NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

What is HIPAA and how does the Privacy Rule affect you? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to comply with the regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information? Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment and /or that identifies you as an individual.

What is the Notice of Privacy Practice? Our official Notice of Privacy Practice is posted in our reception area and informs our patients about their rights surrounding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained or retained by our practice. We may update our Notice of Privacy Practices at any time. Our Notice of Privacy Practice will be posted in our reception area and you may ask for a copy at any time.

The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information:

- Treatment
- Payment
- Treatment Options
- Health-related benefits and services
- Appointment Reminders
- Health Care Operations
- Disclosures required by law
- Release of information to Family/Friends

The following categories describe unique situation in which we may disclose your individually Identifiable Health Information:

Public Health Risks
Lawsuits and Similar Activities
Organ and Tissue Donation
Military
Worker's Compensation
Research
Health Oversight Committees
Deceased Patients
Serious Threats to Health or Safety
National Security Inmates
Law Enforcement

What are your rights concerning your Individually Identifiable Health Information? You have rights regarding the Individually Identifiable Health Information that we maintain about you. The policies and procedures for the following circumstances are listed in our Notice of Privacy Practices:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

I have read the short notice provided by Physician Care Centers and have been informed of how to obtain more information regarding the practice's Notice of Privacy.

_____ _____
Signature Date

_____ _____
Print Name Date

CONSENT TO TREAT

I, the undersigned, voluntarily give consent to Physician Care Centers' professionals to provide and perform such medical/diagnosis/minor surgical treatment (s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in this office.

_____ _____ ___ / ___ / _____

Patient Printed Name Date Date of Birth

_____

Signature of Patient/Legal Representative

……..

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received/reviewed a copy of Physician Care Centers' Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date _____ Initials _____ Reason _____

Authorization and Assignment

I hereby authorize Physician Care Centers practice to release any medical information necessary to process all claims for reimbursement on my behalf: I authorize payment to be made directly to Physician Care Centers for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover insures. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above names entity. I understand that I am financially responsible for all charges if. they are not covered by my insurance. In the event of default, I agree to pay all cost of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative Date

PHYSICIAN CARE CENTERS

REGISTRATION FORM

Name (Last, First, M.I): _____ **DOB:** _____

Address: _____ **Social Security #:** _____

City: _____ **State:** _____ **Zip Code:** _____ ☐ **M** ☐ **F**

Phone: _____ **Email:** _____

Language: ☐ **English** ☐ **Spanish** ☐ **Other:**_____ **Ethnicity:** ☐ **Hispanic** ☐ **Non- Hispanic**

Race: ☐ **White** ☐ **Black** ☐ **Asian** ☐ **Native American** ☐ **Other:** _____

Employer: _____ **Employer Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:**_____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Seperated**

Spouse Name: _____ **Spouse Phone #:** _____

INSURANCE INFORMATION

Please present your card(s) at every visit to ensure proper assignment of your benefits

Primary Insurance Name: _____ **Phone:** _____

ID Number: _____ **Policy Number:** _____

Subscribers Name: _____ **Group Number:** _____ **DOB:**_____

Policyholder's SS#: _____ **Policyholder's Employer:** _____

Secondary Insurance Name: _____ **Phone:** _____

Secondary Policyholder's Name: _____ **Secondary Policyholder's DOB:** _____

Secondary Policyholder's SS#: _____ **Secondary Policyholder's Employer:** _____

I hereby assign all medical and/or in-office surgical/procedure benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Physician Care Centers. This assignment is valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information to secure payment.

Patient Signature: _____ **Date:** _____

PHYSICIAN CARE CENTERS

REGISTRATION FORM

Please fill out as completely and clearly as possible

Are you here today due to an injury from a motor vehicle accident or work-related injury? □Yes* □No
*** If you answered yes, please see the receptionist before continuing to complete this form.**

Do you have or have had any of the following? (check the box if the diagnosis applies to you)

□Diabetes □Seizures □Multiple Sclerosis □Parkinson's Disease □Restless Leg Syndrome □Hypertension □Headaches
□Neuropathy □Alzheimer's Disease □Arthritis □High Cholesterol □Cancer,type:_____
□Broken Bones:_____ □Other_____

Have you ever been hospitalized in the past? □No □Yes If yes, please complete the following:
□Surgery,Reason(s):_____ □ Other Medical Condition(s):_____
□ Childbirth ----> Natural □ C-Section □

Have you ever used tobacco in any form? □No □Yes Cigarettes□ Snuff/Skoal-type□ Chewing Type □ Pipe□ Cigar□
Other□_____ When did you start using?_____
How much do/did you use daily?_____ If you have since quit, when did you quit?_____

Have you ever used recreational drugs in any form? □No □Yes
□Marijuana□LSD□ Pills□(type_____) Cocaine□ Heroin□ Meth□ Other□_____
When did you start using?_____ How much do/did you use daily?_____
If you have since quit, when did you quit?_____

Have you ever used alcohol in any form? □No □Yes: Wine □ Beer □ Liquor □
When did you start drinking?_____ How much do/did you drink daily?_____
If you have since quit, when did you quit?_____

Do you have any allergies? _____ **Would you like allergy testing?** : □No□Yes
□Medications _____ □Foods_____
□Environmental(cats, pollen, trees, etc) _____
If there are things that you are intolerant to, but do not have a true allergy, please list them here:
(for example, some medications give certain people muscle aches, or stomach upset)

Please list your medications, vitamins, and supplements: Medication Name: How do you take this: Written by (PCP or Other)

_____ _____ _____
_____ _____ _____

What pharmacy do you use: _____ **Pharmacy Address:** _____
Do you have an Advanced Directive? □No □Yes **Does it indicate Do Not Resuscitate?**□No □Yes
Do you have a Durable Power of Attorney? □No □Yes If yes, please provide a copy at your earliest convenience.

Do you have a family history of chronic diseases or premature death? □No □Yes If yes, please describe:

Is there anything else you'd like the doctor to know about your medical history, social history or general condition that may help him deliver better care to you? _____

PHYSICIAN CARE CENTERS

REGISTRATION FORM

Please fill out as completely and clearly as possible

Main Office Hours
Monday & Wednesday 7:30 AM - 4:30 PM
Tuesday & Thursday 8:00 AM - 5 PM
Friday's 7:30 AM - 12 NOON

We are glad you have chosen us to provide you with your medical needs. We have adopted the following policies, if you have any questions please discuss them with the office manager. We are dedicated to providing the best possible care for you and your family.

1.APPOINTMENTS - This office is an appointment only office. You need to schedule an appointment in order to see the physician. If you arrive earlier you will only be seen sooner if there is an opening. **NO WALK INS ALLOWED.**
NEW PATIENTS -Confirmation is required no later than 24 hours before the appointment to avoid cancellation.
2.PAYMENT FOR SERVICE - Unless other arrangements have been made in advance, we require payment at the time of service. We accept cash, checks, and Visa or MasterCard credit cards only.
3. INSURANCE - We have made prior arrangements with many health plans to accept an assignment of benefits. This means we will bill those plans with which we are contracted.
4. THIRD PARTY INS . - We do not accept third party insurance (i.e. automobile insurance- if involved in an auto accident, or Letter of Protection- payment directly from a law office). If you are involved in any of these cases, you will be required to pay the office visit in full, and be reimbursed by your third party.
5. MINORS - All minors must be accompanied by an adult over 18 years old. For all services rendered to minor patients, the adult accompanying the patient will be held responsible for payment, unless prior arrangements have been made.
6. NO-SHOWS - In order to ensure that all appointments available are being used, we do charge a **$50.00** fee for **"NO SHOWS"** and/or APPOINTMENTS that are NOT canceled 24 HOURS prior to the scheduled appointment time. Acquiring (3) NO SHOWS may result in termination from the practice.
7. PRESCRIPTIONS - If you require a refill on your medications, please call your pharmacy, they will contact us. The providers write your prescriptions with enough refills to last until you are due for follow up. If you are out of refills, you may be due for a follow up. The only exception is if you require a triplicate prescription. All controlled medications require a current Toxicology Screen. Please allow 48-72 hours for refills so we may review your chart. **PAPER PRESCRIPTIONS** - will only be written if required by the DEA. Otherwise, there will be a $5 charge if not necessary.
8. REFERRALS - All HMOs require a referral by your PCP, if you need to see a specialist. Please allow up to 72 hours, depending on your insurance plan, to process the referral.
9. FMLA - Family Leave and Disability Forms, Sports/Work Physical Forms and/or any professional Letters, will require a $40.00 administration fee, and is paid up front. These are not covered by your insurance company. Please allow 7-10 business days for completion after your payment.
10. MEDICAL RECORDS - If you would like copies of your medical records(electronic or paper) a fee will apply.
As a courtesy, there is no charge for transferring your medical records directly to another physician's office for continuity of care.
11. AFTER HOUR CARE - If you require medical care after office hours, simply call our office and you will be forwarded to an answering service. Depending on the situation, the Dr. will be paged. You will always have access to your Doctor.
12. LATE APPOINTMENTS - If you arrive later than 15 minutes after your scheduled appointment, you will be asked to reschedule.
13. RIGHT TO REFUSE SERVICE - Verbal abuse to any of our doctors or staff will not be tolerated. Foul language and or aggressiveness will lead to immediate termination of your patient/doctor relationship and our right to refuse service to you.

I have read and understand the office policies.

_____ _____

Patient/Guardian Signature Date

Office use only: Initial of Employee: _____ Date: _____

Release Of Medical Information

I, _____, date of birth _____ hereby give permission to **PCC of Texas** to release any or all of my medical information, including AIDS/HIV, mental health, and alcohol/drug related issues to:

Name: **Relationship:**

1._____

2._____

3._____

4._____

Check all that apply:

□ Progress Notes as requested
□ Labs and X-rays
□ Correspondence
□ Personal Demographics
□ Diagnosis
□ Other Information_____

_____ _____

Patient/Guardian Signature **Date**

PHYSICIAN CARE CENTERS

Patient Health Questionnaire-9 (PHQ-9)

Name: _____ Date of Birth: _____ Date: _____

	Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" 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 your 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

FOR OFFICE CODING __0___ + _____ + _____ + _____

=Total Score: _____

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	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

0	No depression	10-14	Moderate depression
1-4	Minimal depression	15-19	Mod - Severe depression
5-9	Mild depression	20-27	Severe depression

PHYSICIAN CARE CENTERS

Patient Name:_____
Date of Birth: _____
Phone: _____
Date: _____
Doctor: _____

Cognitive Assessment Form

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Sensation of not feeling right, being a little confused or unsteady?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Spells you would describe as feeling faint or as if you might pass out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Events where you've experienced altered awareness?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Episodes of temporary confusion or brain fog?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness accompanied by loss of awareness or confusion?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty finding the right words or expressing yourself?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Lapse of time or zoning out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty recalling the details of conversations you just had or TV shows you just watched?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

Are you experiencing migraines associated with the following symptoms?

• Aura or flashing/shimmering lights, zigzagging lines, or stars	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Loss of awareness/consciousness	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Nausea	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Do you have history of:

• TBI (Traumatic Brain Injury)	☐ Yes	☐ No
• TIA (Transient Ischemic Attack/ Mini-Stroke)	☐ Yes	☐ No
• Brain concussion or Post-concussion Syndrome	☐ Yes	☐ No
• Dementia	☐ Yes	☐ No
• Stroke	☐ Yes	☐ No
• Brain injury, surgery, or tumors	☐ Yes	☐ No

Physician/ Office Use Only:

Notes: _____

_____

Onset: _____

_____

Patient Signature: _____ Date:_____

PHYSICIAN CARE CENTERS

Neuropathy Screening

Patient Name: _____ DOB: _____ Date: _____

Please take a few minutes to answer the following questions about your legs, and feet. Please check yes or no on how you usually feel.

	YES	NO
1. Are your legs and/or feet numb?		
2. Have you ever had burning sensation in your legs and/or feet?		
3. Are your feet sensitive to touch?		
4. Do you get muscle cramps in your legs and/or feet?		
5. Does it hurt when the bed covers touch your skin?		
6. Do you have difficulty telling the hot water from the cold water when showering/bathing?		
7. Have you ever had an open sore on your foot, not due to injury?		
8. Do you ever feel prickling on your legs and/or feet?		
9. Have you ever been told you have neuropathy?		
10. Do you feel leg/foot weakness and/or fatigue?		
11. Are your symptoms worse at night?		
12. Do your legs hurt when you walk?		
13. Are you unable to sense (feel) your feet when you walk?		
14. Is the skin on your feet so dry that it cracks open?		
15. Have you ever had an amputation?		
16. Have you ever been treated for neuropathy? If yes: What treatment have you had?_____ _____		
17. Do any, or all, of your symptoms as stated above effect your ability to work, exercise, or sleep?		

OPERATIONS: *List and indicate approximate year*		
Year	Reason	
HOSPITALIZATIONS: *Other than operations, especially in the last year*		
Year	Reason	
SERIOUS INJURIES: *Other than above*		

MEDICATIONS: (*Check if take any of the following*)					
Asthma wheezing medication	☐	Insulin or Diabetic pills	☐	Weight-reducing pills	☐
Aspirin, Bufferin, Anacin, Tylenol or other	☐	Anemia medicine	☐	Blood thinners or Coumadin	☐
Blood Pressure Pills	☐	Laxatives	☐	Dilantin	☐
Cortisone, Prednisone	☐	Motrin, Advil, Ibuprofen	☐	Diuretics, water pills	☐
Cough Medicine	☐	Sleeping Pills, Tranquilizer	☐	Antibiotics	☐
Digitalis or Heart Medicine	☐	Thyroid Medicine	☐	Phenobarbital/barbiturates	☐
Hormones	☐	Stomach/Digestive Medicine	☐	Vitamins	☐

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

PHYSICIAN CARE CENTERS

Authorization to Release Information

Patient Name: _____ DOB: _____ Phone: _____

Address:_____

I Authorize copies of my Medical Records to be released as stated below:

RELEASE RECORDS FROM:	RELEASE RECORDS TO: **PCC MEDICAL HOLDINGS**
Doctor/Office:	PCC Location:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone:	Phone:
Fax:	Fax:

A.) I authorize release of information for:

_____ Medical Care *(physicians, etc.)* _____ Personal Use _____ Other: *(Attorney, Insurance, Employer, etc.)*

B.) I authorize release of my *(refer to **section C**, if applicable)* _____ Entire Medical Record

-OR-

Medical Records for the specific treatment dates from: _____ to _____

C.) I authorize release of the following **additional** portions of my medical record:
***(initial** beside each area to also be included in release)*

_____ Mental Health _____ Substance Abuse _____ HIV/AIDS _____ Communicable Disease

I understand that this authorization shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

Should my case require review by a governing agency or another medical professional actively involved _in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical professional for review.

_____ _____
Patient/legal representative Date

_____ _____
Relationship to Patient Witness Date

NOTICE: The information has been disclosed to you from records whose confidentiality bas been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization is NOT sufficient for this purpose.