Female Patient Registration

Patient Name: _____ DOB _____ SS#_____

Gender: M F Race: _____ Marital Status: S M W Sep D

Religious Affiliation: _____ Email: _____

Ethnicity: Hispanic Non-Hispanic Other

Legal Parent or Guardian if a minor: _____

Street Address: _____ City:_____ Zip:_____

Mailing Address: _____ City:_____ Zip:_____

Home Phone: _____ Work: _____ Cell:_____ Other:_____

How did you hear about our office? ____ Friend _____ Newspaper _____ Internet _____ Other

Preferred Pharmacy: _____

Account Information

Responsible Party: _____ Relationship to Patient:_____

Address if different than above: _____ City: _____ Zip:_____

Driver's License# _____ SS#_____ DOB:_____

Home Phone: _____ Work:_____ Employer:_____

Insurance Company Name: _____ Phone: _____

Member ID# _____ Group# _____

Policy Holder Name: _____ DOB:_____ SS#:_____

Medicaid #: _____ Medicare #: _____

Secondary insurance information: _____

Emergency Contact: (must have different contact number other than patient's phone number)

Name: _____ Relationship to patient: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip:_____

Authority to Treat (please initial the appropriate statements)

_____ I hereby authorize Heart 2 Heart Family Practice to treat, perform and/or order such diagnostic, laboratory, medical, surgical and x-ray procedures as are necessary in the provider's judgement for my care or the care of my child.

_____ I am legally responsible for the above-named patient now and in the future when the child is brought in for care.

_____ I permit a copy of this authorization to be used in place of an original and such document will remain in effect until revoked by me in writing.

Patient/Parent Signature: _____ Date: _____

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Female Adult History Form

Date: _____

Name: _____ DOB:_____ 1st day of LMP _____

Single _____ Married _____ Separated _____ Divorced _____ Living w/Partner _____

If Married, how long _____ If living with partner, how long _____

Occupation _____ How many hours per week_____

How many years at current position _____The stress Level is H M L

Reason for visit: Routine Physical _____ With Pap Smear _____ Menstrual Problems_____

Birth Control_____ Infection_____ Conception Issue_____ Birth control Issues_____

Is this your 1st pelvic exam_____ Are you currently on Birth Control _____Type_____

Other: _____

Current Problems: Vaginal Itching/Burning_____ Vaginal Odor _____Vaginal DC _____

Painful Urination _____How Long _____Pelvic Pain_____ How Long _____

Breast Tenderness_____ Breast Lump_____ Discharge for Nipple _____

Lifestyle History: _____

Allergies to Medication: _____

Other allergies: _____

Current Medications: _____

Do you smoke_____ # Per Day_____ Do you Drink_____ How much per week_____

Do you exercise _____Frequency_____ What type of activity _____

Ever been in an Abusive Relationship_____ Currently_____ When_____

Ever been raped or molested at any time in your life_____ Receive Counseling_____

Do you do monthly breast exams_____ Been exposed to STD's _____

Other_____

_____

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Female History **Page 2**

Name: _____

Have you or an immediate family member had any of the following, please list dates if possible:

MEDICAL	SELF	FAMILY MEMBER	MEDICAL	SELF	FAMILY MEMBER
Heart Disease			Liver Disease		
Cancer			Gallbladder		
Lung Disease			Tuberculosis		
Thyroid			Epilepsy		
Diabetes			Blood Issue		
Migraines			Immune Issue		
Chronic			Leg Issue		
Bowel Issues			Blood Transfusion		
Mental/Emotional			Kidney Disease		
Breast Lump/Cyst			Alcohol/Drug Issue		
Eating Disorder			Rheumatic Fever		

Surgical History: Have you ever had any surgery anywhere on your body

SURGERY	YES	NO	DATE	SURGERY	YES	NO	DATE
Abortion #				Laparoscopy			
Hysterectomy				Appendectomy			
Tubal Ligation				Cryo Surgery/Cervix			
D & C (Scrape uterus)				LEEP Procedure			
Colposcopy				Breast Implants			

Please List any other surgeries: _____

_____

GYN History

At what age did you first start your period _____ Was it Regular or Irregular _____

How many days does it last _____ Is Flow **Light** **Medium** **Heavy**

Date of Last Pap _____ Normal _____ Abnormal _____ Follow Up Yes No

Any abnormal Pap smears ever Yes No If Yes, when _____

Please list all forms of birth control you have used, approximate dates you were on them and why you've stopped using them or why you changed to a different type.

_____

_____

_____

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Female History **Page 3**

Name: _____

Are you currently sexually active **Yes** **No** Is sex comfortable and enjoyable _____

Number of sexual partners this **Month**_____ **Year**_____ **Lifetime** _____

Current Partners **Male**_____ **Female**_____ **Both** _____

Do you experience any of the following when having sex? **Pain** **Bleeding**

List ages and delivery method (vaginal or C-Section) of all of your children: _____

_____

_____

Please Check All That Apply

PROBLEM	YES	NO	DATE	PROBLEM	YES	NO	DATE
Gonorrhea				Endometriosis			
Chlamydia				Ovarian Cyst			
Syphilis				Uterine Fibroid			
HIV/AIDS				Infertility			
Trichomonas				Herpes Simplex			
Yeast Infection				Group B Strep			
Bacteria Vaginosis				Condyloma/HPV Genital			
Pelvic Inflammatory Disease				Other			

Are there any other issues that you would like to have addressed at this appointment?

_____

_____

_____ _____

Signature Date

No-Show Policy

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Heart 2 Heart defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 15 minutes late and is consequently unable to be seen.

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-show" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient.
- Is unfair (and frustrating) to other patients that would have taken the appointment.
- Disrespects not only the provider's time, but also the time of the entire practice staff.

How to Avoid Getting a "No-Show"

- Confirm your appointment.
- Arrive 5-10 minutes early.
- Give 24 hours' notice to cancel appointment.

1. Appointment Confirmation

Our automated health record will send an email 1 week prior to your appt. It will also send a text message 3 days before your appointment.

- ❖ Heart 2 Heart staff will also contact you one business day prior to your scheduled appointment to confirm your visit.
- ❖ If we are unable to speak with you, we will leave a message. To cancel an appointment, you will need to contact Heart 2 Heart by 2:30pm the business day before the appointment — otherwise the appointment will be considered a "no-show".

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider.
2. If you are not dismissed and need an appt., you will have to call in and be seen as the schedule allows as a sick visit. You will not be able to reserve an appt. Only emergency medical treatment will be offered within the first 30 days of dismissal.

_____ _____

Patient Signature Date

I have read and understood the Heart 2 Heart Family Practice "No Show" Policy as described above.

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Pledge of Patient Responsibility

Thank you for choosing Heart 2 Heart Family Practice, PA as your healthcare provider. We are committed to fulfilling our responsibilities in your successful treatment. However, for our relationship to be successful, it is important that you understand your responsibilities as a patient. They are as follows:

Patient Responsibilities

1. You need to keep your appointment, however if for some reason you cannot, it is your responsibly to give a minimum of forty-eight (48) hours' notice. Repeated failure to give appropriate notice could result in your provider discharging you from care.
2. It is your responsibility to pay patient co-pays, deductible and other appropriate fees at the service. Failure to pay in a prompt fashion could result in charging of interest. If charged interest it is your responsibility to pay it promptly.
3. It is your responsibility to follow the treatment plan established by your provider. This means going to appointments for test, consults, attending recommended therapies and doing home activities that have been recommended for you.
4. Prescription medicine may be a part of your treatment. It is your responsibility to follow instructions closely. No early refills in narcotics will be provided. Prescriptions can only be refilled during work days, Monday through Friday 9AM to 4PM.

I pledge to fulfill my responsibilities as a patient.

Signature:_____ Date:_____

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

General Consent part 1

Heart 2 Heart Family Practice, PA is intended as an alternative approach to Childbearing, Primary care, well women and well man and well child care, in a small rural area where few services are available. It may appeal to and be desired by some people and not others. For this reason, we feel that you must be fully informed of our scope of services and limitations to more traditional physician services.

As our patient we require that you participate in orientation procedures generally performed on your first visit which includes but are not limited to 1. Your personal inspection of the facility. 2. Services, methods and procedures related to your healthcare. 3. Mutual expectations. 4. A discussion about recommendations and alternatives available to you or your child with regards to health decisions and lifestyle choices that affect your health. 5. Potential risks to the patients, childbearing couple and child that pertain to your personal history and circumstance and procedure for management of complications.

We have taken every reasonable precaution to ensure the safety, comfort and satisfaction of our essentially healthy client population that we service in this practice. We are not however a hospital and do not have extensive lifesaving equipment of highly specialized services that are needed in some crisis or emergencies that arise when people seek medical care. Basic lifesaving equipment and techniques will be used, and we will transfer all emergencies via 911 Ambulance to the nearest hospital.

Should consultation, referral or hospitalization become necessary during your care we will inform you in a timely manner of your options and make all of your records available to the referring physician and/or hospital. After your specialized care needs are met, you may return to us for continued healthcare management as long as you desire to do so and as long as your medical condition is stable.

It is the philosophy of this practice that whatever possible decisions about your health care are needed they will be made as a result of consultation with you the patient or patient's guardian. Do not hesitate at any time to ask questions you have about the practice and its services or functions as well as anything that concerns you, your child or your family. Continued enrollment in the practice is determined by your desire to work together with the clinical staff toward optimal health and your appropriateness as our patient. If the provider feels your care is more appropriate with another practice you will be informed, and the staff will help you to find care with a practice more appropriate for your healthcare needs.

I have read and agree with the above statements and have had opportunity to ask questions.

_____ _____

Patient/Guardian Signature Date

Financial Polices & Lifetime Authorization

1. **Release of Information** I, the below named patient or guardian do herby authorize any provider examining and/or treating me to release any third party, such as an insurance company or governmental agency, medical records generated at Heart 2 Heart Family Practice, PA related to diagnosis and treatment when such information is requested by such third party for its use in determining a claim for payment for such treatment and or diagnosis.

2. **Physician Insurance Assignment**: I, the below named patient or guardian herby authorize payment directly to ay provider examining and/or treating me for medical and/or surgical benefits herein specified and otherwise payable to me for their service as described.

3. **Medicare/Medicaid:** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Administration/Division of Family Services or its intermediaries any information needed to determine a Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the provider treating me. I also understand that certain procedures or injections may not be covered by my policy and therefore I will be responsible for payment for these services.

4. I permit a copy of these authorizations and assignment to be used in pace of the original which is on file at the provider's office. This assignment will remain in effect until revoked by me in writing.

5. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full at the time of service unless other arrangements are made in advance with the office.

6. I hereby assign all Medicaid and/or surgical benefits to include major medical benefits to wish I am entitled (Medicare, Medicaid, Private Insurance or other health plans) to Heart 2 Heart Family Practice, PA for payment for services rendered to me by its providers.

7. I request that payments of authorized Medigap benefits be made on my behalf to Heart 2 Heart Family Practice, PA for services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payables for related services.

You are responsible for any balances due for services rendered. We can only estimate insurance benefits and will file the insurance claims as a courtesy to our patients**. It is my responsibility to know my insurance yearly maximums, copays, and deductibles.** You are financially responsible for all charges not paid by your insurance company. You are financially responsible for any claims not paid by your insurance company within 90days.

Sliding fee Scale: Our office offers a sliding fee scale to those who qualify for a discount on services. Applications for this are available at the front office. Applications must be updated every six months.

Service Charge: A service charge of 1.5% per month will be charged unless prior arrangements have been made. Patient/Guardian understands that if this account is placed with a collection agency that he/she will be responsible for any collections and/or attorney's fees, plus costs.

Patient/Guardian Signature _____ Date _____

Signature of Guarantor if different than above: _____

HEART 2 HEART FAMILY PRACTICE
HEALTH AND WELLNESS SERVICES

Notice of Privacy Polices

This notice describes how information about you may be used and disclosed and how you can get access to the information. Please review this document carefully.

Introduction

At Heart 2 Heart Family Practice, PA, we are committed to treating and using your protected health information responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective October 15, 2020 and applies to all protected health information as defined by federal regulation.

Understanding Your Health Record/Information

Each time you visit Heart 2 Heart Family Practice, PA, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment and a plan for your future care or treatment. This information which is referred to as your health or medical record services as a:

- o Basis for planning your care and treatment
- o Means of communication among the many health professionals who contribute to your care
- o Legal Documents describing the care you have received
- o A means by which you or a third party payer can verify that services billed were provided
- o A tool in the education of health professionals
- o A source of data for medical research
- o A source of information for the public health officials charged with improving the health of this state and the nation
- o A source of data for our planning and marketing
- o A tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

Notice of Patient Rights

Understanding what is in your records and how your health information is used helps you to ensure it accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of this Medical Office, the information belongs to you. You have a right too:

- o Obtain a paper copy of this notice of information practices upon request
- o Inspect and copy your health record as provided for in 45 CFR 164.524
- o Amend your health records as provided in 45 CFR 164.528
- o Obtain an accounting of disclosures of health information as provided in 45 CFR 164.528
- o Request communications of your health information by alternative means to alternative locations
- o Request a restriction on certain uses and disclose health information except to the extent that action has already been taken

Our responsibilities

Heart 2 Heart Family Practice, PA are required to:

- o Maintain the privacy of your health information
- o Provided you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- o Abide by the terms of this notice
- o Notify you if we are unable to agree to a requested restriction
- o Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practice change, we will post a revised notice in our office and you may request a copy of the most current notice at any time.

We will not disclose your health information without your authorization except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information you may contact Heart 2 Heart Family Practice, PA Privacy Officer at 386-659-2104

If you believe your privacy rights have been violated you can file a complaint with our Privacy Officer or with the Office for Civil rights, US Department of Health and Human Services. There will be no retaliation for filling a complaint with either the Privacy Office of the Office for Civil Rights.

The address for the Office for Civil Rights is;

US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. We will also provide your primary or referring physician or subsequent health provider with copies of various reports that should assist him or her in treating you. We will use your health information for payment from third party payer. We will use your health information for regular health operations.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangered one or more patients, workers or the public.

Patient Consent For use and Disclosure of Protected Health Information

I allow Heart 2 Heart Family Practice, PA to use and disclose my protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for 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.

Heart 2 Heart Family Practice, PA have the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy officer at 1326 SR 100, Melrose FL 32666.

Heart 2 Heart Family Practice, PA may call my home or other designed locations 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 but not limited to: appointment reminders, insurance items, clinical care, lab or clinical results etc.

Heart 2 Heart Family Practice, PA may mail to my home or other designated locations any items that assist the practice in carrying out TPO such as but limited to: appointment reminder cards and patient statements.

I have to right to request the restriction or disclosures of my Personal Health Information in an effort to carry out my treatment, payment and healthcare operations. However, I understand that the practice is not required to agree to my request but will comply to my request to best of its ability.

I have received a copy of Heart 2 Heart Family Practice, PA Privacy Practice Notice for my records.

By signing this for, I am consenting to Heart 2 Heart Family Practice, PA use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Please restrict the use of my records as follows:_____

_____

_____ _____

Signature Date

_____ _____

Patient's Name Date of Birth

_____ _____

Legal Guardian Date

1326 SR 100 Melrose, Florida 32666

Phone 386-659-2104 – Fax 386-659-2196

Authorization for use or disclosure of protected health information

Date:_____ Name: _____

DOB:_____ Social Security # _____

Purpose of disclosure

Specific items requested: _____

Purpose of release: _____ Changing physician _____ Consult/2nd Opinion ____ Legal _____ School

_____Insurance ____ Continuing Care _____ Other

1. I understand that this authorization will expire one (1) year or until after I revoke it in writing.

2. I understand that I may revoke this authorization at any time by notifying the Heart 2 Heart Family Practice, PA staff in writing and it will become effective the date the notification was received.

3. I understand the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by Federal Privacy regulations

_____ _____ _____ _____

Patient's Signature Date Parent/Guardian Signature Date

Patient Declines to request any previous medical records.

_____ _____ _____ _____

Patient's Signature Date Parent/Guardian Signature Date

_____

Previous Doctor or Practice Name: _____

Previous Doctor's Address: _____

Previous Doctor's Phone#: _____ Fax#_____

The following pages allow you to fill out a living will and power of attorney. These documents allow you to name a person in your life that you trust to make decisions in your healthcare.

If you do **NOT** want to sign these papers sign and date the first form. If you choose to complete the forms the front office will scan them into your file where they will be kept permanently. I will then give you the original to save with your important paperwork at home.

Thank You.

Advance Directives Form

Date: _____

I,_____

(Physicians Name)

Have discussed the Living Will and Durable Power of Attorney with

_____

(Members name)

_____Yes, the member has completed the Living will and a copy will remain in his/her medical file.

_____ Yes, the member has completed the Durable Power of Attorney and a copy will remain in his/her medical files.

_____ No, the member declines to complete a Living Will.

_____ No, the member declines to complete a Durable Power of Attorney

Physician's Signature: _____

Member's Signature: _____

Designation of Health Care Surrogate

(Power of Attorney for Health Care decisions)

In the event that my physician determines that I am incompetent or so incapacitated as to provide expressed and informed consent for medical treatment, surgical intervention or diagnosis procedures.

I, _____

(Last Name) (First Name) (Middle Name)

Wish to designate the following person to make those decisions for me.

Designee

Name Telephone

_____

Address Relationship (if any)

Alternative Designee

If the person that I have named is unable to act on my behalf, I authorize the following person to act on my behalf:

_____

Name Telephone

_____

Address Relationship (if any)

I fully understand that this document will permit the above identified designee to support, withhold or withdrawal consent for intended treatment and to do so on my behalf. That individual may also apply for public benefits to defer the cost of the health care and authorize for my transfer to or from a health care facility. I further reaffirm that this designation is not being made as a condition of treatment of admission to a healthcare facility. I understand should my judgmental incapacitation or incompetence be reserved such that I am once again considered competent to make my own decisions, such decisions will once again be mine. I understand that I may rescind the declaration at any time so long as I am judged to be competent and capable to make such judgements.

Additional Instructions: _____

_____

Do you have a living will declaration? _____Yes _____No

_____

Signature Date

_____

Witness#1 Date

_____

Witness #2 Date

Note: One witness should not be a spouse, blood relative, heir to the estate of the designee or responsible for paying health care costs for the individual.

Living Will

Declaration made this_____ day of ,_____ 20_____, I,_____

Willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and (initial one or more of the following three conditions)

_____(Initial) I have a terminal condition

Or _____ (initial) I have an end-stage condition

Or_____ (initial) I am in a persistent vegetative state

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that my life-prolonging procedures be withheld or withdrawn when the application of such procedure would serve only to prolong artificially the process of dying, and that I be permitted to die naturally either only the administration or medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intension that this declaration be honored by my family and physician and the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name:_____

Address:_____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):_____

_____

Signed:_____

Date: _____

Witnesses' signature, address, and phone number:

1._____ 2._____

_____ _____

_____ _____

_____ _____