ELIZABETH K. NEWMAN, APRN-C
4551 WEST US 90
LAKE CITY, FL 32055
INFO@NEWCAREPRIMARY.COM
PHONE: (386) 319-8178 | **FAX:** (386) 243-8786

PLEASE NOTE: All Information Requested is Required; If Not Applicable, simply put N/A

BASIC INFORMATION:

Full Name: ____
First Middle Last Suffix

Name you prefer to be called by if different than your first name: ___________________________

Sex: _____ Male _____ Female

Home Phone: ________________________________

Date of Birth: ______________________

Mobile Phone: _______________________________

*** SSN**: ____________________________

Work Phone: ________________________________

Marital Status: ___ S ___ M ___ D ___ W

Primary Phone: ___ Home ___ Mobile ___ Work

Maiden Last Name: ___________________________

*** E-Mail**: __________________________________

*** Driver's License (DL) State**: ______

*** DL Number**: ________________________________

Primary Address: ____

____

DEMOGRAPHICS:

Ethnicity: ___ White/Non-Hispanic ___ Black American ___ Hispanic ___ Asian ___ Other

Primary Language: English ___ Spanish ___ Other: ________________________________

REFERRALS:

If you were referred to our office by another provider or person, please let us know who so we can than them:

____

*** Indicates Required**

REV 01.2024

EMERGENCY CONTACT INFORMATION:

Name: ______________________ Relationship to You: ______________________

Phone Number(s): ______________________ E-Mail: ______________________

Address: ____

____

FINANCIAL INFORMATION:

<u>Responsible Party</u> - Who will be financially responsible for you? ___ Self ___ Other

<u>Responsible Party's Name</u>: ______________________

If not Self, Complete the Information below for person responsible for payment:

Relationship to You (the Patient): ______________________

Sex: _____ Male _____ Female

Home Phone: ______________________

Date of Birth: ______________________

Mobile Phone: ______________________

SSN: ______________________

Work Phone: ______________________

Primary Phone: ___ Home ___ Mobile ___ Work

E-Mail: ______________________

Driver's License (DL) State: ______

DL Number: ______________________

Primary Address (if not same as Patient): ______________________

____

Method of Payment: Please note that you are responsible for your part of the financial obligation at the time service is provided. **<u>Please have Driver's License and Medical Insurance Card available upon Check-In</u>**.

What will be your method of payment? ___ Insurance ___ Self Pay

Insurance: ______________________

Insurance ID Number: ______________________ Group Number (if applicable): ______________

Insurance Company Address: ____

Insurance Phone Number: ______________________

Please provide the Receptionist with Current Copies of your Insurance Card(s) and a copy of your Driver's License or Photo ID.

Please Note: NewCare Primary Medicine, LLC does <u>not</u> treat for injuries associated with motor vehicle accidents or Worker's Compensation.

PERSONAL MEDICAL HISTORY:

PLEASE CHECK ALL THAT APPLY to your Personal Medical History:

GENERAL

_ Headaches
_ Loss or change of Memory
_ Fatigue
_ Depression
_ Dizziness
_ Sweats
_ Sleeping Problems
_ Seizures
_ Fainting
_ Facial Pain
_ TNJ (Jaw Pain)
_ Menstrual Cramps Pain
_ Menstrual Irregularity
_ Prostrate Trouble
_ Cancer
_ Shortness of Breath
_ Hernia
_ Diabetes
_ Joint Pain

ARMS & HANDS

_ Numbness in Arms/Hands
_ Pins/Needles in Arms/Hands

GASTROINTESTINAL

_ Bowel Changes
_ Intestinal Gas
_ Constipation
_ Stomach Pain
_ Vomiting Blood
_ Gall Bladder Trouble
_ Hemorrhoids

CARDIOVASCULAR

_ Anemia
_ Chest Pain
_ Heart Attacks
_ High Blood Pressure
_ Stroke
_ Poor Circulation
_ Irregular Heartbeat
_ Rapid Heartbeat

SKIN

_ Hives
_ Itching
_ Rash
_ Sores that won't heal

EYE/EAR/NOSE/THROAT

_ Loss of Hearing
_ Sinus Trouble
_ Allergies
_ Asthma
_ Persistent Cough
_ Ringing in Ears
_ Blurred Vision

MUSCULOSKELETAL/BACK

_ Neck Pain
_ Grinding/Popping in Neck
_ Mid-back Pain
_ Low-back Pain
_ Spinal Curvature / Scoliosis
_ Numbness in Legs / Feet
_ Pain in Knee / Ankle / Foot

OTHER

____
____
____
____
____

How are your health conditions affecting your work, family, daily and/or recreational life?

____
____
____
____

MEDICATIONS & ALLERGIES:

Patient Name: ____

ALLERGIES: Please List ALL Prescriptions and Over-the-Counter Medications to which Patient is Allergic

Drug: ____________________________ Reaction(s): ____________________________________

Drug: ____________________________ Reaction(s): ____________________________________

Drug: ____________________________ Reaction(s): ____________________________________

MEDICATIONS: Required / Must be Completed for all Medications

Name of Medication:	MG	How Often:	Prescribed by:

**** Please bring ALL your Medications with you to your Appointments.**

**** A Medication List is appreciated, but does not take the place of the actual medication bottles.**

If additional space needed, please use the back of this form.

AUTHORIZATION FORM – CONSENT FOR MEDICAL TREATMENT:

1. Promise to Pay: I understand that I am obligated to pay the account of NewCare Primary Medicine in accordance with the regular rates and terms of the practice. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above practice visit may be applied directly to any delinquent account for which I or my guarantor are legally responsible at the time of the collection of the overpayment.

2. Patient Consent for E-Prescribing (Electronic Prescribing): I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see my information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

3. Consent to Release Health Information: I understand this practice uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the practice's electronic medical record or by other means (for example, fax, telephone, email or hand delivery): (1) to the practice; (2) to my past, current and future health care providers and other health care organizations that provide care to me; and (3) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment, and (3) to do health care operations activities (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sex and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire ONE YEAR AFTER MY DEATH.

4. Notice of Privacy Practice: Required pursuant Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the NewCare Primary Medicine's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all my protected health information generated during hospitalization and outpatient treatment at the practice, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, development disabilities, genetic testing and other types of treatment received.

5. General Consent for Tests, Treatment and Services: I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice and licensure of medical staff.

(Continued on Next Page) Patient Initials ____________

AUTHORIZATION FORM – CONSENT FOR MEDICAL TREATMENT (Continued):

6. Consent for Virtual Health / Telemedicine Services: I hereby consent to engaging in virtual healthy or telemedicine services, where available, as a part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care deliver, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

7. Advance Directive Acknowledgement: Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Power of Attorney or designation of surrogate decision made for health care decisions. If you have already completed any of these documents, please inform your physician and the practice.

____ I have executed an advance directive and have supplied a copy to the practice.

____ I have executed an advance directive and have been requested to supply a copy to the practice.

____ I have not executed an advance directive, but have received information about advance directives from this practice.

____ I have not executed any advanced directives, and I do not wish to receive information about advance directives from this practice.

____ ____________________________

Patient Signature Date

HIPAA COMPLIANCE PATIENT CONSENT FORM:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment of healthcare operation. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment or healthcare operations.
2. The practice reserves the right to change the privacy policy as allowed by law.
3. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES / NO (circle one)

If YES, please name the members allowed:

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

This consent was signed by: ________________________________ (Print Name)

Patient Signature: __________________________________ Date: ____________________

Emergency Contact: ____

Phone Number(s): ____

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NO SHOW POLICY:

Here at NewCare, we strive to see our patients when they need us. Please be courteous to our office and others by calling us at your earliest convenience to cancel if you are unable to make your appointment. This will allow someone else in need of a visit to be seen at that opportunity.

NO SHOW POLICY:

1st Missed Appointment; Patient will receive a warning.

2nd Missed Appointment; Patient will be assessed a Fee of $30.

3rd Missed Appointment; Patient will be discharged from the practice.

Late arrivals beyond 15 minutes may be asked to reschedule.

By signing this form, I am verifying that I fully understand and agree to NewCare Primary Medicine's NO SHOW Policy.

Signature: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________

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TELEMED / TELEHEALTH POLICY:

At NewCare Primary Medicine, we strive to see our patients in the most efficient manner possible. Our office offers a Telemed / Telehealth option for our patients.

Included below is our policy for scheduling these types of visits.

Each patient will be allowed two (2) consecutive Telemed / Telehealth visits. It is required that the next visit be an in-person office visit. There may be exceptions if the provider believes it to be necessary such as for homebound or acutely ill patients. Our providers feel this is in the best interest of our patients to be seen in person at this interval.

By signing this form, I am verifying that I fully understand and agree with NewCare Primary Medicine's Telemed / Telehealth policy.

Signature: ____ Date: ____________________

Witness: ____ Date: ____________________

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OFFICE POLICIES:

1. WEARING OF MASKS: When the CDC requires, we ask that all patients and guests wear a mask while they are in the building. This is for the safety of all our patients and our staff. If you have a health issue that makes it difficult to wear a mask, please notify our receptionist as soon as you enter the lobby, and we can put you in a private room.

2. TIME FACTOR: Our office will do its best to see you as close to your appointment time as possible. However, due to emergencies and unforeseen circumstances, we will not be liable for delays.

3. CHILDREN: For the safety and protection of your children, as well as our patients, we prefer that you plan for the care of your children. If your children come with you to your appointment, they must either remain with you or be accompanied by another adult in the lobby while we care for you.

4. CELL PHONES: ALL cell phones MUST be turned OFF or put on SILENT MODE when you are called back for your medical visit.

5. PRESCRIPTION REFILLS: Our office requires 72 hours' notice for ALL prescription refills.

6. FORMS: All forms and/or letters to be completed by the provider require an office visit to discuss the matter. The forms may require up to 1 WEEK to complete.

7. AFTER HOURS / WEEKENDS: Please DO NOT call for controlled substances on weekends or after hours. This will NOT be tolerated and could potentially lead to you being discharged from our practice. Most controlled substances (Sleep, Anxiety, Pain) medications require special handling by our provider. Therefore, an appointment is needed.

8. NON-COMPLIANCE: Failure to comply with requests for testing such as labs or x-rays, or follow-up appointments that are believed to be medically necessary, could potentially lead to your discharge as a patient of our practice.

9. FAMILY: Patients with Dementia or Disabilities will be allowed to have no more than two (2) family members present with them during an exam or in-office visit.

Signature of Patient or Designated Power of Attorney: ____

Date: ________________________

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENTS:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

Patient Name (Print): ____

Person Authorized to Obtain My Medical Information: ______________________________________

Signature of Patient or Designated Power of Attorney: ______________________________________

Date: ______________________