LAST NAME: _____ FIRST NAME _____ MI ___

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____

DATE OF BIRTH _____ SEX: MALE _____ FEMALE ____ DRIVER'SLICENSE# _____

SOCIAL SECURITY NUMBER _____ MARITAL STATUS: S M W DIV SEP RACE _____

EMERGENCY CONTACT:

LAST NAME _____ FIRST NAME _____

PHONE NUMBER _____ RELATIONSHIP TO PATIENT _____

INSURANCE:

PRIMARY INSURANCE _____ ID NUMBER _____

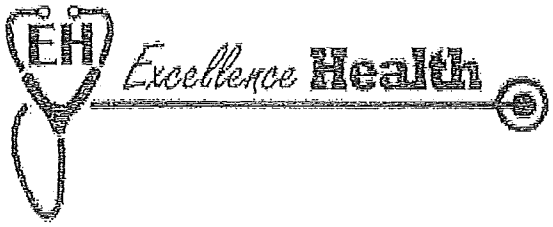
SECONDARY INSURANCE _____ ID NUMBER _____

EMPLOYER _____

THIS OFFICE WILL CHARGE A $25.00 NO SHOW FEE SO YOU ARE ADVISED TO CALL THE OFFICE WITHIN 24-48 HOURS IF YOU NEED TO CANCEL OR RESCHEDULE.

Patient Signature **Date**

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: WWW.Excellencehlth.com



General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date:

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, if we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The Practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name Patient or Responsible Party

_____

Patient Signature or Responsible Party Date

_____

Relationship to Patient (if other than patient)

Witness: _____

Printed Name Practice Representative

_____ __/__/__

Signature Date

If none please N/A & Sign!!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ Signature of Patient or Legal Representative

_____ Date

_____ Printed Name of Patient

_____ Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name:_____ Relationship _____ Phone_____

2. Name:_____ Relationship:_____ Phone:_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____, Please initial _____.

Or

_____ I decline to receive communications via text.

_____ I decline to receive communications via email.

Revocation – Use this area to document revocation of a previous form of communication.

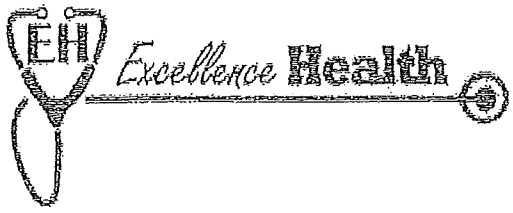
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.



CONTROLLED SUBSTANCE AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines, sedatives and stimulants.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: WWW.Excellencehlth.com

_____ I agree to use this pharmacy _____ located at this address _____ with the telephone number of _____ for filling my prescriptions for all of my pain medicine.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused pain medicine to every office visit.

_____ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 201__.

Patient Signature: _____

Patient Name (printed):_____

Provider signature: _____

Provider Name (printed):_____

Witnessed by: Signature: _____

Name (printed):_____

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: WWW.Excellencehlth.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name:_____ DOB:_____

Address: _____

Phone: _____

I give EXCELLENCE HEALTH the authorization to obtain/release my medical records.

Requesting records from:

_____

Address: _____

Phone: _____ Fax:_____

Release: All Records _____ Labs _____ Radiology _____ Consults _____ Other_____

PLEASE FAX RECORDS TO: 386-238-9063

I understand that my medical record may contain sensitive information and will include general medical information from my medical record as well as psychiatric/psychological information, alcohol and/or drug abuse information, HIV/AIDS testing and other information pertaining to these tests or to treatment in connection with these test results and/or testing for sexually transmitted diseases (STD's).

This information is disclosed to you from records whose confidentiality are protected by law. Any redisclosure is strictly prohibited without written permission of the patient/client/legal representative identified below.

I understand this consent is revocable by me, in writing, at any time except after the action has taken place. I also understand that this consent will expire either one year after the date of the signature or automatically when the records requested on this form have been turned over to the above requested provider.

Date: _____ Patient's Signature: _____

Printed Name: _____

Date: _____ Witness Signature: _____

Printed Name: _____

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: www.excellencehlth.com

Excellence Health

HEALTH HISTORY

Patient Name: _____ DOB: _____ Date: _____

PAST SURGICAL HISTORY: Please list year and type of any and all surgeries you have had in the past.

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY: Please list any and all chronic medical conditions that you have been diagnosed with. _____

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Do you current smoke cigarettes/cigars? Yes / No If so, how many packs per day? If so, how many years have you been smoking? _____

If not, have you ever smoked cigarettes/cigars in the past? Yes / No

When did you quit smoking? _____

Do you consume alcoholic beverages? Yes / No If so, how many glasses per day? _____

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: WWW.Excellencehlth.com

FAMILY HISTORY:

Significant health problems of:

Father: _____

Mother: _____

Siblings: _____

WOMEN ONLY:

Age of onset of menstruation: _____ Date of last period: _____

Number of pregnancies: _____ Number of live births: _____

Date of last Pap smear? _____

MEN ONLY:

Do you get up at night to urinate? Yes / No If so, how many times? _____

Date of last prostate exam? _____

MENTAL HEALTH HISTORY:

Do you feel depressed? Yes / No

Do you have panic attacks? Yes / No

Do you cry frequently? Yes / No

Do you have problems with your appetite? Yes / No

Have you ever attempted suicide? Yes / No

Do you have trouble sleeping? Yes / No

Have you ever seen a counselor/psychologist/psychiatrist? Yes / No

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: WWW.Excellencehlth.com

MEDICATIONS

Do you have any medication allergies? Yes / No

If so, what medications are you allergic to? _____

_____

CURRENT PRESCRIPTION MEDICATIONS:

NAME OF MEDICATION DOSAGE FREQUENCY

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PHARMACY:_____PHONE:_____

1630 Mason Avenue Unit C
Daytona Beach, Fl 32117
O: 386-238-9064
F: 386-238-9063
Web: WWW.Excellencehlth.com