PHC
OF PINELLAS

Professional Health Care of Pinellas, LLC

Patient Name: _____ Appt Date & Time: _____

Primary Care Physician: _____ Phone: (_____) _____

Primary Care Address: _____
Address

_____
City, State, Zip

Dear _____,

Thank you for choosing PHC as your medical care provider. Enclosed in this packet you will find: our patient information, medical history forms, financial policy, and patient's rights and responsibilities information.

Please complete these forms and bring them **completed** with you to your appointment, along with your **medication list**.

As a courtesy, we will file for reimbursement from your insurance company. Please keep us updated with any changes to your insurance and personal information. **ALL FEES INCLUDING CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.**

Please remember to bring the following to your appointment:

- Photo ID
- Insurance card(s)
- Bring Medication(s)

Please refrain from wearing any cologne, perfume, or scented body lotion. These are chemical irritants that can cause problems for other patients and staff with breathing difficulties. We strive to ensure your comfort and safety by encouraging a fragrance-free environment.

We look forward to seeing you soon.

Sincerely,

PHC Physicians and Staff

1839 Central Avenue (3rd Floor)
St. Petersburg, FL 33713
Tel: 727.322.1054
Fax:727.322.2725

5500 Dr. MLK Jr. Street North
St. Petersburg, FL 33703
Tel: 727.525.5500
Fax: 727.522.2574

8133 54th Avenue North
St. Petersburg, FL 33709
Tel: 727.541.4458
Fax: 727.546.6663

PHC
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WELCOME TO OUR OFFICE

PATIENT INFORMATION

Demographics

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____

Sex: Male / Female Race: _____ Primary Language Spoken: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Employer Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Pharmacy Information

☐ **CVS** ☐ **Publix** ☐ **Target** ☐ **Sam's Club** ☐ **Walgreens** ☐ **Winn Dixie** ☐ **Wal-Mart**

☐ **Other** _____

Pharmacy Phone: _____ Address: _____

I, _____ here by authorize the medical staff of Professional Health Care of Pinellas, LLC. to render medical services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. **If our office prescribes any pain medications to you, you will be subject to random drug testing.** I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatment with any physician. I understand that I am ultimately responsible for full payment of my treatment and care. My insurance policy is a contract between Professional Health Care of Pinellas and my insurance company(s). Professional Health Care of Pinellas will file my claim. I am required to provide the most correct and updated information about my insurance and will be responsible for any charges incurred if information provided is not correct or updated. **Patients are responsible for the payment of all co-pays, coinsurances, deductibles, procedures, treatments and explanations of any services not covered. Payment is due at the time services are rendered. Insurance companies will only pay for services that it determines to be "reasonable and medically necessary" under the Insurance Companies standards. Insurance companies may deny payment for services that they deem are screenings or not meeting medical necessity guidelines per the local coverage determinations. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.**

Professional Health Care of Pinellas , LLC cannot waive co-payments or bill on your behalf. For your convenience we accept cash, check, and most major credit cards.

X _____ Date: _____

Patient Signature

PATIENT CASE HISTORY

Patient Name: _____ **Date:** _____

Height: _____ **Weight:** _____

Chief complaint/Reason for visit: _____

Duration of Present Condition: _____

Medication Allergies

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, what medication(s) _____

What is your reaction to this medication? _____

Past Medical History

☐ High Blood Pressure ☐ Diabetes Mellitus ☐ Bleeding Problems ☐ Hepatitis / HIV ☐ Skin Cancer

Previous Surgery

Type	Date
_____	_____
_____	_____

Social History

Do you smoke? ☐ **Yes** ☐ **No** **If so how many pack(s) per day?** _____

Have you ever smoked ☐ **Yes** ☐ **No**

Family History (Please list)

_____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

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Please List the medications that you are taking.

Name of Medications, dosages, and how many times a day you take it.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.

Patient's Name: _____ Date of Birth: _____/_____/_____

Date: _____/_____/_____

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HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated there under, as amended from time to time (collectively) referred to as "HIPAA".

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Professional Health Care of Pinellas, LLC will not condition treatment, payment, enrollment in a health plan or eligibility for benefits, as applicable, on your providing authorization for the requested use of disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that ***Professional Health Care of Pinellas, LLC*** may use or disclose your personal health care information to other medical professionals relating to your treatment, payment, or health care options.

Further by signing this authorization you acknowledge that you have been provided a copy of, have read and understand Professional Health Care of Pinellas, LLC's HIPAA Notice of Patient Privacy Practices containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While, ***Professional Health Care of Pinellas, LLC*** has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from ***Professional Health Care of Pinellas, LLC.*** at any of its offices or by sending a written request with return address to 1839 Central Avenue, St. Petersburg, FL 33713, or 5500 MLK St. N. St. Petersburg, FL 33703 or 8133 54th Avenue N. St. Petersburg, FL 33709, depending on your primary care office. In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or ask for a copy of your Personal Health Information (PHI) in the designated record set maintained by ***Professional Health Care of Pinellas, LLC.*** for as long as the Personal Health Information (PHI) is maintained in the designated record set.

You have the right to revoke this authorization, in writing; at any time, except to the extent that ***Professional Health Care of Pinellas, LLC*** has taken action in reliance on it. A revocation is effective upon receipt by ***Professional Health Care of Pinellas, LLC*** of (a) written request to revoke and a copy of the executed authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of ***Professional Health Care of Pinellas, LLC*** or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA. Professional Health Care of Pinellas, LLC will provide you with a copy of this signed authorization, if requested.

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HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

You have the right to request a copy of our ***"Notice of Patient Privacy Practices"*** prior to signing this authorization for a more complete description of health information uses and disclosures.
I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Acknowledged and agreed to by:

Patient: _____ _____

Signature **Printed Name**

Date: _____

Name of Guardian or Representative:

_____ _____

Signature **Printed Name**

Date: _____

*If other than patient is signing, are you the parent, legal guardian, and legal custodian, or have a Healthcare **Power of Attorney** for this patient? Yes [ ] No [ ]

RELATIONSHIP: _____

FOR OFFICE USE ONLY:
Patient refused to sign the form. Reason: _____
Acknowledges and agreed to by:

Patient: _____ _____

Signature **Printed Name**

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Professional Health Care of Pinellas, LLC

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Professional Health Care of Pinellas, LLC originates, maintains paper and electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatments, any plans for future care or treatment and payment for the services or treatments we've provided. We use this information to:

- Plan your care and treatment
- Communicate with other healthcare professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", 45 CFR Parts 160 &164 WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as referrals to or consultation with, other healthcare providers and healthcare entities (such as referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment or healthcare.

To request from other healthcare entities or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc) specific healthcare information we may need for planning your care and treatment.

To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies or individual(s) for payment of our services or treatments provided to you.

To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, email or with a household family member.

[ ] Please check here if you do not want us to leave messages on your answering machine.

[ ] Please check here if you do not want us to leave messages with a household family member.

[ ] Please check here if you do not want us to leave message on your mobile voice mail.

[ ] Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.

To discuss your healthcare or payment information (only the minimum necessary in our judgment) with family members or others persons who are or may be involved with your healthcare treatment or payments. Please list by name and relationship the persons with whom we may share this information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Signature: _____ **Date:** _____/_____/_____

Professional Health Care of Pinellas, LLC

1839 Central Avenue
St. Petersburg, FL 33713
Joi Frazier, HIPPA Privacy Officer
Direct Number: 727-210-8393
General Information: 727-322-1054

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

07/01/2018

This Notice of Privacy Practices applies to the following organizations.

Professional Health Care of Pinellas, LLC
1839 Central Avenue
St. Petersburg, FL 33713

Joi Frazier, HIPPA Privacy Officer
Direct Number: 727-210-8393
General Information: 727-322-1054