Patient Information

Last Name: _____ First Name: _____ M.I: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Work Phone: _____ EXT: _____ Email Address: _____

Birth Date: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐Married ☐ Single ☐ Divorced ☐ Widowed

Student : ☐ Not a student ☐ Full-time student ☐ Part-Time Student

Employer Name: _____

Employer Address: _____

Emergency Contact

Name: _____ Relation: _____
Home Phone: _____ Cell: _____ Work: _____

********If the person resides with you please give us a second contact person*******

2nd Name: _____ Relation: _____
Home Phone: _____ Cell: _____ Work: _____

Insurance

Guarantor:
Last Name: _____ First Name _____ MI: _____
Date of Birth: _____ Social Security: _____
Telephone: _____

Primary Insurance Name: _____
Address: _____
Effective Date: _____ Subscriber Number: _____
Group Number: _____

Secondary Insurance Name: _____
Address: _____
Effective Date: _____ Subscriber Number: _____
Group Number: _____

Preferred Pharmacy

Name: _____ Address/Phone : _____

Mail Order : _____ Address: _____ Phone/Fax# _____

Primary Care Physician Name : _____ Phone #: _____

Scott D. McDowall, MD

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES		Mother Father	ANEMIA		Mother Father
HIGH BLOOD PRESSURE		Mother Father	LEUKEMIA		Mother Father
STROKE		Mother Father	SICKLE CELL		Mother Father
HEART ATTACK		Mother Father	BLEEDING PROBLEMS		Mother Father
ASTHMA		Mother Father	STOMACH ULCER		Mother Father
MIGRAINE HEADACHES		Mother Father	GALLSTONES		Mother Father
CANCER		Mother Father	SEIZURES		Mother Father
EMPHYSEMA		Mother Father	TUBERCULOSIS		Mother Father
KIDNEY PROBLEMS		Mother Father	ALCOHOLISM		Mother Father
ARTHRITIS		Mother Father	SUICIDE		Mother Father
GLAUCOMA / EYE PROBLEMS		Mother Father	DEPRESSION		Mother Father
SKIN RASH		Mother Father	MENTAL ILLNESS		Mother Father
OTHER		Mother Father	OTHER		Mother Father

OPERATIONS / SURGERIES: _____

_____

Family History: _____

OTHER HOSPITALIZATIONS: _____

_____

BLOOD TRANSFUSIONS: _____

MEDICATIONS: _____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: (Any reaction to any medication of any kind?) _____

OCCUPATION / WORK HISTORY: _____

Any exposure to pesticides, chemicals, or other hazards? YES _____ NO _____

If yes, What kind? _____

Family / Household: (Who lives at home with you?)_____

_____

HABITS: Cigarettes: _____ PPD ____ X _____ years Quit in _____ (year)

Other Tobacco Products? _____ Alcohol _____

Drug Use _____ Caffeine (coffee/colas)_____

Seat Belt Use: Yes: _____ No _____ Exercise: _____

FOR WOMEN ONLY

Age of first menstrual period _____ How many days between periods? _____

How many days does it last? _____ Is bleeding heavy or light? _____

Date of last menstrual period _____ Was it normal? _____

If menstrual periods have stopped, have you had any bleeding since? _____

Any Vaginal Discharge? Yes _____ No _____ Last Pap Smear _____

Method of Preventing Pregnancy: _____

Pregnancies _____ Births _____ Abortions/Miscarriages _____

Any other concerns? _____

_____

Name:

_____

Social Security:

_____

Birth Date:

_____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practices describes how e may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. I t also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may indentify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **Treatment:** We will use and disclose your protected health information to provided, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration area desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

  We may use or disclose your protected health information in the following situations **without** your authorization. These situations include:

  As Required By Law
  Public Health issues as required by law
  Communicable Diseases
  Health Oversight
  Abuse or Neglect
  Food and Drug Administration requirements
  Law Enforcement
  Coroners, Funeral Directors, and Organ Donation
  Military Activity and National Security
  Workers' Compensation
  Inmates
  Required Uses and Disclosures
  Criminal Activity
  Research
  Legal Proceedings

  Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and how you may exercise these rights.

- **Inspect and Copy your protected health information:** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

- **Request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

  Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

- **Request to receive confidential communications from us by alternate means or at an alternate location:** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

- **Have a physician amend your protected health information:** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such a rebuttal.

- **Receive an accounting of certain disclosures we have made, if any.**

- **Obtain a copy of this notice from us.**

3. Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the practice manager, telephone 904-429-9892. **We will not retaliate against you for filing a complaint.**

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity unless required by law.

You may revoke this authorization, at any time, in writing, except that your physician or physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

This notice was published and becomes effective on/or before **April 14, 2003.**

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Flagler Family Medicine, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Flagler Family Medicine, PA to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ***Financial Policy***, which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor.
2. For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.

Missed appointment: Unless canceled at least 24 hours in advance, you may be subject to $25.00 no-show fee at the physician's discretion. Please help us serve you by keeping scheduled appointments.

Co-pays and Balances: Co-pays are due at the time of service. If we need to bill you for the co-pay, there will be an additional $5.00 processing fee. You will also be asked to pay any outstanding patient balance.

Insufficient Fund Fee: Checks that are returned will be charged a $45.00 insufficient funds fee.

Collection Fee: Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

Thank you for understanding our ***Financial Policy***. Please let us know if you have any questions or concerns.

I have read the *Financial Policy* and I understand and agree to its provisions.

_____ Date_____

Signature of patient or responsible party

Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

I. My Authorization

You, Flagler Family Medicine may use or disclose the following health care information:

☐ **ALL** my health information maintained by you.
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s): _____
☐ Other: _____

You may disclose this health information to:
Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

This Authorization ends: ☐ on (date) _____
☐ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Flagler Family Medicine at the address provided below. If I do, it will not affect any actions already taken by Flagler Family Medicine based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

- 100 Health Park Blvd Suite 206, St Augustine, FL 32086

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disabled, etc.) _____

Patient Portal Policy and Procedures

Do Not use portal to communicate if there is an emergency.

Proper subject matter:

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc) are not permitted
- We do not refill controlled substance medications drugs on patient portal. You can request a refill but must come in to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message.

Current functionality of Patient Portal:

- Email and secure messaging for Non-urgent needs
- Refill request (must include pharmacy info)
- Viewing of labs results that have been sent to you.
- Viewing and printing of continuity of health records
- Viewing and updating health information
- Viewing of selected health information (allergies, medications, current problems, past medical history). Note you can make changes/ additions to your health records, medication list, etc, but this will not change your permanent records without our review of the information,
- Referral requests
- Appointment request
- Billing questions
- Updating demographic information (address, phone #) and insurance information.

All communication via portal will be included in your chart: Privacy:

- All messages sent to you will be encrypted.
- Message from you to the staff should be through this portal or they will not be secure
- We will keep all email lists confidential and will not share this info with other parties.
- Any member of our staff may read your message or replay in order to help the Physician that has been email. This is similar to how a phone message is handled.
- Our system will check when message are viewed, so you do not have to replay that you have read it

Response time:

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need immediate response.

Patient and Family request for Patient Portal

I hereby request access to the patient portal maintained by Dr. Scott McDowall for the patient named below. I understand that Dr. Scott McDowall office take seriously its responsibility to safeguard the privacy of its patient and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign on and password that I am assigned and will not share my log in information with anyone else. I agree that Dr. Scott McDowall will not be liable for any disclosure of information due to the unauthorized use of my sign on and password. If I feel my sign on and password combination has been compromised, I will contact Dr. Scott McDowall immediately or go to the portal and request a new password.

I understand that is the patient portal will allow me to view my records for the patient. If I accidently gain access to another patient information, I will cease to view it and contact Dr. Scott McDowall immediately. In no event, will I deliberately attempt to access information for any person other than myself. I represent to Dr. Scott McDowall that I am personal representative of the patient with the right to access the patients' health information, or the patient has expressly authorized me to have access. If my status as a personal representative change so that I no longer have such rights, or if the patient authorization expires or is revoked, I will immediately cease using the patient portal to access the patient information and will notify Dr. Scott McDowall.

Patient Name (print): _____

Email address: _____

DOB: _____

Patient Signature: _____

Parental Guardian: _____

OR

_____ **Patient does not have an email address or Does not want access to patient portal**

Scott D. McDowall, M.D.
100 Whetstone Place Suite 206, St. Augustine, Florida 32086 PH: 904-429-9892 FX 904-217-7631

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____
Address: _____
City/State/Zip Code: _____
Patient's Phone: ( ) _____ - _____

☐ I authorize **Dr. Scott McDowall** to ***release*** my medical information to:

Name of Provider or Facility _____
Address _____
City, State, Zip Code _____
Phone# (include area code) _____
Fax# (include area code) _____

OR

☐ I authorize **Dr. Scott McDowall** to ***obtain*** my health information from:

Name of Provider or Facility _____
Address _____
City, State, Zip Code _____
Phone# (include area code) _____
Fax# (include area code) _____

PURPOSE FOR THIS REQUEST: (check one)
☐ Healthcare ☐Personal ☐Transfer of Care ☐Other Explain: _____

TYPE OF RECORDS REQUESTED: (Check One)
☐ All medical records related to a specific illness or injury.

_____
Specify illness/injury Date(s) of treatment

☐ Treatment Summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Immunization History
☐ Specific information (Select one or more as applicable):
- ☐ Procedure Report ☐ History & Physical ☐ Laboratory test results ☐X-ray reports ☐ HIV/AIDS
- ☐ Psychiatric/Psychological evaluations/treatments ☐ Drug and Alcohol Treatment Information
- ☐ Other: _____

☐ Copy of entire medical record as allowed by law.

AUTHORIZATION VALID FOR: (Check One)
☐ This request only.
☐ One year from the date of this authorization **OR** _____. (Insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **AND** for medical records of any **future** treatment of the type described above until _____(insert date)

I understand that:

- My right to healthcare treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address below except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by federal privacy regulations, the information stated above could be re-disclosed.
- Authorization for Release of HIV/AIDS related information, mental health, or substance abuse diagnosis and treatment information will expire in **60 days.**
- There may be a charge for the request records.

Signature of Patient/Legal Representative _____ Date: _____

Printed Name of Signer: _____

Relationship to Patient: _____