DEVEN MEDICAL CENTER

WEST FLORIDA MEDICAL ASSOCIATES, PA

Ulhas Deven, M.D.
BOARD CERTIFIED INTERNAL MEDICINE
Elizabeth Grant, APRN-C
BOARD CERTIFIED FAMILY NURSE PRACTITIONER
Janis Donahue DNP, FNP-C
BOARD CERTIFIED FAMILY NURSE PRACTITIONER

11707 N. Williams Street
Dunnellon, FL 34432
Phone : (352) 465-1919
Fax: (352) 465-7576

41 N Inglis Ave
Inglis, FL 34449
Phone: (352) 447-2122

Today's Date: _____/_____/_____

Name: _____ D.O.B: _____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____)--_____--_____

E-Mail: _____

SSN: _____--_____--_____ Gender: _____

Race	Ethnicity	Language
_____ Caucasian	_____ Non-Hispanic	_____ English
_____ African American	_____ Hispanic	_____ Spanish
_____ Asian	_____Unknown	_____Indian
_____ Native American/Eskimo		_____ Other
_____ Other		

Pharmacy & City: _____

Emergency Contact: *Name*_____

Phone #: _____ *Relation:* _____

ADVANCED DIRECTIVES

(*FOR COMPLIANCE WITH THE PATIENT SELF-DETERMINATION ACT OF FLORIDA STATUTES CHAPTER 765*)

*__HAVE YOU EXECUTED AN ADVANCED DIRECTIVE?__ YES _____ NO_____

IF YES, IS THIS DIRECTIVE IN THE FORM OF:

_____ A LIVING WILL

_____ A DURABLE POWER OF ATTORNEY

_____ A HEALTH CARE SURROGATE

*__HAVE YOU PROVIDED THIS OFFICE WITH A COPY OF ADVANCED DIRECTIVE?__ YES _____NO_____

IF YOU WOULD LIKE MORE INFORMATION REGARDING ADVANCED DIRECTIVES PLEASE ASK THE NURSE OR RECEPTIONIST.

I HAVE BEEN PROVIDED WITH INFORMATION REGARDING THE "PATIENT SELF-DETERMINATION ACT"

*__SIGNATURE OF PATIENT OR REPRESENTATIVE__: _____ __DATE:__ ____/_____/_____

Medical History

NAME: _____ **DATE OF BIRTH :** _____

Medication Name	Dosage	How often do you take medication with directions ?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(***If longer, please attach a list with this form***)

MEDICAL HISTORY: Please check all that apply.

__HYPERTENSION
__COPD
__HEART DISEASE
__STROKE
__CANCER_____
__DIABETES
__OSTEOPROSIS
__CHF
__THYROID DISEASE
__KIDNEY DISEASE
__SEIZURE
__HEART ATTACK
__DEPRESSION
__ANXIETY
__MENTAL ILLNESS
__ALZHEIMERS/DEMENTIA
__GERD/ACID REFLUX
__ANEMIA
__PACEMAKER
__DEFIBRILLATOR
__CLOTTING DISORDER

OTHER: _____

ALLERGIES: Are you allergic to any medications ? YES NO

IF YES, PLEASE LIST _____

SURGICAL HISTORY: Have you ever had surgery? NO YES

Surgery Name	Date (Month/Year)
1.	
2.	
3.	
4.	

FAMILY HISTORY: _____

SOCIAL HISTORY: Circle ALL that apply

1. **Do you use any tobacco products**? Non-smoker Former smoker Current smoker Smokeless Vape Device

   If you were a former smoker: How long has it been since you last smoked?

   1-3 months <1 month 3-6 months 6-12 months 1-5 years 5-10 years >10years

   If current smoker: How many do you smoke daily?

   5 or less 6-10 11-20 21-30 31 or more

2. **Do you use any recreational drugs?** NO YES

3. **Do you consume alcoholic beverages?** NEVER YES

   If yes, How often: _____per day_____per week_____per year

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PATIENT ACKNOWLEDGMENT & UNDERSTANDING OF WFMA PRIVACY PRACTICES.

PATIENTS NAME: _____DATE OF BIRTH: _____/_____/_____
SOCIAL SECURITY NUMBER _____/_____/_____PREVIOUS NAME: _____

I UNDERSTAND THAT THE PATIENT'S HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT DEVEN MEDICAL CENTER WORKS VERY HARD TO PROTECT THE PATIENT'S PRIVACY AND PRESERVE THE CONFIDENTIALITY OF THE PATIENT'S PERSONAL HEALTH INFORMATION. I UNDERSTAND THAT DEVEN MEDICAL CENTER MAY USE AND DISCLOSE THE PATIENT'S PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTHCARE TO THE PATIENT, TO HANDLE BILLING AND PAYMENT AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. (IN GENERAL, THERE WILL BE NO OTHER USES AND DISCLOSURES OF THIS INFORMATION UNLESS I PERMIT IT. I UNDERSTAND THAT SOMETIMES THE LAW MAY REQUIRE THE RELEASE OF THIS INFORMATION WITHOUT MY PERMISSION. THESE SITUATIONS ARE UNUSUAL. ONE EXAMPLE WOULD BE IF A PATIENT THREATENED TO HURT SOMEONE.)
WFMA HAS A DETAILED DOCUMENT CALLED THE "NOTICE OF PRIVACY PRACTICES." IT CONTAINS MORE INFORMATION ABOUT THE POLICIES AND PRACTICES PROTECTING THE PATIENTS PRIVACY AND IS ATTACHED TO THIS ACKNOWLEDGMENT. I UNDERSTAND THAT I HAVE THE RIGHT TO READ THIS "NOTICE" BEFORE SIGNING THIS ACKNOWLEDGMENT.

DEVEN MEDICAL CENTER MAY UPDATE THIS ACKNOWLEDGEMENT AND "NOTICE OF PRIVACY PRACTICES." IF I ASK, I WILL BE PROVIDED WITH A COPY OF THE MOST CURRENT "NOTICE OF PRIVACY PRACTICES".

WITHIN THIS "NOTICE" IS CONTAINED A COMPLETE DESCRIPTION OF MY PRIVACY/CONFIDENTIALITY RIGHTS. THE RIGHTS INCLUDE BUT ARE NOT LIMITED TO, ACCESS TO MY MEDICAL RECORDS, RESTRICTIONS ON CERTAIN USES RECEIVING AND ACCOUNTING DISCLOSURES AS REQUIRED BY LAW; AND REQUESTING COMMUNICATION IS BY SPECIFIED METHODS OF COMMUNICATIONS OR ALTERNATIVE LOCATION.
DEVEN MEDICAL CENTER HAS ESTABLISHED PROCEDURES WHICH HELP THEM MEET THEIR OBLIGATIONS TO PATIENTS. THESE PROCEDURES MAY INCLUDE OTHER SIGNATURE REQUIREMENTS, WRITTEN ACKNOWLEDGMENT,AUTHORIZATIONS, REASONABLE TIME FRAMES FOR REQUESTING INFORMATION, CHARGES FOR COPIES AND NON-ROUTINE INFORMATION NEEDS ECT. I WILL ASSIST DEVEN MEDICAL CENTER BY FOLLOWING THESE PROCEDURES IF I CHOOSE TO EXERCISE ANY OF MY RIGHTS DESCRIBED IN THE "NOTICE OF PRIVACY PRACTICES."

****MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN THE CHANCE TO REVIEW A CURRENT COPY OF DEVEN MEDICAL CENTER'S "NOTICE OF PRIVACY PRACTICES."***

Signature:_____Date and Time: _____

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE and RELATIONSHIP TO PATIENT

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CONSENT FOR TREATMENT & BILLING OF INSURANCE

I RECOGNIZE AND ACCEPT FULL RESPONSIBILITY FOR ALL SERVICES RENDERED AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIM AND ASSIGN REQUEST PAYMENT DIRECTLY TO THE PROVIDER.

* **NAME**: _____ **D.O.B**: _____

***SIGNATURE:** _____**DATE:** _____/_____/_____

NO-SHOW POLICY

Initials:*_____ A **$25.00 fee will be charged to your account if you fail to show up for your appointment.

Please call 24 hours prior to your appointment to cancel or reschedule, to avoid the *$25.00* fee.

ATTENTION: MEDICARE PATIENTS ONLY

OUR CENTER HAS BEEN APPROVED AS A RURAL HEALTH CLINIC. MEDICARE CLAIMS ARE PROCESSED BY BCBS OF TENNESSEE. IN ORDER FOR US TO FILE WITH BCBS OF TENNESSEE, THEY REQUIRE A SIGNATURE FROM YOU SIGNIFYING THAT YOU ARE ALLOWING US TO FILE MEDICARE CLAIMS FOR YOU AND ARE REQUESTING PAYMENT TO US. YOUR SIGNATURE WILL ALLOW US TO RELEASE ANY MEDICAL INFORMATION THAT MEDICARE MAY NEED TO PROCESS YOUR CLAIM.

PLEASE READ AND SIGN THE FOLLOWING TO PERMIT PAYMENT OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS ON MY BEHALF OF ANY SERVICES FURNISHED BY DEVEN MEDICAL CENTER. I AUTHORIZE ANY HOLDER OF MEDICAL AND OTHER INFORMATION ABOUT ME TO BE RELEASED TO MEDICARE AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS RELATED SERVICES.

NAME: _____**D.O.B:** _____

_____

PATIENT SIGNATURE/ MEDICARE NUMBER

DATE: _____/_____/_____

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MEDICATION POLICY AND PROCEDURES

1. PATIENTS MUST BRING **ALL** MEDICATION BOTTLES TO **EVERY** OFFICE VISIT.
    a. *EXCEPTIONS* INCLUDE: SICK VISITS, PAP SMEARS, EAR LAVAGES, SKIN PROCEDURES AND BLOOD DRAWS.
    b. HOSPITAL FOLLOW -UPs **MUST** BRING MEDICATION BOTTLES AND DISCHARGE PAPERWORK.
    c. IF MEDICATION BOTTLES ARE NOT PRESENT AT OFFICE VISIT REFILLS MAY NOT BE GIVEN AT THE TIME OF VISIT. ELECTRONIC MEDICATION LIST NEEDS TO BE UPDATED AT **EVERY** OFFICE VISIT.
    d. PHONE CALLS FOR MEDICATION REFILLS WILL BE **LIMITED TO EMERGENCY** REFILLS ONLY. IF AN EMERGENCY REFILL IS REQUIRED YOU **MUST** CONTACT THE OFFICE 24 HOURS IN ADVANCE. WE WILL **NOT** FILL REQUESTS FROM THE PHARMACY.
    e. FOLLOW UP APPOINTMENTS ARE REQUIRED TO BE KEPT TO GET REFILLS. i.e.: A 90 DAY SUPPLY OF MEDICATION IS SUFFICIENT FOR A 3 MONTH FOLLOW UP. PLEASE KEEP APPOINTMENTS WITHIN THE TIME FRAME OF YOUR MEDICATION REFILLS.
    f. CONTROLLED SUBSTANCES **MUST** BE RECEIVED AT THE TIME OF THE OFFICE VISIT AND WILL **NOT** BE CALLED IN IF YOU ARE NOT SEEN. *–REFER TO CONTROLLED CONTRACT*
    g. ANTIBIOTICS WILL **NOT** BE CALLED IN WITHOUT BEING SEEN FIRST; THEY WILL **ONLY** BE GIVEN AFTER SEEN BY THE PROVIDER.

IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE FEEL FREE TO ASK YOUR MEDICAL ASSISTANT OR PROVIDER. PLEASE OBTAIN COPY FOR YOUR RECORDS. THANK YOU.

*PRINT NAME: _____

*SIGNATURE: _____ DATE: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS, GUARDIANS, AND OTHERS.

Patient Name: _____ Date of Birth: _____

I hereby authorize medical providers and personnel of Deven Medical Center to discuss and/or release medical information to the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand I may revoke this authorization at any time. I understand it must be in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will **EXPIRE ON THE FOLLOWING DATE: _____.** If I fail to specify an expiration date, this authorization will expire in (1) one year.

I understand that the release of this health information is voluntary. I understand I can refuse to sign this release. I need not sign this form in order to assure treatment. I may inspect this form or copied information to be released as provided in 45 CFR 1642524. I understand any release of information that carries with it the potential for re-release by the recipient, and may not be protected by the privacy laws. If I have any questions I may direct them to the office manager.

Patient Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH**: _____

I AUTHORIZE THE USE OR RELEASE OF THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:

PREVIOUS PHYSICIAN OR FACILITY NAME: _____
ADDRESS: _____
_____

PHONE: _____ **FAX:** _____

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR RELEASED IS AS FOLLOWS:
EMERGENCY DEPT. _____ RADIOLOGY _____ LABS_____ CONSULTATION _____ EYE EXAM_____
PATHOLOGY_____ COLONSCOPY_____ MAMMOGRAM_____ ENTIRE RECORD _____*(LAST 1 -2 YEARS)*
OTHER_____

_____(Initial)* I UNDERSTAND THIS INFORMATION MAY INCLUDE RECORDS RELATED TO ***SEXUALLY TRANSMITTED DISEASE, AIDS/HIV, BEHAVIORAL OR MENTAL HEALTH SERVICES OR TREATMENT FOR ALCOHOL OR DRUG ABUSE.***

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:
NAME: **Deven Medical Center**
ADDRESS: **11707 N WILLIAMS ST. STE 3** & **41N INGLIS AVE**
DUNNELLON, FL 34432 & **INGLIS FL 34449**

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND IT MUST BE IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE MEDICAL RECORDS DEPT. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL **EXPIRE ON THE FOLLOWING DATE:** _____. IF I FAIL TO SPECIFY AN EXPIRATION DATE, THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS.

I UNDERSTAND THAT AUTHORIZING THE RELEASE OF THIS HEALTH INFORMATION IS VOLUNTARY. I UNDERSTAND I CAN REFUSE TO SIGN THIS RELEASE. I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I MAY INSPECT THIS FORM OR COPIED INFORMATION TO BE RELEASED AS PROVIDED IN 45 CFR 1642524. I UNDERSTAND ANY RELEASE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR RE-RELEASE BY THE RECIPIENT, AND MAY NOT BE PROTECTED BY THE PRIVACY LAWS. IF I HAVE ANY QUESTIONS I MAY DIRECT THEM TO THE PRACTICE MANAGER.

***Signature of patient or Legal Representative:** _____ ***DATE**: _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: _____