Advantage Primary Care

Name: _____ DOB:_____

Male/Female (circle one)

Mailing Address:

_____

_____

Phone: _____ Work Phone: _____

Social Security Number: _____ Email Address:_____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Insurance Company: _____ ID Number: _____

How did you hear about us? _____

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE/IDENTIFICATION

Do you have any allergies to medications? If so, please list the medication and reaction:

_____

_____

_____

_____

Please list all
medications:_____

_____

_____

_____

Please list all prior surgeries:

_____

_____

_____

_____

Please list all medical diagnoses:

_____

_____

_____

_____

Please list any family medical history:

_____

_____

_____

_____

Authorization and Release

I authorize Advantage Primary Care to release to any third party payor any information including the diagnosis and the records of any treatement or examnation rendered to me or my child for its use in connection with determining a claim for payment or when arequired by a third party provider in the assissment, planning, and/or implementation of my care.

If a Medicare/Medicaid beneficiary, I certify that the information given by me in applying payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services any informaion needed for this or a related Medicare/Medicaid claim.

I authorize and request all insurance payments pertaining to treatment shall be assigned ot the physician, physicial assistant, or nurse practitioner treating me. I understand that my insurance carrier may pay less than the actual fees for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that all fees still pending with insurance carriers after 90 days will be my responsibility.

Financial Policy

Payment for services is due at the time services are rendered. We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company.

Consent for Treatment:

I consent freely and voluntarily to participate in the treatmnets that my be ordered by my Health Care Provider. I understand that I may withdraw my consent at any time.

Patient (Guarantor) Signature:_____

Date:_____

Name: **Date:**

Men Only:

When was your last PSA(Prostate) blood test, Month and Year?

Women Only:

When was your last Mammogram, month and year?

When was your last Pap Smear, month and year?

Are you 60 years or older, and had a bone density screening, month and year?

Both Men and Women:

Do you have a Living Will or Advanced Directives?

When was your last Flu Shot, Month and Year?

When was your last Colonoscopy or Colo Guard, Month and Year?

Have you had any falls this year?

When was your last blood work done?

Do you need refills on anything?

Do you need a new Lab Order?

Do you need Radiology Order?

Please list concerns for today, below:

Total Life

PHQ9 - PATIENT HEALTH QUESTIONNAIRE

Total Life's Fax: **1-866-393-9101**

Patient First Name: _____

Patient Last Name: _____

Date of Birth: _____

Doctor Name : Tracy Riddle

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half of the days	Nearly everyday
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

Column Totals: ( ) + ( ) + ( )

Result:

Depressive Severity

1-4	5-9	10-14	15-19	20-27
Minimal	Mild	Moderate	Moderately Severe	Severe

If you scored mild depression or higher, take the first step towards feeling better by calling **1-800-567-LIFE** or signing up at **www.totallife.com**

Health Screening

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		

Advantage Primary Care

Patient/Provider Contract

As our patient, we appreciate your trust, and we value your time. In an effort to keep scheduled appointments on time, we ask that you read and acknowledge our policies by initialing each term.

_____If I am more than 10 minutes late for my scheduled appointment, I will need to reschedule.

_____If I "No Show" more than three (3) appointments, I will be discharged from the practice.

_____ All co-payments or self-payments are due at the time of service and will be collected before the appointment unless other arrangements have been made in advance.

_____ All laboratory and radiology orders must be requested 24-48 hours in advance. We ask that you do not walk in to request orders as this disrupts the flow of patients.

_____ Please do not walk in to ask the nurse or provider questions. Please call to leave a message or schedule a time to speak to the nurse or provider.

_____ For routine non-narcotic medications, please allow 24-48 business hours for refills.

_____ For any narcotic or controlled medications, you will need an appointment at least every 3 months (possibly more frequently) as these are closely monitored. You will be required to leave a urine sample at least once yearly and possibly more frequently. Narcotic refills require at least one week's notice if appropriate. This is not a pain management clinic; you may be referred elsewhere if we cannot safely meet your needs and comply with licensure and certification in the state of Florida.

_____ Appointments are generally scheduled in 15 minute increments. To remain on schedule, you may be asked to schedule another appointment to properly evaluate multiple or complex health issues.

We close every day from 1pm-2pm for lunch. Doors will be unlocked at 1:55pm. Phones are not answered during lunch.

HIPAA Disclosure Authorization Form

Full name_____

Advantage Primary Care
20212 E. Pennsylvania Ave. Ste B
Dunnellon, FL 34432
Ph: (352) 484-0422 Fax: (352) 484-1430

I hereby authorize _____ to use or disclose my
(Discloser)

Protected health information related to Medical
(Type of information)

to_____ for the following purpose:
(Recipient)

_____

_____

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Date Signature of Individual or Representative

_____
Authority or Relationship to Individual, if Representative

ADVANTAGE PRIMARY CARE

20212 E. Pennsylvania Ave Suite B
Dunnellon, Florida 34432
Tel. 352-484-0422
Fax: 352-484-1430

Client's Name:_____
SS#:_____
DOB:_____

Before signing, Cross Out Any Part(s) That do(es) Not Apply

Consent for release of medical information

Florida law requires that information contained in medical records be held in strict confidence and not be released with or without you written authorization. The authorization you sign on this page will remain in effect until you request in writing that you authorization be withdrawn, which you may do at anytime. You have a right to receive a copy off this authorization upon request.

Authorization for release of medical information

I,_____ authorize_____
(Name of patient/legal representative) (Agency/indiv. In possession of record)
to release (**initial** by {a,b,c,d,e,f,g,h,i} any or all that apply):

✓ a. The general medical record created at the medical facility. Past year
____b. The following information from the medical or case management record:
_____
____c. Records obtained from the following providers:
_____
____d. STD records_____ e. TB records_____ f. HIV/AIDS records
____ g. Drug/alcohol treatment records _____ h. Psychiatric/psychological information
____ i. Adult and child abuse information

to: **Advantage Primary Care**
for the purpose of:_____

Date:_____ Signature of Patient/Legal Guardian:_____

Witness:_____ _____
(Legal Guardian's relationship to patient)

Dr. Phone:_____

Dr. Fax: _____

Dr. Address:_____