PERSONAL INFORMATION

GADH FAMILY PRACTICE "Traditional Care With A Modern Approach"

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

BIRTH DATE: _____ MALE / FEMALE SOC. SEC. #: ____-____-____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT INFORMATION:

HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE #: _____ RELATION: _____

NAME: _____ PHONE #: _____ RELATION: _____

EMPLOYER NAME: _____ PHONE #: _____ CONTACT: _____

INSURANCE INFORMATION: (PLEASE PROVIDE COPIES OF INSURANCE CARDS & OFFICIAL ID CARD)

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

MOTOR VEHICLE INSURANCE: _____

MEDICAL HISTORY

CHECK IF YOU HAVE ANY OF THE FOLLOWING:

	ALCOHOL OVERUSE		DEPRESSION/ANXIETY		HEPATITIS/LIVER DISEASE
	ALLERGIES/HAYFEVER		DIABETES		HIGH BLOOD PRESSURE
	ANEMIA		DIALYSIS		MIGRAINE
	ARTHRITIS		EMPHYSEMA/COPD		SEXUALLY TRANSMITTED DISEASE
	ASTHMA		EPILEPSY		SICKLE CELL ANEMIA
	BLEEDING TENDENCY		KIDNEY/BLADDER INFECTION		STOMACH ULCER
	CANCER		GALLBLADDER DISEASE		STROKE
	CHICKEN POX/MEASLES		GOITER/THYROID DISORDER		TUBERCULOSIS
	COLITIS		GOUT		OTHER:
	CONGENITAL HEART DISEASE		HEART ATTACK		OTHER:

OPERATIONS/SURGERIES/HOSPITALIZATIONS/SERIOUS INJURIES: **please list type and year**

1. _____
2. _____
3. _____
4. _____

PATIENT NAME: _____ **DOB:** _____

FAMILY PRACTICE
"Traditional Care with A Modern Approach"

LAST COLONOSCOPY/COLON CANCER SCREENING: _____

FINDINGS: NORMAL or ABNORMAL _____

MEDICATIONS

DO YOU TAKE ANY OF THE FOLLOWING? (please check the box next to it)

	ASTHMA MEDICATION		INSULIN OR DIABETES MEDICATION		BLOOD THINNER / COUMADIN
	ASPIRIN		IRON PILLS		SEIZURE MEDICATION
	TYLENOL OR SIMILAR PRODUCTS		LAXATIVES		WATER PILLS / DIURETICS
	BLOOD PRESSURE PILLS		MOTRIN / ADVIL / ALEVE		ANTIBIOTICS
	PREDNISON / CORTISONE		SLEEPING PILLS / TRANQUILIZERS		VITAMINS
	COUGH MEDICINE		THYROID MEDICATION		BIRTH CONTROL PILLS
	HEART MEDICINE		STOMACH / DIGESTION MEDICATION		CBD OIL / SUPPLEMENTS
	HORMONES		WEIGHT-LOSS PILLS		OTHER:

LIST EACH MEDICATION, DOSE AND HOW OFTEN YOU TAKE IT:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

If yes, please list any allergies: _____

PLEASE BRING ALL MEDICATIONS WITH YOU TO EVERY VISIT

Do you have any health complaints that are especially important to you today?

1. _____
2. _____
3. _____
4. _____

PATIENT NAME: _____ **DOB:** _____

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Please check ONLY if the problem is of significant concern in the past 1 month.

√	GENERAL	√	CARDIOVASCULAR	√	NERVOUS	√	EYES	√	ENT
	Persistently tired		Chest pain/pressure		Headaches		Eye pain		Hearing difficulty
	More thirsty		Abnormal EKG		Dizziness		Glaucoma		Ringing in ears
	Weight gain		Fast heartbeat		Loss of speech		Blurry vision		Earache/Discharge
	Weight loss		Swelling in feet/ankles		Fainted/Black out		Halo around lights		Nosebleeds
	Lightheaded		Cramps in calf		Memory problems		Vision changes		Hoarseness
			Numbness in finger/toe		Convulsions		Cataract/Implant		Bleeding gums
					Suicidal		Glasses/Contacts		Post nasal drip
√	GASTROINTESTINAL	√	MUSCULOSKELETAL	√	RESPIRATORY	√	URINARY	√	SKIN
	Change in appetite		Back pain		Frequent colds		Burning / Pain		Color changes
	Trouble swallowing		Joint stiffness / pain		Pneumonia		Frequently		Rash / Itching
	Indigestion/ Heartburn		Trouble walking		Coughing blood		Get up at night		Growths/ Lumps
	Vomiting blood		Knee pain		Trouble breathing		Urine loss with cough/sneeze		Sores / Wounds
	Constipation / Diarrhea				Wheezing		Blood in urine		Warts
	Abdominal pain				Asthma		Prostate issues		Moles
	Blood in stool						Vasectomy (male)		
	Colon polyps								
	Reflux (GERD)								
√	WOMEN ONLY			√	PERSONAL				
	Pregnancies (if yes →)		How many? _____		Living Will				
	Breast lumps/masses				Power of Attorney				
	Menopause								
	Abnormal vaginal bleeding		**Last PAP:** **Results:**						
	Hysterectomy/Tubal lig		**Mammogram:** **Results:**						
	Vaginal discharge								
	Herpes								

PATIENT NAME: _____ **DOB:**_____

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Please check YES or NO to the following:

LIVING ARRANGEMENTS	YES	NO
Do you own your home?		
Do you rent your home?		
Do you live alone?		

PERSONAL HABITS	YES	NO
Have you ever smoked tobacco?		
Are you a regular smoker now?		
# cigarettes per day:		
How many years?		
Do you drink alcohol regularly?		
# Hard liquor: oz per day		
# Beer: bottles per day		
# Wine: glasses per day		
Do you drink coffee?		
# cups per day:		
Do you exercise regularly?		
Have you used any of the following: (please circle)		
Marijuana LSD Heroin Cocaine Speed		

ACTIVITIES OF DAILY LIVING	YES	NO
Do you use any of the following? Please circle		
Cane Walker Wheelchair Hearing Aid Catheter		
Are these aids in good condition?		
Do you have a problem using the toilet?		

OCCUPATIONAL HISTORY	YES	NO
Are you presently employed?		
Has you ever been exposed to excess: (please circle)		
Dust Noise Radioactivity Lead Other		
Are you limited at work due to disability?		

SOCIAL HISTORY	YES	NO
Have you recently lived or traveled outside the U.S?		
Do you eat less than 3 meals a day?		
Do you have special food customs or restricitons?		
Do you use any of the following: (please circle)		
Meals on Wheels Transportation Sr. Center		

LIFESTYLE (OPTIONAL)		
Are you sexually active? If yes, please circle		
Same Sex Oppposite Sex Both Sexes		
Do you use contraceptives?		

ASSOCIATESMD

Acknowledgement of Privacy Practices

Patients' Rights: As a patient, you have the following rights pertaining to your protected health information (PHI): obtain a copy of your medical records, request corrections to your medical records, limit the sharing of your medical information by the practice, receive a copy of this acknowledgement, assign a health surrogate, file a complaint regarding violations to your PHI, and determine the manner in which the practice communicates with you, for example, home, cellular, and or work telephone number, electronic correspondence, or text messaging to your mobile device.

Timeframes: Your request for copies of medical records may have an associated cost, and the processing time will be within 30 days. Corrections to your medical records may be denied, but the denial and written confirmation is available within 60 days.

Disclosures: In order to sustain continuity of care and reimbursement of rendered services, the practice will be sharing your PHI with your health plan and or medical professionals involved in your treatment plan. There are situations in which the practice will be statutorily required to disclose your PHI. These instances include: filing of birth and death certificates, reporting communicable diseases to governmental monitoring agencies, response to legal actions, disease prevention, addressment of pharmaceutical and or medical recalls, reporting suspicion of abuse, neglect, or domestic violence, prevention or reduction of an immediate threat to life or public safety, and compliance with other applicable state and or federal laws.

Practice's Responsibilities: As required by law, AssociatesMD is responsible for the following: maintaining the privacy and security of your PHI, expeditious notification of a breach that may potentially compromise the security and privacy of your PHI, adherence to the privacy practices described in the notice, provide a copy of such notice upon request, and prohibit the disclosure of your PHI other than those described in the notice without your explicit consent.

Confidentiality: AssociatesMD shall comply with the confidentiality requirements of the Health Information Portability and Accountability Act (HIPAA) as well as Section 456.057 of the Florida Statutes. Your health information cannot be disclosed without your or legal representative's explicit consent. You may revoke consent at any time and further disclosure is prohibited without your specific consent. If not revoked, the consent will be valid for 180 days from the date of signature. A copy of the practice's privacy notice is available upon request.

Consent to Release of Information: As a patient, you have the right to determine who will have access to your PHI, and staff is available to inform you of this right and assist with the completion of a consent to release of information form. The document consists of the following elements: patient's full name and date of birth, complete information of the authorized individual, type of information to be disclosed, reason for the disclosure, and patient's dated signature.

File a Complaint: If you feel the practice has violated your rights to privacy, you may file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW Washington D.C. 20201 or call the Department at 1-877-696-6775. You will not experience retaliation from the practice for issuing the complaint.

I, _____ acknowledge full understanding of this document and my dated signature serves as my attestation.

Patient's Signature or Legal Representative: _____

Date: _____

Effective Date: 1/29/2021

ASSOCIATESMD

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information: I attest the provided insurance information is accurate and current and I have no other means of medical coverage. To the extent that AssociatesMD receives or transmits my medical information or protected health information (PHI) to a health information exchange (HIE) that is accessed by other organizations, I hereby consent and authorize for my medical information to be shared for such purposes. I understand that I may request that my information not be shared with an HIE by providing notice to AssociatesMD. I understand the following: AssociatesMD will be receiving payment from my health insurance for all rendered services and AssociatesMD will file an appeal to my health insurance on my behalf for denial of payments or adverse benefit determinations. By signing the Authorization and Consent to Treatment document, I authorize representatives of AssociatesMD to release information needed to facilitate a determination of benefits and payment from my health insurance. Authorized payment will be addressed and sent to AssociatesMD at **4780 SW 64th Ave, Suite 102, Davie, FL 33314**.

Guarantee of Payment and Attendance to Scheduled Medical Visits: I agree to pay all applicable out of pocket expenses for my health insurance such as deductibles, coinsurances, and copayments at the time of the appointment. I understand all open charges will be sent monthly via correspondence to my attention. After three sequential months without payment, my outstanding balance will be sent to collections for resolution. I understand appointments will be confirmed 24 hours in advance; a charge of $25 will be incurred for all missed appointments with the physician or clinician in the absence of advanced notice of cancellation. For a missed plain stress test appointment, the fee will be $50, while a missed nuclear stress test (myocardial perfusion imaging) will be $200, plus associated pharmaceutical costs. I understand a copayment may be charged if the scheduled annual wellness visit involves the identification of an acute episode of care as determined by the attending physician or clinician.

Consent to Treatment: I voluntarily consent to all treatments deemed necessary by the physicians and clinicians of AssociatesMD. My consent will cover face-to-face and telehealth encounters with the physician and clinician, diagnostic testing, and screenings. The diagnostic testing and screenings may include but not limited to: annual physical examination, electrocardiogram (EKG), electroencephalogram (EEG), laboratorial procedures, medication reconciliation, nerve conduction study, nuclear stress test (myocardial perfusion imaging), plain stress test, sleep study, and spirometry.

Consent to Obtain Medical Records: I consent to have staff from AssociatesMD request my medical records on my behalf to facilitate continuity of care. I also consent to have staff from AssociatesMD process all orders not provided within the office to externally contracted vendors with my health insurance. All consents will cover the exchange of only necessary health information for the execution and maintenance of my treatment plan.

Consent to Call, Email, and Text: I understand and agree to have staff from AssociatesMD contact me via the telephone, email, and or text messages from my mobile device. I understand the reasons for the communications may include confirming the status of my appointment, advising me of my financial obligations, and coordination of care. I understand I can opt out of receiving communications through specific modes of delivery by speaking with the administration of AssociatesMD.

I, _____ acknowledge full understanding of this document and my dated signature represents my consent to treatment with the physicians and clinicians of AssociatesMD.

Patient's Signature or Legal Representative: _____

Date: _____

600 South Pine Island Road
Suite 104
Plantation, FL 33324

Phone: 954-474-4401
Fax: 954-474-9883

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME:_____ **DOB:**_____

PHONE NUMBER:_____ **SSN:**_____

PROVIDER AND/OR FACILITY THAT WE ARE RELEASING INFORMATION TO:

NAME:_____

ADDRESS:_____

PHONE:_____

- ☐ Complete Medical Records
- ☐ Office encounters
- ☐ Records relating to drug and alcohol abuse
- ☐ Psychiatric and other mental health records
- ☐ Consultation notes or reports
- ☐ Lab reports
- ☐ Procedure reports
- ☐ **HIV/AIDS: I do _____ do NOT_____** consent to the release of any positive or negative test result for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS with the rest of my medical records. **INITIAL _____DATE_____**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity below. **Also include current and previous medical records from other practices and practitioners, hospitals and/or clinics which are a part of my medical records to be sent to:**

Gadh Family Practice
600 South Pine Island Road, Suite 104
Plantation, FL 33324

This authorization will expire one year from the date of the signature below. This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the written consent of the patient and/or authorized representative. I hereby release the facility from any liability, which may arise as a result of the information contained in the records.

Patient Name:_____ **Date:**_____

Signature:_____