ISLAND DOCTORS
PATIENT REGISTRATION
(PLEASE PRINT)

NAME _____ **S / M / D / OTHER** **M / F**
(CIRCLE CORRECT RESPONSE) **(MARITAL STATUS)** **(SEX)**

SS#_____ **DATE OF BIRTH** _____/_____/_____ **AGE** _____

MAILING ADDRESS _____

PHYSICAL ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____**EMAIL**_____

HOME PHONE# (_____)_____**CELL PHONE# (_____)**_____

EMPLOYER _____ WORK PHONE#(_____)_____ EXT: _____

DO YOU HAVE A LIVING WILL? YES OR NO (CIRCLE RESPONSE)

NEXT OF KIN:

NAME: _____ **RELATIONSHIP** _____ **PHONE#(_____)**_____

PRIMARY INSURANCE AND BILLING INFORMATION (CIRCLE TYPE OF PAYMENT)

INSURANCE COMPANY: _____

POLICY HOLDER _____RELATIONSHIP TO PATIENT _____

POLICY HOLDER DATE OF BIRTH _____/_____/_____ SS# _____

INSURANCE ID# _____

SECONDARY INSURANCE AND BILLING INFORMATION (CIRCLE TYPE OF PAYMENT)

INSURANCE COMPANY: _____

POLICY HOLDER _____RELATIONSHIP TO PATIENT _____

POLICY HOLDER DATE OF BIRTH _____/_____/_____ SS# _____

INSURANCE ID# _____

******I UNDERSTAND THAT PAYMENT FOR SERVICE IS DUE AT TIME OF SERVICE******

FOR HUMANA GOLD MEDICARE ADVANTAGE HMO PATIENTS -I UNDERSTAND THAT ISLAND DOCTORS PERFORMS SEVERAL NON-INVASIVE SCREENING TESTS AT MY FIRST VISIT AND PERIODICALLY DURING MY RELATIONSHIP WITH ISLAND DOCTORS. I UNDERSTAND THAT THESE TESTS ARE DONE FOR MY BENEFIT AND AS PREVENTATIVE CARE MEASURES. THESE TESTS ARE AT NO COST TO THE PATIENT AND ARE ONLY SUBMITTED TO MY INSURANCE COMPANY FOR THEIR HEALTH INFORMATION RECORDS, AND ARE DONE AS AN AID TO HELP MY DOCTOR BEST TREAT ME.

I HEREBY REQUEST AND CONSENT TO MEDICAL TREATMENT AND EXAMINATION BY ISLAND DOCTORS / DR. ROY H. HINMAN II.

PATIENT'S SIGNATURE _____ **DATE**_____

IF PATIENT IS A MINOR PARENT/GUARDIAN SIGNATURE _____

RELATIONSHIP TO MINOR _____**PRINTED NAME** _____

PATIENT NAME _____ **DOB** _____

PLEASE CHECK THE APPROPRIATE BOX IF YOU OR ANY OF YOUR BLOOD RELATIVES (LIST RELATIONSHIP OF THE RELATIVE) WHO HAS EVER HAD ANY OF THESE CONDITIONS:

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES			ANEMIA		
HIGH BLOOD PRESURE			LEUKEMIA		
STROKE			SICKLE CELL		
HEART ATTACK			BLEEDING PROBLEMS		
ASTHMA			STOMACH ULCER		
MIGRAINE HEADACHES			GALLSTONES		
CANCER			SEIZURES		
EMPHYSEMA			TUBERCULOSIS		
KIDNEY PROBLEMS			ALCOHOLISM		
ARTHRITIS			SUICIDE		
GLAUCOMA/EYE PROB.			DEPRESSION		
SKIN RASH			MENTAL ILLNESS		
OTHER			OTHER		

OPERATIONS/SURGERY/HOSPITALIZATIONS:

BLOOD TRANSFUSIONS:

MEDICATIONS: _____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES: **(any reaction to any medication of any kind?)** **IF NONE, CHECK HERE _____; if yes, please list below:**

_____ _____ _____ _____ _____ _____

OCCUPATION/WORK HISTORY: **Any exposure to pesticides, chemicals, or other hazards?**

No _____ Yes _____ If yes, what kind_____

FAMILY HOUSEHOLD:

Who lives at home with you? _____

HABITS: Cigarettes: _____Packs per day x _____years; if quit, # of years _____.

Other tobacco products: _____

Drug Use: _____**Caffeine (coffee/colas):** _____

Seat Belt use: No ____ Yes____ Exercise: No_____ Yes_____, Method _____

FOR MEN ONLY: (CIRCLE RESPONSE)
DO YOU PERFORM TESTICULAR SELF-EXAM? **YES** **NO**

FOR WOMEN ONLY:
DO YOU PERFORM A MONTHLY BREAST SELF-EXAM? **YES** **NO**

CHILDHOOD IMMUNIZATIONS: SEE ATTACHED COPY/COPY REQUIRED_____

****PLEASE PROVIDE A COPY OF CHILD'S IMMUNIZATION RECORD FOR OUR FILES****

Signature _____ **Date:** _____
(Patient/Parent/Guardian)

PATIENT NAME _____ **DOB** _____

IT IS OUR POLICY THAT PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY, WE WILL FILE YOUR INSURANCE. HOWEVER, **YOU** ARE RESPONSIBLE FOR ALL COPAYS, DEDUCTIBLES, AND NON- COVERED SERVICES AT THE TIME OF SERVICE.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I CERTIFY THAT THE INFORMATION PROVIDED ON THE FRONT OF THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THIS INFORMATION. A PHOTOSTATIC COPY OR OTHER REPRODUCTION OF THIS WILL BE AS VALID AS THE ORIGINAL.

DATE: _____ SIGNATURE: _____

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE ISLAND DOCTORS TO FURNISH MY INSURANCE COMPANIES, HOSPITALS, REFERRING OR CONSULTING PHYSICIANS AND BILLING AGENTS ALL INFORMATION WITH REGARD TO MY MEDICAL CARE.

DATE: _____ SIGNATURE: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ISLAND DOCTORS FOR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE.

DATE: _____SIGNATURE: _____

NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

DATE: _____SIGNATURE: _____

Island Doctors

NOTICE OF PRIVACY PRACTICES

This notice describes how certain information about **you** (the **Patient**) may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact the office administrator at **(904) 825-4368**

1. **Uses and disclosures for Treatment Payment, and Health Care Operations**

   Island Doctors may use or disclose your Protected Health Information (**PHI**) for Treatment, Payment, and Health Care Operation purposes with your consent. To help clarify these terms, here are some definitions:

   - ***PHI*** refers to information in your health record that could identify you.
   - ***TREATMENT*** is when Island Doctors provides, coordinates, or manages your health care and other services related to your health care. We may disclose certain information about our patients to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of them.

   For example, a doctor treating a patient for a broken leg may need to know if he/she has diabetes because diabetes may slow the healing process.

   - ***PAYMENT*** is when Island Doctors obtains reimbursement for your healthcare.
     Example of payment is when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
   - ***HEALTHCARE OPERATIONS*** are activities that relate to the performance and operation of our practice. Examples of how we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
   - ***USE*** applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
   - ***DISCLOSURE*** applies to activities outside our office, such as releasing, transferring, or providing access to information about you to other parties.

2. **Uses and Disclosures Requiring Authorization**

   Island Doctors may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

   You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization: (2) If the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

3. **Uses and Disclosures with Neither Consent nor Authorization**

   Island Doctors may use or disclose PHI without your consent or authorization in the following circumstances:

   - ***CHILD ABUSE***: If we know, or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.
   - ***ADULT AND DOMESTIC ABUSE***: If we know, or have the reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
   - ***HEALTH OVERSIGHT ACTIVITIES****:* Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspection, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.
   - ***JUDICIAL OR ADMINISTRATIVE PROCEEDINGS****:* If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law and we will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
   - ***SERIOUS THREAT TO HEALTH OR SAFETY****:* When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

4. **Patient's Rights and Island Doctor's Duties**
    - ***PATIENT'S RIGHTS:***
        - ***RIGHT TO REQUEST RESTRICTIONS:*** You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
        - ***RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are being seen by Island Doctors. Upon request, we will send bills to another address.
        - ***RIGHT TO INSPECT AND COPY:*** You have the right to inspect and/or obtain a copy of PHI in our health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.
        - ***RIGHT TO AMEND:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
        - ***RIGHT TO AN ACCOUNTING:*** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.
        - ***ISLAND DOCTOR'S DUTIES:***
            - We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
            - We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

5. **Complaints**

If you are concerned that we have violated your privacy rights or disagree with a decision we made about access to your records, you may file a written complaint with our practice or to the Secretary of the U.S. Department of Health and Human Services.

ISLAND DOCTORS

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

Patient Name: _____
Last First Initial

Address: _____
Street City State ZIP

Phone: (____) _____ **DOB:** ____ / ____ / ____ **SSN:** XXX-XX- _____

1. _____
NAME OF PREVIOUS PROVIDER **ADDRESS**

Phone: _____ **Fax:** _____

2. _____
NAME OF PREVIOUS PROVIDER **ADDRESS**

Phone: _____ **Fax:** _____

I authorize the above-named previous provider to release medical information from my medical records to:

ISLAND DOCTORS
1023 St. Johns Ave.
Palatka, FL 32177
PH: (904) 664-8460 **FX:** (904) 794-2715

For the purpose of review/examination and further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

☐ **Entire Record** ☐ **Specific Information:** _____ ☐ **Old Records from Previous Physicians**

Preventive Records:
☐ **Last Two Years Eye Exam** ☐ **Colonoscopy (Within Last 10 Years)** ☐ **Last Mammogram** ☐ **Last Bone Density**

I give special permission to release any information regarding:
(Initial on the line(s) below that you grant us permission to release the information to the above)

_____ Substance Abuse _____ Psychiatric / Mental Health Info. _____ HIV Info.

This authorization will automatically expire **one (1) year from the date signed**. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed: _____ Date: ____ / ____ / _____
(If not patient, state relationship)

Reason for Request: _____ **Witness:** _____

ISLAND DOCTORS
1023 St. Johns Ave., Palatka, FL 32177
PH (386) 328-2222 FX (386) 328-2238

I, _____, give

Island Doctors Providers and Staff permission to speak with,

_____ my _____
(Name) (Relation)

in regards to any and all of my medical condition and any information in my medical chart, until otherwise indicated in writing.

Thank you.

_____
Signature

_____
Witness

_____
Date