ACCESS MEDICAL GROUP

4554 EAST HIGHWAY 20
NICEVILLE, FLORIDA 32578

Jennifer Lay, M.D. Jessica Rapa, PA-C Christi Hays, FNP-C

What brings you to Access Medical?

PERSONAL INFORMATION

Name: ____ Marital Status: S M D W
(Last Name) (First Name) (Middle)

Home Address: ______________________________________ Apt #: ____________

City: __________________________ State: ________ Zip Code: ____________

Preferred Phone: (_____) _____-_______ Cell Phone: (_____) _____-_______ Alternate: (_____) _____-_______

Email Address: ____

Date of Birth: ________ / ______ / _________ Social Security #: ________-_____-_________ Gender: Male / Female

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other: ____________________

Name: ____ Phone: (____) ____-______
(Last Name) (First Name) (Middle)

Home Address: ______________________________________ Apt #: ____________

City: __________________________ State: ________ Zip Code: ____________

Date of Birth: ________ / ______ / _________ Social Security #: ________-_____-_________

PRIMARY INSURANCE

☐ Medicare ID#: ____________________ ☐ Tricare, Sponsor SS#: ____________________ Tricare Prime? Yes No

☐ Other: ______________________________ Member ID/Group#: ______________________________
(Insurance Company Name)

Name of Insured: ______________________________________ Date of Birth: _____ / ____ / ______
(Last Name) (First Name) (Middle)

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other: ____________________

Home Address: ____________________________ City: ________________ State: ____ Zip Code:________

SECONDARY INSURANCE

☐ Medicare ID#: ____________________ ☐ Tricare, Sponsor SS#: ____________________ Tricare Prime? Yes No

☐ Other: ______________________________ Member ID/Group# : ______________________________
(Insurance Company Name)

Name of Insured: ______________________________________ Date of Birth: _____ / ____ / ______
(Last Name) (First Name) (Middle)

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other: ____________________

Home Address: ____________________________ City: ________________ State: ____ Zip Code:________

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PRESCRIPTION REFILLS

All prescription refills require an appointment. If your labs are past due, refills will only be written for a short supply. Labs should not be altered and are to be done fasting. **Do not take your medications the morning of your blood draw.** As soon as you get your blood drawn, call us to make your follow up appointment.

Initials ________________

INSURANCE INFORMATION- Co-payments and Deductibles

We currently accept Medicare, Tricare, and Blue Cross Blue Shield (not Blue Select). Otherwise, full payment is due at the time services are rendered. All applicable co-payments and deductibles will be collected at the time of service.

Initials ________________

LATE/CANCELLATION/NO SHOW POLICY

If you no-show or cancel less than 24 hours in advance, **you will be required to pay a fee** prior to any future appointments. Your health insurance will not be billed for this fee. 10 or more minutes late will be considered a no-show. The fee for your 1st offense will be **$50**, the 2nd will be **$75**, the 3rd will be **$100**. After 3 offenses, you may be permanently dismissed from Access Medical Group.

Initials ________________

HIPPA POLICY

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This law prohibits any staff member of Access Medical Group from discussing appointments, medications, test results, or treatment plans with anyone other than the patient. If you would like to permit someone to discuss your medical conditions, confirm appointments, or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with your health information. You may update this list at any time.

Names of Individuals (please print)	Relationship to Patient	May Pick Up Prescriptions?	
		Yes	No
		Yes	No

Emergency Contact Names (please print)	Relationship to Patient	Phone Number

Notice of Privacy Policy Patient Acknowledgement

I understand that under the Health Insurance Portability Accountability Act of 1998, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understood the Notice of Privacy Policy for the above named Provider.

The Provider reserves the right to change the terms of the Notice or Private Policy. I understand the Provider will supply a current Notice or Private Policy upon request.

I certify that the information that I have provided is correct. I authorize the release of medical information if necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filling and payment of medical claims, I authorize payment of medical benefits to the Provider.

Signature: ____ Date: ____________________

Signature of insured or authorized person, patient, or guardian

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PERSONAL HEALTH HISTORY INFORMATION

Primary Care Physician: ____ Phone: (______) ______ - _________

Other Medical Doctors (Specialists)

Name: ____ Specialty:_______________________

Name: ____ Specialty:_______________________

Have you been vaccinated against COVID-19? Yes No

If yes, which one? ________________________________

PREFERRED PHARMACY

Name: ____ Phone: (______) ______ -_________

Address: ____ City: ___________________________ State: _________

PREFERRED LAB

Quest LabCorp Other: ____

MEDICATIONS: List your current medications below

Medication	Strength	Times per Day	Year Started

DRUG ALLERGIES: List drug names with allergic reaction below

Name of Drug	Allergic Reaction

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MEDICAL HISTORY: List all your Medical Conditions

Diagnosis:	Year

SURGERIES

Year	Surgery	Location

HOSPITALIZATIONS

Year	Cause	Hospital

FAMILY HEALTH HISTORY

	Living/Deceased	Age	Significant Health Conditions
Father			
Mother			
Brothers			
Sisters			

HEALTH MAINTENANCE

	Date of Last Test		Date of Last Test		Date of Last Test
Flu		PAP		Chest X-ray	
Pneumonia		Mammogram		EKG	
Tetanus		Bone Density Scan		Colonoscopy	
Thyroid Ultrasound		Lipid Panel		PSA	

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SOCIAL HISTORY/HABITS

Employment: □ Student □ Employed-Occupation: ____

Tobacco Use: □ No- Have never used tobacco □ Previous tobacco user □ Current tobacco user

Quit date?: _____________ Number of packs per day?: _____________ Number of Years: ___________

Alcohol Use: □ No use of alcohol □ Previous use of alcohol □ Current use of alcohol

Number of drinks per week?: _______

Caffeine: □ Soda Number per week?: _______

□ Coffee Number per week?: _______

□ Tea Number per week?: _______

Salt intake: Do you add salt to your food after it has been prepared? _____________

Exercise: Do you exercise? If yes, what type and duration? ____

****

FEMALES ONLY

PREGNANCY HISTORY

How many children do you have? _________________

How many times have you been pregnant? ________________

	Birth Date	Term (weeks)	Type of Delivery (Vaginal, C/S, ect)	Complications (HBP, Gest. Diabetes, ect)
1.				
2.				
3.				
4.				

MENSTRUAL CYCLE HISTORY

*****In your teenage years only, prior to any birth control*****

Age at first period? __________

How often did you get your menstrual cycle?: Every ____________ days, lasting ____________ days.

Were your cycles?: □ Regular □ Irregular

Did you experience: □ Pre Menstrual Tension (PMS) □ Heavy periods

If menopausal, age/year of menopause: ______________
Check any that apply:

□ Natural Menopause □ Total Abd Hysterectomy □ Total Vaginal Hysterectomy
□ Left Ovary Removed □ Right Ovary Removed □ Bilateral Ovary Removed

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MEDICAL SERVICES AGREEMENT

a. As a service to me, Access Medical Group files health insurance claims for me. I agree to pay all fees applied to my insurance deductible, cost share, co-payment, or fees for services not covered by my insurance or if I don't have insurance at the time services are rendered.

b. I agree to pay any balance on my account within 30 days of receipt of a bill. I agree that any balance remaining on my account at 90 days from the date of service will be sent to a collection agency for collection at my expense.

c. If I have no health insurance, I agree to pay the minimum fee of $100.00 before seeing a medical provider. I agree to pay any remaining fees from that visit when services are rendered, prior to leaving the facility.

d. For medical services covered by auto, liability, or workman's compensation insurance (for example: injury or illness on the job, at school, on another's property, or from an auto accident, ect.), I agree to pay all medical fees when services are rendered. I understand my health insurance cannot be billed for any of these fees.

e. I agree to pay a $25.00 fee for any returned checks, a $50.00 fee for missed appointments (10 or more minutes late) or appointments canceled less than 24 hours in advance, a $30.00 fee for prescription refills without an appointment, and $1.00 per page to copy my medical records. I understand my health insurance will not be billed for any of these fees.

f. I understand that medical care providers other than an M.D., such as an osteopathic physician (D.O.), a physician assistant (P.A.), a nurse practitioner (ARNP), a medical student, an intern, or a resident physician may participate in the provision of my health care at Access Medical Group facilities. I understand that all providers are under the direction of the senior physicians, and I agree to conduct myself as if they were providing such care themselves.

g. I understand that Access Medical Group currently provides only outpatient (in physician's office) medical services. No inpatient (in hospital) or obstetrical services are provided. I concur with this policy, and accept referral to a military or civilian consultant or emergency service when warranted.

h. I request and authorize the release of any medical information necessary to process my insurance claim. I request and authorize payment of medical benefits to Access Medical Group, for medical services rendered.

Signature: ____ Date:____________________

Signature of Patient or Legally Authorized Representative

May Access Medical Group leave information on your answering machine or voicemail? Yes No

I understand that my social security number is now required by insurance companies in order to file claims. I will be responsible for the full bill if I do not supply my SSN. *Initials*

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PRESCRIPTION HISTORY CONSENT

In connection with the medical services that I am receiving, I hereby consent for Access Medical Group to gain access to and use my prescription medication history from other healthcare providers, pharmacies, and third party payers. I understand that my prescription history (which includes, but is not limited to, medications, labs, and other healthcare related drug information) from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by providers and staff at Access Medical Group, and that it may include prescriptions dating back several years.

I acknowledge that Access Medical Group may use health information exchange systems to electronically transmit, receive, and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect as long as I receive services from Access Medical Group, unless revoked by me in writing.

Patient Name (Please Print)

Signature of Patient or Legally Authorized Representative   *Date*