



Patient Information/ Financial Responsibility

Patient Name: _____

Address: _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Work/Alternate # _____

DOB _____ SS# _____

E-mail address: _____

Employed by: _____ Occupation: _____

Parent/Legal Guardian Name _____

In Case of Emergency Notify: _____ Phone # _____

Pharmacy Name _____ Pharmacy # _____

Pharmacy Address or 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 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 if 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.

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 \$25.00 charge for weekday appointments and \$30.00 charge for Saturday appointments if they are not canceled OR if 24-hour notice is not given. 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 of _____.

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 Coastal Plus Medical Center: From: _____ To: _____

_____ 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, except 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 Statute 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 representatives

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 Statutes, 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 than 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 record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, 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 patients' records pursuant to Florida Statute 456.057 (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

Documents furnished to: _____ on: _____

Staff Signature: _____ Date: _____