TRINITY HEALTHCARE MEDICAL CENTER

CONFIDENTIAL PATIENT DEMOGRAPHICS FORM

Last Name	First Name	MI	Social Security #
Date of Birth	Gender	Marital Status	Home Phone
Address			Cell Phone
			Work Phone
Email Address		How did you hear about us?	
Employer and/or Occupation			Pref. Language (Medicare Req'd)
Emergency Contact Name	Contact Phone		Race (Medicare Required)
Primary Insurance Co.	Policy #		Group #
Secondary Insurance Co.	Policy #		Group #
Preferred Pharmacy Name	Location		Pharmacy Phone

With which relatives or personal contacts may we discuss your Protected Health Information?

Name_____ Relationship _____

Name_____ Relationship _____

Please list the name, phone number and address of your previous primary care physician and all physician specialists currently caring for you:

Previous PCP:_____

Specialist:_____

Specialist:_____

Specialist:_____

TRINITY HEALTHCARE MEDICAL CENTER

COMPREHENSIVE CONSENT FORM

HIPPA PATIENT CONSENT

By signing this consent form, you give Dr. David Kuhn permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified and to which we have agreed. Protected health information is individually identifiable information we create or receive, including demographic information, or relating to your physical or mental health, for provision of health care services to you, and to the collection of payment for providing health care services to you.

You have the right to request that we restrict how protected health information about you is used and/or disclosed for treatment, payment or health care operations. We are not required to agree to any restrictions.

If you do not sign this consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment, or we are required by law to treat you. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

I authorize Dr. David Kuhn and his assistants/designee to discuss my medical history, diagnoses, treatment and prognosis as provided in the notice of privacy practices. I understand that this may include information regarding testing, examination, and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse. I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time. I understand that there are times when the law allows Dr. David Kuhn and his assistants/designees to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, Dr. David Kuhn and his assistants/designees may release information to doctors, nurses and others who provide me with health care or are prospective health care providers; to government agencies as authorized by law; to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand that this information may be released either orally or in document form.

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that my health condition may require a diagnostic workup and extended treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by Dr. David Kuhn, his consultants, associates, and assistants or designee. I also understand student nurses, medical students, residents and others in medical training programs may be among the individuals who provide care to me or review my medical record.

I also understand and acknowledge that Florida law provides that if any health care worker is exposed to my blood or other bodily fluid, Dr. David Kuhn and his assistants/designees may perform tests, with or without my consent, on my blood or other bodily fluids to determine the presence of any communicable disease including but not limited to hepatitis, HIV/AIDS and syphilis. I understand that the results of the tests taken under these circumstances are confidential and do not become a part of my medical record.

NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that Dr. David Kuhn has made no guarantees or warranties to me as to the outcome of examinations, diagnoses, or treatments.

IT IS TO BE KNOWN, that all testing and imaging facilities are not without possible error and Dr. David Kuhn and his assistants/designees cannot guarantee that imaging/laboratory results and/or specialist progress notes will be sent or forwarded to us in a timely manner or without the potential for a technical error upon transmission. I, the patient, and/or patient advocate, assume responsibility for making certain that I inform Dr. Kuhn and his assistants/designees of the testing and imaging that I have done, as often testing procedures and labs may be ordered but are not obtained as ordered or in the time frame discussed and agreed upon by the physician. I also absorb responsibility for following up as directed and scheduled, to review all results and take responsibility for any negative health outcomes that may result from my own non-compliance and/or negligence associated with the lack of such follow-up.

CONSENT TO OBTAIN MEDICATION HISTORY

A patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources including pharmacies and health insurers contribute to the collection of this history, which is stored in the practice electronic medical record system and becomes a part of your personal medical record. It is very important that you disclose all of your medications and non-prescription supplements to ensure that your recorded medication history is accurate. Some pharmacies do not make drug histories available and it might not include drugs purchased without using your health insurance. I give my permission to allow my health care provider to obtain my medication history from my pharmacy, my health plans, and my other health care providers. By signing this consent form, you are giving your healthcare provider, permission to collect, and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any insurance plan. This includes prescription medications used to treat HIV/AIDS, and medications used to treat mental health conditions.

Print Patient Name: _____ **Date**: _____

Patent or Surrogate Signature: _____

TRINITY HEALTHCARE MEDICAL CENTER

HIPPA Compliance and Patient Contact Information (Continued)

I wish to be contacted in the following manner (check all that apply):

__ **Home Telephone** _____
- __ OK to leave a message with detailed information
- __ Leave message with call back number only

__ **Work Telephone** _____
- __ OK to leave a message with detailed information
- __ Leave message with call back number only

__ **Cell Phone** _____
- __ OK to leave a message with detailed information
- __ Leave message with call back number only

__ **Written Communication**
- __ OK to mail to my home address_____
  _____
- __ OK to fax to this number _____
- __ OK to email to my email address _____

__ **Personal Contacts**
- __ OK to release Protected Health Information to the following person(s)

Name: _____ Relationship: _____
Address:_____
City/State:_____ Zip Code:_____
Best Contact Phone Number:_____

Name: _____ Relationship: _____
Address:_____
City/State:_____ Zip Code:_____
Best Contact Phone Number:_____

Name: _____ Relationship: _____
Address:_____
City/State:_____ Zip Code:_____
Best Contact Phone Number:_____

I understand it is my responsibility to change this information should circumstances change.

Patient or Guarantor Printed Name: _____

Patient or Guarantor Signature: _____ Date: _____

Financial Policy

TRINITY HEALTHCARE MEDICAL CENTER

Trinity Healthcare Medical Center as well as Dr. David Kuhn believe a good part of health care practice is to establish and communicate a financial policy to our patients. We are dedicated in providing the best possible care for you, and we want you to completely understand your financial policy prior to your visit.

VERIFICATION OF INFORMATION. By signing below, you have reviewed the above information which you entered into the PATIENT INFORMATION FORM and verify that all of your demographic information is correct. *You are also verifying that if health insurance is listed, it is current and there is valid coverage.*

PAYMENT is due at the time of your visit. We will accept cash, checks, Visa, MasterCard, and any payments through your Health Savings Account. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance or your coverage is currently under a preexisting condition clause, your payment is due in full at the time of your visit.

ESTIMATED COST OF SERVICES We are happy to always provide an estimated cost of payment required with all services. As insurance policies continuously change their reimbursement rates, deductible on plans, and covered services, we will do the best we can to provide a close estimate of costs. However, this cannot be a guarantee of payment you may be responsible for.

INSURANCE We participate with many insurance plans. We will file all of these insurance claims. Feel free to verify with us that we accept your insurance company. Please also remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable time period, you will be billed.

Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy. Patients who insist on "day of" urgent/emergent care but have insurance coverage through a policy which needs pre-authorization for visits may be billed the visit in full if the insurance denies payment. Please be aware of what your plan covers

RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. All bad checks written to this office are subject to collections and will be prosecuted in Marion County.

ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to David B. Kuhn MD/Trinity Healthcare Medical Center LLC for charges not covered by the assignment of insurance benefits.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to David B. Kuhn MD/Trinity Healthcare Medical Center LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize David B. Kuhn MD/Trinity Healthcare Medical Center LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to David B. Kuhn MD/Trinity Healthcare Medical Center LLC. I authorize L David B. Kuhn MD/Trinity Healthcare Medical Center LLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

RELEASE OF INFORMATION: I hereby authorize direct David B. Kuhn MD/Trinity Healthcare Medical Center LLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all the information needed to substantiate claim and payment.

COLLECTION FEES: I understand that in the event I do not make a payment after three subsequent months of statements being sent, my account will be considered overdue and all outstanding fees will be sent to collections.

CONTINUITY OF CARE: I understand that Trinity Healthcare Medical Center along with the physicians employed in this facility have the obligatory right to discontinue care if I "no show" to three appointments. Appointments cancelled within 24 hours of the scheduled appointment will be considered a "no show".

Patient or Guarantor Printed Name: _____

Patient or Guarantor Signature: _____ Date: _____

Authorization to Obtain/Release

TRINITY HEALTHCARE MEDICAL CENTER

Medical Records

Patient Name: _____

DOB: ___ /___ /____ SSN# ***-**-_____

Address: _____

I hereby request and authorize: Trinity Healthcare Medical Center to:

[ ] Obtain records from: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

OR

[ ] Send records to: _____
Address: _____
_____
_____
Phone: _____ Fax: _____

The type and amount of information to be used or released is as follows:

	History and Physical	From (date)	/ /	To (date)	/ /
	Consultation	From (date)	/ /	To (date)	/ /
	Pathology Report	From (date)	/ /	To (date)	/ /
	Laboratory	From (date)	/ /	To (date)	/ /

(i.e. MRI/CT/US/CR and include body part)

	Radiology	From (date)	/ /	To (date)	/ /	Test Type:	
	Radiology on CD	From (date)	/ /	To (date)	/ /	Test Type:	
	Cardiac Reports	From (date)	/ /	To (date)	/ /	Test Type:	
	Entire Record	From (date)	/ /	To (date)	/ /	Test Type:	

[ ] Other: _____

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____ Today's Date_____

PAST AND CURRENT MEDICAL HISTORY

TRINITY HEALTHCARE MEDICAL CENTER

Condition	Y	N	Comments/Year	Condition	Y	N	Comments/Year
Heart Attack				Stroke			
Cardiac Stents				Periph Artery Disease			
CABG				Aortic Aneurysm			
High Cholesterol				Anemia			
Heart Catheterization				Blood Clots			
Heart Valve Replaced				High Blood Pressure			
Heart Failure				Liver Problems			
Diabetes				Low Thyroid			
Neuropathy				Hashimoto's Disease			
Kidney Disease				Fibromyalgia			
Leg Ulcers/Wounds				Chronic Fatigue			
Amputations				Neck Pain			
COPD				Neck Surgery			
Asthma				Low Back Pain/Sciatica			
Smoker's Cough				Low Back Surgery			
Acid Reflux				Rheumatoid Arthritis			
Diverticulosis				General Arthritis			
Irritable Bowels				Migraines			
Depression				Seizures			
Anxiety				Enlarged Prostate			
Chronic Stress				Urinary Incontinence			
Active Cancer				Sexual Problems/ED			
Cancer in Remission				Skin Problems			

List any other diseases or conditions not listed above: _____

_____

_____

PAST SURGICAL HISTORY

Condition	Y	N	Comments/Year	Condition	Y	N	Comments/Year
Amputation				Gallbladder Removal			
Bowel Resection				Hysterectomy			
Hernia Repair				Ovaries Removed			
Pacemaker Placement				Prostate Surgery			
Thyroid Surgery				Knee Surgery			

List any other surgeries including the year:_____

_____

Patient Name: _____ Date of Birth: _____ Today's Date_____

FAMILY HISTORY

Condition	Y	N	Relationship	Condition	Y	N	Relationship
Heart Disease/Attack				Breast Cancer			

TRINITY HEALTHCARE MEDICAL CENTER

High Blood Pressure					Colon Cancer			
Stroke					Uterine/Ovarian Cancer			
Autoimmune Disease					Other Cancer			

List any other surgeries including the year:_____

_____

HEALTH SCREENING TESTS AND PROCEDURES STATUS

Most Recent Blood Work:
□ I have never had bloodwork Year: _____ Doctor/Clinic: _____

Most Recent Colonoscopy:
□ I have never had a colonoscopy Year: _____ Performing Doctor: _____

Most Recent Mammogram:
□ I have never had a mammogram Year: _____ Ordering Doctor: _____

Most Recent Bone Density Test:
□ I have never had a DEXA scan Year: _____ Ordering Doctor: _____

Most Recent Flu Shot:
□ I have never had a flu shot Year: _____ Clinic/Pharmacy: _____

Most Recent Pneumonia Shot:
□ I have never had a pneumonia shot Year: _____ Clinic/Pharmacy: _____

Most Recent HgbA1C (A1C) Diabetes Blood Test:
□ I have never had bloodwork Year: _____ Performing Doctor: _____
□ I am not diabetic

Most Recent Diabetic Eye Exam:
□ I have never had an eye exam Year: _____ Doctor/Clinic: _____
□ I am not diabetic

Most Recent PAP Smear:
□ I have never had a PAP Year: _____ Performing Doctor: _____

Most Recent Lower Extremity Arterial Ultrasound:
□ I have never had a LEAD ultrasound Year: _____ Ordering Doctor: _____

Most Recent PSA Prostate Blood Test:
□ I have never had a PSA test Year: _____ Doctor/Clinic: _____

TRINITY HEALTHCARE MEDICAL CENTER

Patient Name: _____ Date of Birth: _____ Today's Date_____

MEDICATION ALLERGIES

Medication	Type of Reaction	Medication	Type of Reaction

FOOD & ENVIRONMENTAL ALLERGIES

Trigger	Type of Reaction	Trigger	Type of Reaction

CURRENT MEDICATION LIST

Medication name, dosage, and how many times per day	Why are you taking this medication?

VITAMINS AND SUPPLEMENTS

Supplement or product name	Why are you taking this supplement?

TRINITY HEALTHCARE MEDICAL CENTER

SOCIAL HISTORY AND HEALTH HABITS

My general health is:	□ excellent	□ good	□ fair	□ poor
My health habits and lifestyle are:	□ excellent	□ good	□ fair	□ poor
I describe my stress as:	□ daily/high	□ moderate	□ occasional	□ rare

Relationship Status:

□ married □ single □ dating □ widow/widower □ divorced

Dietary Habits: (check all that apply)

□ No special diet habits	□ I prepare almost all my own meals	□ Strict low carb diet
□ I use intermittent fasting	□ I eat out _____ times per week	□ I eat fast food _____ x week
□ Vegetarian/Vegan	□ I eat packaged food _____ x week	□ I rarely/never eat red meat

Typical morning meal or snack:_____

Typical lunch meal or snack: _____

Typical dinner meal: _____

Typical evening snack: _____

Coffee/caffeine habits: _____

Sleep Habits:

I typically fall asleep at: _____ What medications/supplements do you take for sleep? _____

I typically wake up at: _____ □ I use an alarm to wake up

Exercise Habits:

□ I never intentionally exercise □ I exercise _____ times per week □ Aerobic exercise

Describe your outdoor activity or exercise habits: _____

Describe your work related physical activity: _____

Tobacco History:

□ I have never smoked cigarettes or chewed tobacco.
□ I currently smoke _____ packs of cigarettes per day. I have smoked for _____ years.
□ I quit smoking in the year _____. I smoked _____ packs per day for _____ years.
□ I use a pipe or chew tobacco.

Alcohol History:

□ I never drink alcohol.
□ I drink occasionally or socially.
□ I drink _____ glasses of wine each night.
□ I regularly drink _____ beer(s) or liquor drink(s) per day.

Illicit Drug History:

□ I have never used illicit drugs.
□ I currently use marijuana _____ times per week.
□ I currently use cocaine/heroin/amphetamines.
□ I have used cocaine/heroin/amphetamines/other in the past