2306 North Highway 77
Panama City, Florida, 32405
Phone: 850-250-0021
Fax: 850-250-0022

Today's Date	**PATIENT INFORMATION** *This Form Must Be Completed Annually*	Method of Payment

Patient Information

Last Name	First Name	Middle Name	Primary Phone

Street Address	Apt #	City	State	Zip

Permanent Address	Apt #	City	State	Zip

Social Security	Birth Date	Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐Married ☐Divorced ☐ Widowed

Employer	Address	Business Phone

Emergency Contact	Address	Primary Phone	Other Phone

E-mail Address	E-mail Address 2

Do you give permission to Access Point Healthcare to leave a general message on your primary phone number to ask that you return a call to our office?
☐ Yes ☐ No

Responsible Party (If patient is younger than 18)

Last Name	First Name	Middle Name

Street Address	City	State	Zip

Social Security Number	Birth Date	Relationship to Patient

Employer	Address	Business Phone:

Accident Information

If your condition is related to an accident: Date: Time: ☐ am / ☐ pm	Did this happen at: ☐Home ☐ Work ☐Other: _____

Specifics of Accident

Insurance Information

Primary Insurance	Secondary Insurance

Policy #	Group #	Policy #	Group #

Name of Policyholder	Name of Policyholder

Address of Policyholder	City	State	Zip	Address of Policyholder	City	State	Zip

Policyholder Phone	Policyholder Birthdate	Policyholder Phone	Policyholder Birthdate

Social Security Number of Policyholder	Employer of Policyholder	Social Security Number of Policyholder	Employer of Policyholder

Relationship to Patient	Relationship to Patient

HIPAA Authorization Acknowledgement and Consent

I acknowledge that I have received or been offered a copy of Access Point Healthcare's Notice of Information Practices. I hereby authorize Access Point Healthcare to release to the below listed individuals, upon their request and without further authorization from me, information concerning treatments the above listed patient receives as a patient of Access Point Healthcare and copies of any and all medical records. This authorization is made at my request and will not expire unless revoked by me. I understand that I may revoke or restrict at any time the right of any of these individuals to receive this medical information by providing said revocation or restriction to Access Point Healthcare in writing. I understand that Access Point Healthcare will not condition treatment upon whether I authorize these individuals to receive this information. I understand that any health information and medical records disclosed to the below listed individuals may possibly be re-disclosed by them without any restrictions under federal or state privacy regulations.

Name	Name

Relationship	Relationship

accesspoint healthcare

New Patient Medical History Form

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ☐ No Known Drug Allergies

ALLERGY	ALLERGIC REACTION

MEDICATIONS

Medications (Please list all medications including OTC and Vitamins)	**Dose** (mg, pill, etc)	**Frequency** (Times per Day)

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

Colonoscopy	Date:	Facility/Provider:	Abnormal Results? Y N
Mammogram	Date:	Facility/Provider:	Abnormal Results? Y N
Pap Smear	Date:	Facility/Provider:	Abnormal Results? Y N
Bone Density	Date:	Facility/Provider:	Abnormal Results? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pneumovax (Pneumonia):
Last Flue Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles):	

I attest that all of the information provided is accurate and true.

Patient Name: _____ **DOB:** _____

Personal Medical History

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: _____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: _____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (Hypertension)			
High Cholesterol (Hyperlipidemia)			
Hypothyroidism/Thyroid Disease			
Renal (Kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

Surgeries

Type (Specify left/right)	Date	Location/Facility

Women's Health History

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

I attest that all of the information provided above is accurate and true.

Patient Name: _____ **DOB:**_____

FAMILY MEDICAL HISTORY

☐ No Significant Family History Is Known

Check All That Apply	Alcohol/Drug Abuse	Asthma	Cancer (type: _____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stoke	Thyroid Disease	Migraines	Other: _____	Other: _____	Other: _____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grand Mother																		
Maternal Grand Father																		
Paternal Grand Mother																		
Paternal Grand Father																		
Other: _____																		

SOCIAL HISTORY

Occupation (or prior occupation):	☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled
Employer:	Years of Education or Highest Degree:
If employed do you work the night shift? Y N N/A	
Marital Status (Check One): ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

Tobacco Use	Smoke Cigarettes? Y N (If you never smoked, please move to Alcohol/Drug Use)		
Current: Packs/Day: _____ # of Years: _____	Past: Quite Date: _____ Packs/Day: _____ # of Years: _____		
Other Tobacco (Check One): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew			
Alcohol/Drug Use	Do you drink alcohol? Y N	If yes: ☐ Beer ☐ Wine ☐ Liquor	Number of Drinks per Week: _____
Do you use marijuana or reactional drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

I attest that all of the information provided above is accurate and true.

Patient Name: _____ **DOB:** _____

OTHER HEALTH ISSUES continued…

Sexual Activity	Are you sexually involved currently? Y N (If no sexual history, please continue to Exercise)		
Sexual partner(s) is/are/have been: ☐ Male ☐ Female			
Birth control method: ☐ None ☐ Condom ☐ Pill/Ring/Patch/Injection/IUD ☐ Vasectomy			
Exercise	Do you exercise regularly? Y N (If you answered no, please move to Sleep)		
What kind of Exercise?		**Duration**: How long (min.): _____ How often: _____	
Sleep	How many hours, on average, do you sleep at night (or during the day, if working night shift)?		
Diet	How would you rate your diet? ☐ Good ☐ Fair ☐ Poor	Would you like advice on your diet? Y N	
Safety	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N	
Working smoke detectors in home? Y N N/A		If you have guns at home, are they locked up? Y N N/A	
Is violence at home a concern for you? Y N		Have you completed an Advanced Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N	

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonology		
Endocrinology		
Oncology		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

I attest that all of the information provided above is accurate and true.

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS (Check All That Apply)

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite Change		Leg swelling		Pallor (Paleness)
	Chills		Palpitations		Rash
	Diaphoresis (Sweating)		**GASTROENTESTINAL**		Wound
	Fatigue		Abdominal Distention		**ALLERGY/IMMUNOLOGY**
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
	HEAD, EARS, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		**NEUROLOGICAL**
	Dental problems		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal Pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial Swelling		**ENDOCRINE**		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia (Drinking a lot)		Syncope (Loss of Consciousness)
	Postnasal drip		Polyphagia (Swallowing a lot)		Tremors
	Rhinorrhea (Runny nose)		Polyuria (Increased urination)		Weakness
	Sinus pressure		**GENITOURINARY**		**HEMATOLOGIC (BLOOD/LYMPH NODES)**
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria (Painful urination)		Bruises/bleeds easily
	Tinnitus (Ear Ringing)		Enuresis (Unable to control urination)		**PSYCHIATRIC**
	Trouble Swallowing		Flank Pain		Agitation
	Voice Change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Hematuria (Blood in urine)		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
	RESPIRATORY		Urgency		Sleep disturbance
	Apnea episodes (Stop breathing)		Urine decreased		Suicidal ideas
	Chest tightness		**MUSCULAR**		
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

I attest that all of the information that is provided above is accurate and true.

Patient Name: _____ **DOB:** _____

PATIENT CONSENT FOR MEDICAL TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The terms and conditions constitute a binding agreement between you and Access Point Health Group, LLC d/b/a Access Point Healthcare ("Access Point Healthcare").

I understand that I have the right to make informed decisions about my health care treatment. I agree to have the providers and staff do test and treatments they feel are needed for my care. These may include x-rays, lab tests, vital signs, medication and other therapy. I know other treatments or tests that have more risk will be explained to me so I can give informed consent for the if I need them. I know I can ask my doctor any questions I have about my treatment. I know that Access Point Healthcare Urgent and Primary Care is not responsible for any of my belongings that I choose to keep with me.

I hereby give my consent to Access Point Healthcare to use and disclose protected health information about me to carry out treatment, payment and health care operations. Access Point Healthcare's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review Access Point Healthcare Urgent and Primary Care's Notice of Privacy Practices prior to signing this consent. Access Point Healthcare reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Access Point Healthcare at 2306 North Highway 77, Panama City, Florida, 32405.

With this consent, Access Point Healthcare, may call my home, send e-mail or mail to my home or other alternative locations, and leave a message on a voice-mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations. These items include, but are not limited to appointment reminders, insurance items, correspondence from medical and/or nursing staff, any calls pertaining to clinical care, including laboratory/radiology results, and billing statements.

I have the option to request that Access Point Healthcare restrict how it uses or discloses my personal health information to carry out treatment, payment and health care operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Access Point Healthcare's use and disclosure of my personal health information to carry out treatment, payment and health care operations with those organizations and health providers necessary for my medical care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Access Point Healthcare may decline to provide treatment to me.

I agree and consent to Access Point Healthcare to releasing information to me in the following manners:

By Mail: ☐ Ok to Mail to Home Address (Initial: _____) ☐ Ok to Mail to Work Address (Initial: _____)

By Home Telephone: ☐ Ok to Leave Detailed Message (Initial: _____) ☐ Leave Call Back Number Only (Initial: _____)

By Work Telephone: ☐ Ok to Leave Detailed Message (Initial: _____) ☐ Leave Call Back Number Only (Initial: _____)

By Fax: ☐ Ok to Fax to: _____

_____ _____

Signature of Patient or Legal Guardian **Printed Patient Name**

_____ _____

Patient's Date of Birth **Date**

FINANCIAL ACKNOWLEDGEMENTS AND OFFICE POLICIES

Insurance Information

Access Point Healthcare accepts most major insurance payers. As a courtesy, we will file your medical claims for you. However, it is your responsibility to check with your insurance plan to advise you on your coverage. Most plans are specific to your employer group and we do not know what a covered benefit under your plan is. Your employer benefit advisor at your place of employment will be able to answer your questions regarding coverage and benefits. It is your responsibility to ensure that our providers are covered under your health plan.

It is your responsibility to provide accurate and updated insurance information at each visit. You will be responsible for any balances that your insurance carrier denies as a result of inaccurate information. Please check with our receptionist at each visit to verify if we have the most up to date insurance information and insurance card on file.

You are ultimately responsible for payment of charges for services that you receive from our office. If your claim is denied or payment is not made within thirty (30) days from the date of service, you must contact your insurance plan for an explanation and pay us any amounts not covered by your health plan. It is important that you go over your insurance company's explanation of benefits concerning billing questions prior to contacting our office concerning a bill from Access Point Healthcare.

Laboratory Services

Many insurance plans now require you to go to or send your lab specimens to specific laboratories. Please let us know if this is the case. Access Point Healthcare does have a lab on site and some tests may be performed here while other tests must be referred to an outside laboratory. However, if you wish to have your lab tests done here, they are subject to cash payment at the time of the test being completed.

Missed Appointments/No Shows

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve a specific time for your care, we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a 24-hour notice is required. If you DO NOT contact us before this 24-hour window, whether in person, phone, voicemail or email, it will result in a $25 fee assessed on your account. If you are fifteen minutes late for an appointment, the provider will determine if you can be seen or your appointment may need to be rescheduled. Any appointments later than thirty minutes will have to be rescheduled. Please note, not all clinics schedule appointments.

Returned Checks

We accept all major credit cards, cash or check. For checks that are returned not payable, there will be a $30 returned check fee and checks will not be accepted on future visits.

Copies of Medical Records

Medical records request must be received at least five (5) business day prior to the date needed. There is no charge for records provided from doctor to doctor. There is a global charge of $25 fee plus $.25 per page.

Forms for disability, handicap parking, FMLA, insurance authorization for brand or non-formulary drugs, letter for employers, school, health clubs, etc., may be subject to an administrative fee of $40. Completion of these forms has a 24-72 hour turn-around time.

My signature below indicates that I have read and understand this Financial Acknowledgement and Financial Policy and accept these terms. My acceptance covers my visit today and all future visits.

_____ _____

Signature of Patient or Legal Guardian **Date**

AUTHORIZATION FORM TO COMMUNICATE MEDICAL AND/OR FINANCIAL INFORMATION TO OTHERS

I, _____ authorize the following individuals:
(Patient's Printed Name)

Printed Authorized Individuals Name	Relationship

These individuals will perform the following activities on my behalf with any Physician, Nurse Practitioner or Staff Member at Access Point Health Group.

Please check the following that you are authorizing:

- ☐ **FULL ACCESS** to Medical, Financial & Scheduling Information

Or

- ☐ Make and cancel Appointment on my behalf
- ☐ Request and discuss medical information (including medications)
- ☐ Handle and discuss financial records and information
- ☐ Deliver and pick up information to/from Access Point Health Group, LLC on my behalf
- ☐ Other (Please Describe): _____

_____

_____

This authorization is effective from: _____ to _____ or **Indefinitely (Circle)**

_____ _____

Signature of Patient or Legal Guardian **Date**