



In the Sea Of Healthcare Choices, Let Us Be Your Anchor.

I CAME HERE TODAY TO SEE DR. _____.

DATE: _____

PATIENT INFORMATION: (Please Print Patient's Complete Legal Name)

PATIENT NAME: First _____ MI _____ Last _____
STREET ADDRESS: _____ Apt. or Unit #: _____
CITY / STATE / ZIP: _____
HOME TELEPHONE # (INC. AREA CODE): _____
CELL / BEEPER # (INC. AREA CODE): _____
EMERGENCY TELEPHONE # (INC. AREA CODE): _____
EMERGENCY CONTACT NAME: _____
DATE OF BIRTH: _____
SEX (Circle One): Male Female
MARITAL STATUS (Circle One): Single Married Divorced Widowed
SOCIAL SECURITY #: _____
LOCAL PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____
NON-LOCAL PRIMARY CARE PHYSICIAN (if applicable): _____
PHARMACY: _____

PATIENT EMPLOYER / SCHOOL INFORMATION

NAME OF EMPLOYER / SCHOOL: _____
(CIRCLE ONE): Full Time Part Time Retired Unemployed
STREET ADDRESS: _____ Suite / Unit #: _____
CITY / STATE / ZIP: _____
TELEPHONE # (INC. AREA CODE): _____ Ext. #: _____

NORTHERN ADDRESS

STREET ADDRESS: _____ Apt. or Unit #: _____
CITY / STATE / ZIP: _____
TELEPHONE # (INC. AREA CODE): _____

INSURANCE INFORMATION

**NOTE: We will need to make a copy of your insurance card(s) for billing information. If the policy holder is different, please complete the following:
POLICY HOLDER'S NAME: _____
STREET ADDRESS: _____ Apt. or Unit #: _____
CITY / STATE / ZIP: _____
TELEPHONE # (INC. AREA CODE): _____ Ext. #: _____
DATE OF BIRTH: _____
SEX (Circle One): Male Female
SOCIAL SECURITY #: _____
EMPLOYER: _____

By signing below, I acknowledge the following:

***A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. Anchor Health Centers cannot be bound by any divorce or other family relationship contracts.

***I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and it's agents, or any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.

***I have reviewed and understand all the information on the second page of this document, including the HIPAA Notice of Privacy Practices Statement, as indicated with my signature and date below.

Signature _____ Date _____

Welcome to Anchor Health Centers!
Thank you for choosing us as your healthcare provider!

We believe it is important for our patients to fully understand our **Financial Policy** and acknowledge that they have read our policy. Please review the **Financial Policy** document carefully. To avoid any misunderstanding regarding this policy, it is necessary for you to read and sign below, before treatment is rendered. Please ask us any questions you may have regarding this document and take a copy of this policy home for future reference if necessary.

OUR FINANCIAL POLICY

This policy covers office visits, lab or radiology testing and therapy services performed at Anchor Health Centers' facilities. By signing below, I am agreeing to the terms of this Financial Policy.

Medicare Patients: We are participating physicians with Medicare. This means that you will be responsible for the 20% of the approved Medicare fee for covered services, **the \$135 yearly deductible and full payment of any non-covered services.** Non-covered services include, but are not limited to, complete annual physical examinations and most diagnostic tests performed for screening purposes.

Payment is at the time of service: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate (please see insurance below). Returned checks will be charged a \$25 service fee, no exceptions.

Insurance: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time that you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those **patients in insurance plans with which we ARE participating providers, all co-payments, deductions and non-covered services are due at the time of service.** We will file the insurance claim to the insurance company. In the event that your insurance coverage changes to **a plan where we ARE NOT participating providers, we will require payment in full at the time of service.** You will be responsible to submit a claim with your insurance company for reimbursement. Any charges that are not paid by your insurance are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

Collections: Please note, if payment is not received from either you or your insurance company within 60 days from the date of services, your account will be considered delinquent and subject to referral to an outside collection agency.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES STATEMENT

I have been given the opportunity to review Anchor Health Centers' (AHC) Notice of Privacy Practices (a separate document) prior to signing this acknowledgment. AHC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained from this office or by forwarding a written request to the Office of Clinical Compliance and Quality Improvement at 801 Anchor Rode Dr., Suite 300; Naples, FL 34103.

I hereby acknowledge that AHC may use and disclose my protected health information to carry out treatment, payment and healthcare operations. AHC's Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization.

I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restriction and Revocations must be in writing. By signing this document I am acknowledging that I have received AHC's Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If AHC determines that my restrictions make it impossible for them to carry out my treatment, payment and healthcare operations, they may refuse to accept me as a patient.

I agree to the Financial Policy and acknowledge that I received the Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date

Patient's Name

Name of Legal Guardian

Name: _____ D.O.B. _____ Age: _____ Physician: _____

MEDICATION ALLERGIES: NONE: _____

IMMUNIZATIONS:
LAST TETANUS _____ (Year)
Up to Date? Yes _____ **No** _____

Childhood Immunizations Up to Date?
Yes _____ **No** _____

Your Medical History:

- | | |
|---|---|
| <input type="checkbox"/> Diabetes controlled by;
<input type="checkbox"/> Diet
<input type="checkbox"/> Pills
<input type="checkbox"/> Insulin
<input type="checkbox"/> Heart attack (date: _____)
<input type="checkbox"/> Other heart disease (type: _____)
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Stroke
<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer (type: _____)
<input type="checkbox"/> Asthma
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Other lung disease (type _____)
<input type="checkbox"/> Arthritis (type: _____)
<input type="checkbox"/> Auto immune disease (type: _____)
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Reflux / Heartburn
<input type="checkbox"/> Gallstones
<input type="checkbox"/> Other stomach illness (type: _____)
<input type="checkbox"/> Hepatitis (type: _____)
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Kidney disease (type _____)
<input type="checkbox"/> Depression/anxiety
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Obesity |
|---|---|

Please list all hospitalizations and surgeries – include dates if known:

Medications: Please list all medications you are currently taking, include doses and over the counter meds.

1) Med: _____ Strength: _____ Times/Day: _____	6) Med: _____ Strength: _____ Times/Day: _____
2) Med: _____ Strength: _____ Times/Day: _____	7) Med: _____ Strength: _____ Times/Day: _____
3) Med: _____ Strength: _____ Times/Day: _____	8) Med: _____ Strength: _____ Times/Day: _____
4) Med: _____ Strength: _____ Times/Day: _____	9) Med: _____ Strength: _____ Times/Day: _____
5) Med: _____ Strength: _____ Times/Day: _____	10) Med: _____ Strength: _____ Times/Day: _____

Family History

Relative	Alive Y or N (circle)	Age (if deceased, age at death)	Cause of Death	Illnesses
Mother	Y N			
Father	Y N			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	Y N			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	Y N			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	Y N			

Social History:

Employment? Occupation _____ Retired _____ Unemployed _____
 Marital status? Single _____ Married _____ Divorced _____ Widowed _____
 Do you smoke? No _____ if Yes, _____ #packs/day. If Quit when _____ # years smoked _____ packs/day _____
 Drink alcohol? No _____ if Yes, _____ Type _____ Quantity _____
 Use any illicit Drugs? No _____ if Yes, _____ Type _____ How often? _____



Name: _____ D.O.B. _____ Age: _____ Date: _____

What problem are you here to have evaluated? _____

Preferred Pharmacy: _____

Please circle or **underline** any symptoms you presently have:

General: fever, chills, sweats, fatigue, weakness, poor appetite, weight loss, weight gain,
other _____

Head: injury, headache, facial pain, hair loss, other _____

Eyes: glasses/contacts, injury, pain, redness, irritation, itching, drainage, change in vision, double vision,
foreign body sensation, sensitivity to light, other _____

Ears: injury, pain, discharge, hearing problems, ringing in ears, other _____

Nose: congestion, stuffiness, runny nose, discharge, nosebleed, other _____

Throat: soreness, painful swallowing, toothache, gum swelling or bleeding, sores in mouth or throat,
painful tongue, other _____

Neck: injury, pain, lumps, goiter, other _____

Breasts: injury, pain, lumps, discharge, other _____

Heart: chest pain or pressure, irregular heart beat or palpitations, rapid heart beat, trouble breathing,
leg swelling, other _____

Lungs: short of breath, cough, sputum (what color? _____), wheezing, painful breathing,
other _____

Abdomen: injury, pain, nausea, vomiting, diarrhea, constipation, indigestion, heartburn, gas, black BM's,
blood in stool, rectal pain, hemorrhoids, hernia, other _____

Urinary: burning, urgency, frequent urination, back or flank pain, blood in urine, loss of bladder control,
decreased urine stream, other _____

Female Genital: Last Menstrual Period _____, sores, discharge, pain, menstrual problems, abnormal
vaginal bleeding, painful intercourse, impaired sexual function, other _____

Male Genital: sores, discharge, pain, impaired sexual function, other _____

Muscle/ Skeletal: injury, muscle or joint pains, joint swelling, neck pain, back pain, calf pain, swelling,
stiffness, other _____

Skin: laceration, injury, wound, rash, itching, other _____

Neuro: fainting, blackouts, seizures, numbness or loss of sensation, weakness, paralysis, tremors,
loss of balance, other _____

Psych: anxiety, depression, stress, sleep problems, hallucinations, suicidal thoughts, domestic violence,
other _____

Endocrine: heat or cold intolerance, excessive sweating, excessive thirst or hunger, excessive urination,
other _____

Heme/Lymph: bruising, bleeding, swollen lymph nodes (glands), other _____

Allergic/Imm: HIV/AIDS, infection, allergies, other _____