Health Care Services, LLC
REGISTRATION FORM

PATIENT INFORMATION (Please Print)		
Last Name:	First Name:	Middle Initial:
Social Security Number:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (circle one): Single / Married / Divorced / Separated / Widowed
Responsible Party: ❑ Self ❑ Other Name:	Birth Date:	Age: Sex:
Mailing Address:	City/State:	Zip:
Email :	Home Phone: ( )	Cell Phone: ( )
Race:	Ethnicity: Hispanic/Latino or Not Hispanic/Latino or Other:	Language:
Employment Related: ❑ Yes ❑ No	Date of Accident:	Auto Accident: ❑ Yes ❑ No
Attorney:	Phone: ( )	
Occupation:	Employer:	Work Phone: ( )
Pharmacy Name:	Phone: ( )	Location:
Are you being referred by another Doctor? ❑ No ❑ Yes Name:		
Would you like us to supply you with an Advance Directive (Living Will)? ❑ Yes ❑ No Would you like us to supply you with a Do Not Resuscitate Form (DNR)? ❑ Yes ❑ No		

IN CASE OF EMERGENCY	
Name of Local Friend or Relative:	Home Phone: ( )
Relationship:	Cell Phone: ( )

METHOD OF PAYMENT				
❑ Insurance	❑ Cash	❑ Check	❑ Credit Card	❑ Other

Patient Name:____

Please fill in the appropriate bubble for each question completely.

Allergy

Rash?	O Yes O No	Itchy Eyes?	O Yes O No
Runny Nose?	O Yes O No	Ear Fullness?	O Yes O No
Scratchy Throat?	O Yes O No	Sinus Congestion?	O Yes O No

Respiratory

Wheezing?	O Yes O No	Chest Congestion?	O Yes O No
Shortness of Breath?	O Yes O No	Cough?	O Yes O No
Chest Pain?	O Yes O No		

Cardiology

Leg Pain?	O Yes O No	Chest Pain?	O Yes O No
Murmur?	O Yes O No	Palpitations?	O Yes O No
High Blood Pressure?	O Yes O No	Leg Swelling?	O Yes O No
High Cholesterol?	O Yes O No	Shortness of Breath?	O Yes O No
Dizziness?	O Yes O No	Varicose Veins?	O Yes O No

Constitutional

Chills?	O Yes O No	Weakness?	O Yes O No
Weight Gain?	O Yes O No	Weight Loss?	O Yes O No
Loss of Appetite?	O Yes O No	Fatigue?	O Yes O No
Fever?	O Yes O No		

Dermatology

Hair Loss?	O Yes O No	Dry/Sensitive Skin?	O Yes O No
Itching?	O Yes O No	Hives?	O Yes O No
Rash?	O Yes O No	Acne?	O Yes O No
Mole?	O Yes O No	Skin Cancer?	O Yes O No
Lumps?	O Yes O No		

Endocrinology

Weight Gain?	O Yes O No	Sleep Disturbance?	O Yes O No
Fatigue?	O Yes O No	Cold Intolerance?	O Yes O No
Excessive Thirst?	O Yes O No	Heat Intolerance?	O Yes O No
Excessive Urination?	O Yes O No	Diabetes?	O Yes O No
Weight Loss?	O Yes O No		

Ear/Nose/Throat

Ear Pain?	O Yes O No	Hearing Loss?	O Yes O No
Ear Discharge?	O Yes O No	Change in Voice?	O Yes O No
Trouble Swallowing?	O Yes O No	Sore Throat?	O Yes O No
Nasal Discharge?	O Yes O No	Ringing in Ears?	O Yes O No
Cough?	O Yes O No	Sinus Pain?	O Yes O No
Nose Bleed?	O Yes O No		

Gastroenterology

Jaundice?	O Yes O No	Trouble Swallowing?	O Yes O No
Nausea?	O Yes O No	Diarrhea?	O Yes O No
Heartburn?	O Yes O No	Constipation?	O Yes O No
Vomiting?	O Yes O No	Blood in Stool?	O Yes O No
Abdominal Pain?	O Yes O No	Hemorrhoids?	O Yes O No

Hematology/Lymph

Swollen Glands?	O Yes O No	Varicose Veins?	O Yes O No
Fatigue?	O Yes O No	Easy Bruising/Bleeding?	O Yes O No

Musculoskeletal

Neck Pain?	O Yes O No	Joint Swelling?	O Yes O No
Back Pain?	O Yes O No	Leg Cramps?	O Yes O No
Joint Stiffness?	O Yes O No	Fracture?	O Yes O No
Joint Pain?	O Yes O No	Carpal Tunnel?	O Yes O No

Neurology

Loss of Consciousness?	O Yes O No	Seizures?	O Yes O No
Tremor?	O Yes O No	Insomnia?	O Yes O No
Head Injury?	O Yes O No	Memory Loss?	O Yes O No
Headache?	O Yes O No	Dizziness?	O Yes O No
Tingling/Numbness?	O Yes O No	Gait Abnormality?	O Yes O No

Ophthalmology

Eye Pain?	O Yes O No	Drainage from Eyes?	O Yes O No
Double Vision?	O Yes O No	Blurred Vision?	O Yes O No
Diminished Vision?	O Yes O No	Seasonal Eye Symptoms?	O Yes O No
Eye Irritation?	O Yes O No	Loss of Vision?	O Yes O No

Psychology

Confusion?	O Yes O No	Suicidal Ideas?	O Yes O No
Depression?	O Yes O No	Eating Disorder?	O Yes O No
High Stress Level?	O Yes O No	Mental/Physical Abuse?	O Yes O No
Sleep Disturbance?	O Yes O No	Anxiety?	O Yes O No

Urology

Difficulty Urinating?	O Yes O No	Voiding Dysfunction?	O Yes O No
Blood in Urine?	O Yes O No	Recurrent Infections?	O Yes O No
Frequent Urination?	O Yes O No	Bedwetting?	O Yes O No
Urinary Incontinence?	O Yes O No		

Social History

Smoking?	O Yes O No	Alcohol?	O Yes O No
Recreational Drug Use?	O Yes O No	Sexually Active?	O Yes O No
Exercise?	O Yes O No	Travel Outside the U.S.?	O Yes O No
Caffeine?	O Yes O No	Occupation?	____________________

Marital Status? O Married O Single O Divorced O Widowed

Patient Name:____

Past Medical History

O NONE

O Heart Disease
O High Blood Pressure
O High Cholesterol
O COPD/Emphysema
O Asthma
O Diabetes
O DVT/ Blood Clots
O Stroke
O TIA
O Anemia
O Migraines/Headaches
O Cancer (Type):____________________________
O Osteoporosis
O Arthritis
O Neck Condition
O Back Condition
O GERD
O Other (Please List):____
____

Past Surgical History

____
____

Allergies

____

Current Medications

Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________
Name:______________________________Dose:______________________

Family History

Father: O Alive O Deceased Age___ Medical Conditions:________________
Mother: O Alive O Deceased Age___ Medical Conditions:________________
Paternal Grand Father: O Alive O Deceased Age___ Medical Conditions:____________
Paternal Grand Mother: O Alive O Deceased Age___ Medical Conditions:____________
Maternal Grand Father: O Alive O Deceased Age___ Medical Conditions:____________
Maternal Grand Mother: O Alive O Deceased Age___ Medical Conditions:____________
Siblings: O Alive O Deceased Age___ Medical Conditions:____________________
Children: O Alive O Deceased Age___ Medical Conditions:____________________

AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

CONSENT TO TREATMENT: I understand that medical treatment is necessary for the patient and that medical care; treatment and procedures will be performed by licensed physicians, and/or other employees of Health Care Services, herein after "HCS" during normal operating hours. I understand that medical treatment only is being provided. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, which may be obtained.

COMPLICATIONS: I understand that it is my responsibility to HCS to immediately report any changes in my condition.

SELECTION OF A PERSONAL PHYSICIAN: I understand that if hospitalization or further treatment is required, HCS will attempt to contact the patient's personal physician to provide service. If the patient does not have a personal physician or the personal physician cannot be contacted, HCS may select any other qualified physician to provide this care.

AGREEMENT TO PAY SERVICES: For and in consideration of the care and treatment provided to the patient not covered by insurance, I promise to pay to HCS, all charges for services rendered to or on behalf of the patient not covered by insurance. In the event the account becomes delinquent and is turned over to a collection agency or an attorney, the patient shall be responsible for any and all additional costs, fees and/or charges incurred for such collection efforts by said agency and/or attorney.

Co-Payment Responsibility: If your insurance policy requires a co-payment, this will be required at the time of service.

RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS:

I hereby authorize and direct payment to HCS for medical benefits, if any, otherwise payable to me under the terms of my insurance. Furthermore, I authorize HCS and give them power of attorney to endorse/sign my name on any and all checks, drafts or money orders for payment to HCS or to any Doctor who is employed by HCS for services rendered to me as a result of injury or illness for which I have treated by said office.

CHECK APPROVAL: The following information is required prior to accepting personal checks. This form need only be completed once and will be kept on file with your medical records. Please present your driver's license at the front desk. A minimum of $25.00 service charge will be added to your account for any returned check payments in addition to any bank service charges incurred by HCS.

NOTE: All returned checks will be turned over to the state attorney for criminal prosecution. I have read and fully understand the above. The information I have provided is true to the best of my knowledge.

I acknowledge full financial responsibility for services rendered by Health Care Services or employees, and authorize transfer of all unpaid amounts to my Discover/Visa/Master Card/American Express, or any other credit card I may have used.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Health Care Services reserves the right to modify the privacy practices posted in the waiting room.

I have received a copy of the Notice of Privacy Practices for Health Care Services.

I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS, AND FULLY UNDERSTAND THE SAME.

INDIVIDUAL PATIENT DISCLOSURE FORM

I hereby give my authorization to disclose my protected health information to (name of person such as daughter, husband, etc):

____

I understand this authorization provides that:

- **I have the right to access my protected health information to be used or disclosed.**
- **I may revoke this authorization at any time by contacting your office.**
- **This practice will not condition treatment on my providing authorization.**
- **I will receive a copy of this completed and signed authorization form.**

MISSED APPOINTMENT AGREEMENT

As a courtesy, our office will do our best to confirm your appointment the day before it is scheduled. If you do not show up at your scheduled appointment time without giving a 24 hour notice, your appointment will be considered a **NO-SHOW**. There will be a $25.00 charge for a **NO-SHOW** appointment for a doctor visit and a $50.00 charge for a **NO-SHOW** diagnostic study appointment. This is our policy and it is your responsibility as the patient to know when your appointment is. Please give us at least 24 hours notice if you are unable to keep your scheduled appointment. This policy is effective as of 01/01/2013. Thank you for your cooperation and understanding.

PATIENT'S NAME: ____

SIGNATURE: ______________________________ DATE: ____________________

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ________________

First Middle Last

Mailing Address: ______________________________ Telephone: ________________

____

The undersigned hereby requests and authorizes the release of records **from** the following:

____

To the following:

- ☐ Paul Elliott, D.O.
- ☐ Suzann Leslie, D.O.
- ☐ Michael Carpino, P.A.
- ☐ Olympia Morris, P.A.

- ☐ 506 SW Federal Highway Suite 101, Stuart, FL 34994 Telephone: 772-288-6300 Fax: 772-288-6374
- ☐ 1889 SE Port St. Lucie Blvd. Port St Lucie, FL 34952 Telephone: 772-224-2221 Fax: 772-288-6374

- ☐ Most recent History and Physical or specific date(s):________________
- ☐ Most recent Discharge Summary or specific date(s):________________
- ☐ Most recent lab result or specific date(s):________________
- ☐ Pathology report, specific date(s):________________
- ☐ Radiology and other Diagnostic Reports/test results, specific date(s):________________
- ☐ Entire Record (All Labs, Diagnostic Reports, Operative Notes, Pathology Reports, Office Notes)

Certain confidential information may be in your records. Please check below to specifically authorize disclosure of:

- ☐ HIV/AIDS Test Results/Record Notations
- ☐ STD Records (Sexually Transmitted Diseases)
- ☐ Mental Health Treatment Records (excluding **Psychotherapy Notes – separate authorization form required for release**)
- ☐ Drug and Alcohol Treatment Records
- ☐ Genetic Testing

Purpose(s) of Request: ______________________________

Pursuant to Florida Law and the Health Insurance Portability and Accountability Act if 1996 (HIPPA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPPA and may no longer be protected by HIPPA. A covered entity (that is, a source of medical information about you) may not condition, treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to the address listed below, **Medical Records Custodian, 506 SW Federal Hwy. Suite 101, Stuart, FL 34994,** provided that the information has not yet been released.

This authorization expires in six (6) months unless otherwise specified: ______________________________

Patient or Authorized Signature: ______________________________ Date: ________________

Relationship to Patient: ________________ Witness: ________________ Date: ________________

Explain and/or attach Legal Documentation

Revised 11/08/2018