Referred by: Name:_____ TODAY'S DATE:_____

Patient Information Form (Please Print)

	Primary Care Physician:	**Have you been a patient of Primary Care Plus or Stanocola in the past?** ☐ Yes ☐ No

PATIENT

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Last	**First**	**MI**	**Date of Birth**	**Age**
Address		**City**	**State**	**Zip**
Sex: ☐Male ☐Female			**Are you a student?** ☐ Yes ☐ No	
Street Address (if different from mailing)			**City**	**State** / **Zip**
Phone (Home)	**Name of Employer**		**Employer's Phone #**	
Phone (Mobile)	**Employer's Address**			

Preferred Method of Contact? ☐Home Phone ☐Mobile Phone
May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐No

Email:

Spouse's Name	**Date of Birth**

ADDITIONAL INFORMATION

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic | What Language do you prefer? ☐English ☐Spanish

Name of your Pharmacy		**Address**	
City	**State**	**Zip**	**Phone #**

RESPONSIBLE PARTY

☐ Self
☐ Spouse
☐ Guardian
☐ Other

Last	**First**	**MI**	**Phone Number:**
Address			
City		**State**	**Zip**

IN CASE OF EMERGENCY NOTIFY

Name	**Relation**
Address	**Phone #**

INSURANCE INFORMATION

Primary Insurance		**Address**		
Policy Contract #	**Group #**	**City**	**State**	**Zip**
Name of Policy Holder		**Date of Birth**		
Secondary Insurance		**Address**		
Policy Contract #	**Group #**	**City**	**State**	**Zip**
Name of Policy Holder		**Date of Birth**		

Date:_____

PATIENT INFORMATION FORM

Patient's Name: _____ Guardian's Name (if under 18): _____

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

Medication or Other (Environmental)	Reaction

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	Cause of death	Age at death	Relationship	Cause of death	Age at death

YOUR HEALTH HISTORY

(Check if you have had any of the following)

	Abnormal Heart Rhythm		Chronic Pain		Heartburn/GERD		Obesity
	Allergies (any)		Chronic Kidney Disease		Heart Murmur		Osteoporosis
	Anemia		Depression		Hepatitis		Peripheral Vascular Disease
	Anxiety/Stress		Diabetes		High Blood Pressure		Seizures/Epilepsy
	Asthma		Emphysema/COPD		High Cholesterol		Sleep Apnea
	Arthritis		Gallbladder Disease		HIV/AIDS		Stomach Ulcers
	Atrial Fibrillation		Gout		Irritable Bowel Syndrome		Stroke
	Colitis or Crohn's Disease		Headaches/Migraines		Kidney Failure		Thyroid Disease
	Cancer		Heart Attack/Failure		Kidney Stones		

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician
Colonoscopy			
Cholesterol Screening			
Cardiac Stress Test			
Bone Density			
Mammogram			
Breast Exam			

Vaccine Type	Date
Tetanus (Td)	
Pneumonia	
Hepatitis B	
Influenza (Flu)	
Shingles	
Other	

OB/GYN HISTORY

Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** **If yes, please describe**

NAME:_____ Date:_____

PAST SURGICAL HISTORY

Date	Surgery	Date	Surgery

Please List Any Additional Medical Information:

_____

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___ How many packs per day? ___

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

Device	Yes/No	Device	Yes/No	Device	Yes/No
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

_____

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

Name	Dose	Frequency	Ordering Provider

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

Specialty	Physician	Specialty	Physician	Specialty	Physician
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**

Advanced Healthcare *Associates*

Heather Taylor FNP-C

2687 Jenks Ave. Panama City, FL 32405
Tel: (850) 215-7920 Fax: (850) 848-9295

Notice of Privacy and Practice Policies

I acknowledge that I have read and AHA HIPPA Notice of Privacy Policies and AHA Practice Policies as it pertains to Privacy of Individual Consent and Authorization.

Print Name: _____

Signature: _____ Date: _____

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Financial Policy

Thank you for choosing Advanced Healthcare Associates as your care provider. We are committed to providing you with quality and affordable healthcare. This policy is designed to answer the most frequently asked questions our patients have regarding payment for services. A copy will be provided to you upon your signature.

Insurance: If you are not insured by one of our participating insurance plans, we will file your claim as a courtesy. However, payment in full is expected at the time of service. A current copy of your driver's license and a valid insurance card are required for timely processing. We will submit your claim(s) and assist you in any way we can to help get your claim paid. Your insurance company may need certain information from your directly; it is your responsibility to comply with their requests. If you change carriers or policies, please notify us so we can make the changes and help you receive your maximum benefits.

Co-payment, Co-insurance & Deductibles: All co-payments, co-insurance and deductibles **are due at the time of service.** These arrangements are part of your insurance contract. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud.

Non-covered Services: Be aware that some or all of the services you receive will be considered non-covered or not considered necessary by your insurance company. These services **must be paid in full at the time of service.**

Self-Pay: **All payments** are due at the time of service unless PRIOR arrangements have been made with our financial counselor. Cash discounts will be given only if payment is made in full at time of service.

Non-payment: If your account is over ninety (90) days past due, it may be turned over to 3rd party collection agency.

_____ (Initials) I understand, that if my account should go to a third party collection agency, that I will be charged an additional 50% of my outstanding balance, to pay for the collection agency's fees.

Refunds: Refunds are not issued until all charges have been posted and processed. If you are expecting a refund and have not received it after at least sixty (60) days from your last visit, please call our office so we can research your account.

We accept cash, checks, cashier's checks, money orders, Visa, AMEX, MasterCard, Discover and Debit cards. Our charges are considered usual and customary for this area.

I have read and understand this policy and have received a signed copy and agree to abide to its guidelines.

_____ _____
Patient Signature or Responsible Party Date

_____ _____
Printed Name of Patient or Responsible Party Patient DOB

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RELEASE OF PATIENT INFORMATION

I, _____, authorize Advanced Healthcare Associates to use and disclose my Protected Health Information to carry out treatment, payment, and other care operations. I understand that Advanced Healthcare Associates works hard to protect my privacy and preserves the confidentiality of my Protected Health Information.

Your Protected Health Information is any information as it relates to your past, present, or future physical or mental health condition or payment of your health care.

This information can include spoken or written facts used for the purpose of treatment, payment or healthcare operations as their terms are defined in federal HIPAA privacy rules. This consent also gives permission for any listed person(s) you designate below, access to your Protected Health Information.

Advanced Healthcare Associates may refuse treatment if you (or an authorized representative) do not sign the consent form. You may revoke your consent in writing, except to the extent the practice has already made disclosure and reliance upon your prior consent. If you do not consent to the Protected Health Information, or later revoke, Advanced Healthcare Associates may refuse to provide treatment.

I HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED TO ME AND I HAVE RECEIVED A SIGNED COPY OF THIS FORM.

_____ _____ _____

Patient Signature or Authorized Representative | Date of Birth | Date

_____ _____

Printed Name | Relation to Patient (if applicable)

THE NAMES LISTED BELOW ARE AUTHORIZED TO HAVE ACCESS TO MY PROTECTED HEALTH INFORMATION

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize Advanced Healthcare Associates to release or obtain confidential information about me by releasing/requesting a copy of my medical records, summary or narrative of my personal health information to/from the physical/person/facility below/ disclose the following protected health information:

Records requested from:

Facility: _____

Address: _____

Phone: _____ Fax: _____

Release Records To:

Facility: _____

Address: _____

Phone: _____ Fax: _____

- o Entire Record
- o Progress Notes
- o Entire Record
- o History & Physical
- o Lab Report
- o Radiology Reports
- o Other: _____

This authorization shall be valid for one year from the date signed, at which time this authorization to use or disclose protected health information expires. 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 the facility has taken action in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

_____ _____-____-_____ _____

Signature of Patient or Personal Representative — Date of Birth — Date

_____ _____-____-_____

Printed Name of Patient or Personal Representative — Patient's Social Security Number

Received by: _____

Advanced Healthcare *Associates*

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Patient Name: _____ **DOB:** _____/_____/_____ **Date:** _____

PATIENT AGREEMENT FOR THE USE OF CONTROLLED SUBSTANCES

Please initial each of the following and sign at the bottom

_____ I agree to inform my provider of all current medications, including those prescribed by other providers.

_____ I will obtain all of my medications related to this condition from Advanced Healthcare Associates. If another provider prescribes me meds I will advise Heather Taylor within 72hours.

_____ I agree to adhere to the dosage and interval set forth by my Heather Taylor APRN.

_____ I agree to the use of only one pharmacy for all of my prescriptions and I give my authorization to discuss my prescriptions with the pharmacist as needed.

_____ I agree to refrain from the use of any illegal drugs (Cocaine, Heroin, Marijuana, and Meth) alcohol, over-the-counter meds while taking the meds given by my provider.

_____ I understand that my prescriptions will not be given at night, on weekends, or without an appointment and that only a 30day supply will be given at a time.

_____ I understand that no prescription for controlled substances will be refilled earlier than 30days from the last filled date.

_____ I agree to take strict precautions to prevent unauthorized access to my medications.

_____ I understand that it is illegal to have in my possession a medication that is not prescribed to me. I further understand that it is illegal for me to furnish others with medications not prescribed to them.

_____I will submit to random urine and /or blood tests as requested by Heather Taylor APRN to assess my compliance with the treatment plan.

_____ I will comply with my provider's request to come in between scheduled appointments for a pill count.

_____ I understand that I will be discharged if:

- I miss appointments. I must call at least 24 hours in advance to reschedule.
- I give away, sell or misuse my medications.
- I refuse a drug test or have a positive drug test.
- I refuse alternative treatment methods offered by the provider.
- I obtain these medications from another provider, emergency facility, etc.
- I use illegal drugs, alcohol, and/or over-the-counter pain, medications.

I have discussed the risks, benefits, and alternative treatment with Heather Taylor APRN. I have had an opportunity to ask questions and have received satisfactory answers to those questions. My signature below confirms my consent to this agreement. I have read and understand each article in this document and agree to abide by its requirements. I understand that my failure to do so will result in immediate termination of my treatment with Heather Taylor APRN.

Patient Signature: _____ Date: _____

Provider Signature: _____ Witness Signature: _____