lawsuit): ☐ No ☐ Yes against_____working with _____

Radiological studies / Lab studies

- MRI ☐ Neck_____☐ Upper back_____☐ Lower back_____☐ Other

_____

Date Date Date Date

- CT ☐ Neck_____☐ Upper back_____☐ Lower back_____☐ Other _____

Date Date Date Date