PATIENT REGISTRATION FORM

DATE:_____

Patient's Name First: _____ M: _____ Last: _____

Date of Birth____/____/_____ Age ____ Sex ____ Race ____ Language _____

SS# _____ /____ /_____ Marital Status □ Married □ Single □ Divorced

Parent/Guardian First: _____ M: ____ Last: _____

Local Address _____ City _____ State ____ Zip_____

Permanent Address _____ City _____ State ____ Zip_____

Contact Info: Home#: (___) _____ Mobil #: (___) _____ Email: _____

Employer Name: _____ Phone: (___) _____ Address: _____

How did you hear about us? _____

Type of Injury/Illness _____ Date of onset of Symptoms ___ /___ /___

If Accident, Date: ____/____/____ where did it occur: □ Auto □ Work □ School □ Home □ Other: _____

INSURANCE INFORMATION

Primary Carrier	Secondary
Policy #	Policy #
Group #	Group #
Policy Holder	Policy Holder
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder SS#	Policy Holder SS#

GUARANTOR/ PERSON RESPONSIBLE FOR MEDICAL EXPENSES

Name First _____ M ____ Last _____ DOB_____ Relationship _____
Address _____ City _____ State ____ Zip_____ Phone (___) _____
Employer _____ City _____ State ____ Zip_____ Phone (___) _____

EMERGENCY CONTACT:

Name First _____ M ____ Last _____ Phone (___) _____ Relationship _____

Chief Complaint

Name _____ Today's date _____ Date of Birth _____

Height_____ Weight _____ (Please do not leave this blank, an estimate is okay)

What brings you in today?

_____

Tell me about your **PAIN**.. (if applicable)

Where does it hurt? (front, back, inside, outside) _____

How bad does it hurt? (severe, moderate, mild) _____

When does it hurt? (constant, comes and goes, morning/ night) _____

MEDICATIONS

(Include non-prescription, such as aspirin, herbal medications, vitamins)

Medication	Dose	Reason for Medication	Side Effects

(If you are taking more medications, circle Yes and ask for an additional sheet of paper)

SURGERIES, ETC

Surgeries/Hospitalizations/Injuries	Date	Complications

Past Medical History/Review of Systems

Are you currently having, or have you had problems with your:

	Circle		Describe all "Yes" responses
General (fever, weight loss, fatigue, weakness)	No	Yes	
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
High blood pressure	No	Yes	
Bleeding problems	No	Yes	
Cardiovascular	No	Yes	
Respiratory	No	Yes	
GI (digestion, stomach, reflux, etc.)	No	Yes	
Kidney	No	Yes	
Gynecologic, breast (women only)	No	Yes	
Skin problems	No	Yes	
Urinary	No	Yes	
Stroke	No	Yes	
Seizures (epilepsy)	No	Yes	
Neurologic (numbness, tingling)	No	Yes	
Psychological (depression, anxiety)	No	Yes	
Diabetes	No	Yes	
Endocrine (thyroid, etc.)	No	Yes	
Allergic/Immunologic	No	Yes	
Rheumatoid arthritis	No	Yes	
Gout	No	Yes	
Cancer	No	Yes	
HIV/AIDS	No	Yes	
Hepatitis	No	Yes	
Tuberculosis	No	Yes	
Other Illnesses	No	Yes	

Social History

Smoke/Vape currently? No Yes **Quit smoking/vaping date:**_____

Drink alcohol? No Yes → **How much?** Drinks ___ per day or ___ per week

Patient Signature: _____ **Date:** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____ Telephone: _____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Brittany Lewis**

Address: **6266 Lake Osprey Dr. Lakewood Ranch, FL 34240**

Telephone: **OFFICE #: 941-867-2560**

Fax: **OFFICE FAX #: 941-946-8750**

Website: https://www.suncoastfamilywellness.com/

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

Signature: _____ **Date**: _____

AUTHORIZATION/CONSENT FORM

A. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION:

I authorize **Suncoast Family Wellness** to release to your health insurance company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above-named doctor the amount due to me in my pending claim for Medical or Surgical treatment or service by reason of such treatment or service.

Please initial here _____ *

B. FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayment and co-insurance at the time of the visit. Please initial here _____ *

C. CONSENT TO TREAT:

I authorize **Suncoast Family Wellness** to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the providers to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate mediation and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made.

I understand that it is my responsibility to advise your office of any changes in the information contained in this form. Please initial here _____ *

D. TREATMENT OF MINORS:

I, as a parent/legal guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so. Please initial here _____ *

E. LIABILITY/ WAIVER AND RELEASE:

I know and agree that **Suncoast Family Wellness** is not responsible for any loss or damage to personal valuables. I hereby release, discharge, and acquit **Suncoast Family Wellness**, its agents, representatives, affiliates, employees, or of and from any and all liability claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and /or medical services, including but not limited to ambulance, EMT, or Physician service. Please initial here _____*

F. INSURANCE:

As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and **Suncoast Family Wellness**. You are responsible for full payment of your account, regardless of the status of your insurance claim. I understand fully that in the event my

insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. Please initial here _____ *

For patients without health insurance, payment is REQUIRED at the time of your visit. Please initial here if applicable_____*

G. NOTICE OF PRIVACY:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. Please initial here _____ *

I, THE PATIENT/GUARANTOR/LEGAL GUARDIAN, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND INSURANCE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PHYSICIAN AND INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

*PATIENT/ GUARANTOR SIGNATURE x. _____ DATE: _____

*GUARDIAN SIGNATURE x_____ DATE: _____

If patient is under 18 years of age

Authorization to Discuss Medical Information

I hereby authorize **Suncoast Family Wellness and Urgent Care** to use and/or disclose the specific information described below, only for the purposes and/or parties listed below.

Description of the specific information to be discussed:

_____ Appointment: Date & Time(s) _____ Diagnosis _____ X-Ray Results _____

_____ Medications _____ Lab Test/Results _____ Summary of Medical Records _____

_____ Care Plan _____ Other (Specify): _____

Indicate Confidential Information:

Mental Health _____ HIV Information _____ Alcohol/Drug Information _____

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone/Fax: _____

This authorization shall remain in effect from the date signed below until (Please check one):

☐ NO EXPIRATION DATE ☐ _____ (Specify expiration date)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving **Suncoast Family Wellness** the right to discuss my medical information with the above mentioned.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature: _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

ELECTRONIC COMMUNICATION CONSENT FORM

Texting Consent:
As part of our practice's communications with you, we can send you SMS (text) Messages directly to your phone.

☐ I **consent** and accept receiving **text messages**. I understand I can withdraw my consent at any time. Please provide your cellular number: _____

☐ I do not consent to receiving any text messages.

Email Consent:
The use of email is limited to setting up or canceling appointments and for sending appointment reminders. Due to security, details of one's case cannot be discussed via email. Email may also not be used as a means of providing services. You also agree not to use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as our clinic cannot guarantee a rapid response via email.

By signing, you are also aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold our clinic or your service provider responsible for any breach of confidentiality that results from the use of the email addresses listed below.

☐ I **consent** and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
Email: _____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Print name of Patient: _____ Date: _____

Patient Signature: _____