





Preparing for your new patient appointment:

-  Complete all new patient forms.
-  Gather and bring any relevant reports, labs, records, and a list of your current medications along with the new patient forms.
-  Bring your insurance card(s) and photo I.D. Please be aware that your copayment, coinsurance, or deductible is due at the time of service.
-  Please arrive 30 minutes early for your new patient appointment.

Thank you for choosing Allergy, Asthma, and Immunology.

We look forward to seeing you soon!

Please complete as accurately and thoroughly as possible. Relate all answers to your own experiences.

Patient's Name: _____ Preferred or nick name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Email: _____

Parents' names if patient is a minor: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

INSURANCE INFORMATION

Name of primary coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber name: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

Certificate Number: _____ Group Number: _____

Name of Secondary Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

Certificate Number: _____ Group Number: _____

Primary Care Doctor / Pediatrician: _____ Phone: _____

Address: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____

How did you hear about us? _____

If referred, who referred you? _____

Describe the reason for your visit:

List the name and dates of all medications you have tried for the above symptoms:

List all chronic medical conditions:

List all surgeries with approximate dates:

List any drug allergies with type of reaction:

List all daily and as-needed medications you are currently taking/prescribed with dose and frequency (include over-the-counter medications, inhalers, nasal sprays, eye drops, creams/ointments, epinephrine, etc.):

Medication:

Dose:

Frequency:

Social History

Occupation: _____ Employer: _____
Marital Status: _____ Hobbies: _____
Are you a smoker? Never Current, everyday Current, some days Former smoker(what year did you quit?)
If you are a current or former smoker, how many packs per day: _____ For how many years: _____
Do you use: any other tobacco marijuana illicit drugs (if either of these, describe)?
Do you drink alcohol (if so, what kind and how much): _____

Social History

House Type: Apartment House Mobile Home Condo Dorm **Approx age of home:** _____
Heating: Electric Gas Fireplace None **Air Conditioning:** Central Window None
Mattress: Air Bed Foam Spring Water Bed **Pillow:** Feather Fiberfill Foam Other
Flooring in Bedroom: Carpet Hardwood Tile Linoleum **Do you use a humidifier:** Yes No
How many of what type of pets do you have: None Dogs: _____ Cats: _____ Birds: _____ Chickens: _____ Horses: _____
How many smokers live in the household?: _____ **Do they smoke inside the house?** Yes No
When are your symptoms worse: Spring Summer Fall Winter All year long
If asthmatic, do any of these trigger your symptoms: Cold Heat Exercise Strong Scents Illnesses
If asthmatic, please check the box to answer the following questions (Check only 1 box for each question):
A. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school, or at home?
All of the time Most of the time Some of the time A little of the time None of the time
B. During the past 4 weeks, how often have you had shortness of breath?
More than once a day Once a day Three to six times a week Once or twice a week Not at all
C. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?
Four or more nights a week Two to three nights a week Once a week Once or twice Not at all
D. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)
Three or more times per day One or two times per day Two or three times per day Once a week or less Not at all.
E. How would you rate your asthma control during the past 4 weeks?
Not controlled at all Poorly controlled Somewhat controlled Well controlled Completely controlled
Are there any other allergy, asthma or immunology concerns you have today?

Family History

Illness/Complaint **Father** **Mother** **Brother(s)** **Sister(s)** **Son(s)** **Daughter(s)** **Grandparent(s)**

Asthma

Environmental Allergy

Food Allergy

Eczema

Hives

If anyone in your family have had the following, please indicate which family member:

Diabetes:

Heart disease:

Cancer (What kind?):

High Cholesterol:

High blood pressure:

Autoimmune disease:

Other Pertinent Family History:

Review of Systems: Please check problems you have had recently (within 6-12 months)

Constitutional: Fever Fatigue Weight loss (unintended) Weight Gain

Eyes: Itching Redness Watering Dryness Pain Loss of Vision

ENT: Congestion Runny Nose Post Nasal Drip Nosebleeds Sore Throat Hoarseness
 Snoring Itching Ringing in Ears Ear Popping Hearing Loss Smell/Taste Changes

Cardiovascular: Chest Pain Palpitations Swelling of Ankles

Respiratory: Cough Wheeze Shortness of Breath Chest Tightness

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Abdominal Pain Bloating Reflux

Genitourinary: Difficulty with Urination Frequent Urination Incontinence

Musculoskeletal: Joint Pain Muscle Pain Weakness

Skin: Itching Rash Hives

Neurologic:: Headaches Numbness Tremor Difficulty Sleeping Dizziness

Psychiatric: Anxiety Depression

Endocrine: Thyroid Disease Diabetes

Hematologic/Lymphatic: Anemia Easy Bleeding Easy Bruising Swollen Lymph Nodes

Allergic/Immunologic: Frequent/Persistent Infections History of Anaphylaxis (to what?)

PLACE LABEL OR PRINT PATIENT INFORMATION BELOW



MCC No.: _____
Patient First Name: _____
Patient Last Name: _____
Patient DOB: _____
Date of Service: _____

PATIENT INSURANCE ASSIGNMENT & RESPONSIBILITIES ACKNOWLEDGEMENT

Please read and initial each section and sign acknowledgement below:

Consent to Treatment: I consent to care, treatment, testing, and all other services performed by healthcare providers at Medical Center Clinic. I understand that I have the right to refuse any proposed care, treatment, testing, surgery, or other procedure. I understand that I have the right to ask questions and discuss my care with my healthcare provider. **Initials of Patient or Legal Representative:** _____.

Lifetime Insurance Assignment: I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

West Florida Medical Center Clinic, P.A.
8333 North Davis Highway
Pensacola, FL 32514

for all medical, surgical, and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MCC and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to MCC. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) MCC accepts Medicare assignment and Medicare payments will be directed to MCC and 2) Medical Center Clinic does not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim and any account balance not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures. **Initials of Patient or Legal Representative:** _____.

Patient Financial Responsibility Policy: Co-payments, deductibles, co-insurance, and all other appropriate payment will be due at time services are rendered. Insurance companies require physician offices to collect all applicable patient portions prior to services being rendered. **Initials of Patient or Legal Representative:** _____.

Tobacco-Free Campus: Use or sale of tobacco products (cigarettes, including electronic; cigars; pipes; and smokeless tobacco) is prohibited on all Medical Center Clinic premises, campuses, parking lots and grounds. **Initials of Patient or Legal Representative:** _____.

I acknowledge and understand the above notices and assignments and will comply with all specified responsibilities.

Signature of Patient or Legal Representative

Date

Notice of Health Information Privacy Practices

Effective September 23, 2013



This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Thank you for choosing the Medical Center Clinic for your healthcare needs. Each time you visit one of our providers, we create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of your records of your care received by a provider at Medical Center Clinic and explains how we may use and disclose your health information as well as your rights regarding the health information we maintain about you.

We are required by law to make sure that health information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this Notice at any time.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

Treatment: We will use and disclose your health information to provide medical treatment to you, and to coordinate or manage your health care related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose your health information when you need a prescription, lab work, an x-ray or other health care services. Also, we may use and disclose your health information when referring you to another health care provider.

Payment: We may use and disclose your health information to bill and receive payment. For example: A bill may be sent to you or your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Operations: We may use and disclose health information about you for health care operations. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including compliance program activities and business planning.

Business Associates: We may disclose your health information to our Business Associates to carry out treatment, payment or health care operations. For example, we may disclose health information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the services we provide.

Appointment Reminders, Treatment Alternatives or Health-Related Services: We may contact you to provide appointment reminders, tell you about health-related services, to recommend possible treatment options or alternatives that may be of interest to you.

Research: We may use and disclose information to researchers or to collect information in databases used for research. Research projects are reviewed and approved by a Review Board to protect the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Military and Veterans: If you are a member of the armed forces, or separated or discharged from the military services, we may disclose your health information as required by national military command authorities or the Department of Veterans Affairs.

Public Health: We may disclose your health information to a public health authority that is permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary to provide you with healthcare; to protect your health and

Medical Center Clinic

Notice of Health Information Privacy Practices

Effective September 23, 2013

safety or the health and safety of other individuals; or for the safety and security of the correctional institution.

Law Enforcement: We may disclose health information in response to a valid subpoena, warrant, summons or similar process. We may also release information for purposes of locating a suspect, a fugitive, a material witness, or missing person.

Health Oversight Activities: Federal law makes provisions for your health information to be released to an appropriate health oversight agency for activities such as audits, investigations, and inspections. This includes government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and the civil rights laws.

SPECIAL CIRCUMSTANCES

Florida Privacy Laws: Health information related to substance abuse, mental health, or sexually transmissible diseases have special privacy protections in Florida. We will not disclose health information relating to substance abuse, mental health, or sexually transmissible disease unless: 1) the patient consents in writing, or 2) a court order requires disclosure of the information, or 3) medical personnel need information to meet a medical emergency, or 4) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits or program evaluation, or 5) it is necessary to report a crime or a threat to commit a crime, or 6) to report abuse or neglect as required by law.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or law that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights with respect to your health information:

Right to Inspect and Copy Your Health Information: You have the right to see and obtain copies of health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

Right to Amend: If you think that health information we have about you is incorrect or incomplete, you may ask us to correct or add to the information, but we are not required to agree to the requested amendments.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your protected health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment or health care operations, but we are not required to agree to the requested restrictions.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to your health plan for purposes of carrying out payment or your health plan's operations; and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to Breach Notification: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to Obtain a Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice, or believe that your privacy rights have been violated, please contact Sharon Hoyle, CHC, CHPC, CPC, Corporate Compliance and Privacy Officer toll free at 1-866-822-3571, by e-mail at privacy.officer@medicalcenterclinic.com, or by U.S. Mail at:

Medical Center Clinic
Attn: Sharon Hoyle, Corporate Compliance and Privacy Officer
8333 N. Davis Hwy
Pensacola, FL 32514

You have the right to file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

PLACE LABEL OR PRINT PATIENT INFORMATION BELOW

MCC No.: _____
Patient First Name: _____
Patient Last Name: _____
Patient DOB: _____
Date of Service: _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Thank you for choosing Medical Center Clinic for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"). To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

Patient Signature

Date of Signature

PERSONAL REPRESENTATIVE

Complete this section ONLY if you are signing this Notice of Privacy Practices as the patient's personal representative i.e., parent of minor child, power of attorney, health care surrogate, legal guardian.

Personal Representative (Print Name)

Personal Representative Signature

Date of Signature

OFFICE USE ONLY

A good faith attempt was made to obtain the patient's written acknowledgement of receipt of MCC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual declined to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (please describe below)

Employee Name (please print)

Date