Patient Information/ Financial Responsibility

Patient Name: _____

Address: _____

City_____ State _____ Zip _____

Home # _____ Cell # _____ Work/Alternate # _____

DOB _____ SS#_____ E-mail address: _____

If Patient is a minor Parent/Guardian Name_____ Phone Number_____

Occupation: _____ Employed by: _____

Emergency Notify: _____Phone # _____

Pharmacy Name _____ Pharmacy Location _____

CONSENT FOR TREATMENT: I authorize the physicians at Coastal Plus Medical Center, Inc to provide medical and surgical care to myself and/or my minor children. The signed statement will serve as my authorization for the treatment of my minor children if I am unavailable. I authorize all diagnostic testing including laboratory studies and x-rays studies as well as any treatment modality that the physician deems appropriate in my medical care. I understand that Coastal Plus Medical Center, Inc is strictly for non-emergent medical care. I acknowledge that if any medical problem occurs during the hours that Coastal Plus Medical Center, Inc is not open, I have been advised to be evaluated and treated at a hospital emergency room or by another physician of my choice.

ASSIGNMENT OF BENEFIT:
I hereby authorize payment to be assigned by my insurance company directly to the physicians at Coastal Plus Medical Centers. PLEASE DIRECT ALL MEDICAL BENEFITS TO THEIR OFFICE. I authorize the release of any information acquired in the course of my examination and/or treatment that may be needed to facilitate payment for the medical services rendered. I accept financial responsibility for any and all payment not received from my insurance carrier.

RELEASE OF MEDICAL RECORDS: I give my consent to Coastal Plus Medical Center and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Coastal Plus or its agents suspect illegal activity. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by Coastal Plus without order of the clerk or court.

CONTROLLED MEDICATION AGREEMENT:
I understand that I may be receiving a prescription(s) for controlled medication. I understand that I am fully responsible for the prescription(s) before and after the prescription(s) is (are) filled. By signing this you give Coastal Plus the right to directly communicate with other healthcare providers, pharmacies and law enforcement regarding the controlled substances we prescribe if a violation should arise.

In the event that the prescription(s) or the medication(s) is (are) lost, destroyed, or stolen, the physicians will NOT rewrite or refill a replacement prescription for the same or any other controlled medication(s). Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.

FINANCIAL RESPONSIBILITY: I hereby acknowledge and accept financial responsibility for all medical services rendered to me and/or my minor children, by the physicians at Coastal Plus Medical Center, Inc. I agree to remit payment in full at the time services are rendered.

ACKNOWLEDGEMENT OF PRIVACY ACT:
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

NOTICE:
We require 24-hour notice for canceling any appointments. There is a $30.00 charge for weekday appointments if they are not canceled OR if 24-hour notice is not given. If you are 10 minutes or more late for your appointment, we reserve the right to cancel that appointment and require you to reschedule. Any charge backs to credit cards will result in your account being made a cash only accepted payment type account. A $35.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred. We charge for medical records, and all disability, FMLA, work and/or insurance paperwork. The medical record fee may vary on # of pages; the paperwork fee is $25.00 flat fee.

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS, DIRECTION TO PAY AND AUTHORIZATION FOR INSURANCE INFORMATION

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and to directly pay COASTAL PLUS MEDICAL CENTER, INC. for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of COASTAL PLUS MEDICAL CENTER, INC. This assignment of insurance benefits pertains to any and all professional services, including past services, provided by COASTAL PLUS MEDICAL CENTER, INC. in relation to my health insurance **and/or** motor vehicle accident that occurred on _____.(leave blank if not an auto accident)

This assignment of insurance benefits is provided so that COASTAL PLUS MEDICAL CENTER, INC. may attempt to collect any unpaid or overdue insurance benefits from the insurance carrier. This includes the assignment of any cause of action that might accrue against such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to COASTAL PLUS MEDICAL CENTER, INC. needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize COASTAL PLUS MEDICAL CENTER, INC. to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

I understand that there may be services provided that may not be paid under the benefits of my insurance plan and therefore I am responsible to pay for these services in addition to any co-payment amounts.

A copy of this agreement will be as valid as the original.

I have read and I do understand this Assignment of Benefits thoroughly.

Patient's Signature: _____

Signature of Legal Guardian: _____ Date: _____

(when patient is a minor child)

Patient History

NAME **DATE OF BIRTH** **DATE**

OCCUPATION: _____ **MARITAL STATUS:** _____

CHILDREN/AGE: _____

MAIN PROBLEMS **ADDITIONAL INFORMATION**

1.

2.

3.

ALLERGIC TO:

LIST ALL MEDICATIONS YOU ARE NOW TAKING

1. **3.** **5.**

2. **4.** **6.**

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR SURGERY	YEAR	ILLNESS OR SURGERY
Not Including Pregnancies				

Smoking Y N How many packs per day? # years **Alcohol** Y N How many per week? # years

PAST MEDICAL HISTORY (DO NOT include today's symptoms) PLEASE CHECK ALL THAT APPLY

☐ Heart Problems
☐ Heart Attack
☐ Heart Valve Problems
☐ Mitral Valve Problems
☐ Heart Failure
☐ High Blood Pressure

☐ Stroke
☐ Lung Problems
☐ Asthma

☐ Emphysema/COPD
☐ Bronchitis
☐ Diabetes
☐ Diabetes - Pregnancy
☐ Glaucoma
☐ Kidney Stones
☐ Thyroid/Goiter Problems
☐ Ulcers
☐ Hepatitis
☐ Cancer

☐ HIV/AIDS
☐ History of STD's

☐ Rheumatic Fever

☐ Scarlet Fever
☐ Tuberculosis
☐ Anemia/Sickle Cell
☐ Gout
☐ Chicken Pox
☐ Polio

☐ Mumps
☐ Measles
☐ German Measles

☐ Chronic Fatigue
☐ Osteoporosis
☐ Chest Pain
☐ Chest Pressure
☐ Chest Tightness
☐ Palpitations
☐ Fainting/Dizzy Spells
☐ Shortness of Breath
☐ Difficulty Breathing
☐ Wheezing

☐ Cough
☐ Leg Blood Clots
☐ Swollen Ankles/Varicose Veins

☐ Diarrhea
☐ Constipation
☐ Bloody or Tarry Stools
☐ Diverticulitis
☐ Abdominal Pain
☐ Hemorrhoids/Hernia

☐ Difficulty Swallowing
☐ Heartburn
☐ Nausea & Vomiting

☐ Weight Loss
☐ Loss of Appetite - recent
☐ Weight Gain - recent
☐ Indigestion/Ulcers
☐ Kidney/Bladder Problems
☐ Frequent Urination
☐ Burning Urination
☐ Night Urination - frequent
☐ Blood in Urine
☐ Nose Bleeds – recurrent

☐ Sinus Trouble
☐ Sore Throats - frequent

☐ Hayfever/Allergies

☐ Hoarseness-prolonged
☐ Arthritis/Rheumatism
☐ Back Pain
☐ Shoulder Pain
☐ Knee Pain
☐ Multiple Pain Location

☐ Bone Fracture/Joint Injury
☐ Accidents (Auto or Falls)
☐ Foot Pain
☐ Injuries – neck, back, knee, spine
☐ Gallbladder Disease
☐ Seizures/Convulsions
☐ Hearing Problems
☐ Headaches - frequent
☐ Rashes/Hives
☐ Psoriasis
☐ Eye Pain/Problems
☐ Double or Blurred Vision
☐ Depression

☐ Nervous Disorders
☐ Emotional Disorders

Females – Please Complete

Possibly Pregnant? Y N

Menstrual Flow
☐ Regular
☐ Irregular
☐ Pain/Cramps
1st day of last period: _____
☐ Pain/Bleeding during or after sex

Number of:
☐ Pregnancies _____
☐ Miscarriages _____
☐ Abortions _____
☐ Live Births _____

Birth Control Method:
☐ Pill:_____
☐ Other: _____
☐ Flushing/Menopause

Date of last PAP test :_____
☐ Normal
☐ Abnormal

Date of last Mammogram:
_____
☐ Normal
☐ Abnormal

Family History: Please specify any blood relatives who had the following:

DIABETES _____ THYROID _____

ASTHMA _____ HEART DISEASE _____

STROKE _____ HYPERTENSION _____

CANCER WHAT KIND:

Patient Request for Copies of Records and Authorization for Release of Information and Accounting Disclosures

Name_____
Date of Birth _____ SSN: _____
Address_____
City _____ State _____ Zip Code _____

I hereby request and authorize copies of and/or release of my medical records and or x-rays from/to Coastal Plus Medical Center:

From:_____ To: _____
_____ _____
_____ _____

For the Purpose of: _____ For Treatment Dates:_____

Circle: Imaging/Radiology Labs Office Notes Entire Record Other: _____

_____ I acknowledge and hereby consent to such, that the released information may contain alcohol drug abuse, psychiatric, HIV testing, HIV results, or AIDs information.

_____ I, undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand this authorization may be revoked by me at any time, expect to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with the "Authorization for Release of Information".

_____ I hereby authorize Coastal Plus Medical Center to release a copy of my patient records or x-rays containing protected health information to. This authorization is given pursuant to Florida Statue 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representation.

_____ This authorization expires 180 days from the date signed below and covers treatment for the dates specified above. Fees/charges will comply with all laws and regulations applicable to release of information.

_____I understand that Section 460.413 (1) (m), Florida Statues, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more that the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board, The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages, The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs, The phrase "actual costs" means the cost of the material and supplies used to duplicate the records, as well as the labor costs and overhead costs associated with such duplications. The Board of Chiropractic Medicine Rule 64B17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.

_____There is a record of any and all disclosures of information contained in the medical record to any third party, including the purpose of the disclosure, required to be maintained by Florida Statute 456.057 (12) and provided to a patient upon request pursuant to HIPAA regulations. This record/form shall be maintained as part of the patient's records pursuant to Florida Statue 456057 (12). A copy of this form shall be provided to any patient requesting an accounting or a copy of their patient records. This form will be maintained as part of the medical records for at least six years. I am aware I can request a list of disclosures at any time.

_____ _____ _____
Date Patient/Parent/Guardian Relationship to Patient

Controlled Medication Agreement

I, _____ , understand that I may be receiving a prescription(s) for controlled medication. I understand that I am fully responsible for the prescription(s) before and after the prescription(s) is (are) filled. By signing this you give Coastal Plus the right to directly communicate with other healthcare providers, pharmacies and law enforcement regarding the controlled substances we prescribe if a violation should arise.

In the event that the prescription(s) or the medication(s) is (are) lost, destroyed, or stolen, the physicians will NOT rewrite or refill a replacement prescription for the same or any other controlled medication(s). Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.

I understand while I am receiving controlled medications from Coastal Plus I am not to seek any other medical providers out for the same or similar controlled medication. Violating this will result in me discharged from care. By signing the following, I state that I have not received any prescription for any controlled medication from any other physician since my last prescription for a controlled medication at Coastal Plus Medical Centers. The patient also authorizes us and any other healthcare provider, pharmacy, law enforcement, or judiciary body to receive and/or release any pertinent information regarding the patient's prescription or urine/blood screen as the result of a violation of this agreement.

****Violation of this policy will result in dismissal from care****

- ❑ **I HAVE NOT received any prescription for a controlled medication from ANY physician in the last three (3) months.**

- ❑ **I HAVE received one or more prescriptions for a controlled medication in the past three (3) months from the following physicians:**

NAME OF MEDICATION RECEIVED	**NAME OF PRESCRIBING PHYSICIAN**

_____ _____

PATIENT SIGNATURE **DATE**

Quality Health Assessment

Name: _____ **DOB:** _____

Please provide dates for the following screenings.

Colorectal Cancer Screening (Colonoscopy): _____
Breast Cancer Screening (Mammogram):_____
Cervical Cancer Screening (Pap Smear): _____
Human Papillomavirus Vaccine (HPV) for female:_____
Chlamydia Screening for Women: _____

If you have High Blood Pressure:

What medication are you taking:_____ Statin Therapy:_____

If you are Diabetic, when was your last:

What medication are you taking:_____ Statin Therapy:_____

Eye exam performed :_____

Foot Exam or Podiatry visit :_____

If you have COPD, when was your last:

Spirometry Test:_____

What medication are you taking for COPD:_____

If you have Asthma:

Do you use an inhaler:_____

What medication are you taking for it:_____

If you have Rheumatoid Arthritis:

What Anti-rheumatic drug therapy are you on: _____

Are you followed by a specialist, if so who: _____

If you have Osteoporosis:

What medication are you taking:_____

If you have been diagnosed with Depression:

What anti-depressant are you on: _____

Have you recently been hospitalized? If so, for what and when : _____

Do you have a WILL or Advanced Directive: _____

WOMEN SIDE

Name: **Date:**

E-Mail: **DOB** **Age**:

Symptom *(check mark)*	Never	Mild	Mod	Seve
Depressive mood (feeling dow n/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/w ake up tired)				
Mood changes/Irritability				
Tension				
Migraine/headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History: (circle all that apply)

Heart Dissease Diabetes Osteoporosis

Breast Cancer Alzheimers Disease

Medcial History; (cirle all that apply)

On Birth control:_____ Still Menstrating

Exeriencing Symptoms

Currently Pregnant

On HRT (type/dose)_____ Hashimotos

Currently on Thyroid Medciation (type/dose) _____

History Breast Cancer Hyterectomy

PCOS Fibrocystic Breast Disease

Smoker History of Uterine Fibroids or endometria Polys

Symptoms: (circle all that apply)

Acne Breast Tenderness

Facial Hair Pre-menstraul Migraines

Weight: _____

Ethnicity: _____

BHRT CHECKLIST FOR MEN

BHRT CHECKLIST FOR MEN **Date:**

E-mail: **DOB:** **Age:**

Symptom *(check mark)*	Never	Mild	Mod	Seve
Decline in general well being (General state of health)				
Joint pain/muscle ache (Low er back/joint/limb pain)				
Excessive sweating (Sudden episodes/hot flash)				
Sleep problems (Difficulty falling/staying asleep/w ake up tired)				
Increased need for sleep (Feel tired often)				
Irritability (Aggressive/easily upset/moody)				
Nervousness (Inner tension/restlessness)				
Anxiety (Feeling panicky)				
Depressed mood (Feeling dow n/sad/lack of drive/nothing of any use)				
Exhaustion/lacking vitality (Decreased performance & activity/lack of interest/motivation)				
Decline Mental Ability/Focus/Concentrate				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/unable Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History: (circle all that apply)

Heart Dissease Diabetes Osteoporosis Alzheimers Disease

Medcial History: (cirle all that apply)

Hashimotos Prostate Cancer: _____ On 5a reductase

Urological WorkUp Performed & OK

Currently on Thyroid Medication:(type/dose) _____

Activity Level: Low Moderate Medium High High

Weight: _____ Ethnicity:_____