



1424 US HWY 331
DeFuniak Springs, FL
32435
P (850)920-1700
F (850)520-5357

PATIENT'S DEMOGRAPHICS

NAME _____
DOB _____ AGE _____ SEX _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
CELL _____ HOME _____ WORK _____
EMAIL _____
OK to receive email and text appointment reminders ☐ YES ☐ NO
RACE : _____ ETHNICITY: _____

INSURANCE

PRIMARY: _____	SECONDARY: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
POLICY HOLDER DOB: _____	POLICY HOLDER DOB: _____
RELATIONSHIP TO PATIENT: _____	RELATIONSHIP TO PATIENT: _____
POLICY #: _____	POLICY #: _____

GUARANTOR (Responsible for Bill):

FIRST _____ MI _____ LAST _____ RELATIONSHIP _____
SS# _____ DOB _____ AGE _____ SEX ☐ Female ☐ Male
ADDRESS _____ CITY _____
STATE _____ ZIP _____ HOME _____ CELL _____

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP: _____ PHONE NUMBER: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____
PREFERRED PHARMACY _____

I hereby authorize the performance of any medical or surgical treatment rendered under the general and special instruction of my physician. I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. Any pre certification required by the insurance company is the patient's responsibility; however, we will gladly assist you with this. For your convenience we will file up to two (2) insurances for you.

I hereby authorize the below listed additional individuals to have access to my medical information:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Signature (Patient/Responsible Party)

Date

Name: _____ DOB: _____

Reason for Visit: _____

Operations:	Year	Operations:	Year	Self and Family Cancer History:
Tonsils		Heart Stenting / Bypass		Breast · Colon · Thyroid ·
Bariatric		Hysterectomy		Who?
Appendix		Vasectomy		Other Cancers:
Gallbladder		Breast Augmentation/Mastectomy R / L		
Knee R / L Hip R / L		Spinal Neck/Back		

Other Operations: Year Performed	
Allergies to Medications or Other Substances:	
Current Medications and Dosage:	
Habits:	Start / Quit year
· Cigarettes: _____	_____
· Oral tobacco: _____	_____
· Vape: _____	_____
Caffeine: Cups per day: _____	
Alcohol: Drinks per day: _____	
Other Drugs: _____	
MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
Your Living Situation and Who Lives There:	
Occupation/Retired:	
Do you have a POA?	
Do you have an advanced directive or living will?	

	Self	Father	Mother	Brother	Sister
Headaches/Migraines					
Stroke / CVA / TIA					
Kidney Disease					
Thyroid HYPER / HYPO					
High Blood Pressure					
High Cholesterol					
Heart Attack					
CHF					
Peripheral Artery Disease					
Epilepsy					
Asthma					
COPD					
Liver/Hepatitis					
Diabetes					
Reflux / Other GI					
Mental Illness: ADHD, Bipolar, Anxiety					
Clotting Disorders					
History of Medullary Thyroid Cancer?					
History of Multiple Endocrine Neoplasia Syndrome Type 2?					
History of pancreatitis?					
Pain with eating food?					
Do you have any metal implanted in your body? If so, where?					

What other problem areas or services are you interested in learning about?
(please check all that apply)

- ☐ Weight loss
- ☐ Urinary Incontinence (stress or urge)
- ☐ Erectile Dysfunction
- ☐ Vaginal Rejuvenation
- ☐ Skin Care (Facials/ALASTIN)
- ☐ Fine lines/Wrinkles
- ☐ Waxing

- ☐ Non-surgical facelift
- ☐ Chemical Peel (Face)
- ☐ Microneedling
- ☐ Cellulite Reduction/Skin Tightening
- ☐ Stubborn Fat - Body Sculpting
- ☐ BOTOX/Dysport
- ☐ Filler



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PLEASE INITIAL THE POLICY'S BELOW

_____ Privacy Policy Notice

We are committed to preserving the privacy of certain confidential health care information. The law requires us to protect the privacy of your medical information and to abide by the terms of the notice. This notice describes how medical information about you may be used and released and how you can get access to this information. We may use and release your medical information for: payment, treatment, healthcare operations, business associates, appointment reminders, treatment alternative education, health related benefits or services, as required by law to state/federal agencies, family or friends involved in your care, entities assisting in disaster relief. We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current Privacy Policy.

_____ Assignment of Insurance and Financial Responsibility

I do, hereby, authorize payment of all insurance benefits, basic and major medical, for the services I receive, to be made directly to Defuniak All-Care. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing, or attempting to collect or secure payment, including reasonable attorney's fees or collection agency fees.

_____ ePrescribing Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows our providers to see important information, such as drug interactions and your prescriptions history.

_____ Audio Consent

I do, hereby, grant permission to Defuniak All-Care, and its providers to record audio for charting purposes.

_____ Consent for Lab Services

Defuniak All-Care uses 2 laboratories to process labs. It is my responsibility to ensure that these lab services are in network with my insurance company. If the lab is out of network, I will notify Defuniak All-Care in advance. I am responsible for any out of network fees associated with lab processing if I have not made arrangements in advance with Defuniak All-Care.

_____ Clinic Policies

Defuniak All-Care Clinic **IS NOT** a pain management clinic; therefore, we **DO NOT** dispense narcotics or any other controlled medications.

Proper identification and proof of current insurance must be provided at time of service.

Payments and Copayments are due at time of service.

Date

Signature (Patient/Personal Representative)

Print Patient Name

Date

Witness

Print Authorized Individual/Relationship

MEDICAL RELEASE CONSENT

Patient Legal Name: _____ Birth Date: _____ XXX-XX-_____
Social Security No. _____

Patient Address _____ Telephone No. _____

City _____ State _____ Zip Code _____

I hereby authorize _____
Name of Physician and/or Practice Name to Release Records

Fax Number _____ Telephone Number _____

To disclose medical record information and/or protected health information of the patient listed above to:

DEFUNIAK ALL-CARE
Michael Jeter APRN/Tommy Simmons APRN/Whitney Rushing APRN
1424 S. US 331
DEFUNIAK SPRINGS, FL 32435
PHONE: (850) 920-1700
FAX: (850) 520-5357

Purpose: _____

Type of Access: Select Portions of Personal Health Information:

- | | | |
|---|--|---|
| ☐ Copies of the record | ☐ Lab | ☐ Medication Records |
| ☐ Entire Record | ☐ Imaging / Radiology | ☐ Path Report |
| ☐ Emergency Room | ☐ Demographics | ☐ Physician Order |
| ☐ History & Physical | ☐ Progress Notes | ☐ Billing Records |
| ☐ Consult Report | | ☐ Other _____ |
| ☐ Operative Report | | |

Expiration: This authorization shall expire in one year unless otherwise specified below:

- ☐ Fulfillment of the request (according to HIPAA or State Regulations, whichever is shorter)
☐ Date _____ (Not to exceed one year)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. Fees/changes will comply with all laws and regulations applicable to release of information. Power of Attorney (POA) must be attached if signing as POA.

Date _____ Signature of Patient/Responsible Party _____ Relationship to Patient _____