High Springs Pediatrics / Primary Care

19228 NW US HWY 441
High Springs, FL 32643
Phone: (386)454-1156 Fax: (386)454-1158

THE STAFFOF HIGH SPRINGS PEDIATRICS WELCOME YOU.
IN ORDER TO SERVE YOU BETTER PLEASE TAKE A MOMENT TO ANSWER THESE QUESTIONS.

Date: _____ S.S. #: _____

Patient's Name: _____ D.O.B: _____ Male / Female

Spouse's Name: _____ D.O.B: _____

Child/Children's Name and Ages: _____

Physical Address: _____
City State Zip

(Mailing address if different) _____
City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Place of Employment: _____

E-Mail: _____

Insurance Company Name: _____ ID#: _____

Primary Insured: _____ Relationship to Patient: _____

Emergency Contact: Name: _____ Phone: ( )_____

Please list all **ALLERGIES**: _____

Please list all Medications you are currently taking: _____

_____

Is English the primary language spoken in your household? Y N
If not, what is the primary language spoken? _____

Who will interpret? _____

PRINT NAME: _____ Signature: _____ _____
Date

WITNESSED BY: _____ Date: _____

PAST MEDICAL HISTORY

Patient's Name: _____

FAMILY HISTORY (please include parents, siblings, and grandparents)

DIABETES _____
HEART DISEASE _____
HIGH BLOOD PRESSURE _____
CANCER _____
ASTHMA _____
SICKLE CELL DIEASE _____
ANEMIA _____
TUBERCULOSIS _____
EPILEPSY _____
LEUKEMA _____
HEART PROBLEMS _____
STROKE _____
SICKLE CELL ANEMIA _____
ADD/ADHD _____
HIV/AIDS _____
ALLERGIES _____

CURRENT HISTORY (please mark any medical conditions you may have or had)

DIABETES _____
HIV/AIDS _____
ASTHMA _____
ADD / ADHD _____
EPILESPY _____
STROKE _____
HEART DISEASE _____
HIGH BLOOD PRESSURE _____
SICKLE CELL ANEMIA _____
SICKEL CELL DISEASE _____
TUBERCULOSIS _____
HEART PROBLEMS _____
THYROID DISORDERS _____
STD'S _____
CANCER _____
LEUKEMIA _____
ALLERGIES: _____

Social History (please circle one)

SMOKING	Y	N
ALCOHOL/DRUGS	Y	N
GUNS	Y	N
PHYSICAL ABUSE	Y	N
MENTAL ABUSE	Y	N
SEXUAL ABUSE	Y	N
HIV /AIDS	Y	N
TUBERCULOSIS	Y	N

OTHER:

_____

_____

ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH THE PHYSICIAN / PRACTITIONER?

_____

_____

Review of Systems (please circle one)

FEVER	Y	N	WEIGHT LOSS	Y	N
SORE THROAT	Y	N	HEADACHE	Y	N
HEARING LOSS	Y	N	BLURRED VISION	Y	N
DECREASED VISION	Y	N	COUGH	Y	N
PALPITATIONS	Y	N	HEART TROUBLE	Y	N
ABDOMINAL PAIN	Y	N	N/V	Y	N
DIARRHEA	Y	N	RECTAL BLEEDING	Y	N
CHEAST PAIN	Y	N	DECREASED APPEITITE	Y	N
HERNIA	Y	N	TESTICLE PAIN/MASSES	Y	N
INCREASED THIRST	Y	N	ANEMIA	Y	N
CONVULSIONS/SEIZURES	Y	N	PAINFUL URINATION	Y	N
BACK PAIN	Y	N	STD'S	Y	N
DEPRESSION	Y	N	BIRTH CONTROL	Y	N
ANXIETY	Y	N	PAIN	Y	N
EXCESSIVE URINATION	Y	N			

_____ _____

PARENT'S SIGNATURE DATE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION AND MEDICAL RECORDS RELEASE

I HERE BY REQUEST AND AUTHORIZE _____
(PREVIOUS PHYSICIAN INFORMATION)

_____
TO USE DISCLOSE A COPY OF SPECIFIC HEALTH AND MEDICAL INFORMATON DISCRIBED BELOW REGARDING:

_____ _____
PATIENT NAME D.O.B

CONSISTING OF:

_____ ALL MEDICAL RECORD INFORMATION
_____ SUMMARY OF OFFICE VISITS
_____ PRENATAL MEDICAL RECORDS
_____ IMMUNIZATIONS
_____ OTHER (SPECIFY)
_____

HIGH SPRINGS PEDIATRICS / PRIMARY CARE MEDICINE
19228 NW US HWY 441
HIGH SPRINGS, FLORIDA 32643
PHONE: (386)454-1156 FAX: (386)454-1158

FOR THE PURPOSE OF _____

All the information I hereby authorize to be obtained from this AGENCY will be held strictly confidential and cannot be released by the RECIPIENT without my written consent and in accordance to HIPAA privacy regulations. If we are requesting this authorization from you for our own use and disclosure or to allow another health care, provide or health plan to disclose information to us.

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization.
- You may inspect a copy of the protected health information to be used or disclosed.
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this authorization at anytime, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to request. HIV/SUBSTANCE ABUSE INFORMATION WILL NOT BE RELEASED WITHOUT A SPECIAL SUBSEUENT WRITTEN RELEAE. I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____
Patient/Parent/Guardian

_____ _____
Relationship to Patient Witness

Description of representative's authority: _____

Identifier: _____

HIGH SPRINGS PEDIATRICS & PRIMARY CARE MEDICINE

DR. NASIR AHMED, MD

Policy on Narcotics, Opiod, Control Medications, Benzodiazepam, Barbiturate, and other habit forming pain and non-pain medications.

1. I do not provide any of the above mentioned medications for long time and for monthly basis.
2. In case of emergency acute situation, the above mentioned medications will be prescribed (if needed) for few days (not more than 5 to 7 days).
3. If patient needs above mentioned medications for long time and for repeated time, patient will have to find a Pain Medication Physician.

_____ _____

Dr. Nasir Ahmed, MD Date

AGREEMENT

I have read and understand that the Policy of High Springs Pediatric and Primary Care Medicine regarding aboved mentioned Medications. By signing I confirm that I will abide by the above mentioned Policy.

_____

Patient Name

_____

Patient Signature

_____

Date

PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

Section 381.026, Florida Statutes, addresses the Patients Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care facility recognize your rights while you are reciving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You must request a copy of thye full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows.

A patient has the right:

- To be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- To a promt and reposibale response to questions and request.
- To know who is provding medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To know what rules anf regulations apply to his her conduct.
- To be given by the health care provider information concerning diagnosis, planned course of treatment alternatives, risks, and prognsis.
- To refuse any treatmeant, except as otherwise provided by law.
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- To know, upon requeat and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment reat.
- To recevie, prior to treatment, a reasonable estimate of charges for medical care.
- To recevie a copy of a reasonably clear and understandable, itemized bill and upon request, to have the charges explained.
- To impartial access to medical treatment or accommadations, regardless of race, national orgin, religion, handicap, or source of payment.
- To treat for any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is for purpose of experimental research and to give his his or her cosent or refusal to participate in such experimental research.
- To express grievances regarding any violation of hie or her rights, as stated in Florida law, through the grievance procedure of the health care provider or ealth care facility which served him or her and to the appropiate stste licensing agency.

A patient is responsible:

- For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hositalizations, medications, and other matters retating to hie or her health.
- For reporting unexpected changes in his or her conditon to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- For following the treatment plan recommended by the health care provider.
- For keeping appointments and when he or she is unable to do so for any reason for notifying the health care provider or health care facility.
- For his or her actions if he or she refuses treatment or does not follow the health care providers instructions.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following healith caree facility rules and regulations affecting patient care and conduct.

High Springs Pediatrics / Primary Care Medicine

PATIENT PRIVACY PRACTICE ACKNOWLEDGEMENT & CONSENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),
I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plus and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and in-directly.
- Obtain payment for third party payers.
- Conduct normal health care operations such as quality assessment and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to this Notice of Privacy Practice from time to time and that I may contact this organization at any time at this location to obtain a current copy of the Notice Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have reviewed and consent to all the above statements. I understand that I may revoke this consent in writing at any time. Except to the extent that you have taken action relying on this consent.

_____
PATIENT'S SIGNATURE

_____
SIGNATURE PARENT/GUARDIAN

_____
RELATIONSHIP TO PATIENT

_____
DATE

FOR OFFICE USE ONLY
I attempting to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to so as documented below:

DATE:	INITIALS:	LOCATION: HIGH SPRINGS

REASON: