New Smyrna Wellness Center

New Patient Intake

Welcome to New Smyrna Wellness Center. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs.

The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

Demographics

Patient Name: _____ Gender: _____ Date of Birth: _____/_____/_____

Name by which you preferred to be called: _____ Social Security Number: _____

Cell Phone: _____ Home Phone: _____ Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of spouse or significant other: _____

Insurance Information

Primary Plan Name: _____ Policy #: _____ Group #: _____

Secondary Plan Name: _____ Policy #: _____ Group #: _____

If policy is through an employer

Employer's name: _____ Phone #: _____

Subscriber's Information (*If Insurance Plan is not in your name*)

Relationship to contact: Spouse_____ Child _____ Other_____ Date of Birth: _____/_____/_____

Name: _____ Phone #: _____

Address: _____ Insured Id #: _____

Your Care Team

Primary Care Doctor: _____

Doctors that assist in your overall wellness: _____

_____

Emergency Contact

Contact's relationship to you: _____ Name: _____

Address: _____ Phone: _____

Preferred Communication Phone _____ Email _____ Patient Portal _____

Would you like to join our Patient Portal? Yes _____ (*If Yes, email address above is required)*
No _____

Your Preferred Local Pharmacy: _____ City: _____ State: _____

Your Preferred Mail Order Pharmacy: _____ City: _____ State: _____

How did you hear about New Smyrna Wellness Center? _____

Medical History (Please put a "C" for current or "P" for past)

Head		**Respiratory**		**Musculoskeletal**		**Endocrine**	
Trauma		Asthma		Arthritis		Goiter	
Eyes		Bronchitis		Gout		Hyperlipidemia	
Blindness		COPD		M/S injury		Hypothyroidism	
Cataracts		Pleuritis		**Skin**		Thyroid disease	
Glaucoma		Pneumonia		Dermatitis		Thyroiditis	
Glasses/contacts		**Gastrointestinal**		Mole(s)		Type I DM	
Ears		Cirrhosis		Psoriasis		Type II DM	
Hearing aids		GERD		Other skin condition(s)		**Heme/Onc**	
Nose/Sinuses		Gallbladder Disease		**Neurological**		Anemia	
Allergic Rhinitis		Heartburn		Epilepsy		Cancer	
Sinus infections		Hemorrhoids		Seizures			
Mouth/Throat/Teeth		Hepatitis		Severe headaches/migraines		**Infectious**	
Dentures		Hiatal Hernia		Stroke		HIV	
Cardiovascular		Jaundice		TIA		STDs	
Aneurysm		Ulcer		**Psychiatric**		Tuberculosis Diagnosis	
Angina		**Genitourinary**		Bipolar disorder		Tuberculosis Exposure	
DVT		Hernia		Depression		**Other**	
Dysrhythmia		Incontinence		Hallucinations, Delusions			
HTN		Nephrolithiasis		Suicidal ideation			
Murmur		Other Kidney Disease		Suicidal attempts			
Myocardial Infarction		STDs					
Other heart disease		UTI(s)					

Surgical History (*list all surgeries and/or hospitalizations with dates)*

_____

_____

Family History Adopted: Yes _____ No _____

Mother: Living _____ A*ny known health issues?* _____

Deceased _____ Cause of death*?* _____

Father: Living _____ *Any known health issues?* _____

Deceased _____ *Cause of death?* _____

Any other significant family history of genetic diseases, autoimmune disorders, or cancer?

_____

_____

Social History

Smoking Status: Never _____ Former _____ Current _____

IF Current, how many per day? _____ *How many years?* _____

IF Former, year you quit? _____ *How many years did you smoke?* _____

Alcohol Use: Never _____ Daily _____ Socially _____

IF Daily, how many drinks per day? _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

With whom do you live: (check all that apply)

Spouse _____ Partner _____ Parents _____ Friends _____ Children _____ Alone _____ Other _____

Women's Health History

Age at start of periods: _____ Age at end of periods: _____

Are you currently pregnant? Yes _____ No _____

Number of Pregnancies _____ Number of Abortions _____

Number of Deliveries _____ Number of Miscarriages _____

Allergies (Environmental, Food and Medications)

Allergen	Severity *(Severe, Moderate, Mild, Unknown)*	Reaction	Date of onset *(If known)*

Medications

Name	Dose	Frequency

Implantable Devices

Do you have any implantable devices? (Defibrillator, titanium plates, knee replacement)

Yes _____ No _____ *IF yes, is it Active or Inactive?* _____

Unique Device Identifier: _____

What are the main goals for your visit to our clinic today?

1) _____

2) _____

3) _____

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding.

Consent to Heath Care Services at and by New Smyrna Wellness Center (NSWC):
I am requesting that health care services be provided to me (or my minor child or the patient named below) at NSWC. I voluntarily consent to all medical treatment and health care-related services that the caregivers at NSWC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging and laboratory services, including HIV testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between NSWC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay NSWC for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below. Or, b. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay NSWC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below named patient), I hereby assign to NSWC all rights, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding NSWC's regular and customary charges for the health care services rendered. I authorize customary charges is available upon request. I consent to any request for review or appeal by NSWC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer.

Office visits, physical exams, and procedures must be billed accordingly, based on patient diagnosis and treatment. Physical exams are only billable through third party payors for when ONLY screening and counseling services are rendered. If a patient seeks treatment for a medical issue, medication refill, imaging review, initiation of a referral, or lab review, this falls under an "office visit". You may be subject to the terms of your Plan if you are seen for an "office visit", in addition to or in place of a Physical/Wellness Visit.

Notice of Privacy Practices: I have read the "Notice of Privacy Practices". All of my questions have been answered and I have the opportunity to have a copy of these Notices in the office or at www.newsmyrnawellness.com.

By signing below, I am indicating that I have reviewed and acknowledged and consent to the terms described above:

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____

Name of Patient (if signed by other Responsible Party): _____

New Smyrna Wellness Center

HIPAA Release Form

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

The Patient identified above hereby authorizes New Smyrna Wellness Center to release and disclose Patient's Protected Health Information as defined by HIPAA ("PHI") to the following person or organization ("Recipient"):

Recipient Name: _____ Relationship to patient: _____

This Authorization applies to the following PHI:

- ☐ All Records pertaining to: _____
- ☐ Other: _____

This disclosure of PHI <u>will not</u> include the following information <u>unless</u> the appropriate box is checked:

- ☐ Any records of treatment for drug and/or alcohol dependency or abuse.
- ☐ Any record of mental health treatment, psychological services, social services, including communications made to a social worker or psychologist.
- ☐ Any record of testing, care, treatment or research pertaining to HIV, AIDS or other communicable diseases.

I understand that (i) authorizing the disclosure of PHI to the Recipient is voluntary, (ii) this Authorization covers multiple requests for and disclosures of PHI and authorizes New Smyrna Wellness to make such disclosures, (iii) I may refuse to provide authorization for disclosure of PHI to the Recipient, and New Smyrna Wellness may not condition treatment, payment for services, or eligibility for benefits on whether I sign this Authorization, (iv) and disclosure of PHI carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal or state privacy rules, and (v) New Smyrna Wellness must provide a copy of this signed Authorization to me.

This Authorization may be revoked at any time in writing by providing a signed revocation to New Smyrna Wellness Center at 502 Palmetto St. New Smyrna Beach, FL 32168. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid. If not previously revoked, this Authorization shall expire one (1) year from date of the Patient's last visit to New Smyrna Wellness Center. For additional information on uses and disclosures of PHI by New Smyrna Wellness please refer to our Notice of Privacy Practices.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION PRIOR TO NEW SMYRNA WELLNESS CENTER'S DISCLOSURE OF THE PHI, NEW SMYRNA WELLNESS IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF FAILURE TO DISCLOSE ANY INFORMATION TO THE RECIPIENT AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT I WILL NOT HOLD NEW SMYRNA WELLNESS AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF MY REFUSAL TO PROVIDE THIS AUTHORIZATION, REVOKING THIS AUTHORIZATION, AND/OR IN CONNECTION WITH ANY DISCLOSURE OF PHI PURSUANT TO THIS AUTHORIZATION.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Medical Records Request

New Smyrna Wellness Center

Patient Name: ____ DOB: _____/____/_______

Address: ____ Phone: _____________________

The Patient identified above hereby authorizes and requests the following organization or person (the "Responder"):

Facility Name: ____ Phone: _________________________

Address: ____

to release and disclose the Patient's Protected Health Information as defined by HIPAA ("PHI") to (please select one):

New Smyrna Wellness Center
Ph: (386) 957-1854

- ☐ 502 Palmetto Street, New Smyrna Beach, FL 32168
- ☐ Fax: (386) 878-4967 (PREFERRED)

This Authorization applies to the following PHI:

- ✓ Last 6 months of office visits and/or most recent office visits
- ✓ Most recent Bone Density scan
- ✓ Most recent Mammogram
- ✓ Most recent Colonoscopy
- ✓ Most recent labs or labs within one year
- ✓ All imaging (X-rays, CT scans, MRI reports)
- ✓ Other: _____________________________

NOTICE

This authorization if for **full disclosure** of pertinent records, including Clinical Findings, Diagnosis, Treatment, Assessment, Recommendations for further care, Names of Health Care Personnel, and dates of Hospitalizations and Clinic Visits and photographic images.

If you **do not want** any information that may be related to Drug, Alcohol, Psychiatric Conditions, and/or Sexually Transmitted Diseases, including HIV/AIDS information released to the above individual/agency, indicate below what portions of the record you would like excluded. **EXCLUSIONS:** ____

Information about the person or organization Authorizing the disclosure of PHI, *if Other Than the Patient Listed Above*:

Name: ____ Relationship to Patient: ____________________

I understand that: (i) authorizing the disclosure of PHI to New Smyrna Wellness Center ("Practice") is voluntary, (ii) this Authorization covers multiple requests for and disclosures of PHI and authorizes Practice to make such requests and the Respondent to respond to such requests; (iii) I may refuse to provide authorization for disclosure of PHI to Practice, and Practice may not condition treatment, payment for services, or eligibility for benefits on whether I sign this Authorization; (iv) Practice, as a Covered Entity under HIPAA, is required to keep PHI private and secured; however, any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal or state privacy rules; and (v) Practice must provide me a copy of this signed Authorization.

This Authorization may be revoked at any time in writing by providing a signed revocation to the Responder's address listed above. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid. If not previously revoked, this Authorization shall expire one (1) year from the date of the Patient's last visit to Practice.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION, PRACTICE MAY NOT BE ABLE TO OBTAIN PHI FROM THE RESPONDENT, AND Practice IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF SAME AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT I WILL NOT HOLD PRACTICE AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF MY REFUSAL TO PROVIDE THIS AUTHORIZATION, REVOKING THIS AUTHORIZATION, AND/OR IN CONNECTION WITH ANY DISCLOSURE OF PHI PURSUANT TO THIS AUTHORIZATION.

Patient's Signature: ____ Date: _____/______/_____

Patient's Authorized Representative's Signature: ______________________________ Date: ______/______/______

Appointment Reminder Consent

☐ I _____ authorize New Smyrna Wellness Center to contact me by automated SMS Text Message, Voice Messaging, or email for appointment reminders. I understand that message and data rates may apply.

Please check your preferred contact method below & provide email or phone number:

☐ Email reminders and messaging

☐ SMS mobile text reminders and messaging

☐ Voice reminders and messaging

Cell phone:_____ Email:_____

I understand that text messages, voice messages and emails are not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed or intercepted by unauthorized third parties.

Information included in the text messages, voice messages and emails may include your first name, date/time of appointments, name of provider, and office phone number or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above and accept the risks explained and consent to receive text messages, voice messages, and/or emails via automated technology from the New Smyrna Wellness Center to the phone number or email I have provided.

I may opt out of receiving these communications at any time by calling the office at (386) 957-1854. Please allow 2-3 days for processing.

By signing below, I am indicating that I have reviewed, acknowledged, and consent to the terms displayed above:

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Name of Patient (If signed by other responsible party): _____

New Smyrna Wellness Center Policies and Procedures:

Welcome to New Smyrna Wellness Center! At NSWC, we have many highly skilled and trained providers. Every provider is held to the same gold standard of care and follows the same medical guidelines. The medical director also oversees the care of the entire clinic and all the patients. So, whether you see the doctor or a physician assistant, rest assured that you are getting the best care possible. NSWC has taken great care to hire providers with excellent track records in the community, experience, and a positive attitude toward giving great patient care. This means that you will not see the physician on every visit. You will have the opportunity to meet and have a visit with one of our physician assistants. If you need to see the physician, please inform the front office staff. However, the physician is unable to see every patient for every visit. Thank you for your understanding.

Cancellation Policy: New Smyrna Wellness Center requires ***24 hours advanced notice*** for any cancellations and/or rescheduling of appointments.

- New patients: If you fail to contact us 24 hours prior to your **first** appointment, we will not be able to schedule any future appointments with our office. If you accumulate a total of three (3) rescheduled (24 hours advanced notice) appointments, you may not be rescheduled for future appointments and you may be discharged from the practice
- Established patients: If you fail to contact us 24 hours prior to your appointment, you will be subject to a cancellation fee of $50 or the amount of your copay per the guidelines of your in-network contract. If you accumulate a total of three (3) missed and/or canceled/rescheduled appointments, you may not be rescheduled for future appointments and you may be discharged from the practice.

Appointment Times: Please note that your said appointment time is not necessarily the exact time that you will be seen by a physician. Your appointment time is your arrival time so that the medical staff can properly prepare you for your visit. Late patients may need to be rescheduled for another time or date. While we make every effort to serve every patient in a timely manner, emergencies may arise, and some situations are more time consuming than anticipated. We ask for your understanding during extended wait times, and you will be given the same attention during your visit. Please be aware there is more than one provider in the office, therefore you may not be called back in the order of arrival time.

Lab/Biopsy/Imaging: Physicians and clinical providers may order diagnostic and screening imaging, labs, referrals and tests, which they deem medically necessary according to medical guidelines and current medical practices. Prior to your test, please contact the testing facility regarding any potential uncovered medical expenses or fees that may be associated with your test(s).

Patients are recommended to please follow the prescribing provider's plan of care regarding laboratory, biopsy, and imaging review follow-up visits. This is to ensure proper and consistent care in all patients. If you have questions or concerns about a result or have not heard from our office regarding your test(s), you are encouraged to call our office and/or make an appointment, 386-957-1854.

Prescription Refill Requests: If you need medication refills, please call the office and press Ext 314 to speak to our Prescription Refill Specialist at least one week before you need a refill (2 weeks for a mail order refill). Our office has up to 72 business hours to respond to refill requests. Please do not rely on the pharmacy to initiate the refill request. Multiple phone calls and messages to the office will only delay your request. Patients must have up to date labs and a recent office visit for medication refills.

Miscellaneous: Please refrain from wearing any perfumes, colognes, or heavily scented lotions to the office, as these may exacerbate or worsen some of our patient's underlying conditions.

Authorization Fees: Prior Authorizations: Some insurance companies require "prior authorizations" on certain medications. These are typically medications that are not on the insurance company's formulary. If a medication is not covered, a patient can: a.) pay for the prescription without using their insurance. b.) ask their insurance company what alternative is covered. c.) a patient may pursue prior authorization. Alternatively, if a patient would like our office to do the P.A. for them, we send documentation, office notes, labs, imaging, etc. to your insurance company. We also must speak to them on the phone at length. The

process takes 20-40 minutes, or longer per medication. It is very time-consuming for our staff. We are happy to assist you with this. Our fee for this service is $25.

Urine Drug Screen (UDS) Per the CDC and DEA recommended guidelines, all patients on controlled substances are subject to urine drug screening prior to a prescription being written and while on therapy. We apologize for any inconvenience. Thank you for helping NSWC remain compliant with State and Federal regulations. To help expedite your visits to NSWC, please drink plenty of liquids prior to your arrival to the office and be prepared to give a urine sample at your appointment. If a patient is unable to give a urine sample at their appointment time, they will be rescheduled for a later date when they can give a urine sample.

Patient Portal: With our secure online patient portal, PATIENT FUSION, patients get instant access to their personal health record (PHR), including diagnosis, medication, immunizations, and procedure history. With our EHR patient engagement software, patients are also able to request prescription refills, email their physicians, and access their health information at any time.

Automated Appointment Confirmations: Due to the large volume of daily appointments and other duties, staff are unable to call patients personally for every appointment. Patients have the option to receive their automated appointment reminder via email, text, and/or voice message. Please inform the front office staff using the consent form indicating your reminder preference.

By signing below, I am indicating that I have reviewed and acknowledged and consent to the terms described above:

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____

Name of Patient (if signed by other Responsible Party): _____