DEVEN MEDICAL CENTER

WEST FLORIDA MEDICAL ASSOCIATES, PA

Ulhas T. Deven, M.D.
BOARD CERTIFIED INTERNAL MEDICINE
Elizabeth Pike, ARNP-C
BOARD CERTIFIED FAMILY NURSE PRACTITIONER
Samantha Kreisle, ARNP-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

DATE: _____/_____/_____ EMAIL: _____

NAME: _____ D.O.B: _____/_____/_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____)--_____--_____ SSN: _____--_____--_____ GENDER: _____

EMERGENCY CONTACT: *NAME, RELATION, ADDRESS & PHONE #* _____

_____

PHARMACY: _____ LOCATION: _____

HOW DID YOU HEAR ABOUT US? *CIRCLE ONE* YELLOW PAGES, INTERNET, BILLBOARD, OR OTHER_____

RACE

_____ WHITE
_____ AFRICAN AMERICAN
_____ ASIAN
_____ NATIVE AMERICAN/ESKIMO
_____ PACIFIC ISLANDER/NATIVE HAWAII
_____ OTHER
_____ UNKNOWN

ETHNICITY

_____ NON-HISPANIC
_____ HISPANIC
_____ UNKNOWN

LANGUAGE

_____ ENGLISH
_____ SPANISH
_____ INDIAN
_____ OTHER

ADVANCED DIRECTIVES

(*FOR COMPLIANCE WITH THE PATIENT SELF-DETERMINATION ACT OF FLORIDA STAUTES 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:** ____/_____/_____

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NAME: _____ **DATE OF BIRTH** _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____YES _____NO
IF YES, PLEASE LIST _____

LIST OF MEDICATION (If longer, please attach a list with this form)

NAME	**DOSAGE**	**FREQUENCY**

MEDICAL HISTORY: Please check each one that applies.

	SELF	**MOTHER**	**FATHER**
LIVING	X	_____	_____
DECEASED	X	_____	_____
DIABETES	_____	_____	_____
HYPERTENSION	_____	_____	_____
HEART DISEASE	_____	_____	_____
STROKE	_____	_____	_____
MENTAL ILLNESS	_____	_____	_____
CANCER	_____	_____	_____
COPD	_____	_____	_____
EMPHYSEMA	_____	_____	_____
ALZHEIMERS	_____	_____	_____

OTHERS: _____

DO YOU SMOKE CIGARETTES? Non-smoker _____ former smoker _____ current smoker _____

IF YES, HOW MANY DAILY: _____ LESS THAN ONE PACK _____ ONE PACK _____ MORE THAN ONE PACK

SMOKELESS TOBACCO: _____ YES _____ NO

DO YOU USE ANY RECREATIONAL DRUGS? _____ YES _____NO

DO YOU DRINK ALCOHOLIC BEVERAGES? _____ NEVER _____MONTHLY OR LESS _____ 2 TO 4 TIMES A MONTH

_____ 2 TO 3 TIMES A WEEK _____ 4 OR MORE TIMES A WEEK

SURGICAL HISTORY

HAVE YOU EVER HAD SURGERY? _____YES _____NO
IF YES, LIST

_____

_____

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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 HEALTH CARE 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 PRIVACTY 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."**

_____
PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE/RELATIONSHIP TO PATIENT

DATE AND TIME _____

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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.

***SIGNATURE:** _____

DATE: _____/_____/_____

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 MY 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.

_____

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 PAPER WORK.
    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: _____**

***SIGN NAME: _____ DATE: _____**

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

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

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

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE INFORMATION:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR RELEASED IS AS FOLLOWS:

EMERGENCY DEPT. _____ RADIOLOGY _____ LABS_____ CONSULTATION _____

PATHOLOGY_____ ENTIRE RECORD _____ OTHER _____

_____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**

DUNNELLON, FL 34432

PHONE: **352-465-1919 OR 352-447-2122** FAX: **352-465-7576**

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 CARRRIES 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.

***SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE**: _____

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: _____

***DATE**: _____ SIGNATURE OF WITNESS: _____

DATE FAXED: _____ FAXED BY: _____

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***DATE**: _____ SIGNATURE OF WITNESS: _____

DATE FAXED: _____ FAXED BY: _____