CENTERS FOR HEALTHY LIVING

2056 CENTRE POINTE LANE * TALLAHASSEE, FL 32308

TELEPHONE
(850)877-9355

FAX
(850)325-1375

PATIENT REGISTRATION FORM

Date_____

Name _____

Address _____Zip _____

City_____St._____

Date of Birth _____Social Security# _____

Home# _____Cell# _____Work #_____

Email_____

Occupation_____

Health Insurance_____

Policy# _____Group #_____

How did you hear about us? _____

I authorize Centers For Healthy Living to treat me as necessary. I authorize any information necessary to be released to my insurance carrier for this or a related claim. I accept responsibility for all copayments and deductibles due at the time of service. I agree to be responsible for any balance not covered by my insurance carrier or responsible party.

( ) I have received a copy of "Notice of Provider Privacy Practices" handout.

( ) I have received a copy of "Your Health Information Rights" handout.

PATIENT SIGNATURE _____

THIS SECTION FOR STUDENTS ONLY

Name of parent responsible for your medical bills_____

Address_____

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All contact numbers_____

PERSONAL MEDICAL HISTORY

Name_____

Primary Doctor _____Date of last visit_____

Allergies_____

All medications you are taking_____

_____

Current medical problem_____

Chronic medical conditions _____

Previous Surgeries_____

When was your last…

Period_____Mammogram_____Pap Smear_____

Dexa scan_____Colonoscopy_____Prostate Exam_____

Please check any of the following that apply to you:

High blood pressure____
High cholesterol____
Cardiovascular Disease____
Diabetes____
Osteoporosis____
Benign Prostatic Hyperplasia____
Seizures____
Tobacco use____
Alcohol use____
Caffeine use____
Asthma/COPD/TB____
Erectile Dysfunction____
Insomnia____
Muscle loss____
Decreased Libido____

Depression____
Migraines/Frequent headaches____
Cancer____type of _____
Eating Disorders____
Stroke____
Phlebitis/Clots/Varicose veins____
Vision Problems____
Liver Disease/Hepatitis____
Mononucleosis____
Kidney/Bladder problems____
Thyroid Disease____
Anemia/Sickle cell____
Abnormal mammogram____
Breast lumps/discharge____
Other_____

FAMILY HISTORY

Are you adopted?_____

Indicate who of your blood relatives (parents, grandparents, siblings) have or had any of the following problems:

Heart attack/coronary artery disease_____ High blood pressure_____

Diabetes_____Stroke_____Cancer____typeof_____

Phlebitis/clots in veins_____ Birth defects/genetic disorders_____

Sickle cell_____Tay Sachs_____Thalassemia_____

PATIENT SIGNATURE_____DATE_____

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NOTICES OF PROVIDER PRIVACY PRACTICES

Centers For Healthy Living must maintain the privacy of you personal health information and give you this notice that describes the legal duties and privacy practices concerning you personal health information.

Without your written authorization, we can use your health information for the following purposes:

1. *Treatment:* The treatment selected will be documented in your medical record so that other health care professionals can make informed decisions about your care.
2. *Payment:* In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. In the cases in which this is done electronically, the company we deal with is in compliance with all regulations regarding privacy.
3. *Health Care Operations:* Your insurance company may require regular inspection information of our charts to monitor patient care. Appointment reminders will be a phone call to the patient directly. No messages will be left without the express consent of the patient. Mailed notices for appointments or treatment will be sealed card.
4. *As required or permitted by law:* Sometimes we must report some of your health information to legal authorities.
5. *For public health activities:* We may be required to report your health information to authorities to help prevent or control disease, injury or disability.
6. *For activities related to death:* We may disclose your health information to medical examiners and funeral directors so they can carry out their duties related to the death of you or your infant
7. *For organ, eye or tissue donation:* We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes, or tissue of cadavers for donation purposes.
8. *For military, national security, or incarceration/law enforcement custody:* If you are in the custody of law enforcement officials, we may release your health information to the proper authorities so they may carry out their duties under the law.
9. *For worker's compensation:* We may disclose your health information to the appropriate persons in order to comply with the laws related to worker's compensation or other similar programs.

NOTE: Except for the situations listed, we must obtain your specific written authorization for any other release of your health information. If you sign an authorization form, you may withdraw you authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the privacy officer.

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YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the doctors' office. The information in it, however, belongs to the patient. The patient has a right to:

- ❖ Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any reasonable request.
- ❖ Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- ❖ Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- ❖ Appeal a denial of access to your protected health information except in certain circumstances.
- ❖ Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. The physician is not required to make such amendments.
- ❖ File a statement of disagreement if your amendment is denied and required that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- ❖ Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide you upon request.
- ❖ Revoke authorization that you made previously to use or disclose information except to the extent that information or action has already been taken by delivering a written revocation to our office.
- ❖ All patients regardless of age have a right to privacy with their health care information in regards to the pregnancy and birth control.

If you want to exercise any of the above rights, please contact the privacy officer at this office.

This notice of privacy rights is in effect as of April 14, 2003

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RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Centers For Healthy Living and staff consider all patient information confidential. List all individuals with who we may discuss your medical condition, test results, and/or treatment plan. Please sign below indicating you have given this authorization. You may discuss my treatment with:

1) Name: _____Relationship: _____

2) Name: _____Relationship: _____

Patient Signature: _____

Print Name: _____

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FINANCIAL POLICY

We will gladly submit your insurance provided you agree to pay the portion you are responsible for. Your responsibility includes any deductible or co-pay that applies to the visit or the entire amount of the claim should your insurance completely deny.

An estimate of your responsibility will be collected at the time of the visit. After insurance pays or denies a claim we will send you a statement. Your amount due is expected by the due date on the statement. If your amount due is too large to pay by the due date please call to discuss payment arrangements.

Statements that are ignored will be sent to collections. All accounts turned over to collections will be charged a 50% fee.

Some procedures require payment in advance. Under these circumstances we will have verified your approximate responsibility with your insurance company.

We require a 24 hour notice when canceling or rescheduling an appointment. Our providers are very much in demand therefore you will be charged if you do not show for an appointment. Please remember to give 24 hour notice when canceling or rescheduling an appointment. You will be billed for a no show.

We will be happy to answer any questions you may have regarding our financial policy

Patient Signature: _____Date:_____