Donna Johnston, MD
8061 Spyglass Hill Road, Unit 102
Melbourne, FL 32940
p#321-751-7041 f#321-751-7042

NEW "NO SHOW" OFFICE POLICY

Our "no show" fee is $50 as of 11/15/2021. Three "no shows" within a calendar year will be automatic dismissal from the practice. Please understand that I have a very busy practice and another patient could have benefited from that time slot. Please contact our office at least 24 hours ahead to reschedule if needed. We understand emergencies come up but please contact us ASAP.

Thank you for your understanding in this matter.

Donna Johnston MD

Donna Johnston, MD

_____ _____

Sign Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Donna Johnston, MD

Office Policy regarding Follow Up Care

Name _____ Date:_____

Please read carefully then sign below.

I, below signed, agree and understand that it is **my responsibility** to follow up with recommended lab tests, imaging, consultations with specialists, and to keep track of when I am due to return to this office for continued care. I will not expect or rely on notification from this office when follow up is due. The office has systems in place for courtesy reminders but they are not guaranteed and I will not rely on them. If any serious medical issues arise because of my failure to follow through with recommended appointments, labs, imaging, or other medical advice, **I will not hold Dr. Johnston or Andrea Ellison, NP responsible for my negative outcome.**

It is **my responsibility** to keep track of when my next office visit is due. It is my responsibility to get my labs, imaging, consultations accomplished.

I understand that non-compliance with recommended follow up, recommended testing, recommended consultation with specialists ***could be grounds from dismissal from the practice***. This is not meant to be a threat, but a warning that Dr. Johnston and her staff take your health very seriously. Non-compliance with recommended medical care is a serious threat to your health.

Medication refills are usually provided **during your office visit**. If you are on a medicine that requires regular follow up (monthly, every three months, every six months), please arrange for your next follow up visit **BEFORE** your medicine is due to run out. It is **your responsibility** to make that appointment and keep it to ensure your refills will be at the pharmacy when you need them. By signing below, you are acknowledging that you understand it is **NOT** Dr. Johnston or her staff's obligation to refill your medicine if you have not followed up for your office visit. You run the risk of being without your medication which could have negative medical consequences. If a unique situation arises that prevents you from coming when your follow up is due, special arrangements may be granted for an emergency supply of your medicine until you can get in but be aware that you may end up paying two co-pays. Do not abuse this privilege. Do not expect this on a regular basis. Also, there will be a **$25 fee** for the clerical work that goes into **refills accomplished without an office visit** (phone calls, routing of messages, communication with pharmacies). A great deal of time goes into the processing of requests between office visits.

Be aware that any **CONTROLLED SUBSTANCE requires an office visit** to receive a paper script that you bring to the pharmacy. During that office visit, you will need to sign a "controlled substance agreement" and provide a urine specimen for a urine drug screen. This is compliance with Florida Law. Please do not expect otherwise. Please do not request that your controlled substance be *called in* to the pharmacy. If you do not request it during the office visit, another office visit will need to be scheduled to accomplish the urine drug screen and signing of the controlled substance agreement before the paper prescription can be provided.

Patient's signature:_____ Date:_____

you have questions about bring to the office.
INITIAL:_____

Acknowledgment of receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided the Notice of Privacy Practices that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgment. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

Printed patient name: _____

Signature of patient or : _____ Date:_____
legal representative

Witness:_____ Date:_____

If you have purchased any "OBAMACARE" insurance product off of the Marketplace, please realize that if you stop paying your insurance premium but continue to see the doctor, **you will be responsible for paying the full amount of the bill.**
INITIAL: _____

When calling after hours, a message can be left that will be addressed as soon as possible by the staff. Please only use the doctor's pager for reasonable questions, not for scheduling an appointment or to cancel an appointment. Do not page the doctor asking for controlled substances, and not ask for antibiotics: these require an office visit to be prescribed. **Controlled substances and antibiotics will not be prescribed without an office visit.**
INITIAL:_____

Be aware that the doctor can not examine and diagnose over the phone. Before paging the doctor, consider if it can wait until business hours and/or would a visit to an urgent care center be more appropriate. Evaluation to determine whether antibiotics are needed requires evaluation by a physician = office visit.
INITIAL:_____

Chronic conditions require an office visit every 3-6 months. Schedule your next appointment or at least mark your calendar. It is **your responsibility** to be aware when your next office visit will be. Your medication will not be refilled if you are overdue for your office visit. (consider using your cell phone to set an alarm to remind you when your next office visit, labs, etc. are due.)
INITIAL:_____

Your yearly physical is separate from follow up visits for chronic medication conditions. Please do not try to combine the two as the time set for the physical is strictly for the physical. A separate appointment is needed to follow up every 6 months for your hypertension, high cholesterol, diabetes, hypothyroidism, or any other chronic condition being followed.
INITIAL: _____

If under 18, you need to be accompanied by a parent/gaurdian, or have parent/guardian sign a release allowing you to come on your own. INITIAL:_____

Review your **EOB (explanation of benefits)** when it arrives in the mail from your insurance company: it will state, "this is not a bill" but it does break down what portion of your visit was paid by your insurance plan and **what portion is your responsibility.** The amount listed as your responsibility is how much you need to pay the doctor. Feel free to pay that amount at any time. Eventually my biller will send you a statement for that amount, but you do not have to wait for the statement to arrive: you can pay when your EOB arrives. Keep your EOB's in a file at home and bring to any office visit if you would like my staff to go over it with you.
INITIAL:_____

Do not disregard letters from your insurance company as un-important: sometimes they send you a questionnaire to fill out: at times this delays payment of your bill if you do not respond. This could result in you becoming responsible for full payment of the bill. Again, anything they send you that

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Patient responsibilities: please initial after reading each statement.

All patients are responsible for re-scheduling any canceled appointments, especially those to review tests that were performed.
There is a fee for "NO SHOW" (not showing up to an appointment without calling).
There is a fee for showing up late for your appointment.
INITIAL: _____

All patients are responsible to know the details of their insurance, including: coverage, participating labs, diagnostic imaging centers, specialists, and hospitals. Please read and be familiar with the details of your insurance policy as every policy is different.
INITIAL:_____

I assign all medical benefits to which I am entitled to Dr. Donna Johnston for services rendered. A photocopy of this assignment is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. **I understand that I am ultimately financially responsible for ALL CHARGES whether or not approved or paid by my insurance company.** I also authorize the release of any information/medical records regarding my treatment to my insurance company to help secure for services rendered and to any of my health care providers. I understand that any **Co-Payments, Balance Due, or DEDUCTIBLE will be due at the time of service.** I will not ask the staff to "bill me" for this.
INITIAL:_____

If this account is assigned to a collection agency, an additional fee of 40% of amount owed will be added. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and cost of collection.
INITIAL:_____

I am aware that it is my responsibility to determine if Dr. Donna Johnston is an "in-network provider" for my insurance plan. (example: Dr. Johnston is a "BCBS provider" but that does not mean that every person with a BCBS plan can come here: there are some BCBS for which Dr. Johnston is NOT an in-network provider.)
INITIAL:_____

When changing insurance: It is my responsiblity to provide Dr. Johnston with a copy of my New Health insurance card any time I change insurance. If I fail to do so and services are not paid due to submittance to the prior health insurance, I will be responsible for the bill.
INITIAL: _____

If choosing a new insurance company: please consider the PPO product as many HMO products have insufficient coverage, difficult referral processes, or don't cover tests in some cases. Always verify that Dr. Johnston is an "in-network provider" before committing to the new insurance plan.
INITIAL:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Donna Johnston, MD: New Patient Medical History

Patient Name: _____ Age: _____ Date of Birth:_____Today's Date:_____

Past Medical History: Do **YOU** have any of the following: (circle)

Allergies/hay fever, Anemia, Arthritis, Gout, Asthma, COPD, Emphysema, Pulmonary Fibrosis,

Depression, Anxiety, Biopolar Disease, Addiction issues, Neurological issues, Seizure Disorder

High Blood sugar, Diabetes, Heart Disease, Hypertension, High Cholesterol, Heart Murmur,

Erectile dysfunction, Prostate issues, Menstrual issues, PCOS, Hormone issues, Menopause issues,

Stomach Ulcers, GERD (Acid reflux), Diarrhea, Constipation, Bowel issues.

Past Surgeries (list with dates):_____

_____

What specialist(s) do you follow with: please provide their specialty and their name:

Date of Immunizations: TD _____ Tdap _____ Flu_____ Shingles _____

Prevnar _____ Pneumovax _____ Covid 19_____ Other: _____

Family History: What runs in your family? Mom: _____ Dad _____

Siblings:_____ Father's parents: _____ Mother's parents: _____

Other:_____

Men: Date of last prostate exam? _____ Date of last PSA?_____

Women: Date of last period?_____ Date of last pap smear?_____ Date of last mammo? _____

Do you see a gynecologist? Yes No Who:_____

Have you had a hysterectomy? Yes no Was it a partial or full hysterectomy? _____

Type of Birth Control:_____

Advance Directives: Do you have a living will? Yes no (if yes, please provide a copy)

Allergies: _____

Medications: (attach a list if needed):

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Patient_____ **Date of Birth**_____

Address_____ **Age**_____ **Male / Female**

City_____ **State**_____**Zip**_____ **SS #**_____

Home Phone ( ) _____ **Cell/Work Phone ( )**_____

E Mail _____

Person responsible if patient is a minor_____

***Out of State Address** _____ **How did you hear about us?**

City_____**State**_____**Zip**_____ _____

Employer_____ **Phone ( )** _____**Ext**_____

In case of Emergency Notify_____
Name Relationship to Patient Phone #

Other: Person other than Spouse_____
Name Relationship to Patient Phone #

INSURANCE NAME Primary:_____ **ID#**_____

Do you have a Living Will? YES / NO Do you have a Power of Attorney? YES / NO
If you answered yes to either question you MUST provide our office with a copy for your record.

Primary Language_____

Secondary Language_____

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NAME:_____

List of all prescribed medications (name, strength, how many a day):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List of all over the counter medications:

_____
_____
_____

List of all allergies:

_____
_____

Pharmacy Name: _____

Zip Code:_____