PATIENT INFORMATION

Name:		DOB:	SS#:
Mailing Address:			Email:
City:	State:	Zip:	Telephone:
Cell Phone:		Marital Status:	Gender:
Preferred Language:		Race:	Ethnic Group:

RESPONSIBLE PARTY - ONLY IF NOT PATIENT

Name:		DOB:	SS#:
Mailing Address:			City:
State:	Zip:	Telephone:	Cell Phone:
Marital Status:		Relationship to Patient:	

EMPLOYMENT INFORMATION

Employer:	Office Phone:
Occupation:	Cell Phone:

PRIMARY INSURANCE

Name:	ID#:	Group#:

SECONDARY INSURANCE

Name:	ID#:	Group#:

EMERGENCY NOTIFICATION/NEXT OF KIN - SOMEONE NOT IN HOUSEHOLD

Name:	Relationship to Patient:
Telephone:	

Dr. John Hill and/or staff may discuss my medical condition with the following people:

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS
I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physicians. I agree taht this authorization will cover all medical services rendered until such authorization is revoked by me; I understand and agree that regardless of my insurance status I am responsible for any balance of my account.
I Agree :

HEALTH HISTORY QUESTIONNAIRE
All questions contained in this questionnaire are protected by privacy acts under HIPPA and will become part of your medical record. Fill in the blanks or check appropriate answers.

Today's Date:

Name:	DOB:	
Marital Status:		

PERSONAL HEALTH HISTORY

Childhood Illnesses:	Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Please indicate current vaccinations and DATE received:

Tetanus or TET/DIP - Date:	Pneumonia - Date:
Hepatitis (series of 3) - Date:	Chickenpox/Shingles - Date:
Influenza - Date:	MMR (Measles, Mumps, Rubella) - Date:

List any medical problems that other doctors have diagnosed or check applicable items on list.

	High Blood Pressure	Heart Disease
	Hypothyroidism	High Cholesterol
	Diabetes II	Atrial Fibrillation
	COPD	Asthma
	Peripheral Vascular	Arthritis

Surgeries/Procedures (please fill out completely, if not applicable please write N/A)

	Yes	No	Date	Doctor
Carotid Endarterectomy (remove plaque from neck vessels)				
Thyroidectomy:				
Cardiac Catheterization. Stent:				
Pacemaker Automatic Implanted Defibrillator				
Aortic Aneurysm Repair				
Vascular Bypass (specify location):				
Breast Surgery Mastectomy Lumpectomy Biopsy (non-cancer)				
Chest Surgery				
Kidney Surgery				
Hip Replacement Left Right				
Knee Replacement Left Right				
Amputations:				
Endoscopy of Esophagus/stomach/duodenum (EGD)				
Colonoscopy - Findings: Polyps Diverticulosis IBS Crohn's				
Cholecystectomy (Gallbladder Removed)				
Gastric Bypass - Type:				
Appendectomy				
Hysterectomy				
Ovaries & Tubes Left Right				
Tubal Ligation (sterilization)				
Bladder - Specify:				
Prostate: TUNA TURP OTHER:				
Cataracts: LEFT RIGHT				
Plastic Surgery - Specify:				
OTHER:				
OTHER:				
OTHER:				
OTHER:				

Testing in the last two years:

	Date	Doctor
CT (computed tomography) Head Chest Abdomen Pelvis		
MRI Head Neck Abdomen - OTHER:		
DEXA Bone scan for bone mass		
Nuclear Medicine Scan		

Other hospitalizations in the last 2 years

Date	Reason	Hospital

Have you ever had a blood transfusion?	If yes, what year?
Have you ever had radiation therapy?	If yes, indicate reason.
Have you ever had a blood clot in your legs or lungs?	If yes, what year?

Allergies or intolerance to Medications?

Please list the drug and make sure you are specific about your reaction. List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers, eye drops and nasal sprays.

Name the Drug (BRAND and Generic)	Reaction You Had

Current Medications:

Name the Drug (BRAND and Generic)	Strength/Dose/Form	How and when do you take the medication?

RELEASE OF PRESCRIPTION HISTORY

By signing this consent form you are agreeing that your provider at West Volusia Family & Sports Medicine. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation. Understanding all of the above, I hereby provide informed consent to West Volusia Family & Sports Medicine to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I Agree:_____

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS IN THIS SECTION ARE OPTIONAL AND WILL BE CONFIDENTIAL
IN COMPLIANCE WITH PRIVACY POLICIES

The amount of exercise you get on a weekly basis. Please check the appropriate answer.	Sedentary (no exercise)	
	Mild exercise (climb stairs, walk 3 blocks, golf)	
	Occasional vigorous exercise (work or recreation, less than 4x / week for 30 min	
	Regular vigorous exercise (work or recreation, 4x / week or more for 30 min	
Are you happy with your weight?	Are you dieting?	
	If yes, are you on a physician prescribed diet?	
	How many meals do you eat in the average day?	
How many caffeinated drinks do you consume?	None Coffee Tea Cola Other	
	# of cups/cans per day?	
Do you consume alcoholic beverages? Please answer questions to the best of your ability.	None Beer Wine Mixed Drinks Coolers Other	
	How many servings per week?	Are you concerned about your drinking?
	Have you ever experienced blackouts?	Have you considered stopping?
	Are you prone to binge drinking?	Do you drive after drinking?

Do you now or have you ever smoked or chewed tobacco?	I smoke cigarettes: packs per day for years.	
	I quit in , I smoked packs per day for years.	
	Chew times per day / Smoke Pipe times per day	
	Smoke Cigars times per day	
	Are you interested in quitting?	
Personal questions related to your sexual health	Are you sexually active?	
	Are you or your wife trying for a pregnancy?	
	If not, how are you preventing pregnancy?	
	Any discomfort with intercourse such as pain or dryness?	
	Any problems with frequency or loss of interest in intercourse?	
Questions about your health and safety.	Do you live alone?	
	Do you have frequent falls?	
	Do you wear the following:	
	☐glasses ☐contacts☐hearing aids☐dentures	
Questions about your wishes.	Do you have an Advance Directive or Living Will? If yes please furnish a copy for your record.	
	If you do not, would you like information on the preparation of these? If yes please ask our staff or check our website.	
	Have you designated a Healthcare Surrogate? If yes, please furnish a copy of your designation for your records.	
	Are you an organ donor?	

Family Health History
(Please complete to the best of your ability)

Relationship	Age (present or at death)	Alive	Deceased	Health Problems
Father				
Mother				
Siblings				
Children				

Grandmother (Maternal)				
Grandfather (Maternal)				
Grandmother (Paternal)				
Grandfather (Paternal)				

Women Only

How old were you when you started menstruating?	Date of last menstruation:
How many pregnancies? How many live births?	Are you pregnant or breastfeeding?
Have you had a urinary tract, bladder, or kidney infection within the last year?	Do you have problems with control of urination?
Have you had any blood in your urine?	Any hot flashes or sweating at night?
Date of last pap and rectal exam? pap: rectal:	Date of last mammogram?
Have you had any of the following infections? Abnormal PAP HPV Herpes HIV Chlamydia Gonorrhea	

Men Only

Do you usually get up urinate during the night?	If yes, # of times:
Do you feel pain or burning with urination?	Any blood in your urine?
Do you feel burning discharge from penis?	has the force of your urination decreased?
Have you had a urinary tract, bladder, or kidney infection within the last year?	Do you have hesitancy in starting urination?
Have you had any of the following infections? HPV Herpes HIV Chlamydia Gonorrhea	
Do you have problems emptying your bladder completely?	
Any difficulty with erection or ejaculation?	
Any testicle pain or swelling?	
Date of last prostate and rectal exam:	

Additional Information

Family, Significant others, and friends. Under certain circumstances, we may disclose PHI (Protected Health Information) to family members, other relatives, or close personal friends or others that you identify to improve communication of relevant information (most commonly laboratory

results, prescription issues and or changes, appointment scheduling. etc.) to their involvement in your care or payment related to your care; or to notify them of your location, general condition, or death.

In compliance with this office's HIPPA policy, I am authorizing West Volusia Family & Sports Medicine's staff to release PHI as necessary to support and assist in my care. Please list each individual authorized to receive information as stated above and provide us with the information requested.

Please indicate if you wish to have your personal health care information released to your spouse, children, or significant other below:

Name:			Relationship:
Mailing Address:			
City:	State:	Zip:	Telephone:
Date:	authorize the release of my PHI to this person.		

Name:			Relationship:
Mailing Address:			
City:	State:	Zip:	Telephone:
Date:	authorize the release of my PHI to this person.		

Name:			Relationship:
Mailing Address:			
City:	State:	Zip:	Telephone:
Date:	authorize the release of my PHI to this person.		

Name:	Relationship:

Mailing Address:			
City:	State:	Zip:	Telephone:
Date:	authorize the release of my PHI to this person.		

Dear Valued Patient,

We are pleased that you have chosen to partner with us in the care of your health; however, in order to insure that you receive the best care possible and are taken care of in the most efficient way, we

ask that you review the following office policies.

Healthcare Compliance:

- We ask that you make every effort to comply with the physician recommendations regarding routine follow-ups, medications, specialist referrals, procedures, etc.

Pain Management

- Please note that a referral will be made to a pain management specialist for chronic pain management medications at the discretion of Dr. Hill.

Prescriptions

- Please bring **all** of your current medications to your appointment

:**Labs/Imaging/Sleep Study Follow-Up Policy**

- A follow up appointment is required minimally every quarter of the year and labs/images/sleep studies will be reviewed at the time of your appointment.
- You will receive a copy of your lab report at your scheduled follow up appointment

Cancellation / No Show Policy

- Time has been specifically reserved for your physician appointment, procedure, or treatment. Please call at least 24 hours ahead of time if you must cancel an appointment. There is a $25 charge if you fail to show for a scheduled appointment or cancel with less than a 24 hours' notice.

__I hereby expressly acknowledge the receipt of West Volusia Family and Sports Medicine's Notice of Privacy Practices.

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & 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 see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

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

JOHN HILL, M.D.
WEST VOLUSIA FAMILY
AND SPORTS MEDICINE
1590 S. SR 15A • Suite #100
DELAND, FL 32720

Person/Organization Name: _____ Phone: (386) 774-0016

Address: _____ Fax: (386) 774-0606

PURPOSE: To provide me with medical treatment and related services, 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 the earlier of: my death or the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw 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 both 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.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; 42 CFR §59.11 (Family Planning); Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).

I, _____, hereby give permission to the following people to have access to my medical history and records with West Volusia Family and Sports Medicine.

1. _____
2. _____
3. _____

The above names can speak to any of the West Volusia Family and Sports Medicine staff about my health and well-being.

Patient Signature: _____

Date: _____

WEST VOLUSIA
Family and Sports Medicine
www.drjohnhillmd.com

Authorized Pickup for Controlled Substance Prescription <u>ONLY</u>

I, _____, hereby give permission to the following people to have access to be able to pick up my controlled substance prescriptions with West Volusia Family and Sports Medicine.

1. _____
2. _____
3. _____

The above names can speak to any of the West Volusia Family and Sports Medicine staff in regards to picking up my controlled substance prescriptions.

Patient Signature:_____

Date: _____

Dr. John Hill, M.D. ■ 1590 S. S.R. 15A ■ Suite #100 ■ DeLand, FL 32720 ■ (386) 774-0016 ■ Fax (386) 774-0606

Your Caring Physician