# FAMILY DOCTORS

ALWAYS HERE. ALWAYS AVAILABLE

Welcome to the Family Doctors! Always here, always available! Thank you for trusting us with your health care! This welcome packet includes your new patient paperwork to fill out and be dropped off, mailed, or emailed one week prior to your appointment. If you have any questions, please ask the front desk.

We will provide you with same-day office visits for any acute needs, depending on provider availability during normal office hours and provide one of our own highly trained providers on call 24/7 to meet any acute needs that might come up.

In the coming days, one of our staff members will be reaching out to you to give you information, answer any questions and schedule your new patient appointment. In the meantime, please take the time to review the information contained in this packet.

We are excited for the opportunity for us to meet you and to help meet your healthcare needs!

Respectfully,

Family Doctors of North Port

**Family Doctors of North Port**
14279 S. Tamiami Trail
North Port, FL 34287
(P) 941 263-2050
(F) 1 888 714-0214
FamilyDoctorsofNorthPort.com

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# Welcome To Our Practice!

Please keep this form so that you have access to this information when needed.

**Our physicians are available 24 hours a day, after hours, for your urgent healthcare needs. Upon contacting our office after hours, one of our providers will personally return your call. Avoid expensive emergency room co-pays, long wait times, and physicians who are not familiar with your specific healthcare history.**

## Please contact our office

- If you have an urgent healthcare need during business hours, Monday – Friday 8:00 – 4:30, our staff will make necessary arrangements to see you in the office.

- Preferred Hospitals – Our providers have selected the following hospital because of their confidence and professional relationship with the hospital and the specialists.
  - Fawcett Hospital and Englewood Community Hospital

- Preferred Laboratory
  - Lab Corp or Quest Diagnostics

- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your provider will need to see you in the office for a follow up visit within 24 to 48 hours after discharge to assure your continued recovery.

- Medicare patients – Your provider encourages you to be seen at least every six (6) months. This will help both you and your provider maximize preventative care.

- Scheduling Appointments – Call our office to schedule your appointment and be sure to always bring a current list of medications with you to each appointment. If you are unable to keep your appointment, please contact our office at least 24 hours in advance so we may offer that opening to someone else with a healthcare need.

- To Avoid Receiving a Bill – Call the office prior to seeing a specialist or undergoing any procedure, as your Humana insurance requires a referral. DO NOT go for lab tests, x-rays, physical therapy, etc. until our office is notified.

- **Please allow 24-48 hours for prescription refill requests.**

- **No Show Policy: A charge of $35 will be billed to your account for any missed appointments. This is not billable to your insurance company.**

# Family Doctors of North Port

North Port Village Shopping Center
14279 Tamiami Trail
North Port, Fl 34287
(941)263-2050

**New Patient Verification**

Welcome to Family Doctors of North Port. If you need any assistance, please let the receptionist know.

Patient_____

Last Name First Name Middle initial

SS#_____ Birth date_____

Home Phone #_____ Cell #_____

Email: _____

Street Address_____

City_____ State_____ Zip_____

Sex ☐M ☐F Age_____ Significant other ☐Yes ☐No Name: _____

Do you have any specialist appointments scheduled? Yes No

- Where & When _____

Emergency Contact: _____

Name Phone #

***Prior Doctor and Phone Number***:

_____

_____

_____

**Insurance:**_____

_____

Office Use Only:

Availity Done Yes No

ID/License Scanned Yes No

Med Records Requested Yes No

Labs: _____

Dr:_____

# How Did You Hear About Us?

- [ ] Friend or Relative **Name:**
- [ ] Newspaper/ Newsletter
- [ ] Online Advertisement
- [ ] Social Media
- [ ] Humana.com or Medicare.gov
- [ ] Google
- [ ] Insurance Agent **Name**:
- [ ] Shopping Cart Ad
- [ ] Other, Please specify:

If you are a HUMANA member and enrolled with an agent, what was his/her Name?

**For Office Use Only - Name:** _____ **Ins.** _____

# Understanding Your Insurance & the Referral Process

## The insurance plan you have selected is a HMO/managed care plan.

1. Your Primary Care Provider (PCP) will be able to see the total picture of your overall health. This allows your provider to make the best decisions in managing your health and well-being.

2. While your Primary Care Provider (PCP) can provide most of your care, if you need a specialist, your PCP manages the care you receive from these healthcare specialists within the network.

3. Your Primary Care Provider (PCP) needs to issue a referral for you before you see any specialists.

4. Your Primary Care Provider (PCP) will choose a specialist that will best suit your needs within your HMO Network.

5. Within the HMO, there are a select number of Providers that have demonstrated outstanding care and improved outcomes.

6. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

7. The referral process serves as a way for your PCP and your specialist to communicate with each other. When a referral is issued for you to see a specialist, your PCP will inform the specialist of the reason(s) for the referral, as well as the goal(s) for the visit. In other words, your PCP will help coordinate your visit; the referral helps ensure you receive the proper care when seeing a specialist.

8. **Please allow 3-4 days for the specialist's office to call you for scheduling.**

## Thank you for joining our Practice!

**Please bring the following to your first appointment:**

**ALL Prescriptions and**

**Over the Counter Medication bottles**

**that you are currently taking.**

***PLEASE ARRIVE 15 – 20 MINUTES EARLY FOR YOUR FIRST APPOINTMENT TO AVOID DELAYS***

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# Patient Consent

I hereby give my consent for Family Doctors to use and disclose protected health information (PHI) about me, to include HIV/Aids testing/status, to carry out treatment, payment and healthcare operations (TPO). (Family Doctors "Notice of Privacy Practices" provides a more complete description of such uses and disclosures.)

I have the right to review the "Notice of Privacy Practices" prior to signing this consent, Family Doctors reserves the right to review its "Notice of Privacy Practices" at any time. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to Family Doctors, Attn: Privacy Officer, 14279 S. Tamiami Trail, North Port, FL 34287.

With this consent, Family Doctors may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Family Doctors may mail to my home or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal & Confidential".

With this consent, Family Doctors may email to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Family Doctors restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Family Doctors use and disclosure of my PHI to carry out TPO, including third party payors.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke consent, Family Doctors may decline to provide treatment to me.

This information may be released to:

[ ] My Spouse/Partner _____
Name(s) Phone #

[ ] My Child(ren) _____
Name(s) Phone #

[ ] Other _____ OR [ ] Information is not to be released to anyone.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative:

_____

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# Prescription Renewal, Patient Conduct, Exam Room Escort & Health Policy

## Prescription Renewal Policy

Family Doctors physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the medical assistants between the hours of 8am to 4pm, Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality of medical care.

## Patient Conduct and Examination Room Escort Policy

If at any time a patient is physically threating, verbally abusive, or demeaning to staff (or other patients) whether it is in person or other means of communication, we at Family Doctors have the right to refuse treatment to the patient and dismiss them from the practice.

To ensure your comfort, at your request, you may have an escort present with you during your examination. Escorts may be a friend or a family member, or we can furnish a member of our staff to be present during your examination. At the physician's discretion, an escort may also be asked to be present at the time of the examination.

## Health Maintenance

To maintain your good health, it is important to us that you, our patient adhere to the following:

- Not smoke
- Lose weight, if necessary. Maintain your optimum weight
- Exercise daily – walk, swim, etc.
- Follow a healthy diet: Decrease – cholesterol, calories, saturated fats, use salt substitutes
- Do not use alcohol or use in moderate amounts only
- Use your safety belts
- Wear your bicycle helmet
- Get regular mammograms and pap smears (start pap with onset of sexual activity or at 18 years)
- Have yearly eye exams
- Stop use of illegal drugs, marijuana, designer drugs
- Use safe sexual practices; HIV protection, venereal diseases
- Regular prostate exams for the older male

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

# Advance Directive

## What is an Advance Directive?

It is a statement which tells your doctor and family what care you would like to have when you are not able to make those decisions because of the seriousness of your injury or illness.

There are two kinds of advance directives:

- A Living Will
- Durable Power of Attorney for Health Care

## A Living Will – What is it?

It is a statement that lets you tell your doctor and family your wishes if there were no hope for your recovery and you become unable to make your own decisions. An example of this would be whether to continue to use a breathing machine to keep you alive if you were in a permanent coma following an automobile accident.

## Durable Power of Attorney for Health Care – What is it?

It is a statement in which you appoint a person to make medical judgement(s) for you if you become unable to make those decisions for yourself. That person should be someone you trust to make health decisions like the ones you would make yourself if you were able. Usually that person would be a close relative or close friend.

## Is one better than the other?

They are different and are used for different things so they both are good. These statements are to help your family and your doctor make decisions concerning your healthcare at a time when you are not able to. You may use one, or both of these forms of advance directives to provide direction for your medical care. You may combine them into a single statement that appoints a person to make medical decisions for you but also tells that person of your wishes if there is no expectation for reasonable survival.

## Can I change my mind?

Yes! You can change your mind or cancel your statement at any time. Changes should be written, signed and dated. You can also make your change of opinion by telling someone (an oral statement).

## Who should make out an Advance Directive?

Because we may have a serious illness or injury at any age, all adults should have an advance directive.

Patient Name: _____

DOB: _____

## LIVING WILL DECLARATION

I, _____, being of sound mind, and after careful consideration, make this declaration that if I should become unable to make or communicate my own health care decisions, I direct my provider, my health care surrogate, and my family to honor this living will as my legal right. I understand that this living will only becomes effective when two providers have determined that I have any of the below:

- Have a terminal or end-stage condition or condition with little or no chance of recovery.
- Am in a persistent vegetative state and 2 providers have determined that there is no reasonable probability of recovery

I state the following instructions:

| | | |
|---|---|---|
| Cardio-pulmonary resuscitation (CPR) if my heart or breathing stops. | ◯ Yes, I do want | ◯ No, I do NOT want |
| A breathing machine if I am unable to breathe on my own. | ◯ Yes, I do want | ◯ No, I do NOT want |
| Nutrition and fluids through tubes in my veins, nose or stomach. | ◯ Yes, I do want | ◯ No, I do NOT want |
| Aggressive medical care such as kidney dialysis or surgery. | ◯ Yes, I do want | ◯ No, I do NOT want |
| Medications that can prolong my dying. | ◯ Yes, I do want | ◯ No, I do NOT want |
| I want comfort care. | ◯ Yes, I do want | ◯ No, I do NOT want |

Other points that are important to my end of life wishes are: _____

_____

_____

I have read and understand this Living Will and designation of a Healthcare Surrogate, and I am freely and voluntarily signing it on ___/___/_____ in the presence of witnesses. At least one of these witnesses is not a spouse or blood relative.

Signed: _____

Street Address: _____

County: _____ City, State: _____

Patient Name: _____

DOB: _____

## APPOINTMENT OF MY HEALTH CARE SURROGATE

I, _____, appoint the following as my Heath Care Surrogate:

Name: _____

Address: _____

Phone: _____

If my surrogate is unable or unwilling my next choice (alternate Health Care Surrogate) is:

Name: _____

Address: _____

Phone: _____

I authorize my Health Care Surrogate to:

___ (initials) Receive any necessary health information, whether oral or recorded in any form or medium, that is created or received and relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

___ (initials) Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift.

___ (initials) Specific instructions or restrictions: (if none put N/A)

_____

_____

_____

Patient Name: _____

DOB: _____

While I have decision-making capacity, my wishes are controlling and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my Health Care Surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

This Health Care Surrogate Designation is not affected by my subsequent incapacity except as provided by law.

I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation
2. Physically destroying this designation through my own action or by thtat of another person in my presence and under my direction
3. Verbally expressing my intention to amend or revoke this designation
4. Signing a new designation that is materially different from this designation.

My Health Care Surrogate's authority become effective when my primary provider determines that I am unable to make my own health care decisions unless I initial either or both of the following:

If I initial here ___, my Health Care Surrogate's authority to receive my health information take effect immediately.

If I initial here ___, my Health Care Surrogate's authority to make health care decisions for me take effect immediately except that any instructions or health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict made by me.

(At least one of these witnesses cannot be a spouse or blood relative)

WITNESSES:

1. Printed Name: _____ Signature:_____

2. Printed Name: _____ Signature:_____

## YEARLY INSURANCE AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Family Doctors or any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.

I request that payment under the Medicare or other medical insurance program(s) be made to Family Doctors for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by Family Doctors from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Family Doctors for services rendered.

I understand that I am responsible for payment of all charges and fees to Family Doctors that they are entitled to collect that which are not paid for by Medicare or other insurance.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

**A charge of $35 will be billed to your account for any missed appointments. This is <u>not</u> billable to your insurance company.**

Patient Signature:_____ Date: _____

## CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

# Privacy Policy

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of *protected health information* (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, our physicians and staff have the necessary medical and PHI to provide the highest quality of medical care possible. Our facility will always protect the confidentiality of the PHI of our patients to the highest degree possible. Our patients should not be afraid to provide information to our practice, its physicians and staff for purposes of *treatment, payment and health care operations* (TPO).

To that end, our practice, its physicians and our staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patients covenants and/or authorizations, as appropriate. Our practice, its physicians and staff will not use or disclose PHI for uses outside of our practice's TPO; such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us to not to do so.
- Recognize that PHI collected about the patients must be accurate, timely, complete and available when needed.
- Our practice and its physicians and staff will implement reasonable measure to protect the integrity of all PHI maintained about patients.
- Recognize that patients have the right to privacy. Our practice, its physicians and staff respect the patient's individual dignity at all times. Our practice, its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential information. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements. Not disclose PHI data unless the patient has properly authorized the release or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. This may generate a bill according to Rule 64B8-10.003, Florida Administrative Code. In addition, patients have a right to request an amendment to his/her medical record if they believe his/her information is inaccurate or incomplete.

# Privacy Policy Contd.

- Permit our patient access to their medical records when their written request is approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site health care professional review the patient's appeal,
- Provide the patient an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPPA rules. We will provide this list to the patient upon request, as long as the request is in writing.
- All physicians and staff in our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, in accordance with our practice rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy. As always, the privacy policy will be made available to patients upon request.

Effective 2024

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## RECEIPT OF NOTICE OF PRIVACY PRACTICES

### WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of
(Print Patient Name)

Family Doctors Notice of Privacy Practices.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

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# AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby give my permission to (list physician / facility name, address & phone number):

_____ _____

_____ _____

_____ _____

_____ _____

To release a copy of my Protected Health Information (PHI) to: **Family Doctors** I instruct the above named entity to produce the following information (check ONE only):

☐ Release Entire Record
☐ I would like specific records released: _____

My PHI is to be disclosed for: ☐ Continuation of Care ☐ Other: _____

Please forward records to the following location:

14279 S. Tamiami Trail
North Port, FL 34287

Phone: (941) 263-2050
Fax: (888) 714-0214

Unless otherwise noted, this authorization expires one year from date signed.

**I authorize Family Doctors or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including, but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment, unless specified below which may be a part of the medical records. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on the Authorization. I am entitled to a copy of this authorization upon request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. This recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the discloser is specifically required by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.**

Patient Name (Print) : _____ DOB : _____

Patient Signature : _____ Date : _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

# Personal Health Risk Assessment

**Please complete the following packet and bring with you to your first appointment.**

**This information is extremely important as your doctor will need to review your health risk assessment.**

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**Patient Last Name:** _____ **Patient First Name:** _____ **DOB:** _____

**Past Medical History: Have you ever had one of the follow illnesses?**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Amputation | ☐ | ☐ | Diabetes | ☐ | ☐ | Migraine Headache | ☐ | ☐ |
| Anemia | ☐ | ☐ | Falls | ☐ | ☐ | Ostomy | ☐ | ☐ |
| Alcohol Overuse | ☐ | ☐ | Gout | ☐ | ☐ | Paralysis | ☐ | ☐ |
| Arthritis | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Sexually | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Attack | ☐ | ☐ | Transmitted Disease | | |
| Bleeding Disorders | ☐ | ☐ | Heart Disease | ☐ | ☐ | Sickle Cell Anemia | ☐ | ☐ |
| Cancer | ☐ | ☐ | (CHF/CAD) | | | Sleep Disorder | ☐ | ☐ |
| Location: _____ | | | Hepatitis | ☐ | ☐ | Stomach Ulcer | ☐ | ☐ |
| Cardiac Arrhythmia | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stroke, CVA/TIA | ☐ | ☐ |
| Pacemaker: _____ | | | Kidney Disease | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Colitis | ☐ | ☐ | Mental Illness | ☐ | ☐ | Vascular Disease | ☐ | ☐ |
| COPD/Emphysema | ☐ | ☐ | Other Medical History: _____ | | | | | |

Symptoms you would like to discuss: _____

## Personal Habits: Have you ever?

Smoked tobacco? ☐ Yes ☐ No If yes, packs per day____#of years_____ Year quit _____

Used chewing tobacco? ☐ Yes ☐ No If yes, # of cans_____# of years_____Year quit_____

Do you drink alcohol regularly? ☐ Yes ☐ No If yes, how often_____# of drinks per day_____

Have you ever used? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Meth ☐ Other

## Operations: List with approximate year

_____ _____
_____ _____
_____ _____
_____ _____

## Serious Injuries: List with approximate year

_____ _____
_____ _____
_____ _____
_____ _____

## Hospitalization (Other than operations with approximate date):_____

_____

_____

| Immunizations (please include the date): | | Covid-19 _____ | Prevnar 13 _____ |
|---|---|---|---|
| Tetanus _____ | Shingles _____ | Flu _____ | Prevnar 20 _____ |
| Other _____ | MMR _____ | Hep _____ | Pneumovax 23 _____ |

## FAMILY HISTORY

| FAMILY MEMBER | CIRCLE SEX | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|---|
| | | AGE | HEALTH | AGE AT DEATH | CAUSE |
| Father | | | | | |
| Mother | | | | | |
| Brother(s) / Sister(s) | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| Husband / Wife | | | | | |
| Son(s) / Daughter(s) | M F | | | | |
| | M F | | | | |
| | M F | | | | |
| | M F | | | | |

**Check if any blood relative has or had any of the following and enter their relationship to you:**

| | Yes | No | Relationship to you | Comments |
|---|---|---|---|---|
| **Bleeding Tendency** | ☐ | ☐ | | |
| **Cancer** | ☐ | ☐ | | |
| **Colitis** | ☐ | ☐ | | |
| **COPD** | ☐ | ☐ | | |
| **Diabetes** | ☐ | ☐ | | |
| **Epilepsy** | ☐ | ☐ | | |
| **Heart Attack** | ☐ | ☐ | | |
| **High Blood Pressure** | ☐ | ☐ | | |
| **Kidney Disease** | ☐ | ☐ | | |
| **Sickle Cell Anemia** | ☐ | ☐ | | |
| **Stroke** | ☐ | ☐ | | |
| **Suicide** | ☐ | ☐ | | |
| **Tuberculosis** | ☐ | ☐ | | |
| **Other:** | ☐ | ☐ | | |

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## Preventative Service History

### This form needs to be completed to the best of your ability.

We need to know if the below listed testing has: Never Been Done (NO), Has Been Done (YES). If yes, your best estimate as to the month/year the test was performed, and the result.

| Preventative Service | NO | YES | Month/Year Testing Performed | Findings & Recommendations |
|---|---|---|---|---|
| Bone Mass Measurement (Bone Density) | ☐ | ☐ | | |
| Bloodwork | ☐ | ☐ | | |
| Colorectal Cancer Screening | | | | |
| Colonoscopy – NOT High Risk | ☐ | ☐ | | |
| Fecal Occult Blood Test (Stool Card) | ☐ | ☐ | | |
| Vision Screening | | | | |
| Eye Exam | ☐ | ☐ | | |
| Female Screening | | | | |
| PAP & Pelvic Examination | ☐ | ☐ | | |
| Mammogram | ☐ | ☐ | | |
| Male Screening | | | | |
| PSA – Prostate Specific Antigen (Blood Test) | ☐ | ☐ | | |

**FOR PHYSICIAN USE**

**Physician Signature** **Date Reviewed**

**SOCIAL / LIFESTYLE HISTORY:** Primary Language: _____

Interpreter Required: ☐ Yes ☐ No

Is there someone that lives with you in your residence? ☐ Yes ☐ No

If yes, please list name & relationship: _____

Type of Residence: ☐ Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story

☐ Independent Living Facility Facility Name: _____

☐ Assisted Living Facility Facility Name: _____

Durable Medical Equipment? ☐ Yes ☐ No ☐ Wheelchair ☐ Walker ☐ Cane

☐ Oxygen ☐ Nebulizer ☐ CPAP/BIPAP

Other: _____

Can you afford medicine? ☐ Yes ☐ No Potential Referral to Patient Assistance Program: _____

Transportation provided by? _____

**EXERCISE / ACTIVITY:**

Current Activity: _____ How Often: _____

Physical Limitations: _____

**ACTIVITIES OF DAILY LIVING:**

Do you require assistance to bathe or groom? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance for your toilet needs? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance to eat? ☐ Yes ☐ No

If yes, explain: _____

Do you have hearing loss? ☐ Yes ☐ No

Do you wear hearing aids? ☐ Yes ☐ No

Date of last hearing exam: _____

Additional Comments & Notes: _____

# REVIEW OF SYSTEMS

## Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Feeling Poorly
- ☐ Feeling Tired
- ☐ Recent Weight Gain _____ lbs.
- ☐ Recent Weight Loss _____ lbs.

## Eyes
- ☐ Blurry Vision
- ☐ Glaucoma
- ☐ Eye Infection
- ☐ Dry Eyes
- ☐ Red Eyes

## ENT
- ☐ Ringing in the Ears
- ☐ Throat Clearing
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Mouth Sores

## Cardiovascular
- ☐ Heart Rate Slow
- ☐ Heart Rate Fast
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Lower extremity Edema

## Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath on Exertion
- ☐ Spitting up Blood

## Genitourinary
- ☐ Dysuria
- ☐ Incontinence
- ☐ Testicular Pain
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Abnormal Vaginal Bleeding
- ☐ Genital Lesion

## Heme/Lymph
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands

## Musculoskeletal
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness

## Integumentary
- ☐ Skin Rash
- ☐ Skin Wound
- ☐ Itching
- ☐ Jaundice

## Neurological
- ☐ Confusion
- ☐ Numbness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache

## Psychiatric
- ☐ Suicidal
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances

## Endocrine
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Cold Tolerance
- ☐ Excessive Urination

## Gastrointestinal
- ☐ Poor Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Black Tarry Stools
- ☐ Belching
- ☐ Regurgitation
- ☐ Constipation
- ☐ Recent change in Bowel Habits

FAMILY DOCTORS
ALWAYS HERE. ALWAYS AVAILABLE

## MEDICATION LIST / ALLERGIES / PHARMACY

Please help us provide better care by providing us with your current prescription and over-the-counter medications taken regularly.

**PRESCRIPTIONS:**

| Medication Name | Dosage | Times Daily | When Started? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**OVER-THE-COUNTER MEDICATIONS / HERBAL REMEDIES / VITAMINS:**

_____ _____

_____ _____

_____ _____

**ARE YOU ALLERGIC TO ANY MEDICATIONS?** ☐ **Yes** ☐ **No**

**If yes, please list medication and the reaction.**

**MEDICATION ALLERGIES & REACTIONS:**

| Medication Name | Reaction |
|---|---|
| | |
| | |
| | |

**PHARMACY INFORMATION (Required):**

Pharmacy Name: _____

Pharmacy Address or Cross Streets: _____

Pharmacy Phone: _____

**Patient label:**

## Patient Health Questionnaire (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle the number to indicate your answer) | Not At All | Several Days | More than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself, or that you are a failure or have let yourself or family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

Add Columns ☐ + ☐ + ☐

**TOTAL** ☐

| | | |
|---|---|---|
| 10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | ☐ Not difficult at all | ☐ Very difficult |
| | ☐ Somewhat difficult | ☐ Extremely difficult |

## Bladder and Additional Screening

- Are you having any bladder control problems? ☐ Yes ☐ No
  - *If "yes", please answer the remaining questions. This information will help your practitioner better understand your bladder control problem.
  - I started having bladder trouble: ☐ A Month(s) ago ☐ 1 to 2 years ago ☐ ___ years ago
- Do you require assistance to walk? ☐ Yes ☐ No
- Do you have any problems with your hearing, vision or speech?
  - Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Speech: ☐ Yes ☐ No

FAMILY DOCTORS
ALWAYS HERE. ALWAYS AVAILABLE

Date of service: _____/____/_____(mm/dd/yyyy)

**Patients please fill out this form to the best of your ability**

Physician name:

This document is intended to capture requested clinical quality information only. Other write-in information will not be considered.

1159F AND 1160F

| Prescription (Rx) | Dosage | Disease being treated/reason for medication | Side effects discussed |
|---|---|---|---|
| Please see attached medication list. All medications verified with patient (including name, dose, quantity, route and frequency). | | | ☐ |
| Patient educated on what their medication is intended to do and the reason that they are taking it. Potential side effects discussed. | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

1170F

**Functional assessment: Does patient have difficulties performing the following activities?** Date assessed:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Bathing | ☐ | Yes | ☐ | No | ☐ | N/A | Transferring | ☐ | Yes | ☐ | No | ☐ | N/A |
| Dressing | ☐ | Yes | ☐ | No | ☐ | N/A | Using the toilet | ☐ | Yes | ☐ | No | ☐ | N/A |
| Eating | ☐ | Yes | ☐ | No | ☐ | N/A | Walking | ☐ | Yes | ☐ | No | ☐ | N/A |

**Treatment plan discussed with patient**

☐ Occupational therapy referral ☐ Review of Rx ☐ Physical therapy referral ☐ Assistive device evaluation

**Physical activity assessment** Date assessed:

| | | | |
|---|---|---|---|
| Patient is physically active | ☐Yes ☐No | Patient is active 30 minutes a day most days of the week | ☐Yes ☐No |
| Patient plans to become active in the next few months | ☐Yes ☐No | Patient expresses fear to become active or participate in physical activity | ☐Yes ☐No |
| Patient participates in activity regularly | ☐Yes ☐No | If so, what type? _____ | |

1158F

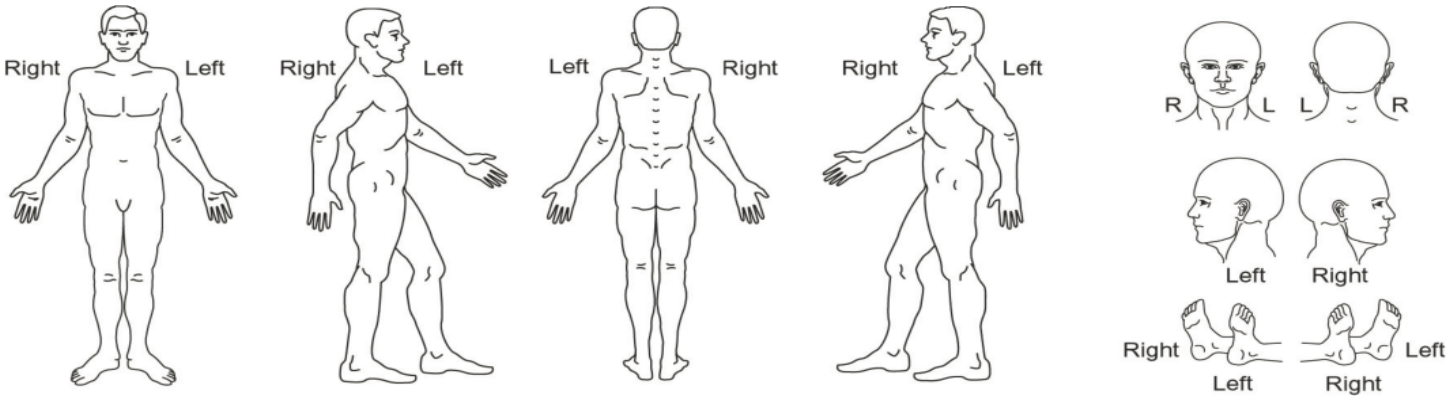
**Patient advised:** ☐ Daily walks ☐ Stretching ☐ Start taking the stairs ☐ Increase walking as tolerated

1157F OR

**Advance care planning:** ☐ Advance directive in medical record Discussion on _____/____/_____

1125F Pain OR 1126F No Pain

**Pain assessment** Date assessed:




Pain intensity (0 lowest to 10 highest)_____ Present pain_____ Worst pain_____ Best pain _____

Quality of pain: _____ Onset, duration, variation and rhythms? _____

What causes the pain? _____ What relieves the pain?_____

***Physician name and credentials:***

Humana

Patient name: _____ Date of service: ____/____/_____(mm/dd/yyyy)

Member ID: _____ Date of birth: ____/____/_____(mm/dd/yyyy)

## Affirmation statement:

The physician acknowledges and agrees that Humana may update and adjust this template form as necessary. Updated forms are available at Humana.com/provider/medical-resources/clinical/quality-resources, under the Preventive Care tab.

Medicare payment to Medicare Advantage organizations is based, in part, on each patient's diagnosis, as attested to by the patient's attending physician by virtue of his or her signature on this medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to a fine, imprisonment or civil penalty under applicable federal laws.

By signing this document, you attest to reviewing the medical documents to complete the form, using the best of your medical knowledge, placing the completed original of this form in the patient's medical record and ensuring fully-documented proof of service of all completed fields is contained in the patient's medical record. (Note: If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record.)

To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

_____

*Physician name and credentials (printed)* *Physician signature and credentials (signed)* *Date*

Provider office number: ( 941) 263-2050 Provider(s): Dr. Benjamin Heflin, Dr. Gene DiBetta, Ashley Bellant, APRN-C

Type: Family Practice

Billing provider ID: _____ National provider ID: _____

Tax ID #: 84-2653866

Provider address: 14279 S. Taiami Trail

Street address

| North Port | Florida | 34287 |
|---|---|---|
| City | State | ZIP |

## ANNUAL PATIENT ASSESSMENT - Continued

**Patient Label:**

### Mini Nutritional Assessment (MNA)

Sex: ☐ M ☐ F Age: _____ Weight: _____ Height: _____

| | | |
|---|---|---|
| A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? | 0 = severe decrease in food intake<br>1 = moderate decrease in food intake<br>2 = no decrease in food intake | _____ |
| B. Weight loss during the last 3 months? | 0 = weight loss greater than 6.6 lbs. (3kg)<br>1 = do not know<br>2 = weight loss between 2.2 = 6.6 lbs. (1 - 3kg)<br>3 = no weight loss | _____ |
| C. Mobility | 0 = bed or chair bound<br>1 = able to get out of bed/chair but do not go out<br>2 = go out | _____ |
| D. Suffered psychological stress within the past 3 months? | 0 = yes 2 = no | _____ |
| E. Neuropsychological problems | 0 = severe dementia or depression<br>1 = mild dementia<br>2 = no psychological problems | _____ |
| *******************STAFF ONLY BELOW THIS FOR MINI NUTRITIONAL ASSESSMENT**************** | | |
| F1. Body Mass Index (BMI) (weight in kg / height in $M^2$)<br>0 = BMI less than 19<br>1 = BMI 19 - less than 21<br>2 = BMI 21 - less than 23<br>3 = BMI 23 or greater | ***If BMI is not available, replace question F1 with F2. Do not answer question F2 if question F1 is already completed.** | _____ |
| F2. Calf Circumference (CC) in cm | 0 = CC less than 31 1 = CC 31 or greater | _____ |
| Screening Score: (Max 14 points)<br>12 - 4 = Normal Nutritional Status | 8 - 11 = At risk of Malnutrition 0 - 7 = Malnourished | _____ _____ |

### Annual Patient Conduct Agreement

If at any time a patient is physically threating, verbally abusive, or demeaning to staff (or other patients) whether it is in person or other means of communication, we at Family Doctors have the right to refuse treatment to the patient and dismiss them from the practice.

_____ _____

Patient Signature Date

**FOR PHYSICIAN USE**

_____ _____

**Physician Signature** **Date Reviewed**

# Social Determinants of Health Screening

**Your physician may ask you follow-up questions.**

## Living Situation

1. **What is your living situation today?**
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live now or in the past 12 months.
   - ☐ I have a stable place to live

## Food

2. **Within the past 12 months, have you not had enough food or worried that your food would run out before you have money to buy more?**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

## Transportation

3. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**
   - ☐ Yes
   - ☐ No

## Material Hardship

4. **In the past 12 months have you had issues paying for your electricity, gas, oil, water, or any other basic needs?**
   - ☐ Yes
   - ☐ No

## Employment

5. **Are you currently employed?**
   - ☐ No
   - ☐ Yes
   - ☐ I am not seeking employment

## Insufficient Insurance

6. **Do you feel like your insurance or welfare support is not enough and that you could benefit from an increase in benefits/support?**
   - ☐ Yes
   - ☐ No

## Financial Insecurity

7. **How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:**
   - ☐ Very hard
   - ☐ Somewhat hard
   - ☐ Not hard at all

## Social Support

8. **How often do you feel lonely, excluded or isolated from family, friends or your community?**
   - ☐ Always
   - ☐ Often
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes

## Living Alone

9. **If you live alone, do you have issues with mobility, cooking, cleaning or worrying about safety issues?**
   - ☐ Yes
   - ☐ No
   - ☐ I do not live alone

## War/Persecution

10. **Have you been a victim of war or persecution or been displaced from your home?**
    - ☐ Yes
    - ☐ No

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient Signature | Date |