# STEPHEN W. DUNCAN, M.D.

2056 CENTRE POINTE LANE * TALLAHASSEE, FL 32308

TELEPHONE (850)325-1212

FAX (850)325-1375


## PATIENT REGISTRATION FORM

Date ________________________________

Name ____________________________________________________________________

Address __________________________________________________Zip _____________

City ___________________________________________________ St.______________

Date of Birth __________________________Social Security# ______________________

Home# ___________________ Cell# _________________ Work # _________________

E-mail ____________________________________________________________________

Occupation _________________________________________________________________

Health Insurance __________________________________________________________

Policy# _______________________________ Group #_____________________________

How did you hear about us? ___________________________________________________

I authorize Dr. Stephen Duncan 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____________________________________________________________________

All contact numbers ________________________________________________________

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## PERSONAL MEDICAL HISTORY

Name___________________________________ Date of Birth________________________
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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## 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:______________

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# RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Dr. Stephen Duncan 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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# NOTICES OF PROVIDER PRIVACY PRACTICES

Dr. Stephen Duncan 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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Dear Patient,

Unfortunately, the Medical Malpractice crisis in the US, under the Affordable Care Act (ie: Obama Care), has yet to be resolved by the US Legislature. After several special legislative sessions called by congress to deal with this issue, the cost of malpractice insurance remains prohibitive and its availability very limited.

Dr. Duncan and staff pride themselves on being diligent, thorough and thoughtful. We expect our patients to be honest in the reporting of their medical histories and to be compliant in follow-up care in order to achieve the best possible outcomes.

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

If you are uncomfortable with remaining under Dr. Duncan's care after reading this letter, he will be happy to refer you to another physician.

Sincerely,

Stephen Duncan M.D.

I have read and understand the above completely.

Patient signature______________________________________Date______________________

Print Name_________________________________________

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# Male Patients Only

# CONSENT FOR HORMONE REPLACEMENT THERAPY

I have met with a member of the medical staff to review the program and have been given the opportunity to have all of my questions regarding hormone balancing answered.

I understand that testosterone replacement can have positive effects on my sleep habits, energy, mood, memory, strength, decrease in body fat, libido and sexual performance. I also understand that while rare, there are possible side effects.

Potential Risk/Side Effects of Testosterone Replacement

- Increased estrogen
- Increased hematocrit (thickness of blood)
- Testicular atrophy (decreased testicular size)
- Decreased sperm count
- Decreased endogenous testosterone (reduction of your own body's testosterone with a low risk of not returning to baseline after stopping therapy)
- Increased body hair
- Decreased head hair
- Acne – face and back
- Water retention
- Increase in prostate size
- Increase in PSA (prostate marker)
- Worsen prostate cancer if it already exists
- TESTOSTERONE DOES NOT CAUSE PROSTATE CANCER

I have not been given any promises or guarantees regarding the expectations or results from hormone replacement therapy. I freely and voluntarily consent to participate and agree to follow the instructions given. I will not change the dosage or frequency of any medications prescribed.

Patient Name (printed) ________________________________

Patient signature _____________________________________ Date _____________

Witness ____________________________________________ Date _____________