Town N Country Medical Care
New Patient Form

Name: _____ Date of Birth: _____

Today's Date: _____ Age: _____ Sex: _____

What name would you like to be called? _____

Marital Status: Single Married Divorced Widowed

Occupation: _____

Do you have allergies to medication, x-ray dyes or other substances? YES NO
If yes, please list medication and reaction. _____
_____

Please list names of medication, dosage and reason for taking medication.
_____
_____
_____
_____
_____

Have you ever had surgery? YES NO
If yes, please list any surgeries
_____
_____
_____

Immunizations

Date of Tetanus vaccine _____ Date of Flu Vaccine _____
Date of Hepatitis B series _____ Date of TB screening _____
Date of last pneumonia vaccine_____

Health Maintenance

Date of colonoscopy_____ Date of last bone density _____
Date of last eye exam _____ Date of last pap smear _____
Date of last mammogram _____

Do you wear seat belts? YES NO Do you drink alcohol? YES NO
Do you use tobacco products? YES NO Do you use any illicit drugs? YES NO
Do you drink caffeine? YES NO

Which of the following conditions are currently being treated or have been treated for you in the past?

__Allergies	__Asthma	__Hemorrhoids	__Heart Disease
__Depression	__Alcoholism	__Insomnia	__Sinus Disease
__Emphysema/COPD	__Back Pain	__Psoriasis	__Anxiety
__Heart Attack	__Dizziness	__Arthritis	__Cancer
__High Blood Pressure	__Erectile Dysfunction	__Acid Reflux	__Diabetes
__Gout	__Epilepsy/Seizure	__Anemia	__Thyroid Disease
__Stroke	__Heart Murmur.	__Headaches	__Other

Family History- Please list family member (mother, father, maternal/paternal grandparent)

Were you adopted? YES NO

Heart Disease: _____

High Cholesterol: _____

High Blood Pressure: _____

Diabetes: _____

Heart Attack: _____

Stroke: _____

Liver Disease: _____

Asthma: _____

Anemia: _____

Breast Cancer: _____

Lung Cancer: _____

Ovarian Cancer: _____

Other Cancer: _____

Thyroid Disease: _____

Drug/Alcohol Addiction: _____

Depression/Anxiety: _____

Suicide: _____

Seizure/Epilepsy: _____

HIV/AIDS: _____

Other: _____

Please list reason for today's visit: _____

_____

Previous Primary Care Doctor

Name: _____

Address: _____

Phone: _____

Fax: _____

Town N Country Medical Care
Financial Policy

We consider payment of services to be the responsibility of the patient-physician relationship. Therefore, we would like to share our payment policy expectations with you to ensure understanding and compliance.

We participate with various insurance companies and managed care plans, which we will file on your behalf directly to the insurance carrier for payment, less any co-payments, coinsurance, deductibles and non-covered benefits.

Please make sure that on your commercial managed plans that you choose us as your primary care providers. If we are not the doctors of choice, we will not be able to provide you with service in the office. Also, make sure that your insurance is active before making an appointment or you will be charged the full cost of the office visit.

Payment is expected at the time of service. We accept cash, check, Visa, MasterCard and Discover Card.

On all returned checks for non-sufficient funds, there is a $25.00 fee charged back to the patient. We will be unable to accept any personal checks until account balances and associated service fees are paid in full. If this becomes a repeated offense, we will only be able to accept cash.

By signing below, I have read and understand the payment terms and my obligations within the financial policy.

Thank you for understanding our financial policy. Please let us know if you have any additional questions or concerns.

_____ _____

Signature of patient or person responsible for account Date

Agreement for use of controlled substances

I understand that the main goal of treatment with chronic controlled substances is to improve my ability to function and/or work and/or reduce pain.
In consideration of that goal and the fact that I am being given potent medication to help me to reach that goal, I agree to help myself by the following better health habits, including exercise, weight control. safe sex, avoiding the use of tobacco, alcohol, and illegal drugs/substances.
Chronic controlled substance medications are intended to improve function and quality of life.
I must comply with the treatment plan as prescribed by my provider.
I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment. Because my provider is prescribing such medication for me to help manage my diagnosis, I agree to the following conditions:

1. I am responsible for my controlled substances medications. If the medication(s) are lost, misplaced, or stolen, or if I use it up sooner than prescribed. **I understand that it may not be replaced.** I will not increase or decrease my dosage without talking with my provider. _____

2. I will not request or accept controlled substance medication from any other provider or facility without notifying Town N Country Medical Care, except in emergency or urgent healthcare situations. I acknowledge that receiving duplicate medications may endanger my health. The only exception is in an emergency or urgent healthcare situation I will not allow anyone else to use my medication and will keep them secure. _____

3. **Refills of chronic controlled substance medications should be:**

A. Will be made during regular clinic hours. Refills will not be made at night, or on holidays or weekends.

B. Any exception such as "I **ran out early**" or "**I lost my prescription**" or "**I spilled or misplaced my medicine**" must be addressed by your provider. I am responsible for taking the medication in the dose prescribed, and or keeping track of the amount remaining.

C. If I need assistance with a chronic controlled substance medication prescription, I will call to discuss this with my provider. ____

4. My provider may require me to see a specialist at any time while I am receiving controlled substance medications. If I am unable to meet the requirements of this agreement, there may be medical and safety risks of continuing my controlled substance medication. I understand that my medications may be continued or refilled. ___

5. I agree to comply with random laboratory testing documenting the proper use of my medications and confirming compliance. I understand the importance of avoiding alcohol or other substances of abuse when taking a controlled substance medication. A positive test for any substance besides my prescribed medications will be grounds for action and/or discontinuation of my medications. ____

6. I understand that controlled substances can cause marked drowsiness. I will not drive a motor vehicle or operate dangerous equipment while I am sleepy. I understand that I will need to talk with my provider

about my ability to drive or operate dangerous equipment. It is my responsibility to comply with the laws of the State of Florida while taking the medication prescribed. _____

7. I understand that if I violate any of the above conditions, my controlled substance prescriptions may be tapered and not refilled, or ended immediately and alternate treatments for pain offered. If the violation involves obtaining controlled substances from any other individual, as described above, or the use of street (illegal) drugs, I may be reported to my provider, medical facilities and other agencies as appropriate. ____

8. I understand that the long-term advantages and disadvantages of chronic opiate usage have yet to be scientifically determined. I understand that my treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my provider will discuss treatment changes with me as appropriate. ____

I have been fully informed by Town N Country Medical Care and staff regarding the probability of addiction to controlled substances, which I understand is low.

I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. In addition, I know that by increasing the medication, a physical dependence of medication, use will be created. This will occur if I am on the medication for several weeks. When I stop the medication, I must do so slowly under a plan developed with my provider, or I may have withdrawal symptoms.

I have read this agreement. By signing this agreement, I hereby grant my provider the right to contact any other professionals involved in my care concerning my use of opioid medications.

I fully understand the consequences of violating this agreement.

_____	_____
Name of patient	DOB
_____	_____
Patient signature	Date
_____	_____
Provider signature	Date

Authorization to Release Confidential Information

I, _____(patient name) ___/____/____(date of birth), authorize

_____(doctor name/address or phone number) to disclose my health information to : **Town N Country Medical Care 6107 Memorial Hwy, Suite A Tampa, Fl 33615**
813-514-2328 Fax: 813-514-2485

Patient must read and initial both sections A and B, then sign and date. Thank you.

A. I CONSENT TO THE RELEASE OF THE HEALTH INFORMATION INTIALED BELOW:

____ All information
____ Only the information checked below:

Clinical Notes	Lab and/or Radiology Reports	Treatment Plan
Case Management Records	History & Physical	Psychiatric Evaluation

Other (Specify): _____

B. THE HEALTH INFORMATION DISCLOSE SHOULD INCLUDE THE FOLLOWING SPECIFIC HEALTH INFORMATION INITALED BELOW: (____initial if waiving this section if not pertinent or do not authorize to disclose)
By placing initials next to a category of highly confidential information listed below, I specifically authorize the use and / or disclosure of the confidential information.

____Alcohol and/or drug abuse ____HIV/AIDS information ____Sexual Assault

____Mental Health Records of Information ____Abuse of an adult or child ____Developmental Disability

If applicable, please add any limit (like by provider, date, service type) _____

This information is needed for the following purposes(s) Checked Below:

____Treatment ____Coordination of Care ____Case Management ___PCP Communication

____Other (please specify) _____

I understand that I may refuse or may revoke (at any time) this authorization for any reason and that such or revocation will not affect the commencement, continuation of care or quality of treatment. Unless revoked, this consent will expire on the following date, event or condition: _____. Otherwise, this consent will remain valid for twelve (12) months from date this consent was signed.

_____ _____
SIGNATURE OF PATIENT/ PATIENT'S LEGALLY AUTHROIZED REPRESENTATIVE** DATE

_____
PRINT NAME

**Relationship to Patient _____

** If you are signing as the patient's legally authorized representative, please attach the appropriate legal document(s) granting you the authority to do so (i.e Health Care Power of Attorney, Court Order, etc)

Town N Country Medical Care

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review this carefully.

Purpose of privacy notice
This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatments, initiate payment or conduct healthcare operations or 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 (PHI) is information about you, including demographic information that may identify you and that related to your past, present or future physical and/or mental health or condition and related healthcare services.

This notice describes the privacy policies of our practice and that of any healthcare professional authorized to enter information into your medication record including all employees of the practice.

Our pledge regarding medical information:
We understand that medical information about you and health is personal and we are committed to protect it. A record of the care and serviced you receive at this practice is created and maintained at this location. This notice applies to all of those records of your care.

We are required by law to make sure that medical information that identifies you is kept private. We will give you notice of our legal duties and privacy practices regarding your medical information. We will follow the terms of this notice currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling our office and requesting that a revised copy be sent to you in the nail or by asking for one at the time of your next appointment.

How we may use and disclose medical information about you:
The following categories describe ways that we use and disclose medical information. Examples of each category are included and not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information falls into one of these categories.
For treatment: We may use medical information about you to provide coordinate or manage medical treatment and services. We may disclose medical information about you to other physicians or healthcare providers who are or will be involved in taking care of you.
For payment: We may use and disclose medical information about you so that the

Treatment and services, you receive at our practice may be billed and payment may be collected from you, your insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval to determine whether your plan will cover treatment, of for undertaking utilization review activities.
For healthcare operations: We may use disclose your PHI in order to support business activities for our practice. These activities include but are not limited to, quality assessment activities, employee review activities and conducting or arranging for other activities.

We may share your PHI with third-party "business associates" that perform various activities (billing) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Sale of closure of practice: In the event that Town N Country Medical Care is sold or acquired by another facility or physician group, your PHI will be disclosed to that group or entity.

Required by law, legal proceeding or law enforcement: We may use or disclose your PHI to the extent that the use of disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable disease: We may disclose your PHI as authorized by law to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections, oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, or other governmental regulatory programs and civil rights law.

Your Rights
The following is a statement of your rights with respect to your PHI and a brief description of how you may excise these rights.
You have the right to inspect and obtain a copy of your PHI about you that is contained in the designated records set for as long ss we maintained the PHI.

You have the right to request a restriction of your PHI which means you may ask us not to disclose any part of your PHI for the purpose of treatment, payment or healthcare operations you may also request that any part of your PHI not be disclosed to family

Members or friends who may be involved in your care or for notification purposes. Other uses or disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that the practice has taken an action in reliance on the use of disclosure indicated in the authorization.

We may have the right to have the practice amend your PHI. This means you may request an amendment of your information. In certain cases, we may deny your request for amendment. You have the right to file a statement of disagreement with us and we may prepare a rebuttal of your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as disclosed in this Notice of Privacy Practices. It excludes disclosures we may have made to you, the family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after January 1, 2006. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions or limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

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 office administrator. We will not retaliate against you for filing a complaint.

Place your initials _____ Date_____

Authorization of Examination, Treatment, and Use/Disclosure of Protected Healthcare Information (PHI) for Treatment, Payment, and Healthcare Operations Acknowledgement

I hereby authorize the physicians at Town N Country Medical Care and staff to examine and/or render treatment. I understand that this may also include diagnostic imaging, use of scopes to examine internal organs, and lab tests (i.e blood-work, pathology, etc.). I understand that I will receive explanation of ordered procedures/associated risks, and explanation of proper preparation for such procedures. I understand that I reserve the right to inquire about alternative courses of treatment and I will be given opportunity to have all my questions answered.

I agree and understand that I have been provided with a Notice of Privacy Practices that provides a description on how my PHI will be used and disclosed. I understand that Town N Country Medical Care reserves the right to change any policies at any time. I understand that I have the right to object to the use of my PHI for directory purposes. I understand that I reserve the right to request restrictions as to how my PHI is disclosed to carry out treatment, payment, and healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With whom may we share PHI (full name/relationship to patient):

_____

_____

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the use/disclosures of my protected health information, the General Administrative and Financial agreement, and Authorization of Examination. I understand these documents in full and I have been given opportunity to have all of my questions answered.

_____

Print Name

_____ _____

Patient Signature Date

Living Wills- Advance Health Care Directives

A living will allow you to decide whether you desire life support under certain circumstances. It is a declaration that such procedures be withheld or withdrawn, and that you be permitted to die naturally with only the administration of medication, or the performance of any medical procedure deemed necessary to provide you with comfortable care.

Living Will Legal Definition

Adults in all States have the right to make decisions about their health care. They are given the rights to accept or reject medical or surgical treatment after being informed of their options. Health care decisions can be made by you, or an agent you appoint to make decisions if you are not capable of making the decision at that time. Forms used for health care matters vary from State to State, but generally are one or more of the following: Living Will, Health Care Directives. Durable Power of Attorney for Health Care, Health Care Declaration, Health Care Directives, Advanced Health Care Directive, Health Care Proxy and others. Sometimes you will see the form named Statuary Living Will or Statutory Health Care Directive.

Living Wills

Although the term Living Wills may indicate that it is a Will, in reality, it is more similar to a Power of Attorney than a Will. Therefore, don't be confused by the title of the document. The purpose of a living will be to allow you to make a decision about life support and directs others to implement your desires in that regard.

Living Wills are needed because advances in medicine allow doctors to prolong and sustain life although the person will not recover from a persistent vegetative state. Some people would not desire to remain in the state while others would. Extending life when death is imminent to some people is only extending the suffering and prolonging the dying process.

The Living Will allow you to make decisions of whether life-prolonging medical or surgical procedures are to be continued, or withheld or withdrawn, as well as when artificial feeding and fluids are to be used or withheld. It allows you to express your wishes prior to being incapacitated. Your physicians or health care providers are directed by the living will to follow your instructions. You may revoke the Living Will prior to becoming incapacitated.

The Living Will generally become operative when it is provided to your physicians or health care provider AND you are incapable of making health care decisions for yourself, such as where you are permanently unconscious or terminally ill and unable to communicate.

Durable Power of Attorney for Health Care

A durable power of attorney for health care is used to appoint an agent to make health care decision for you and usually includes the power of the agent to make decisions regarding terminal conditions whether to prolong life. However, if you have a Living Will, the directions of the Living Will control over the durable power of attorney, because you have already made the decision of what is to be done under certain circumstance. Many people use a Durable Power of Attorney for Health Care and a Living Will because they do not want to place the agent in the position of making decisions regarding choice in dying. The agent still has authority to make other health care decisions for you when you cannot make the decision yourself in situation where you need medical attention but are not terminally ill or in a permanent coma.

Town N Country Medical Care
6107 Memorial Hwy Suite A
Tampa, Fl

Please let us know your wishes:

Check ALL that apply:

_____ I have a living will. **(If yes, please provide a copy)**

_____I have a document that I signed that allows person to make healthcare decisions for me. **(If yes, please provide a copy)**

_____ If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me:

Name: _____

Phone Number: _____

If I become so ill that I cannot tell my doctor what I want, and two doctors agree that they cannot make me better, please: (Check ALL that apply)

_____ Keep me clean and free from pain.

_____ Do NOT use tubes for: ____breathing ____feeding ____IV fluids.

_____ Let my appointed person decide.

_____ If my heart stops, do ____ do not ____ try to restart it.

_____ Do EVERYTHING possible.

_____ I do not wish to complete an advanced directive at this time.

Additional instructions:

_____

_____

_____

Printed name: _____ Date:_____

Signature: _____ Date: _____

1st Witness: _____ Date: _____

Relationship: _____

2nd Witness: _____ Date: _____

Relationship: _____ Date: _____

Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures that the surrogate feels are in your best interest and make health care decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate person to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

HIPAA AUTHORIZATION FORM

Patient's Full Name _____ Patient's Social Security Number _____

Address _____ Patient's Date of Birth _____

City, State, Zip Code _____ Patient's Telephone Number _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specified person/class of person /facility is authorized to use or disclose information about me:
   _____
2. The following person (or entity) is authorized to request my protected health information subject to the limitations below:
   _____
   Name of Person/Entity
   _____
   Address
   _____
   City. State, Zip Code
   _____
   E-mail Address
3. The specific information that should be disclosed is (please give dates of service if possible):
   _____
   _____

   I authorize the disclosure of the following types of highly sensitive information: ___ drug and alcohol; ___mental health (psychiatric); ____HIV/AIDS testing and treatment.
4. I understand that the information used or disclosed maybe subject to re-disclosure by the person or class of person or facility receiving it and would then no longer be protected by federal privacy regulation.
5. I may revoke the authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires on _____ 20___, OR upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of information about me:_____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING-note that signature is required in two places

Signature of Individual _____ Date of Signature _____ Date of Birth _____

Signature of Guardian or Representative _____ Date of Signature _____ Description of authority _____

Official Use Only

Received _____ Processed By _____ Log# _____