COASTLINE PRIMARY CARE

Patient Information

Last Name: First Name: M. Initial: DOB:

Sex: M F Filling out as: Self or Responsible Party

Social Security #: Marital Status:

IF YOU ARE A RESPONSIBLE PARTY, PLEASE FILL OUT FORM ACCORDINGLY. SIGNATURE OF RESPONSIBLE PARTY REQUIRED AT THE END OF THIS PATIENT INFORMATION SHEET.

Mailing Address:
City/State/Zip:

Contact Information
Cell:
Home:
Work:
Email Address:

Emergency Contact	
Name:	Please circle best method of contact: **Work / Cell**
Relationship:	Phone Number:

Previous Primary Care Physician (If applicable):

Patient Signature: Date:

COASTLINE PRIMARY CARE

Active Medications:

Additional Information

Race (please select) :

White ◯ American Indian or Alaska Native ◯ Asian ◯

Hispanic ◯ African American ◯ Native Hawaiian or Pacific Isalnder ◯

Other ◯Decline to specify ◯

Ethnicity (please select) :

Hispanic or Latino ◯

Non Hispanic or Latino ◯

Decline ◯

Pharmacy of record/Preferred pharmacy:

_____

PREFERED PHARMACY IS ONLY SUBJECT TO CHANGE IN WRITING AND MUST BE DELIVERED TO THE OFFICE PRIOR TO ANY CHANGES FROM SPECIFIED PHARMACY ABOVE.

ALLERGIES:

_____

Patient Signature: Date:

_____

COASTLINE PRIMARY CARE

MEDICAL HISTORY:

Alcoholism◯	Depression◯	High blood pressure◯	Neuropathy◯
Anxiety◯	Diabetes 1 or 2	High Cholesterol◯	Osteopenia/Osteoporosis◯
Anemia◯	Diverticulitis◯	HIV◯	Parkinsons◯
Arthritis◯	DVT◯	Hepatitis◯	Peripheral vascular disease◯
Asthma◯	GERD◯	IBS◯	Psoriasis◯
Bladder problems◯	Glaucoma◯	Lupus◯	Pulmonary embolism◯
Cancer:	Heart disease◯	Liver disease◯	Rheumatoid arthritis◯
COPD◯	Heart attack◯	Kidney stones◯	Seizure disorder◯
Dementia◯	Hiatal hernia◯	Kidney disease◯	Stroke◯

Other medical problems not listed:

Please answer accordingly:

Mammogram ◯	Date:	Normal ◯ Abnormal ◯
Colonoscopy ◯	Date:	Normal ◯ Abnormal ◯
Bone Density ◯	Date:	Normal ◯ Abnormal ◯
PAP ◯	Date:	Normal ◯ Abnormal ◯
Tobacco use ◯	Type:	Amount/day:
Alcohol use ◯	Drinks per week:	
Recreational Drug use ◯		Type:

Are you sexually active? Yes ◯ No ◯

Are there any personal problems or concerns at home, work or school you would like to discuss? Yes/No

Are there any cultural or religious concerns you have related to our delivery of care? Yes/No

Are there any financial issues that directly impact your ability to manage your health? Yes/No

How often do you get the social and emotional support you need?
Always ◯ Usually ◯ Sometimes ◯ Rarely ◯ Never ◯

Patient Signature: Date:

COASTLINE PRIMARY CARE

Surgical History:

Family History:

Are you under the care of any other providers (i.e. Cardiologist, Mental health, Kidney doctor, etc)?

Patient Signature: Date:

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- We participate in one or more **Health Information Exchanges (HIE)** which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits to our facilities may be shared with the HIEs for the purposes of diagnosis and treatment.

This includes health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment.

3. **Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice.** We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Donna Siconolfi
Phone:	386.957.4100 Option 5
Address:	602 W. Indian River Blvd. Ste 2 Edgewater, FL
E-mail:	donna.coastlineprimarycare@ yahoo.com

8. **Effective Date.** This Notice is effective February 1, 2019.

STATEMENT OF RESPONSIBILITY CONSENT

PATIENT NAME_____ DOB_____

___Initial : STATEMENT OF FINANCIAL RESPONSIBILITY

We appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a *courtesy*, we will make an effort to verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible(s) and co-payment/coinsurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Coastline Primary Care, for providing services to me or the above named patient. I certify that the information is, the best of my knowledge, true, and accurate. I authorize my insurer to pay any benefits directly to Coastline Primary Care, the full amount entire amount of bill incurred by me or the above named patient or, if applicable any amount due after payment has been made by my insurance carrier.

___Initial : SELF-PAY/TERMINATED/INACTIVE INSURANCE

If I do not have health insurance or my insurance becomes terminated or inactive, I will be responsible for services rendered here at Coastline Primary Care. It is my responsibility to inform Coastline Primary Care of the changes. I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.

___Initial : CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. Our office policy regarding missed appointments enables us to better utilize available appointments for our patients in need of medical care.

Please be courteous and call Coastline Primary Care promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel or reschedule appointments, please call 386.957.4100. Please leave a message if you do not reach the receptionist. We will return your call and give you the next available appointment time.

A *late cancellation* is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

A *"no-show"* is someone who misses an appointment without canceling it at least 24 hours prior to your

appointment.

A late cancellation or a "no-show" will be subject to a $25.00 fee and grounds for discharge from our practice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

___Initial : MEDICAL RECORD

We recognize that patient access to medical records is important and necessary to assure continuity of patient care. Upon written request, we will transfer your records to another physician or provide you with your medical record. The fees are below:

(a) For the first 25 pages, the cost shall be $1.00 per page.
(b) For each page in excess of 25 pages, the cost shall be 25 cents.
(c) For other entities, the reasonable costs of reproducing copies of written or typed documents or reports shall not be more than $1.00 per page.

___Initial : FORMS

(a) School Physical/Sports Forms: Please request during the well child/sports physical visit. If requested at a different time, a charge of $10 per form will apply.
(b) Other Forms: A charge may apply.

___Initial : COURTESY/BEHAVIOR

Our goal is to provide the best medical care for our patients. We will try to make every effort to provide prompt on-time service. However, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience. Please let us know if you have any suggestion or complaint for our office. Inappropriate behavior, including emotionally, psychologically/mentally abuse, touching, threatening, and foul or angry language directed to our staff/provider, regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal or "transfer for cause" from our practice.

___Initial : CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Coastline Primary Care through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Coastline Primary Care to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment

___Initial : CONSENT FOR USE OF TECHNOLOGY/VIRTUAL STAFF

I hereby authorize Coastline Primary Care to use audio and video devices to improve patient care. I authorize Coastline Primary Care to use Virtual Staff in addition to the staff in the office to help improve patient care. This includes accompanying the provider(s) during visits in the exam rooms as a chaperon, obtaining information pertinent to the patient, etc.

___Initial : ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge that I have received a copy of Coastline Primary Care's Notice of Privacy Practices. This notice describes how Coastline Primary Care may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Name of Patient, Guardian or Personal Representative_____

Signature of Patient, Guardian or Personal Representative_____

Date_____

EXHIBIT A - UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last):_____

Date of Birth (mm/dd/yyyy):_____

Address:_____ City:_____ State:_____ Zip:_____

_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name:_____ Phone: (____)_____

Address:_____ Fax: (____)_____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

X_____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor
☐ Guardian
☐ Other personal representative (explain:_____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

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
☐	☐	☐	☐