Stuart Family Practice Center

PATIENT INFORMATION

DATE_______________ SOCIAL SECURITY_______________

LAST NAME_______________ FIRST NAME_______________

ADDRESS_______________

CITY _______________ STATE_______________ ZIP_______________

HOME PHONE NUMBER_______________ WORK_______________ CELL_______________

HOW DO YOU PREFER TO BE CONTACTED? E-MAIL________ TELEPHONE________ MAIL________

DATE OF BIRTH_______________ AGE_______________ MALE__________ FEMALE__________

MARITAL STATUS: M____D____S____W____ RACE_______________ ETHNICITY_______________

EMPLOYER_______________ TELEPHONE_______________

EMPLOYER ADDRESS_______________

EMAIL ADDRESS_______________

PREVIOUS PHYSICIAN_______________

INSURANCE INFORMATION

PRIMARY POLICY HOLDER (if other than self) _______________

PRIMARY POLICY HOLDER'S DOB (if other than self) _______________

PRIMARY POLICY HOLDER'S SOCIAL SECURITY NUMBER (if other than self) _______________

EMERGENCY CONTACT INFORMATION

NAME_______________ RELATION_______________

PHONE NUMBER_______________ ALT PHONE NUMBER_______________

Patient Name:______________________________________ Date of Birth:______________________

Please list drug Allergies and reaction:____

____

Why are you here to see the doctor? ____

____

I. **Medical History**: (Circle below only the condition that you know that you have)

ENT: Allergies / Deafness / Glasses / Glaucoma / Hay fever / Nosebleeds / Postnasal drip / Ringing in the ears / Sinusitis

Lungs: Asthma / COPD / Coughing blood / Cystic Fibrosis / Emphysema / Frequent Chest Infections / Persistent cough / Pleurisy / Pneumonia / Shortness of breath / Sleep Apnea

Heart: A Fib / CHF / Chest Pains / DVT / Enlarged Heart / Fluttering / Heart Attack / Heart trouble / High blood pressure / High Cholesterol / Irregular Heart Beat / Murmurs / Severe Swelling / Stroke

Intestines: Abnormal colonoscopy / Blood in or Black Bowel Movements / Cirrhosis / Difficulty swallowing / Gallbladder Trouble / Hemorrhoids / Hepatitis / Indigestion / Liver Disease / Ulcer / Vomiting Blood / Yellow or Jaundice

Kidneys: Diabetes / Painful urination / frequent urination / Blood in urine / Kidney Stones / Loss of control with cough or laugh / Prostate trouble in men / Do you have impotency or ejaculation problems

Nervous System: Blurred Vision / Convulsions / Epilepsy / Fainting / Headaches / Head injury / Paralysis / Persistent Numbness

Woman Services: Abnormal Pap / Pain in periods / Miscarriages/ Abnormal mammogram / Osteoporosis

Menstrual periods began at age____________ ceased at age_______________

Number of pregnancies_________________ Number of births_________________

II. Have you ever had any surgeries in your life time (please list any)? ______________________________

____

____

III. Any Pertinent hospitalizations? ____

____

____

Patient Name:____ Date of Birth:________________________

IV. Family History:

Mother: __alive what is her health status?____
__deceased what age?____ cause of death?____
Father: __alive what is his health status?____
__deceased what age? ____cause of death?____

V. Social History:

1. Do you smoke Y___N____ How Much ____ For How Long_____
Have you ever smoked Y__N__ How Much___ For How Long____
When did you stop smoking? ___________ (Years/Months)

2. Do you drink alcohol Y__N__ How Much___________ How Long__________
3. Have you ever drank alcohol Y__N__ How Much___________ How Long__________
When did you stop drinking alcohol?___________ (years/months)

4. Do you have a history of Alcoholism Yes_____ No______

5. Do you have a history of Drug Abuse (including prescription drugs) Yes______ No_______

If so what? ____

VI. Medication's you are currently taking (including vitamins and supplements)

Local pharmacy name and number:____

Mail Order pharmacy name and number:___________________________________

Medication	Dose	Frequency

Health Maintenance

Please fill out to the best of your ability we Will go over it with you!

Preventive Services	Yes/No	When/Where
Colorectal Disease Screening	*******	
Colonoscopy		
Stool FBOT		
Diabetes Screening and Management	*******	
HgbA1c		
UA Micro albumin		
Eye exam within a year		
Foot doctor within a year		
Have you seen/had a	*******	
Eye specialist within a year		
Mammogram		
Pap Smear		
Bone Density		
Prostate Cancer Screening		
Immunization History	*******	
Flu Vaccine		
Pneumococcal		
Tetanus		
PPD		
Zoster (Shingles)		

PATIENT HEALTH QUESTIONAIRE

Stuart Family Practice Center

Financial Policy

We are committed to providing you with the best possible medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

This office participates with a variety of insurance plans. It is your responsibility to:

- Bring your updated insurance card at every visit
- Be prepared to pay your copay or deductible at each visit. Payment can be made by cash, check, or credit card.
- For medical care not covered by your insurance, you may be billed in addition to payments that have already been made.
- For cash paying patients, payment in full is due at the time of visit.

Some insurance companies offer Annual physicals at no out of pocket cost to the patients please understand that during a preventative visit you can not discuss any current or previous problems or conditions.

We are not **Medicaid** providers. If you knowingly present as a self pay patient and it is found that you have **Medicaid**, you will be discharged from the practice immediately. We do not accept **Medicaid** as a secondary to Medicare. If it is found that you have this combination of insurance, you will be discharged immediately.

If the patient is a minor (18 years or younger) the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary insurance cards and payment.

If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, the most accurate information will most likely be provided by your insurance company.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. Please sign that you have read and agree to this financial policy.

Signature of Patient or Responsible Party Date

Signature of Co-Responsible Party Date

Preventive Medicine and Practice Policy

Preventative Services include but not limited to the following

Alcohol Misuse Screening & Counseling	**Annual Wellness Visit**	**Bone Mass Measurement**
Cardiovascular Disease Screening Tests	**Colorectal Cancer Screening**	**Counseling to treat Tobacco Use**
Depression Screening	**Diabetes Screening**	**Diabetes Self-Management Training**
Hepatitis C Screening	**Hepatitis B Virus Screening**	**HIV Screening**
Influenza Virus Vaccine	**Pneumococcal Virus Vaccine**	**Tetanus and Pertusis Vaccine**
Human Papilloma Virus Vaccine	**Meningococcal Virus Vaccine**	**Lung Cancer Screening**
Prostate Cancer Screening	**Cervical Cancer Screening**	**STI Screening And STI prevention Counseling**
Breast Cancer Screening	**Abdominal Aortic Aneurysm Screening**	**Obesity Screening**

Preventative Medicine:
At Stuart Family Practice we participate in Preventative Medicine. Above are the services that you will be required to participate in as a patient. Some services are restrictive to age and gender and most are covered by your insurance without any out of pocket cost to you. Failure to participate may hinder our ability to treat you effectively.

Narcotic Medications:
Please be advised that this practice does not prescribe long term narcotics for pain, long term muscles relaxers or long term benzodiazepine for anxiety or sleep. We can refer you to necessary specialist that will accommodate your prescription needs. We realize that some primary care physicians prescribe long term medications for certain conditions, but this practice does not.

Urgent Visits:
Our practice has same day appointments available everyday with most of our providers. If you are in need of a same day appointment, please contact our office first thing in the morning or soon as the need to be seen arises. If you should become ill after hours, over the weekend or during holidays, we encourage you to visit a walk in clinic. If the nature of your emergency is beyond the scope of a walk in, an emergency room visit would be suggested. Our providers are on staff and will see patients of the practice that may become hospitalized at either Martin Memorial north or south hospitals.

Labs: Our office offers lab drawing services on Tuesday and Thursday mornings. We have a limited amount of spaces and may not be able to draw for every test ordered. An appointment must be made for lab visits.

Signature:____ Date\` \` ________________

Lifestyle Changes

Diet

Try to eat foods that are low in fat, cholesterol, sugar and salt. Eat plenty of vegetables, fruits, and grains. Being overweight can predispose you to diabetes, high blood pressure and other diseases. Please discuss any diet or the use of any diet aids or supplements with me before using.

Exercise

Twenty minutes of aerobic exercise (walking, swimming, bicycling, etc.) three times per week to keep your heart and bones healthy.

Bad Habits

- Smoking has been linked to many illnesses including heart attacks, cancer, strokes and lung disease. It affects you and your non-smoking relatives and friends. If you do smoke please ask me for ways to help you quit.
- Alcohol use such as drinking more than one to two drinks a day can lead to liver disease and other illnesses as well as impaired judgment.
- Illicit drug use increases your chances of AIDS, hepatitis, heart problems and mental and social disorders.
- Sexual behavior: Promiscuity and unprotected sex can expose you to potentially fatal diseases such as AIDS and other sexually transmitted diseases.
- Sun Exposure causes skin cancer which is very prevalent here in the sunshine state. Always use sun block of at least SPF 15 when outside.
-

Injury Prevention

Safety products help prevent serious injuries. These include seat belts, bicycle helmets, smoke detectors, safe work habits (lifting, bending, etc.), firearm safety, poison prevention, water safety and good driving habits. CPR and other safety classes are offered in the community. Prevent accidental falls by keeping hallways well-lit and be careful when using walkers and canes.

Dental Health

Visit your dentist for routine visits every six months. Brush and floss after every meal.

Advance Directives

A living will is a document that advises your family and physician of your desire should you become unable to make decisions regarding your health care including the desire for life prolonging measures. A Health Care Surrogate is a person that you designate to make decisions for you in the event that you are unable.

If you have a living will please provide a copy for your chart.

Diagnostic Testing

It is the policy of Stuart Family Practice to call back with all results of tests ordered by the physician or nurse practioner. If you have had a test done and you have not heard from the office within 3 days of having the test done, please call the office.

Please sign below to acknowledge that you have read and fully understand the information provided to you

Print Name:____

Signature:____

Date:___________________________

HIPPA Consent Agreement

Consent to use and disclosure of Health Information for treatment, payment, referrals, prescriptions and healthcare operations.

I____, understand that as a part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatments and any plans for future care or treatment. I understand that this information serves as a base for the planning of my care and and treatment. A means of communication among health professionals who care for me. A source of information for applying my diagnosis information to my bill and a means for third-party payers to verify that services billed are correct and were performed.

The practice reserves the right to change its Privacy Practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that the practice's Notice of Privacy Practices has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me and also necessary for the practice to obtain payment for that treatment. The practice explained to me that the Privacy Notice will be available to me at my request. The practice has further explained my right to have access to copy of the Privacy Notice which is posted in the waiting room prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restrictions requested.

I wish to have the following restrictions to the use or disclosure of my health information:

____

I understand this consent is valid for seven years. I further understand that I may revoke this consent at any time in writing, except to the extent that the practice has already taken action in reliance on the consent. I understand if I revoke this consent at any time, the practice has the right to refuse treatment.

I understand that, and consent to the following age appropriate reminders that will be used by the practice:

- A postcard mailed to the address that I have provided
- An email or telephone call and leaving a message on my answering machine or the person answering the phone
- An automated call to notify me of a message or to remind me of an appointment
- Access to your PHI through our practice patient portal
-

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Signature:____

Date:_____________________________

HIPPA RELEASE OF INFORMATION AUTHORIZATION

Please list below the authorized representative(s) that we may speak with about your healthcare. You may at anytime, with written authorization, change or revoke this authorization. By completing this form please be aware that you authorize the health care providers, and staff of physicians at Stuart Family Practice Center to discuss your health care needs, billing issues, and questions with those listed below.

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Patient Name (Printed) ______________________________ Date of Birth ______________________________

Patient Signature ______________________________ Date ______________________________

HIPAA PRIVACY AUTHORIZATION FORM
REQUEST FOR RELEASE OF MEDICAL RECORDS
Authorization for use or disclosure of protected health information
Required by the Health Insurance and Accountability Act, 45 C.F.R. Parts 160 and 164

AUTHORIZATION

Printed name of patient or personal representative and relationship to patient

____ Date__________________

I authorize ___________________________________(healthcare provider) to release and disclose the protected health information described below to:

Stuart Family Practice Center
Richard B. Weisberg, D.O.
Karissa L. Richards, ARNP
Kelly C. Zukowski, ARNP
1141 SE Indian Street. Suite 101 ~Stuart, Florida 34997
Phone: 772-221-7789~Fax: 772-221-8584
Email: faxessfpc@gmail.com

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

All dates of service unless otherwise specified_____________________.

EXTENT OF AUTHORIZATION

I authorize the release of all records listed below:

- ☐ Complete Medical Record

Limited to:

- ☐ Diagnostic/Radiology Reports
- ☐ Laboratory Reports
- ☐ Progress notes
- ☐ Medication List
- ☐ Problem List
- ☐ Last______years

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that the disclosed information may, unless expressly limited by me in writing, include information relating to alcohol abuse, and/or mental or behavior health or psychiatric care.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or stat law.

Signature of patient or personal representative________________________________

Date:_________________________ Relationship to the patient: ________________________