Coastal Family Practice and Acute Care

Date: ____/____/____ Doctor:_____

Name:_____ Home #:_____ Cell #:_____

Address:_____City:_____State:_____Zip Code:_____

Email: _____Social Security #: _____

Age: _____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address: _____ Office #:_____

Spouse: _____ Phone Number: _____Occupation: _____

Emergency Contact: _____ Relation: _____Phone #: _____

How were you referred to our office? _____

Name of Primary Insurance Company: _____
Member ID: _____ Group Number: _____
Name of Secondary Insurance Company (if any):_____
Member ID: _____ Group Number: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers to secure the payment of benefits. I understand that I am responsible for all costs of my care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Coastal Family Practice and Acute Care to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____/_____/_____

Guardian's Signature Authorizing Care: _____

History of Present and Past Illness:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Date of last physical examination:_____ Last PAP: _____

Last Colonoscopy: _____ Last Mammogram: _____

Last Prostate Exam: _____ Last PSA: _____

Endoscopy: _____ Bone Density: _____

Height: _____ Weight: _____

What medications , drugs, or supplements are you taking and what are the dosages?

_____

_____

_____

Are you allergic to any medications? Yes ( ) No ( ) If yes, describe:_____

_____

Have you had any surgeries? Please list date and type:_____

_____

_____

Women: Are you pregnant? Yes ( ) No ( ) If yes, how many weeks?_____

Social History

Please indicate beside each activity whether you engage in it:
Often="O" Sometimes="S" Never="N"

Exercise___ Alcohol Use___ Drug Use___ Tobacco Use___ Caffeine___

Other(specify)_____

Date of first day of last menstrual period: _____ Contraception type: _____

Number of: pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

Are you currently under the care of any other doctors for any medical problems: yes or no. If yes, whom and for what medical problems:

_____

_____

Medical History

Condition	Self ( )	Father/Mother Ages( )	Siblings Age( )	Grandparent Age( )
Allergies				
Anxiety/Depression				
Arthritis (Location)				
Asthma				
Autoimmune Disease				
Back/Neck Pain				
Cancer (Type)				
Constipation/Diarrhea				
Diabetes				
Emphysema/COPD				
Epilepsy/Seizures				
GERD				
Headaches/Migraines				
Heart Disease				
High Blood Pressure				
High Cholesterol				
IBS				
Insomnia				
Kidney Disease				
Liver Disease				
Neuralgia				
Sinus Problems				
Thyroid Disease				
Other				

Please review the above-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

If any of the above family members are deceased, please list their age at death and cause:

Assignment of Benefits/Authorization

I hereby acknowledge that I am receiving (or about to receive) health care services from Coastal Family Practice, and that the clinic providing the services is willing to wait for payment for the services, provided that there continues to be a reasonable change that payment will be made either by insurance proceeds or out of the settlement of a liability claim. _____(Initial)

Authorization to File Insurance

I authorize Coastal Family Practice to release any information it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by Coastal Family Practice or any member of the staff acting on the clinic's behalf. _____(Initial)

Assignment of Benefits

I authorize the direct payment to Coastal Family Practice of any sum I now or hereafter owe the clinic by any insurance company obligated to reimburse me, and to my attorney, out of proceeds of any settlement of my case for the charges for services rendered or otherwise obligated to make payment to me or Coastal Family Practice based in whole or in part upon the charges made for services rendered. In the event any insurance company obligated by contractual agreement to make payment toCoastal Family Practice or me for the charges made for services refuses to make sure payment upon demand by the clinic, I hereby assign and transfer to Coastal Family Practice the cause of action that exists in my favor against any such company. I authorize Coastal Family Practice to prosecute said action either in my name or the name of the clinic as it deems necessary, and further authorize Coastal Family Practice to compromise, settle or otherwise resolve said claim as it deems necessary. _____(Initial)

Financial Agreements

If an insurance company obligated to pay me or Coastal Family Practice the charges for services rendered refuses to pay upon demand by the clinic, or if there is no insurance company so obligated, then I will pay for services rendered by Coastal Family Practice. I will pay my account in full immediately, or I will keep my account current. If I have a liability claim and my attorney refuses to protect the interest of Coastal Family Practice, or if I have not engaged the services of an attorney, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of two (2) months from the date of my last treatment, whichever comes first. _____(Initial)

Collection Agencies

In the event that your account is placed with a Collection Agency, a collection fee may be added to your account and shall become part of the total amount due. You will be responsible for any and all cost of collection including attorney fees and court costs. You agree that in order for us to service your account or to collect any amount you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. _____(Initial)

If Applicable-Lifetime Authorization to file Medicare

I request that payments authorized by Medicare benefits be made either to me or on behalf of Coastal Family Practice for any services furnished to me by Coastal Family Practice. I authorize any holder of medical information about me to be released to Health Care Financing and its agents any information needed to determine these benefits or the benefits payable for related services. _____(Initial)

Authorization to Leave Message

I hereby authorize Coastal Family Practice to leave a message at my home/cell regarding pending appointments and/or tests. _____(Initial)

Patient or Responsible Party

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE.

Patient/Responsible Party:_____

(PLEASE PRINT)

Signature:_____ Date:_____/_____/_____

Authorization for Treatment

I authorize Coastal Family Practice and Acute Care, LLC to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary.

_____ _____

Patient Name (Please Print) **Signature of patient or legal guardian**

HIPAA Notification- THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

During your care as a patient at Coastal Family Practice, we may use or disclose personal and health related information about you in the following ways:

* Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

* Your health care records, as well as, your billing records may be disclosed to another party, such as insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

* Your name, address, phone number, and your health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances.

* If we are providing health care services to you based on the orders of another health care provider.
* If we provide health care services to you in case of an emergency.
* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
* If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than is outlined above, will only be made upon your written consent.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or if the information remains in our files. In addition, you have the right to request an amendment for your health information. Requests to inspect, copy or amend your health-related information should be provided in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by the law to abide by the terms of these notices while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy practices, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and no longer be protected by federal rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to Robert Marshall, office manager.

If you would like further information about our policies and practices, please contact us.

This notice is effective as of 01/02/2022. This notice and any alterations or amendments made herein will expire seven (7) years after the date the record was created. My signature acknowledges that I can request a copy of the HIPPA Notice and it will be provided to me.

_____ _____ _____/_____/_____

Name (PRINT) Signature Date

If you are a minor, of if you are being represented by another party,

_____ _____ _____/_____/_____

Personal Representative (PRINT) Personal Representative Signature Date

_____

Relationship to patient, if minor or being represented by another party

Disclosures to Friends and/or Family Members

I give my permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the following people:

Name	Relationship	Contact Number

Consent to email/text messages for appointment reminders and other healthcare communications

Patients in our practice may be contacted via email or text messages to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and provide general health reminders/information.

_____patient initials), I consent to emails and text messages to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. The email I authorize is: _____, the phone number I authorize is: _____.

Patient Name: _____ Date:_____

Signature: _____

Revocation

I, _____, deny receiving any future appointment reminders, feedback, and general health information via email and text messages.

Patient Name: _____ Date:_____

Signature: _____

Cancellation and No Show Policy

Office appointments, which are canceled with less than 24 hour notice, may be subjected to a $25 cancellation fee. If no call no show happens twice in a 12 month period may be dismissed from the practice and denied future visits. We understand that special situations are unavoidable and the fees may be waived with management approval.

Patient Name: _____ Date:_____

Signature: _____

Hormone Replacement Therapy Information & Consent

Bioidentical Hormone Replacement Therapy (NHRT) is the therapeutic use of hormones that are identical to the hormones made naturally by the body. There are many different types but the ones used predominantly include: testosterone, progesterone, estradiol (E2), estriol (E3), DHEA, cortisol, and thyroid. These hormones are typically used to treat symptoms of perimenopause, menopause, andropause (male menopause), thyroid dysfunction and adrenal fatigue, although other symptoms may be treated as well.

Objectives:
Bioidentical HRT is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks:
Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant, or planning to become pregnant during this therapy.

Estrogen Therapy: Bioidentical estrogens are available in various forms including oral capsules, troches, patches, pellets, and topical creams. Adverse reactions may include: bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g. from blood clots or cancer) and mood swings. High potency conjugated estrogens (e.g. Premarin) have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.

Progesterone Therapy: Bioidentical progesterone is available in various forms including oral capsules, troches, vaginial or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include: bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

Testosterone Therapy: Bioidentical testosterone therapy is available in various forms including sublingual drops, troches, topical creams, pellets, and injection. Side effects include acne, chronic priapism (persistent abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur.

Although the use of bioidentical HRT has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are health care providers who do not agree with the use of bioidentical hormones.

Statement of Patient:
I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed and comply with recommended dosages.

I agree to comply with the requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.

I agree to immediately report to my provider any adverse reaction or problem that might be related to my therapy. Risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bioidentical and other hormone treatments, and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bioidentical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree with the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bioidentical hormone replacement therapy.

Patient Name: _____ Date: _____

Signature: _____