Downtown office
1040 SW 2nd Avenue Ocala, FL 34471
Phone: (352) 732-3005
Fax: (352) 732-9828

Ocala West office
10230 SW 86th circle, Ocala FL 34481
Phone: (352) 861-6633
Fax: (352) 873-3050

NEW PATIENT INFORMATION

NAME:	**REFERRING PHYSICIAN OR HOSPITAL:**
DATE OF BIRTH:	
ADDRESS:	**EMPLOYER'S NAME/PHONE NUMBER:**
RACE: **REFUSED: _____**	**ETHNICITY:** **REFUSED: _____**
PRIMARY PHONE#:	**SECONDARY PHONE #:**
SOCIAL SECURITY NUMBER:	
INSURANCE: **MEMBER ID#:**	**SECONDARY INSURANCE:** **MEMBER ID #:**

POLICYHOLDER INFORMATION

PRIMARY POLICYHOLDER NAME (IF OTHER THAN PATIENT):
POLICYHOLDER DATE OF BIRTH:
POLICYHOLDER EMPLOYER:
RELATIONSHIP TO PATIENT:

I attest that the above information is true to the best of my knowledge and belief.

Signature:_____ Date:_____

FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENTS FOR SERVICE ARE DUE AT CHECK IN.
We accept cash, personal checks, Mastercard, Visa, and Visa debit. Returned checks less than $50 and $300 have a fee of $30. For checks greater than $300, the fee is $40. You will also lose your privilege to write checks in our office.

We must emphasize that as your medical providers, our relationship and concern is with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. On any balance on your account over 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

FINANCIAL AGREEMENT- We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
- Not all services are a covered benefit in all contracts, some insurance companies arbitrarily select certain services they will not cover (ex. Yearly physicals)

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and I understand the above financial policy.

Signature: _____ Date:_____

AUTHORIZED REPRESENTATIVE FORM

This form is used to confirm a Patient's permission that Marion Heart Center, P.A. and Physician Associates, P.A. may discuss or disclose their protected health information to a particular person who acts as their authorized representative. Use of their information is strictly limited to that purpose described above.

Section A: Patient information (This form is two parts.)

By signing this form in section E below, I understand and agree Marion Heart Center, P.A. and Physician Associates, P.A. may release my personal health information as defined in section C below.

Patient name: _____ Date of birth: _____

Please note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative or if you want to set up a living will, please discuss this with your primary care physician or your attorney. Also, we promise that we will not condition treatment on the execution of this form.

Section B: Type of information

Personal health information including, but not limited to, billing information, diagnosis, procedures, demographic information (but not including any psychotherapy notes)

Section C: Authorized use and/or Disclosure

Intended Use or Disclosure: I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health care. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my information without my authorization. I acknowledge that my authorization is voluntary.

Authorized representative #1	Authorized representative #2
Name:	Name:
Phone#:	Phone#:
Address:	Address:
Relationship to you:	Relationship to you:

NOTICE RECEIPT ACKNOWLEDGEMENT

This form is used to confirm that an individual has received Marion Heart Center, P.A./Marion Physician Associates, P.A. Notice of Privacy Practices.

I, _____, acknowledge that I have received Marion Heart Center, P.A./Marion Physician Associates, P.A. Notice of Privacy Practices. I have had a full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: _____ Date _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal representative's name: _____

Relationship to individual: _____

Print patient name: _____

Address: _____

Telephone: _____ Patient telephone: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Phone: (352) 732-3005
Fax: (352) 732-9828

I hereby authorize Marion Heart Center, P.A./Marion Physician Associates, P.A. to

- o Release to
- o Obtain from

Name/organization: _____

Address: _____

_____

Telephone: _____ Fax: _____

Information to be disclosed (check selection)
_____ General medical records
_____ History and physical results
_____ Progress notes
_____ Diagnostic test reports (specify type of test) _____
_____ Other (specify) _____

I specifically consent to release information relating to: (check selection)
_____ STD _____ HIV/AIDS _____ DRUG/ALCOHOL _____ MENTAL HEALTH

PURPOSE OF DISCLOSURE:
_____ Continuity of care _____ Personal use _____ Other

EXPIRATION DATE: This authorization will expire on _____. I understand that if I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.
REDISCLOSURE: I understand that once the above information is disclosed, the recipient may re-disclose it and federal privacy laws or regulations may not protect the information.
REVOCATION: I understand that I must do so in writing and that I must present my revocation to front reception. I understand that the revocation will not apply to information that has already been released to this authorization. I understand that the revocation will not apply to my insurance.

Patient name: _____ Date of birth: _____

Address: _____

_____

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

PATIENT CONSENT TO RECEIVE MAIL AND/OR VOICEMAILS

Last name: _____ First name: _____ MI: _____

Date of birth: _____ Phone#: _____

We have permission to:

Send recall appointment to your home Y____ or N____

Leave the following information on your home answering machine/voicemail:

Appointment information Y____ N____
Billing information Y____ N____
Medical information Y____ N____

I give my permission to share appointment information with the person/persons named below:

_____

I give my permission to share medical information with the person/persons named below:

_____

I give my permission to share billing information with the person/persons named below:

_____

Signature of patient _____ Date _____

APPOINTMENT REMINDERS UPDATE

Patient name: _____ Date of birth: _____

Please provide us with your preference of notification you would like us to use to confirm your future appointments. Check the appropriate circle(s) that apply (you may choose more than one)

- o Email
- o Text
- o Cell
- o Home

Email address: _____

Text messages: _____

Cell phone: _____

Home phone: _____

Patient signature _____ Date _____

August 13, 2018

RE: Appointment Confirmation Policy

To our valued patients:

Our physician's time is very valuable to be able to give you the very best care provided.

We ask that you help us in achieving this universal goal. Please be advised of the needed policy below effective August 13, 2018.

All patients must confirm their appointments via prompted call, email, or by directly calling our office within 24 hours PRIOR to their appointment. If we do not receive a confirmation or cancelation from you, your appointment will be canceled and replaced with another patient. If you show up and not confirm your appointment, there is only a possibility that you will be worked into the schedule at the doctor's available time, if any.

If you are scheduled to see one of our physicians, or have any type of testing scheduled, you will be called 5 days prior to your appointment via automated call to the phone number we have on file for you. You MUST choose option #1 to confirm your appointment. You may also call our office directly at (352) 732-3005 or email our secure company patient email at clerical@marionpa.com to confirm or cancel your appointment. If there is no confirmation via automated system, a follow up call by one of our staff members will be made to insure you will be making your scheduled appointment.

Thank you for your assistance in this necessary improvement.

****By signing below you have read and understand this policy****

Name: (PLEASE PRINT)_____

DOB:_____

Date:_____

PAST/CURRENT MEDICAL HISTORY (Check box for any "yes" answer)

☐ Muscle problems	☐ Hearing problems	☐ Stroke
☐ Abnormal pap smear	☐ Allergic Rhinitis	☐ Anxiety
☐ Alcohol/Drug abuse	☐ Suicide attempt	☐ Blood clots
☐ Bipolar Disorder	☐ Obesity	☐ Sleep Apnea
☐ Carotid Artery Disease	☐ Congestive Heart Failure	☐ Chronic pain
☐ Chest pain	☐ Hepatitis or other liver disease	☐ High cholesterol
☐ CKD/Renal disease	☐ Colon polyps	☐ Diabetes
☐ Crohn's or Ulcerative Colitis	☐ Insomnia	☐ Low testosterone
☐ CVAD (Cerebral-Vascular Arterial Disease)	☐ Dementia or Alzheimer's	☐ Anemia, Blood problems
☐ Dizziness or fainting spells	☐ Excessive bleeding after surgery or dental work	☐ Hearing aid/ pacemaker/ artificial limb/ other physical apparatus
☐ Epilepsy, Seizures (convulsions)	☐ Pneumonia	☐ Malaria
☐ Erectile Dysfunction (ED)	☐ GERD/ Acid reflux	☐ Glaucoma
☐ Heart valve problems	☐ Arthritis	☐ Asthma
☐ Hip fracture	☐ HIV/AIDS	☐ Thyroid disorders
☐ Hypertension	☐ Depression	☐ Cancer
☐ Migraines	☐ Diabetic Neuropathy	☐ Other Neuropathy
☐ Paralysis/numbness/ tingling	☐ Atrial Fibrillation	☐ Attention Deficit Disorder (ADD)
☐ Prostate enlargement	☐ Chronic cough	☐ Tuberculosis or Positive TB test

Continued..

☐ Recurrent UTIs	☐ Kidney stones	☐ Rheumatoid arthritis
☐ Shortness of breath	☐ Hernia	☐ Diverticulitis
☐ Vitamin B12 deficiency	☐ Vitamin D deficiency	☐ TMJ

☐ Other:

PLEASE LIST ALL DOCTORS OR SPECIALISTS WHO ARE CURRENTLY TREATING YOU:

Provider's name	Specialty and/or Clinic name

Have you been hospitalized within the past year? (Please circle "yes" or "no")

YES or NO

If yes, please give details of your hospitalizations:

Hospital (Name and Location):	Reason for hospitalization:	Dates of stay:

Please list any major surgeries/operations you have had in the past:

Surgery/Operation	Date

Current medications: (Include all prescription, over-the-counter, vitamins, minerals, and herbal supplements)

Medication name	Dose(pill, ml, mg, etc):	Frequency and Route(1x/day by mouth):

Do you have any allergies? (Please circle "yes" or "no"): YES or NO

If yes, please check all that apply:

☐ Anesthesia	☐ Codeine	☐ Penicillin	☐ Iodine	☐ Food
☐ Latex	☐ Morphine	☐ Sulfa	☐ Aspirin	☐ Bee stings

Other Allergies:	Reaction:
1.	
2.	

Family History:
(Check "yes" to identify all illnesses/conditions in your blood relatives, and indicate relationship)

☐ Check here if adopted or unknown family history

Illness/Condition	Yes	Relation(mother, father, brother, sister, grandparent, etc.)
Heart Disease	☐	
High Cholesterol	☐	
Stroke	☐	
Cancer	☐	
Diabetes	☐	
High Blood Pressure	☐	
Alcoholism	☐	
Liver Disease	☐	
Depression or Psychiatric illness	☐	
Genetic disorder(inherited)	☐	
Other:	☐	

Mother: Living or deceased (circle one) If deceased, cause of death _____

Father: Living or deceased (circle one) If deceased, cause of death _____

Number of living children: _____ Number of births (women only): _____

Marital Status (please circle one): Single Married Divorced Widowed Domestic Partnership

Highest level of Education: _____

Occupation: _____ Retired: _____

Do you smoke? (cigarettes, cigars) Yes _____ No _____ Smokeless tobacco _____

If yes, how many packs per day? _____

Are you interested in quitting? _____

If you have quit, how long ago? _____

Do you drink alcohol? Yes _____ No _____

If yes, how often do you drink? _____

Are you interested in quitting? _____

Do family or friends worry about your alcohol intake? _____

Do you currently use recreational drugs, including prescription medications?

Yes _____ No _____

If yes, which drugs do you use? _____

_____

Have you ever had problems with drug use, including prescription medication?

Yes ____ No ____

If yes, have you received treatment? Yes ____ No ____

Activities of daily living: (Please indicate your current level for each activity)				
Bathing	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Dressing	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Grooming	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Oral care	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Toileting	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Transferring	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Walking	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Climbing stairs	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Eating	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Shopping	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Cooking	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Managing Medications	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Using the phone	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Housework	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Doing laundry	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Driving	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do
Managing Finances	☐ Independent	☐ Needs help	☐ Dependent	☐ Does not do

Considering your age, how much would you rate your overall health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

How is your hearing?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Hearing aids/Device _____

How is your vision?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Uses glasses
- ☐ Uses contacts
- ☐ Cataract (s)
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ DM Retinopathy
- ☐ Blind

When was your last eye exam? _____ Eye doctor _____

Vaccinations: (Please check the box for any vaccinations you have received and indicate the date received)		
Vaccine	**Received**	**Date Received**
Flu	☐	
Pneumococcal	☐	
Hepatitis B	☐	
Shingles	☐	
Tetanus	☐	

Are you worried about your memory? Yes____ No____

Do you have a living will or advance directive? Yes____ No____

If yes, please provide a copy for your health record.
If no, would you like information on creating one? Yes____ No____

Have you had a colonoscopy? Yes____ No____
If yes, date received: _____

Have you had a mammogram? Yes____ No____
If yes, date received: _____

Do you exercise? Yes____ No____
If yes, how often?_____

What form of exercise? _____

_____

Do you follow a special diet? Yes____ No____
If yes, specify: _____

Do you practice safe sex? Yes____ No____
If no, have you been tested for HIV/AIDS in the past year? Yes____ No____

Is violence at home a concern for you? Yes____ No____

Are you currently in a relationship? Yes____ No____

If yes, do you feel safe in this relationship? Yes____ No____

Have you fallen 2 or more times in the past 12 months? Yes____ No____

Have you been injured in a fall within the past 12 months? Yes____ No____

Yes____ No____ 1) Have you fallen before or been injured because of a fall?

Yes____ No____ 2) Do you feel weaker than you used to or have less strength in your arms or legs?

Yes____ No____ 3) Have you stopped doing daily activities or avoided exercise because you're afraid of falling?

Yes____ No____ 4) Do you feel unsteady on your feet or shuffle when you walk?

Yes____ No____ 5) Has your hand strength decreased?

Yes____ No____ 6) Has your eyesight diminished or do you have trouble seeing depth or seeing at night?

Yes____ No____ 7) Do you feel dizzy when you stand up?

Yes____ No____ 8) Have you experienced hearing loss?

Yes____ No____ 9) Do you have foot ulcers, bunions, hammertoes or calluses that hurt or cause you to adjust your steps?

Yes____ No____ 10) Do you experience incontinence? Bowel or Bladder? (circle one or both)

Yes____ No____ 11) Do you currently use a cane or walker or have you ever been told you should?

During the past two weeks, have you often been bothered by any of the following problems?

1) Feeling down, depressed, irritable or hopeless? Yes____ No____
2) Little interest or pleasure in doing things? Yes____ No____