lew Patient Registration Form

PLEASE PRINT YOUR ANSWERS

First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____

Home Street Address: _____

City, State, Zip: _____

Social Security #: _____ Preferred Language: _____

Gender: ❑ Male ❑ Female Email: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Other

Race/Ethnicity: ❑ Caucasian ❑ Black ❑ Hispanic ❑ Asian ❑ Native American ❑ Pacific Islander

❑ Asian Pacific American ❑ Alaskan Native ❑ Black-Non Hispanic

❑ White-Non Hispanic ❑ Other: _____

Employment Status: ❑ Employed ❑ Self-employed ❑ Unemployed ❑ Retired ❑ Student ❑ Child

Employer Name/Dept: _____

Personal ph#: _____ Work ph#: _____

ledical Insurance Information (if applicable)

Primary Insurance Co: _____ Policy/Group #: _____

Member ID#: _____ Policy Holder is: ❑ Self ❑ Spouse ❑ Parent

the insurance policy holder is not you:

Policy Holder's Name: _____ Gender: ❑ Male ❑ Female DOB: _____

mergency Contact

First Name: _____ Personal ph#: _____

Last Name: _____ Work ph#: _____

How are you related? ❑ Spouse ❑ Parent ❑ Child ❑ Niece/Nephew
You are the: ❑ Aunt/Uncle ❑ Employee ❑ Grandchild ❑ Other: _____

Personal Medication Form

Name of medicine	Dose (mg, units, puffs)	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

Allergies: Are you allergic to medications, iodine, food, tape, or latex?
List each substance you are allergic to and the reaction you experienced.

Allergy	Reaction	Allergy	Reaction

Contact Information:

Pharmacy name: _____ Pharmacy phone: (___) _____

Emergency contact: Name: _____ Phone: (___) _____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

Patient/Guardian Signature

Date

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____

Printed Name-Patient or Responsible Party

_____

Patient Signature or Responsible Party Date

_____

Relationship to patient (if other than patient)

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Family First Wellness
Dr. Samantha Lindsay

16541 Pointe Village Dr. Suite 211
Lutz, Fl 33558

Ph: 813-920-8300

Fax: 813-920-8334

Signature: _____

Patient Name

Signature of Patient or Personal Representative

Patient Date of Birth or Social Security Number

Printed Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Permission to Verbally Discuss Protected Health Information with Family and Friends

—Completion of this form is optional—

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the HealthPartners Family of Care to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. ***(check all boxes that apply)*** **This form does not authorize releasing copies of my records.**

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ Check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe):_____

The HealthPartners Family of Care has my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

☐ 1 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

☐ 2 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations the HealthPartners Family of Care may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where HealthPartners has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.**

Signature of Patient/Authorized Representative X _____ Date _____

If other than patient, state relationship and authority to sign _____