For Your First Visit With Us, Please….

- Arrive a minimum of 15 minutes before your scheduled appointment IF you have your paperwork completed, 30 minutes if NO paperwork
- Bring your Picture ID
- Bring your Health Insurance Card(s)
- Bring your prescriptions, supplements in their bottles
- Be prepared to pay your copay (if applicable), we accept cash, checks, and credit/debit cards

If you have any questions, please call the office in which you are scheduled prior to your appointment.

WELCOME TO ALL CARE MEDICAL CONSULTANTS
THINGS YOU NEED TO KNOW

Please initial Each selection :

1. ____ **Referrals/Authorizations can take up to 72 hours to 14 business day to submit to your insurance plan**. It is important that we are aware far enough in advance of any appointments you may have so that we can process your referral.

2. ____ **All Care Medical Consultants have their own network of specialists**. We have a great working relationship with a group of specialists that keep us informed of what is going on with our patients as well as participate at the same hospitals.

3. ____ **Follow up appointments**. Follow up appointments to specialists will be determined by your Primary Care Physician not the specialist.

4. ____ **Participating hospitals.** We participate with Largo Medical Center and Morton Plant Hospitals.

5. ____ **We have same day appointments available for emergencies and are always on call 24/7.**

6. ____ **Out of State.** If you are going out of state, please notify the office for any refills while you are gone.

2024 New Patient Registration Forms

(Please Print)

Today's date:	☐ **Clearwater** ☐ Palm Harbor ☐ **Seminole**

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle Initial:**	❑ **Mr.** ❑ **Mrs** ❑ **Ms.**	**Marital Status (circle one)** **Single/ Mar / Div / Sep / Wid**

Street Address:	**Social Security:**	**Birth Date:** / /	**Age:**	**Sex:** ❑ M ❑ F

City:	**State:**	**Zip Code:**	**Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ African American ☐ Other **Race** **Ethnicity:** ☐ Hispanic ☐ Not Hispanic

Primary Phone:	**Email (Patient Portal Access):**	**E-News Letter Opt –In:**
Alternate Phone:	**How did you hear about us?**	Yes, I wish to receive health information and upcoming event notifications through email from the office. **Initials**_____
Occupation: ☐ **Retired** ☐ **Student** ☐ **Disabled** ☐ **Employed**	☐ **Insurance Representative or Website** ☐ **Internet Search** ☐ **Social Media** ☐ **Other** ☐ **Personal Referral (Who can we thank)**	

Primary Insurance Company:_____

Policy Holder's Name:_____ **Policy Holder's DOB:**_____

Policy Holder's Relationship to Patient:_____ **Policy Holder's Employer:**_____

Secondary Insurance Company:_____

Policy Holder's Name:_____ **Policy Holder's DOB:**_____

Policy Holder's Relationship to Patient:_____ **Policy Holder's Employer:** _____

ADVANCED DIRECTIVES

Do you want to receive the following forms:

___Living Will_____Do Not Resuscitate (DNR)_____Health Care Surrogate ___ Decline
_____I have one (Please give copy to front desk for your chart)

_____ _____

Patient/Guardian signature ***Date***

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):_____

Relationship to Patient:_____ **Primary Phone:** _____

_____ _____

Patient/Guardian signature ***Date***

AUTHORIZATION FOR TREATMENT

I hereby request and consent to the services of All Care Medical Consultants, PA, including examination, treatment, and other procedures deemed appropriate from this date forward.

_____ _____

Patient/Guardian signature ***Date***

HEALTH HISTORY

CONFIDENTIAL

Patient Name:_____ **Today's Date:** _____

Chief Complaint(s):_____

MEDICATIONS List current medications and dosages				**ALLERGIES** To medications or substances with reaction.
NAME	**Mg/Mcg**	**Tab/Cap**	**Times a Day**	
				Pharmacy Name: _____
				Cross Streets:_____
				Phone:

MEDICAL CONDITIONS Check (✓) conditions you currently have or have had in the past.

CARDIAC
- ☐ AAA
- ☐ Angina/Chest Pain
- ☐ Arrhythmia
- ☐ Atherosclerosis
- ☐ Blood Pressure
  - ☐ Hypertension
  - ☐ Hypotension
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Pacemaker

CIRCULATORY
- ☐ Anemia
- ☐ Blood Clots
  - ☐ Deep Vein Thrombosis
  - ☐ Pulmonary Embolism
- ☐ Peripheral Artery Disease

ENDOCRINE
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
- ☐ Thyroid
  - ☐ Hypothyroid
  - ☐ Hyperthyroid
  - ☐ Goiter

GASTRIC
- ☐ GERD
- ☐ Barrett's Esophagus
- ☐ Hepatitis
  - ☐ A ☐ B ☐ C
- ☐ Liver Cirrhosis

MUSCULOSKELETAL
- ☐ Gout
- ☐ Arthritis
  - ☐Osteoarthritis
  - ☐Rheumatoid

NEPHROLOGY
- ☐ Kidney Disease
  - ☐ Acute
  - ☐ Chronic

NEUROLOGIC
- ☐ Epilepsy/Seizure Disorder
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Stroke
  - ☐ Full Recovery
  - ☐ Deficits

OPTHALMIC
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

PULMONARY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD/Emphysema

PSYCHIATRIC
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Schizophrenia
- ☐ Suicide Attempt

OTHER
- ☐ Cancer
- ☐ Chemical Dependency
  - ☐ Drugs_____
  - ☐ Alcohol
  - ☐ Narcotics
- ☐ HIV/AIDS positive
- ☐ Ulcers
  - ☐ Skin
  - ☐ Gastric
- ☐ _____
- ☐ _____
- ☐ _____

PREVENTATIVE SCREENINGS

Testing/Immunizations	Date	Result
Flu Shot *Date:* **Pneumonia** *Date:*	**Tuberculosis (TB)** *Date:*	**Tetanus** *Date:* **Shingles** *Date:*
Mammogram		
Eye Exam		
Colonoscopy		
Bone Density (DEXA)		
Pulmonary Function Test (PFT)		
Pap Smear		
Last Menstrual Cycle		☐Normal ☐Heavy ☐ Irregular

SURGICAL / HOSPITAL HISTORY

I have had no surgeries or hospital stays. ☐

Date (Mo/Yr)	Type of Surgery	Reason for Hospital Stay

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FAMILY HISTORY Check (☐) if, your blood relative had any of the following:

Member	Status (Deceased/ Alive)	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental	Cancer	Other
Father									
Mother									
Siblings									
Children									
Grand Father									
Grand Mother									

Please tell us how many siblings and/or children you have and if check (☐) they are healthy.

Siblings	Brothers	Sisters	☐ Healthy
Children	Sons	Daughters	☐ Healthy

Notes:

SOCIAL HISTORY Check (☐) all that apply.

Smoking:

Former Smoker ☐ Yes ☐ No

☐ < 1 month ☐ 1-3 months ☐ 3-6 months
☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ >10 years

Current Smoker ☐ Yes ☐ No

Type: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Vape

Frequency:

☐ Daily ☐ Weekly ☐ Other

Recreational Drug Use: ☐ Yes ☐ No

☐ Marijuana ☐ Cocaine ☐ Heroin/Narcotics
☐ Xanax ☐ Other_____

Alcohol Use: ☐ Yes ☐ No

☐ Occasional ☐ Daily ☐ # of drinks _____
☐ Beer ☐ Wine ☐ Liquor
☐ History of Alcoholism ☐ Active Alcoholism

Caffeine: ☐ Yes ☐ No

☐ Soda ☐ Coffee ☐ Tea

Frequency:

☐ Daily ☐ Weekly ☐ Other_____

Diet:

☐ Healthy diet rich in fresh vegetables and fruit

☐ Diabetic diet ☐ Low Fat ☐ Low Carbohydrate

☐ Kidney diet ☐ Low in Protein

☐ Low Salt ☐ Poor diet compliance

☐ Other_____

Exercise: ☐ Yes ☐ No

☐ Water Exercises ☐ Swimming ☐ Walking ☐ Jogging
☐ Weights ☐ Stretching/Yoga ☐ Recreation

Frequency:

☐ Weekly ☐ Daily ☐ Other_____
☐ Light activity some of the days.

Occupation:

☐ Retired ☐ Student ☐ Disabled-Reason_____

☐ Currently employed as_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____
Reviewed By — Date

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Patient Name: _____ **Date:** _____ **DOB:** _____

What is your current housing situation?

- ☐ I have housing
- ☐ I do not have housing
- ☐ I choose not to answer

What is your highest level of education you have finished?

- ☐ Less than a high school degree
- ☐ High School Diploma
- ☐ More than a High school Diploma
- ☐ I choose not to answer

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

How often do you see or talk to people you care about or feel close to:

- ☐ Less than once a week
- ☐ 1 to 2 times a week
- ☐ 3 to 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer

How stressed are you? Stress is when you feel tense, anxious or can't sleep at night because your mind is troubled:

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer

Social Determinants of health?

☐ **Yes** *If yes, please select any of these below*:

- ☐ **Problems related to education/ literacy**
- ☐ **Problems related to employment/ unemployment**
- ☐ **Occupational exposure to risk factors**
- ☐ **Problems related to physical environment**
- ☐ **Problems related to housing/economic circumstances**
- ☐ **Problems related to social environment**
- ☐ **Problems with upbringing**
- ☐ **Problems with primary support group, including family**

☐ **No**

Note: A "yes" answer means there are social determinants in one's life.
A "no" answer means there are NO social determinants in one's life.

- **<u>Social Determinants means</u>: Conditions in the places where peoplelive, Learn, work, and play that affect a wide range of health risks and outcomes.**
  - ***Available resources to meet daily needs**
  - ***Access to education, economic, and job opportunities**
  - ***Public safety, social support**
  - ***Exposure to crime, violence and social disorder**

***Socioeconomic conditions**

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Name:_____ **Date:**_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly everyday
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite of being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Total Score: _____

Interpretation

- ☐ **Minimal Depression**
- ☐ **Mild Depression**
- ☐ **Moderate Depression**
- ☐ **Moderately severe depression**
- ☐ **Severe Depression**

Interpretation of Total Score for Depression Severity

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

Alcohol and Drug Use, Abuse or Dependence Assessment Tool

Patient Name: _____ DOB:_____
Please list any controlled substance medications, street drugs or alcohol you take or consume, including marijuana.
_____
_____

1. The substance is often taken in larger amounts or over a longer period than was intended.	☐ **Yes** ☐ **No**
2. There is a persistent desire of unsuccessful efforts to cut down or control substance abuse.	☐ **Yes** ☐ **No**
3. A great deal of time is spent in activities necessary to obtain, use of recover from the substance effects.	☐ **Yes** ☐ **No**
4. The patient exhibits craving, or a strong desire or urge to use the substance.	☐ **Yes** ☐ **No**
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐ **Yes** ☐ **No**
6. Continued substance use despite having persistent or continued social or interpersonal problems caused or exacerbated by the effects of it.	☐ **Yes** ☐ **No**
7. Important social, occupational, or recreational activities are given up or reduced because of substance use.	☐ **Yes** ☐ **No**
8. Recurrent substance uses in situations which are physically hazardous.	☐ **Yes** ☐ **No**
9. Substance use is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by it.	☐ **Yes** ☐ **No**
10. Tolerance as defined by either of the following: • **A need for markedly increased amounts of the substance to achieve intoxication or desired effect.** • **A markedly diminished effect with continued use of the same amount of the substance.**	☐ **Yes** ☐ **No**
11. Withdrawal, as manifested by either of the following: • **The characteristic withdrawal syndrome for the substance.** • **The substance is taken to avoid the withdrawal symptoms.**	☐ **Yes** ☐ **No**

Please check any of the following boxes that are applicable to you:

☐ **Purposeful over-sedation**	☐ **Changed route of administration**	☐ **Contact with street drug culture**
☐ **Attempts to obtain scripts from multiple doctors**	☐ **Lost or stolen scripts.**	☐ **Abusing alcohol or illicit drugs**
☐ **Negative mood changes**	☐ **Uses pain meds. in response to stress.**	☐ **Insisting on certain meds. by name**
☐ **Involvement in car accident**	☐ **Arrested**	☐ **Requests frequent early renewals**
☐ **Increased dose without authorization**	☐ **Victim of abuse.**	
	☐ **Hoarding medication**	

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ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: _____ **Gender:** _____ **Date:** _____

Have you had a drink containing alcohol in the past year?

☐ Yes
☐ **No**

If 'Yes': How often did you have a drink containing alcohol in the past year?

☐ **Never (0 points)**
☐ **Monthly or less (1 point)**
☐ **Two to four times a month (2 points)**
☐ **Two to three times per week (3 points)**
☐ **Four or more times a week (4 points)**
☐ **Declined to specify (0 points)**

If 'Yes': How many drinks do you have on a typical day when you were drinking in the past year?

☐ **1 or 2 (0 points)**
☐ **3 or 4 (1 point)**
☐ **5 or 6 (2 points)**
☐ **7 to 9 (3 points)**
☐ **10 or more (4 points)**
☐ **Declined to specify (0 points)**

If 'Yes': How often did you have six or more drinks on one occasion in the past year?

☐ Never (0 **points)**
☐ **Less than monthly (1 point)**
☐ **Monthly (2 points)**
☐ **Weekly (3 points)**
☐ **Dally or almost daily (4 points)**
☐ Declined **to specify (0 points)**

Interpretation **Points:** _____

☐ **Positive**

☐ **Negative**

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- **In men, a score of 4 or more is considered positive.**
- **In women, a score of 3 or more is considered positive.**

HIPAA PRIVACY AUTHORIZATION FORM

****Authorization for Use or Disclosure of Protected Health Information**
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. AUTHORIZATION

_____I authorize All Care Medical Consultants, PA to use and disclose the protected health information described below to

_____
(Individual seeking the information)

_____I do not authorize All Care Medical Consultants, PA to use and disclose my protected health information to anyone other than a medical provider, insurance company or health care professional, for the purpose of continuing care.

2. EXTENT OF AUTHORIZATION

_____I authorize the release of my *complete* health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

_____I authorize the release of only specific information (please specify):_____

3. **This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.**

4. **This authorization shall be in force and in effect until I give *written* permission, at which time this authorization expires.**

5. **I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.**

6. **I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal privacy regulations.**

_____I request a copy of All Care Medical Consultants, PA, HIPAA Health Information Notice

_____
Signature of Patient or Personal Representative

_____ **Date** _____
Print Name of Patient or Personal Representative

CONSENT TO REVIEW PRESCRIPTION HISTORY

Medicare has mandated that all physicians' offices and pharmacies use an electronic system to prescribe medications and refill medications.

Surescripts is an electronic system used by pharmacies to request refills and new prescriptions from physicians' offices. We have implemented this into our practice and have found out that we need your consent in order to review your prescription history.

I,_____ understand that by signing this consent, I give All Care Medical Consultants, PA, permission to review my prescription history.

This is part of my medical record and will be treated according to HIPAA regulations.

_____
Print Name

_____ _____
Signature **Date**

PRESCRIPTION MEDICIATION POLICY

The practitioners and staff at All Care Medical Consultants value the relationship we have with our patients. We strive to do our best when it comes to making sure you receive proper treatment including your medications. It is important you are aware of our medication dispensing policies that will apply for *all* medication prescribed by our office.

- **Please bring all of your medications to each appointment**, especially if you are on multiple medications or have seen other doctors in the months or weeks prior to your last appointment with us. It is important for us to know all of the medicine you are taking at all times. Simply saying "it's the same as last time" is not enough since even the smallest change (as in dosage or frequency) is important for us to know.

- Understand that if you are receiving any medications from our office, **you will need to be seen by the physician or PA at least every 3-6 months.** Your visit frequency will depend on your diagnosis and is at the discretion of the physician. This is necessary for many reasons, but especially to assure the medication is working properly.

- For refills on r*outine* medications, call your pharmacy and notify them of your refill request. The pharmacy will contact our office for approval. Al**low 2 days (excluding weekends) for your refill to be processed! *Do not wait until your medication is out*!** Also note that medication refills will be processed during regular office hours only.

- For refills on any controlled substance/narcotic, it is our policy to ***not approve early refills*** **on controlled medications unless expressed permission is given by the doctor.** *Never* take any medication more frequently than it was prescribed. All patients are to sign a narcotics contract if they are receiving controlled substances from our practice. In that contract it states, "Medications lost or stolen will NOT be replaced. It is the sole responsibility of the patient to keep them in a safe place."

If you have any questions or need further clarification of this policy, please let us know.

By my signature below, I verify that I understand and agree to the above medication policy.

Printed Patient Name:_____DOB_____

Signature:_____Date _____

All Care Medical Consultants, PA Financial Policy

Thank you for choosing All Care Medical Consultants, PA as your health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. **Carefully review the following information and return this form to us with your signature and todays' date.**

INSURANCE:

It is the patient's responsibility to provide the office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We will occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. You are responsible for notifying us of any changes in your insurance coverage. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the clinic.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

CO-PAYS:

Co-payments are due at the time you check in at the front desk PRIOR to being seen by the Physician or Physician Extender. You will also be asked to make a payment on any balance you may have from previous services.

UN-PAID BALANCES:

We require that full payment be made at the time of service. If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. For balances over $50.00, payment arrangements can be made with our office. Acceptable payment arrangements require that the balance be paid within 3 to 6 months depending on balance. Any overdue balances may be considered for further collection activity if not paid. If your account is turned over to a Collection Agency you will be discharged from the practice. At that time a 30% agency fee will be added to your account balance. We accept cash, checks, money order, Visa, MasterCard, Discover and American Express.

RETURNED CHECKS:

The charge for a returned check is $25 payable by cash, money order or credit card. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a "Cash Only" basis following any returned check.

I authorize my insurance company to pay the Physician directly. I understand that I am financially responsible for any balance. I also authorize All Care Medical Consultants, PA, or my insurance company to release any information to process my claims.

I have read and agree with All Care Medical Consultants Financial Policy.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Patient/Responsible Party Signature Date

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with All Care Medical Consultants.

1) **Purpose and Benefits.** The purpose of this project is to use telemedicine to enable patients who are unable or unwilling to commute to the physician's office the opportunity to get medical care without the inconvenience and expense of traveling to the office.

2) **Nature of Telemedicine Consultation.** During the telemedicine consultation: a) Details of your medical history, examinations, x-rays, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. b) Physical examination may take place. c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission. d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal privacy rules also known as HIPAA as well as all applicable Florida State law apply to information disclosed during this telemedicine consultation.

5) **Risks and Consequences.** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact.

6) **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

7) **Financial Agreement.** This telemedicine consultation may be paid for by your insurance company if it is a covered benefit under your plan. We will submit a claim on your behalf and balance bill your for any share of cost above and beyond your copay amount. Your copay will be collected prior to services being rendered.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:_____ **Date:**_____

Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient:_____

Witness:_____ **Date:**_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To (*Physician, Practice or Hospital)*:

_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Fax:** _____

I HEREBY REQUEST THAT **ALL** OF MY MEDICAL RECORDS FROM THE LAST ***3*** YEARS

NO DISC

*In this request, "***ALL***" refers to:

- ☐ **Progress Notes – Last 2 notes**
- ☐ **Laboratory Test (Blood & Pathology)**
- ☐ **Hospital History and Physical(s)**
- ☐ **Discharge Summary Date:_____**
- ☐ **Diagnostic Imaging ;_____**
  (Ultrasounds, Echo's or other applicable imaging reports)
- ☐ **Advance Directives /Living Will**

Initial Each: **____Mental Health _____Communicable disease ___HIV/AID ____Alcohol or drug abuse treatment**

****If medical records exceed 100 pages, please mail****

This authorization shall be in force and in effect until I give ***written*** permission or twelve (12) months from signature, at which time this authorization expires unless otherwise specified below: Expiration Date: _____

Patient Signature: _____ Date: _____

Print Patient Name: _____

Witness: _____ Date: _____

SS#: _____D.O.B _____

www.Allcare4u.com

Seminole	**Clearwater**	**Palm Harbor**
8900 Park Blvd N Seminole FL 33777 **Phone**: 727-545-4545 **Fax:** 727-548-1360	1745 S Highland Ave Clearwater FL 33756 **Phone:** 727-587-0377 **FAX:** 727-587-0527	115 Florida Ave Palm Harbor FL 34683 **Phone:** 727-259-2300 **FAX:** 727-259-2305

Medical Records Request

Please list below specialist offices or Hospitals you've visited since your last office visit to retrieve records for continue of care.

Name of Physician/Location: _____

Address: _____ City, State and Zip Code: _____

Phone: _____ Fax: _____

Name of Physician/Location: _____

Address: _____ City, State and Zip Code: _____

Phone: _____ Fax: _____

Name of Physician/Location: _____

Address: _____ City, State and Zip Code: _____

Phone: _____ Fax: _____

Name of Physician/Location: _____

Address: _____ City, State and Zip Code: _____

Phone: _____ Fax: _____

Name of Physician/Location: _____

Address: _____ City, State and Zip Code: _____

Phone: _____ Fax: _____

Patient Signature: _____DOB:_____

Patient Name: (Print) _____

ALL CARE MEDICAL CONSULTANTS P.A.

Acknowledgement for Advanced Directives

Introduction: As a part of a person's right to self-determination, every adult may accept or refuse any recommended medical treatment. This is relatively easy when people are well and can speak. Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes at the time when many critical decisions need to be made.

During the time, important decisions about your medical care may have to be made. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. You can help your family and physicians by telling them, in advance, what you would want done in certain situations. This planning ahead for future healthcare decisions is known as an Advance Directive.

The Advanced Directives states your wishes regarding various types of medical treatment in several representative situations so that your desires can be respected. It comes into effect only if you become incompetent (unable to make decisions or express your wishes), and you can change it at any time until then. As long as you are competent, you should discuss your care directly with your physician. Before you fill out the Advanced Directive-Living Will, Healthcare Surrogate/or DNR form, you may want to talk to your family, friends, physician, lawyer or spiritual advisor. The Advanced Directives also lets you appoint someone to make medical decisions for you, if you should become unable to make your own; this is a proxy or durable power of attorney. Additionally, it contains a statement of your wishes concerning organ donation.

When you make your personal choices in the Directive, you may want to consider one question. Is there a condition or set of circumstances which could exist in which you would refuse efforts to prolong your life? The Directive describes situations and allows you to indicate which treatments you would or would not want if your physician recommended them. If a situation you are particularly concerned about is not included; you can make additional comments in the section provided.

As your Medical-Doctor, we need to know if you have executed an Advanced Medical Directive:

Yes_____ No _____ Decline_____

If yes, this Directive is in the form of:

_____A Living Will
_____A Durable Power of Attorney
_____A Health Care Surrogate
_____An Executor/Minister of your Estate

If you have executed an Advanced Directive in any of the above format and have not yet provided our office with a copy, could you please do so at your next visit?

_____
Please Print

_____ _____
Patient Signature Date

Living Will

Declaration made this_____day of_____, 20_____

I,_____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(Initial) I have a terminal condition, or

_____(Initial) I have an end-state condition, or

_____(Initial) I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the applications of such procedures would service only to artificially prolong the process of dying, and that I be permitted to die naturally with only the administration of medicine or the performance of any medical procedure deemed necessarily to provide me with comfort care or to alleviate pain.

It is my intension that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate the provisions of this declaration.

Name:_____/ _____
(Relationship)

Address: _____

Phone: _____

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Nutrition and Hydration

I do ( ) I do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

I do ( ) I do not ( ) desire to donate my organs.

Additional Instructions (optional):

_____

_____

_____
(Patient Signature)

_____ _____
(Witness) (Witness)

Address:_____ Address:_____

Phone:_____ Phone:_____

(At least one witness must be neither a spouse nor blood relative of the signatory.)

Designation of Health Care Surrogate

Name: _____
(Last) (First) (MI)

In the event that I have been determined by my physician to be incompetent/incapacitated (lack of ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including, but not limited to, the withholding, withdrawal, or continuation of life – prolonging procedures, I wish to designate as my decision maker (surrogate) to make health care decisions.

Name:_____/ _____
(Relationship)

Address: _____

Phone: _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name:_____/ _____
(Relationship)

Address: _____

Phone: _____

I fully understand that this designation will permit my decision maker to make all health care decisions on my behalf until I regain the ability to make healthcare decisions. The health care may also include if necessary the decisions to withhold, withdraw, or continue life prolonging procedures. My decision maker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or incompetency I may experience.

Nutrition and Hydration

I do ( ) I do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

Additional instructions (optional):

_____

_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they know who my surrogate is.

Name: _____

Name: _____

Name: _____

Patient Signature:_____Date: _____

Witnesses (required): 1. _____

2. _____

(At least one witness must be neither a spouse nor blood relative of the signatory)