# FM Medical, Inc.
# 3560 A1A S
# St Augustine, Fl 32080
# Patient Registration

| | |
|---|---|
| Last Name | Primary Care Physician |
| First Name / MI | Referring Provider |
| Previous Name | Date of Birth (mm/dd/yyyy) |
| Address | Gender<br>□ Male □ Female |
| City | Marital Status<br>□ Single □ Divorced □ Married □ Widowed |
| State / Zip / County | Race : □ American Indian or Alaska Native □ Asian<br>□ Native Hawaiian or Other Pacific □ Black or African American<br>□ White □ Hispanic □ Other □ Refuse to report |
| Home Phone / Cell Phone | Ethnicity<br>□ Hispanic or Latino □ Not Hispanic or Latino<br>□ Refuse to report |
| Work Phone Ext. | Social Security Number |
| Email Address | Preferred Pharmacy and location |

## Responsible Party or Guarantor (If under 18 years of age)

| | | | | |
|---|---|---|---|---|
| Last Name | | Relation Date of birth | | |
| First Name / MI | | Address | | |
| Home Phone / Cell Phone | | City | State | Zip |

## Patient Employer Information

☐ Employed ☐ Retired ☐ Full-time Student ☐Part-time Student ☐ Disabled ☐ Unemployed

| | | | | |
|---|---|---|---|---|
| Employer Name | | Occupation | | |
| Address | City | State | Zip | Work Phone |

## Insurance Information

| | | |
|---|---|---|
| Primary Insurance Company Name | Subscriber's Name | Subscriber's Date of Birth |
| Member ID Number | Subscriber's Address if Different From Above | Subscriber's Home Phone |
| Secondary Insurance Company Name | Subscriber's Name | Subscriber's Date of Birth |
| Member ID Number | Subscriber's Address if Different From Above | Subscribers Date of Birth |

## In Case of Emergency

| Name of local friend or relative | Relationship: | Home #<br><br>Cell # |
|---|---|---|

## Patient Request for Confidential Communications

Patient Name: _____

Patient Date of Birth: _____ Patient SSN: _____

**This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.**

**Please check all that apply to this request:**

_____ Please do not phone me at home. Use the following alternative phone number to contact me:_____
_____ Please do not phone me at work. Use the following alternative number to contact me:_____
_____ Please do not contact me by email.
_____ Other request(s) (describe in detail): _____
_____
_____ When contacting me by phone it is ok to leave messages and discuss my health information with:
Name:_____Relationship_____
Name: _____Relationship _____

_____ **(Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Data Base be released to this office.**

## Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

## Consent for Medical Treatment

**I/we voluntarily consent to medical treatment and diagnostic procedures provided by this office and its' associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.**

## Assignment of Benefits and Patient Responsibility

**I certify that the information on these forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.**

Signature of Patient (or patient's personal representative):_____

Relationship of representative to patient: _____

Date: _____

**Dr. Scott Michaels** — **FM MEDICAL BEACH, INC**

**Patient Name:** _____

## MEDICATIONS:

| START DATE | Medication name | Dose | Times taken per day | Quantity | STOP DATE |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## ALLERGIES:

| ALLERGY | REACTION: HIVES, ANAPHYLAXIS, VOMITING ETC |
|---|---|
| | |
| | |
| | |

## SOCIAL HISTORY:

| | | |
|---|---|---|
| Smoker? Yes ____ No ____ | # of packs per day _____ | How many years? _____ |
| Drink alcohol? Yes____ No____ | # of drinks per day _____ | How many years? _____ |

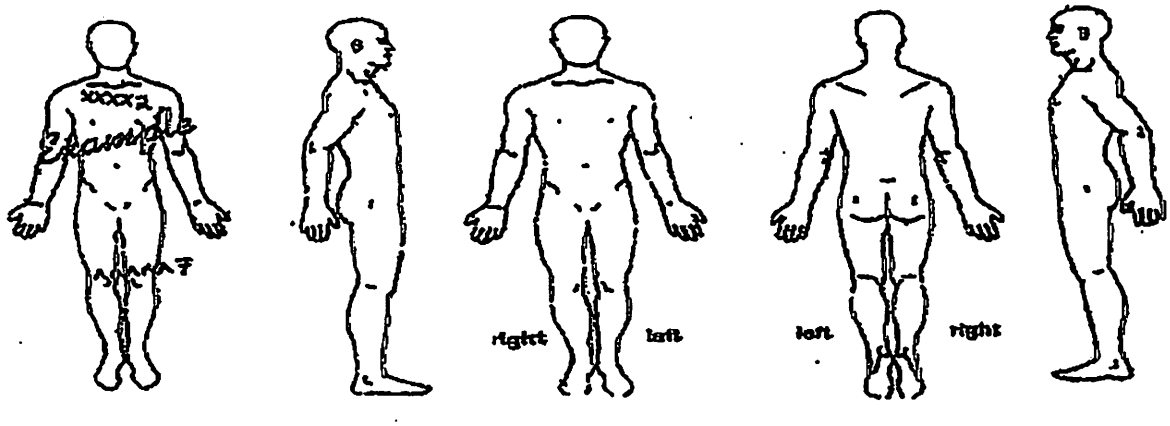
## FAMILY HISTORY:

| MOM | DAD | SIBLINGS | MATERNAL GRANDMOTHER | PATERNAL GRANDFATHER | 1ST COUSIN |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

| Description: | NUMBNESS | PINS & NEEDLES | BURNING | ACHING | STABBING | DULL |
|---|---|---|---|---|---|---|
| Symbol: | NNN | PPP | BBB | AAA | SSS | DDD |



**Dr. Scott Michaels** — **FM MEDICAL BEACH, INC**

Patient Name: _____

## PAST MEDICAL HISTORY

**Please check if you have ever had any of the following:**

- ☐ Diabetes
- ☐ Diabetes Insipidus
- ☐ Obesity
- ☐ Over Weight
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Coronary Artery Disease
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Tuberculosis
- ☐ Blood Disorder
- ☐ Thalassemia
- ☐ Sickle Cell
- ☐ Turners syndrome
- ☐ Klinefelters Syndrome
- ☐ G6PD
- ☐ Congenital Heart Defect
- ☐ Anemia
- ☐ Gastroparesis
- ☐ Essential Tremor
- ☐ Rheumatoid Arthritis
- ☐ Vitamin D Deficiency
- ☐ PMS
- ☐ Lupus
- ☐ Scleroderma
- ☐ Reflux Disease
- ☐ Peptic Ulcers
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Kidney Stones/Disease
- ☐ Lung Cancer
- ☐ Stomach Cancer
- ☐ Colon Cancer
- ☐ Breast Cancer
- ☐ Skin cancer
- ☐ Leukemia
- ☐ Other Cancer
- ☐ Raynaud's
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Diverticulitis
- ☐ Gallbladder Disease
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pleurisy
- ☐ Rib Fractures
- ☐ Conns Disease
- ☐ Cushing's Disease
- ☐ Rib Fractures
- ☐ Hemorrhoids
- ☐ HIV/AIDS
- ☐ Appendicitis
- ☐ Preeclampsia
- ☐ Gestational Diabetes
- ☐ Migraine headaches
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Varicella Shingles
- ☐ Chicken Pox
- ☐ Urinary tract Infection
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Polio
- ☐ Eczema
- ☐ Parkinson's Disease
- ☐ Pulmonary Fibrosis
- ☐ Depression
- ☐ Back Pain
- ☐ Cystic Fibrosis
- ☐ SLE Lupus
- ☐ Scleroderma
- ☐ Psoriasis
- ☐ Brain Injury
- ☐ Bells' Palsy
- ☐ Stroke
- ☐ TIA
- ☐ Normal pressure Hydrocephalus
- ☐ Seizure Disorder
- ☐ Myasthenia Gravis
- ☐ Cerebral Palsy
- ☐ Temporal/Giant cell Arteritis
- ☐ Polio
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bed Wetting
- ☐ Night Terrors
- ☐ Narcolepsy
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Personality Disorder
- ☐ ADD or ADHD
- ☐ PAD
- ☐ Empyema Disease

**SURGICAL HISTORY:** List all surgeries below

| PROCEDURES/OPERATIONS | YEAR |
|---|---|
| | |
| | |
| | |
| | |

# NOTICE OF PRIVACY PRACTICES
# HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

During your treatment at FM Medical Inc. Family Practice and Urgent Care doctors, nurses, and other caregivers may gather information about your medical history and current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information and how you can obtain access to this information.. Please read it carefully.

We are required by law to:

- Assure that your medical information is kept private and secure and to notify you following a breach of unsecured Protected Health information.
- Give you notice of our legal duties and privacy practices in regards to your medical information.
- Follow the term of the notice.

**USE AND DISCLOSURE:**
We are permitted to use and disclose your medical information with obtaining authorization from you in certain instances.
TREATMENT: FM Medical may use or disclose medical information to provide treatment, services, coordinate patient healthcare services, or consult with other healthcare providers who are involved inpatient's care.
PAYMENT: FM Medical may use or disclose medical information in order for the treatment and services rendered to be billed and to obtain payment from you, insurance companies, or a third party.
HEALTHCARE OPERATION: FM Medical may use or disclose medical information in performing business operations that allow us to improve the quality of care we provide and business associates who perform services on behalf of our facility and have agreed in writing to maintain confidentiality.
APPOINTMENTS & FOLLOWUP: FM Medical may use or disclose medical information to contact you about reminders for upcoming medical services or follow up that pertains to medications or treatments prescribed.
TREATMENT ALTERNATIVES: FM Medical may use or disclose medical information to inform you about or recommend possible alternative treatment options that may be of interest to you.
HEALTH-RELATED BENEFITS & SERVICES: FM Medical may use or disclose medical information to inform you of health-related benefits or services that may be of interest to you.
INDIVIDUALS INVOLVED IN OUR CARE OR PAYMENT FOR YOUR CARE: FM Medical may use or disclose medical information about you to a family member or close personal friend who is involved in your care or payment of your care as long as you have not specifically objected to it and we deem it reasonable that it is in your best interest. This applies to the use and disclosure of medical information of the deceased as well.
REQUIRED BY LAW: FM Medical may use or disclose medical information when required or permitted by federal, state or local law.
AVOID HARM: FM Medical may use or disclose medical information to law enforcement agencies in order to avoid a serious threat to the health, welfare and safety of a person or the public.
SPECIAL PURPOSES: FM Medical may use or disclose medical information for the purpose of specifically approved Research, Childhood Immunization Programs, Immunization Records to Schools, Organ and Tissue Donation, Military and Veteran authorities, Workman's Compensation Programs, Elder or Child Abuse or Neglect, Domestic Violence Public Health Risk, Government Programs, National Security, Individual Risk of Disease Exposure, Health Care Oversight, Inmate Affairs, Coroner, Medical Examiners and Funeral Directors. Medical information may be used for fundraising purposes only when the recipient is notified prior and given a clear opportunity to opt out receiving further fundraising communications.

**OTHER USES OF MEDICAL INFORMATION:**
Other uses of medical information not covered by this Notice will require written authorization. These uses may include the request for psychotherapy notes, activities in which payment is received such as marketing or fundraising and the sale of PHI. You must be given an option to opt out of future fundraising and marketing communications. You may revoke that authorization , in writing, at any time, and we will no longer use or disclose that information for the reasons covered on the authorization. We cannot take back any information that was used prior to the written revocation.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:**
You have certain rights regarding your medical information. If you with to exercise these rights, you must submit specific written request in writing. The request will be reviewed and acted upon timely.
RIGHT TO INSPECT AND COPY: You have the right to inspect and request copies of paper and electronic medical information that may be used to make decisions about your care as well as billing information, except for psychotherapy notes, information for civil or criminal proceedings, and certain information governed by the Clinical Laboratory Improvement Act. FM Medical may charge a fee for the cost of copying, mailing, or transmitting records.
RIGHT TO AMEND: If you feel that the medical information in your record is incorrect or incomplete, you may ask that it be amended. You must provide a reason that supports the request to amend. This does not apply to the deletion, erasure, removal or otherwise destruction of any part of the medical record.
RIGHT TO REQUEST RESTRICTION OR LIMITATIONS: You have the right to request a restriction on how your medical information is used or disclosed. If you self pay for a service/procedure, FM Medical may not disclose information regarding the service/procedure to your health plan if you so request, provided that the release is not necessary for your treatment or required by law. You also have the right to request a limitation on the information given to family and friends.
RIGHT TO AN ACCOUNTING DISCLOSURE: You have the right to request a paper or electronic list of an "accounting of disclosures" of your medical information for specific dates not longer than five years.
RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION: You have the right to request and receive confidential communication concerning use and disclosure of your medical information in a specific way, such as email, phone, etcs., or location such as home, work, or cell.
RIGHT TO FILE A COMPLAINT: You have the right to file a complaint with the Administrator of FM Medical or directly with the Secretary of the Department of Health & Human Services regarding concerns pertaining to the use and disclosure of your medical information if you feel your rights have been violated.
RIGHT TO A PAPER COPY: This notice will be posted at FM Medical and on the FM Medical Website. You have the right to request a paper copy of this notice at any time.
CHANGES TO THIS NOTICE: We reserve the right to make revisions to this notice and to make the revised notice effective for medical information we already have, as well as medical information we receive in the future. Any changes to this notice will be posted at FM Medical and at the FM Medical Website.

PRIVACY NOTICE CONTACT:
Administrator
FM Medical Inc.
3560 A1A South Saint Augustine, FL 32080 (904) 584-2273

_____
PRINT NAME Patient / Patient's Representative

_____
SIGNATURE Patient / Patient's Representative

_____
DATE