



**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 Updated Registration Forms

(Please Print)

Today's date:		<input type="checkbox"/> Clearwater		<input type="checkbox"/> Palm Harbor		<input type="checkbox"/> Seminole		
PATIENT INFORMATION								
Patient's Last Name:		First:		Middle Initial:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs <input type="checkbox"/> Ms. Marital Status (circle one) Single/ Mar / Div / Sep / Wid		
Street Address:			Social Security:			Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City:	State:	Zip Code:	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> African American		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> OtherRace		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
Primary Phone:		Email (Patient Portal Access):			<u>E-News Letter Opt -In:</u> Yes, I wish to receive health information and upcoming event notifications through email from the office. Initials _____			
Alternate Phone:		How did you hear about us? <input type="checkbox"/> Insurance Representative or Website <input type="checkbox"/> InternetSearch <input type="checkbox"/> Social Media <input type="checkbox"/> Other <input type="checkbox"/> Personal Referral (Who can we thank)						
Occupation: <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Employed								
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



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.*

- **Social Determinants means: Conditions in the places where people live, 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 QUESTIONNAIRE (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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. There is a persistent desire of unsuccessful efforts to cut down or control substance abuse.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. A great deal of time is spent in activities necessary to obtain, use of recover from the substance effects.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The patient exhibits craving, or a strong desire or urge to use the substance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Continued substance use despite having persistent or continued social or interpersonal problems caused or exacerbated by the effects of it.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Important social, occupational, or recreational activities are given up or reduced because of substance use.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Recurrent substance uses in situations which are physically hazardous.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Tolerance as defined by either of the following: <ul style="list-style-type: none"> • 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. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Withdrawal, as manifested by either of the following: <ul style="list-style-type: none"> • The characteristic withdrawal syndrome for the substance. • The substance is taken to avoid the withdrawal symptoms. 	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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



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)
- Daily 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 MEDICATION 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 *routine* medications, call your pharmacy and notify them of your refill request. The pharmacy will contact our office for approval. **Allow 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 today's 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/AIDS ___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

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