Welcome to Nature Coast Health Care

We are privileged to be your choice for all your healthcare needs and look forward to making every experience a positive one. In this packet you will find important information regarding the practice and your upcoming appointment. Completing the enclosed packet beforehand will save time on appointment day, leaving you less to complete upon your arrival.

You can return the completed packet via:

- Email: info@naturecoasthealthcare.com
- Fax: (352) 260-0960
- Mail: 7562 W Gulf to Lake Hwy Crystal River FL 34429

Some of the questions may be hard to answer, however please complete as thoroughly as possible. If needed, ask a family member to assist.

Appointment Day

We ask that you arrive 30 minutes before your scheduled appointment if your new patient paperwork has been completed in advance. If you have not completed the enclosed paperwork, we ask that you arrive 1 hour before your scheduled appointment time. This will allow time for the staff to ensure your chart is complete for your visit. Remember to bring current insurance card and valid photo ID.
We value your time and will make every effort to ensure the scheduled appointment is timely, as not to create unnecessary wait times.

Driving directions are included as an insert of this packet. If you need assistance with transportation to your appointment, please call (352) 436-4328.

Thank you for selecting our office and we look forward to meeting you!

Sincerely,

Nature Coast Health Care

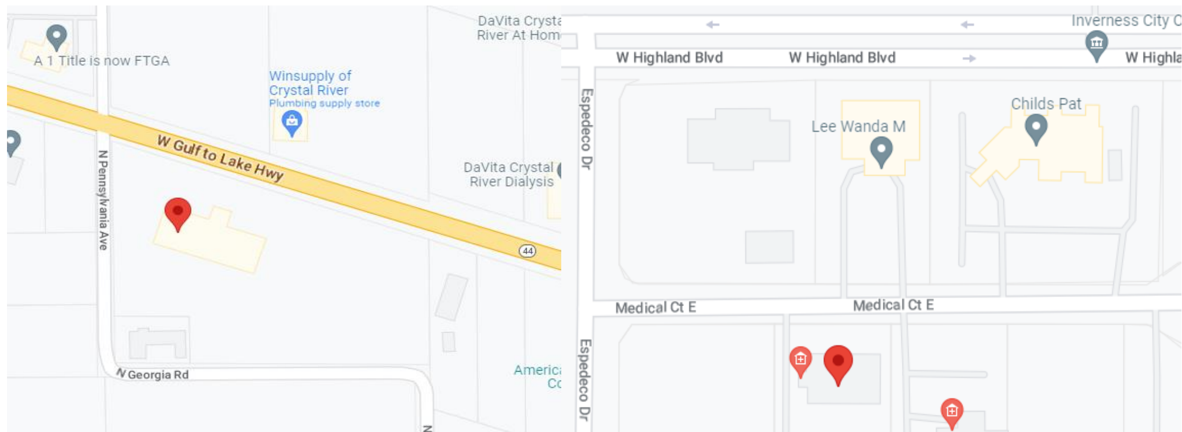
We offer 2 locations for your convenience; Please call us if you have a question regarding becoming a patient, appointment needs, medication(s), etc. The best way to become established is to call the office.

Office Locations & Hours: *The office is closed from 12-1 daily for lunch.*
Email info@naturecoasthealthcare.com

7562 W. Gulf to Lake Hwy., Crystal River, FL 34429
352-436-4328

821 Medical Ct E., Inverness, FL 34452
352-765-2577

Office Hours:
Monday- Friday: 8am – 5pm



After-hours urgent care is provided with immediate access, 24/7, for all patients, by calling any time (352) 436- 4328. The patient's urgent care telephone call will be immediately transferred to the on-call provider, who will provide immediate Tele-Medicine access. All providers on the Medical Home Team rotate this responsibility, with monthly schedule, revised to accommodate changing demands on the provider's schedule.

Here at Nature Coast Health Care our Patient-Centered-Medical-Home team of medical doctors are dedicated to treating patients comprehensively as a whole person. We take a compassionate approach to preventing, diagnosing, and treating diseases to care for you throughout life.

Our Mission is to utilize a Patient-Centered- Medical-Home team approach to treat the patient holistically and work to provide top quality and compassionate care in a timely manner. Our medical providers are experts in family and internal medicine and thus provide services to treat routine problems such as a cold or the flu, or provide in-depth care for illnesses such as diabetes, chronic lung disease or heart disease. Keeping our patients happy and healthy longer through our excellent care and service in a cost-effective manner is something we take seriously.

The following is a list including, but not limited to, the services we offer:

- Adult health, including immunizations and health screening for preventative medicine, which includes counseling on healthy lifestyle, healthy diet, weight control.
- Basic metabolic rate calculation, electrocardiograms, and pulmonary function tests.
- Gender specific services include women's wellness exams.
- Mammography for women, prostate screening for men, and other radiology exams.
- Screening includes colonoscopy orders for colon cancer screening, cardiac stress test orders, and lab work that screen for anemia, diabetes, thyroid dysfunction, high cholesterol, and other medical issues as indicated.
- Physical exams, including school physicals, sports physicals, work physicals, and consultation for pre-op clearance.
- Sick visits, including upper respiratory tract infections, urinary tract infections, gastroenteritis, skin infections, etc.
- Work ups for complaints, such as fatigue or other systems, which includes general, eye, ear, nose, throat, chest, cardiovascular, pulmonary, gastrointestinal, genitourinary, endocrine, hematologic, lymphatic, neurological, and psychiatric complaints.
- Musculoskeletal complaints, such as joint pain, muscle aches, and injuries, in which the patient has the option to request trigger point injections and joint injections as indicated.
- Dermatological complaints, including acne, rosacea, calluses, skin ulcerations, warts, ingrown nails, onychomycosis, and skin cancer, which can include treatments such as medicine, wound care, suturing, skin biopsies, electrocautery, and cryoablation.
- Medical disease management, such as hypertension, diabetes, high cholesterol, hypothyroidism, asthma, COPD (chronic bronchitis and emphysema), CHF and others.

For your convenience, we offer many in-office services. We may refer you to a specialist as needed.

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:_________________________ Patient First Name:_____________________ DOB:___________

Instructions**:** ***Complete all items. Indicate N/A if not applicable***

☐ ***Driver License*** ☐ ***Insurance Card***

Today's Date: _________________ How did you hear about our office? ___________________________________

Patient Name: ____ DOB: _____________
Last First MI

Phone (Day): ____________________ Phone (Evening, Cell): ________________________

Mailing Address: _______________________________ City: __________________ State: _______ Zip:__________

SS#: ______ - ______- ________ Gender: M F Other Marital Status: Single Married Divorced Widowed
(Please Circle One) (Please Circle One)

(Please Circle One

Primary Language: English, Spanish, refused to report, Other: __________
Race: Native American, Indian, Alaskan Native, Asian, African American, Caucasian, Refused to Report, Other: ____________
Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, refused to report, Other: ____________

Email Address: ____

Employer: _______________________________________ Phone Number: _______________________________

Primary Insurance Carrier: ________________________________ Policy ID: _____________________________

Type of Plan: HMO PPO POS Other Insurance Carrier Phone #: _____________________________
(Please Circle One)

Second Insurance Carrier: ___________________________________ Policy ID: ____________________________

EMERGENCY CONTACT INFORMATION
Name: ____
Relationship: ____
Phone: _____________________________

MEDICAL RELEASE INFORMATION
Can we discuss your medical condition or test result(s) with your family member(s)? □ Yes □ No
can be shared with _________________________________
Can we leave a message on your answering machine at: Home? □ Yes □ No Cell? : □ Yes □ No
Fax a copy of your result(s) to another physician if need be: □ Yes □ No

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:__________________________ Patient First Name:______________________ DOB:___________

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, don't answer it. Add any notes you think are important.

Past Medical History (Please check all that apply

- ☐ AIDS/HIV +
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Other:
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines/Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ TB
- ☐ Ulcers

____

____

Past Surgical History

Date: _______________ Reason: ___________________________ Hospital: _____________________________

_____________________ ___________________________ _____________________________

Hospitalizations:

Date: _______________ Reason ___________________________ Hospital: __________________________

_____________________ ___________________________ __________________________

Have you ever had a blood transfusion? □ Yes □ No If so, when? _____________Blood Type? __________________

Have you ever had a cardiac stress test? □ Yes □ No If so, when? ____

Do you have a history of drug addiction? □ Yes □ No

Allergies

Are you allergic to any medications: □ Yes □ No

List anything that you are allergic to (medications, food, bee stings etc.) and how each affects you.

Allergy	Reaction
1.____	____
2.____	____
3.____	____

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:__________________________ Patient First Name:_____________________ DOB:___________

Immunization History✓ ***any vaccine received and date***

	Date: (if known)				
□ Chickenpox	___________	□ Meningococcus	___________	□Typhoid	___________
□ Flu shot	___________	□ MMR (Measles, Mumps, Rubella)	___________	□Smallpox	___________
□Gardasil/HPV	___________	□ Pneumonia	___________	□Pneumococcal	___________
□ Hepatitis A	___________	□ Tdap (tetanus and pertussis)	___________	□ COVID-19	___________
□ Hepatitis B	___________	□ Tetanus	___________	□ Zostavax (Shingles)	___________

Personal Habits:

1) Have you ever smoked? □ Yes □ No If Yes, are you a regular smoker now? □ Yes □ No Have you used chewing tobacco? □ Yes □ No If Yes, number of yrs. _____________
If No, when did you quit? _________
2) Do you regularly drink alcohol? □ Yes □ No If Yes, how often: _________________________________
3) Have you ever used any of the following? □ Marijuana □ LSD □ Heroin □ Cocaine □ Speed
□ Other: ____

Exercise/Activity

Exercise Level □ None □ Occasional exercise □ Moderate exercise □ High level exercise
Current Activity / Frequency ____
Physical Limitations: ____

Nutritional History

Current Weight: _________Lbs. Height: _______Ft. ______In Weight Change in the past 6 mo.? □ Yes □ No
Current Diet Plan?

____ ______________________________
Patient/Guardian/Parent Signature Date

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:__________________________ Patient First Name:______________________ DOB:___________

Family Health History:

Relation	Alive	Age	Significant Health Problems
Grandmother (Maternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Grandfather (Maternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Grandmother (Paternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Grandfather (Paternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Father	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Mother	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Brother (any)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Sister (any)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Other	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke

Social Lifestyle / History:

Education - □ Less than 8th grade □ High school □ 2 Year college □ 4-year college □ Postgraduate
□ Employed Occupation__________________________ □ Unemployed □ Retired □ Disabled

Is there someone that lives in your residence? □YES □NO If yes, please list name and relationship:

Type of Residence □ Apartment □ Mobile Home □ House: □ One Story □ Two Story
□ Assisted Living Name: ________________________

Durable Medical Equipment? □YES □NO □ Wheelchair □ Oxygen □ Walker □ Cane
□ Nebulizer □ CPAP/BIPAP Other: _______________

Can you afford medications? □YES □NO If no, explain:

Do you have a cognitive issue? □ Memory problems □ Dementia □ Learning disability

Do you drive? □YES □NO If no, explain:

Do you live in a safe environment? □YES □NO If no, explain:

New Patient General Information
7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:__________________________ Patient First Name:______________________ DOB:___________

Obstetric and Gynecological History (Women only)

Last PAP exam: _______________________ Date of last Mammogram: _________________________________
Age of first menstrual Period: __________ Date of last menstrual period or age of menopause: _____________
Number of pregnancies: _______________ Births: _____ Living: _____ Miscarriages: _____ Abortions: _____
Cesarean section: if yes, then number: ____

□ Bleeding between periods □ Heavy period Extreme menstrual pain □ Vaginal itching, burning or discharge
□ Hot Flashes □ Breast lump or nipple discharged. □ Self breast exam □ wake in the night to go to the bathroom

Sexual History:

Are you sexually active: □ Yes □ No
Current sexual partner: □ Female □ Male □ Multiple partners
Do you use condoms: □ Yes □ No
Interested in being screened for STD'S? □ Yes □ No

Activities Of Daily Living

Do you require assistance to bathe or groom? □Yes □No If Yes, Explain:
Do you require assistance for your toilet needs? □Yes □No If Yes, Explain:
Do you require assistance to eat? □Yes □No If Yes, Explain:
Do you have hearing loss? □Yes □No
Do you wear hearing aids? □Yes □No
Do you have vision loss? □Yes □No
Do you receive regular Dental Care □Yes □No

Screenings: *if you have a copy or name of provider completed- please list*

	Date:	Provider/where was this done?	
Annual Wellness Visit	__________	__________________________	□Normal □Abnormal
Eye Exam	__________	__________________________	□Normal □Abnormal
Colonoscopy or iFOBT kit	__________	__________________________	□Normal □Abnormal
Labs	__________	__________________________	□Normal □Abnormal
Electrocardiogram	__________	__________________________	□Normal □Abnormal
Blood Pressure	__________	__________________________	□Normal □Abnormal
Mammogram	__________	__________________________	□Normal □Abnormal
Bone Density (DEXA)	__________	__________________________	□Normal □Abnormal

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:_________________________ Patient First Name:_____________________ DOB:___________

I, the undersigned voluntarily give consent to Nature Coast Health Care medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Signature: ____ Date: ______________ DOB: ____________

Patient Printed Name ______________________________________Relationship to Patient: _________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received/reviewed a copy of Nature Coast Health Care's Notice of Privacy Practices and the Florida Patient Bill of Rights.

Signature: ____ DATE: _________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify): ____

____ ________________________________

Signature of Employee Date

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:__________________________ Patient First Name:______________________ DOB:___________

List of Providers

Please list all physicians you are currently being treated by or have seen in the last 2 years.
* Please include last primary care physician

Physician Name	Specialty	City/State	Phone Number	Mo/Yr Last Seen

New Patient General Information

7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

Patient Last Name:__________________________ Patient First Name:______________________ DOB:___________

List of Medications

Please list all medications you are currently taking, including inhalers, oxygen, chemotherapy, prescription drugs, over the counter drugs, and vitamins.

Preferred Pharmacy Name: ______________________________ City: _________________

Drug	Dosage	How often	Date started
Example: Vitamin C	500mg	Daily	

New Patient General Information
7562 W. Gulf to Lake Hwy, Crystal River FL 34429//821 Medical Ct E., Inverness FL 34452

HIPAA NOTICE OR PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Nature Coast Health Care uses an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy and insurance company through a secure electronic prescription connection which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and your specialists, this will allow us to access your medication history through the pharmacies and insurance companies' electronic database.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

a. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

b. Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

c. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity, and national security, workers' compensation, inmates. Required uses and disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. **Other permitted and required uses and disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law. **You may revoke this authorization at any time**, in writing, except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights: Following is a statement of your rights with respect to your protected health information.

a. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

b. You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

c. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

d. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

e. You have the right to obtain a paper copy of this notice from us, upon request, if you have agreed to accept this notice alternatively i.e. electronically.

f. You may have the right to your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

g. You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact or your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy or, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Florida Patient's Bill of Rights and Responsibilities
Florida Statutes Chapter 381(026)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)

  □ I have □ I have NOT made a Living Will

- Health Care Surrogate

  □ I have □ I have NOT designated a Health Care Surrogate

- Durable Power of Attorney

  □ I have □ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may verbally inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: ___________________________ Relationship: ________________ Phone: _________________

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: ___________________________ Relationship: ________________ Phone: _________________

I understand that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL"

Confidential messages (i.e., appointment reminders) □ May □ May NOT be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:

____

I am fully aware that a cell phone is not a secure and private line. ______ ***(initals)***

Please print patient name date of birth ____

_________________________________ *legal representative relationship to patient*

____, 20________

signature of patient or legal representative today's date

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient Information

Patient's Name ______________________ Date of Request ______________ Home Phone ______________

Address ______________________ Date of Birth ______________ Cell Phone ______________

Last 4 of Social Security __________ Email ______________________

*Authorized Representative (if other than the patient) ______________________

*Authority of Authorized Representative ☐ Guardian ☐ Health Care Power of Attorney ☐ Health Care Surrogate ☐Parent of Minor

☐ Representative of Deceased Patient ☐ Other ______________________

Information to be Released

☐ Specified Records for Date(s) of Service: _____ / _____ / _____ *to* _____ / _____ / _____

☐ Provider Name(s) ______________________

☐ Last History & Physical Exams ☐ Last Emergency Room Records ☐ Last Operative Reports/Consults ☐ Last Imaging Reports/Films

☐ Last Physician Progress Notes ☐ Other Records (specify) ______________________

This section to be completed if records will be requested or released to or from another medical facility/practice/provider to Nature Coast Health Care.

Medical Facility Practice/ Provider Name ______________ Contact Name __________ Phone ______________

☐ Mail Address ______________ City ______________ State ______ Zip Code __________

☐ Fax ______________________

Records to be sent to: Nature Coast Health Care Attn: Medical Records

7562 W Gulf to Lake Hwy Crystal River 34429 | (Phone) 352-436-4328 (Fax) 352-260-0960

Purpose of Disclosure: ☐ Continuing Medical Treatment/Continuity of Care ☐ Other (Please Specify) ______________

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulations. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, If applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

In addition to any records checked above, the following initialed records may be released:

☐ Behavioral/Mental Health Information __________ (please initial)

☐ Substance Abuse Information __________ (please initial)

☐ Sexually Transmitted Disease Information __________ (please initial)

☐ Immune deficiency syndrome (AIDS), or Human Immunodeficient Virus (HIV) __________ (please initial)

Right to Revoke Authorization: I may revoke this authorization in writing at any time to the practice, except to the extent that the information has been released in the execution of this authorization. I further understand that I have a right to receive a copy of this authorization upon request.

Authorization: I hereby authorize the use or disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law. I understand that information released in response to this authorization could potentially be re-disclosed and may no longer be protected by federal privacy regulations. I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. I understand that this authorization will **expire one year from the signature date below**.

______________________ ______________

Signature of Patient or Patient's Authorized Representative Date

Name: ____ DOB: ____________

Social Determinants of Health Assessment

Social aspects of life affect your health, so your patient-centered medical-home care team is deeply interested in learning about the existing social needs and opportunities in your life – daily, work, educational, and recreational. Of particular importance are those home or environmental factors that put your health at risk. Please respond to the following questions:

Living Situation

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of the household?

Yes No

2. Think about where you live. Do you have problems with any of the following:

Bug Infestation
Mold
Lead Paint or pipes
Inadequate heat
Oven or stove not working
Zero or not working smoke detectors
Water leaks
None of the above

Food

3. Within the past year, were you worried that your food would run out before you had money to buy more?

Yes No

4. Within the past year, did that happen?

Yes No

Transportation

5. In the past year, has lack of reliable transport kept you from medical appointments, work, or getting things needed for daily living?

Yes No

Utilities

6. In the past year, has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes No

Child Care

7. Do problems with childcare make it difficult for you to work or study?

Yes No

For the remaining questions, please respond with: Never, Rarely, Sometimes, Often, Always

Finances

8. How often does this describe you: I don't have enough money to pay my bills.

Personal Safety

9. How often does anyone, including family, insult to talk down to you?

10. How often does anyone, including family, physically hurt you?

11. How often does anyone, including family, threaten you with harm?

Assistance

12. Would you like help with any of these needs?

Yes No