Reset Form

West Coast Primary Care

NEW PATIENT HISTORY

1. IDENTIFYING INFORMATION

Name: _____ **DOB:** ____/____/_____ **Date:** ____/____/____

Reason for visit: ☐ Preventative/ Well-Woman exam ☐ Other:_____
Age:_____ Marital Status: _____ Occupation:_____
Who referred you? _____
Name of internist or family doctor:_____
Name of last gynecologist:_____

2. MEDICATION HISTORY

List all medications and non-prescription medication that you take with the dose and timing, including vitamins, herbs, and anti-inflammatory medications: ☐ None

DRUG	DOSE	FREQUENCY	REASON FOR MEDICATION

Do you take hormone therapy or birth control pills? Please list dose and timing: ☐ None

_____
_____

Allergies: List all adverse reactions or allergies you have to medications and what happened ☐ None

_____
_____

3. MEDICAL HISTORY ☐ None

Please list any medical problems that you have, the physician taking care of you and how they are being treated.

DATE	MEDICAL PROBLEM	MEDICATION / TREATMENT	PHYSICIAN

Check if you currently have or have ever had:

Alcohol Abuse	☐	Depression / Anxiety	☐	Kidney Stones	☐
Anesthetic reaction	☐	Drug/Substance Abuse	☐	Lupus/Autoimmune Disorder	☐
Anemia	☐	Eating Disorder	☐	Mitral Valve Prolapse	☐
Asthma	☐	Heart Disease	☐	Rheumatic Fever	☐
Bleeding Disorder	☐	Hepatitis/Jaundice	☐	Seizure Disorder	☐
Blood Clots	☐	High Blood Pressure	☐	Stomach Ulcers	☐
Cancer	☐	High Cholesterol	☐	Stroke	☐
Chronic Lung Condition	☐	Hypothyroidism	☐	Transfusion Reaction	☐
Diabetes	☐	Irritable Bowel Syndrome	☐	Tuberculosis	☐

Please explain: _____
_____
_____

4. SURGICAL HISTORY ☐ None

List all surgeries you have had including but not limited to breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom teeth.

DATE OPERATION DIAGNOSIS HOSPITAL/ M.D.

_____

_____

_____

_____

5. GENERAL HEALTH

Date/Place of last pap smear: ☐ None _____
Date/Place of last mammogram: ☐ None _____
Date/Place of last blood work: ☐ None _____
Your Height _____feet _____inches Your weight _____lbs. Your blood type:

_____
How much alcohol do you drink/week? ☐ None ☐ Avg. less than one daily ☐ Avg. one daily ☐ Avg. more
Do you smoke? ☐ Yes ☐ No Amount/Day _____ How many years? _____
If you quit smoking, when did you stop? _____
Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type:_____
Are you currently dieting or do you have a non-traditional diet? ☐ Yes ☐ No
Please Explain: _____
_____
Do you perform self-breast examinations monthly? ☐ Yes ☐ No
Have you been immunized or had the following? Hepatitis A ☐ Yes ☐ No Hepatitis B ☐ Yes ☐ No

6. GYNECOLOGIC HISTORY

Age of first menstrual cycle: _____ Date of last period:_____/_____/_____ ☐ Menopausal ☐ Hysterectomy
How frequently do you bleed? _____ How many days do you bleed? _____

What do you use to keep from getting pregnant? ☐ Nothing

☐ Abstinence ☐ Diaphragm ☐ Rhythm
☐ Birth Control Pills ☐ IUD ☐ Tubal Ligation
☐ Condoms ☐ Patch ☐ Vasectomy

Please check if you have had or currently have the following:

Abnormal Pap Smear	☐	Herpes	☐	Pelvic Adhesions	☐
Chlamydia	☐	HPV	☐	PMS	☐
Condyloma (Warts)	☐	HPV Gardasil Vaccine	☐	Recent Change in Period	☐
Cramps	☐	Incontinence of Urine	☐	Recurrent Vaginitis	☐
Endometriosis	☐	Laser/Freezing Cervix	☐	Syphilis	☐
Fibroids	☐	Mycoplasma/Ureoplasma	☐	Trichomonas	☐
Gonorrhea	☐	Ovarian Cyst	☐		

Sexual History:
Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No

Infertility History: (complete if indicated)
How long have you been trying unsuccessfully to become pregnant? _____
How long have you been trying without any form of contraception? _____

Please describe any test/diagnosis/treatments you have had performed: _____
_____
_____
_____
_____
_____

Pregnancy History: ☐ No Pregnancies
Number of times pregnant _____ Full term births _____ Premature births _____
Elective termination _____ Miscarriage _____ Ectopic pregnancies _____

Early pregnancy loss: Please list date and length of pregnancy with outcome (less than 20 weeks)

DATE Miscarriage/# WEEKS ELECTIVE ABORTION/#WEEKS HOSPITAL/M.D.

_____
_____
_____

Deliveries: Please list date and length of pregnancy with outcome (lasting more than 20 weeks)

DATE # WEEKS VAGINAL/C-SECTION SEX/WEIGHT HOSPITAL/M.D. COMPLICATIONS

_____
_____
_____
_____

Family History: ☐ Adopted
Which of your 1st degree family members have the following:
Anesthesia Problems _____ Heart Disease _____
Breast Cancer _____ High Blood Pressure _____
Colon Cancer _____ Ovarian Cancer _____
Diabetes _____ Other Cancer _____

7. SYSTEMS REVIEW

Please check if you have had or currently have the following:

HEENT	CURRENT	PAST	N/A
Migraines	☐	☐	☐
Chronic Headaches	☐	☐	☐
Visual Changes	☐	☐	☐
Hearing Loss	☐	☐	☐
Dizziness	☐	☐	☐
CARDIOVASCULAR			
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Abnormal Chest X-Ray	☐	☐	☐
Leg Swelling	☐	☐	☐
Heart Murmur/Mitral Valve Prolapse	☐	☐	☐
Take Antibiotics for Dental Work	☐	☐	☐
Wheezing/Heart Palpitations	☐	☐	☐
GASTROINTESTINAL			
Chronic Abdominal Bleed	☐	☐	☐
Frequent Nausea/Vomiting	☐	☐	☐
Chronic Constipation	☐	☐	☐
Persistent Diarrhea	☐	☐	☐
Bloody Stools	☐	☐	☐
Hemorrhoids	☐	☐	☐

NEUROLOGIC	CURRENT	PAST	N/A
Any Neurological Disorders	☐	☐	☐
Fainting	☐	☐	☐
Numbness	☐	☐	☐
Weakness	☐	☐	☐
Head/Nerve Injury	☐	☐	☐
Anxiety/ Depression	☐	☐	☐
BREAST			
Breast Lump	☐	☐	☐
Breast Tenderness	☐	☐	☐
Breast Secretion	☐	☐	☐
Bleeding from Nipples	☐	☐	☐
Breast Implants	☐	☐	☐
URINARY			
Recurrent Urinary Tract Infections			
Blood in Urine	☐	☐	☐
Painful Urination	☐	☐	☐
Kidney Stones	☐	☐	☐
HEMATOLOGY			
Frequent Bruising	☐	☐	☐
Cuts that Do Not Stop Bleeding	☐	☐	☐
Enlarged Lymph Nodes	☐	☐	☐

Please explain: _____
_____
_____
_____
_____
_____

Reset Form

West Coast Primary Care, LLC

HISTORIAL MEDICO PARA NUEVOS PACIENTES

1. INFORMACION PERSONAL:

Nombre: _____ Fecha de nac.: _____ Fecha:_____
Razón de la visita: ☐ Preventivo/Ginecológico ☐ Otro: _____
Edad: _____ Estado civil: _____ Ocupación: _____
Quien lo ha recomendado? _____
Quien es su proveedor medico primario: _____
Quien es su ginecólogo?: _____

2. HISTORIA DE MEDICAMENTOS:

Si usted está tomando medicamentos, vitaminas o tratamientos naturales por favor indique dosis, frecuencia y nombre del medicamento: ☐ N/A

MEDICINA	DOSIS	FRECUENCIA	RAZON DE LA MEDICINA

Esta usted tomando pastillas anticonceptivas o alguna terapia de hormonas? Por favor indique dosis y frecuencia: ☐ N/A

_____
_____

Alergias: Mencione los medicamentos a los que ha reaccionado adversamente ☐ N/A

_____
_____

3. HISTORIAL MEDICO ☐ N/A

FECHA	ENFERMEDAD	MEDICAMENTO / TRATAMIENTO	DOCTOR

Padece usted o ha padecido usted alguna vez de cualquiera de las enfermedades o problemas que se muestran a continuación:

Abuso de alcohol	☐	Depresión / Ansiedad	☐	Piedras en los riñones	☐
Reacción a La anesthesia	☐	Abuso de sustancia	☐	Lupus/enfermedades autoimmune	☐
Anemia	☐	Desórdenes alimenticios	☐	Defectos cardiacos congénitos	☐
soplos cardiacos	☐	Diabetes	☐	Enfermedad cardiaca reumática	☐
Asma	☐	Tuberculosis	☐	Enfermedades cardiovasculares	☐
Problemas en la sangre	☐	Hepatitis	☐	Ataques de convulsiones	☐
Coágulos en la sangre	☐	Presión arterial alta/baja	☐	Enfermedades del pulmón	☐
Cáncer	☐	Colesterol alto	☐	Ataques al corazón	☐
Ulceras gastricas	☐	Hipotiroidismo	☐	Reacción a una transfusión de sangre	☐
Tuberculosis	☐	Problema de la Prostota	☐	Colon irritable	☐

Por favor explique:

_____
_____

4. HISTORIAL QUIRURGICO ☐ N/A

Mencione todas las cirugías incluyendo biopsias, cirugías estéticas

FECHA CIRUGIA DIAGNOSTICO HOSPITAL/ DR.

_____

_____

_____

5. **INFORMACION GENERAL**

Fecha/lugar del último examen ginecológico: ☐ N/A _____
Fecha/lugar de la última mamografía: ☐ N/A _____
Fecha/lugar de su último examen de laboratorio: ☐ N/A _____
Estatura _____ Peso _____ lbs. Tipo de sangre: _____
Cuantas bebidas de alcohol tiene a la semana? ☐ N/A ☐ Approx. menos de una al dia ☐ Approx. Unadiaria ☐ Mas de una diaria
Usted fuma? ☐ Si ☐ No cantidad/Dia Por cuantos anos? _____
Si usted ha dejado de fumar cuando lo hizo? _____
Usted a consumido marihuana o alguna otra droga? ☐ Si ☐ No Tipo: _____
Esta usted actualmente en alguna dieta? ☐ Si ☐ No
Por favor explique: _____
Se realiza usted la auto examinación en los senos? ☐ Si ☐ No
Ha sido usted vacunado o tiene una de las siguientes enfermedades? Hepatitis A ☐ Si ☐ No
Hepatitis B ☐ Si ☐ No

6. HISTORIAL GINECOLOGICO

Edad de su primer ciclo menstrual: _____ Fecha de su último periodo: _____ ☐ Menopausia ☐ Histerectomía

Frecuencia del ciclo menstrual? _____ Cuantos días dura su periodo? _____
Que metodos anticoceptivos usa? ☐ Ninguno

Abstinencia	☐	Diafragma	☐	Metodo del Ritmo	☐
Pastillas anticoceptivas	☐	IUD	☐	Ligaduras de trompas	☐
Condones	☐	Patches	☐	Vasectomía	☐

Por favor diga si usteed ha tenido o tiene unas de las siguientes:

Papanicolaou anormal	☐	Herpes	☐	Problemas pelvicos	☐
Clamidia	☐	HPV	☐	Quiste en los ovarios	☐
Condiloma (verrugas)	☐	HPV Vaccine	☐	Reciente cambio en el ciclo menstrual	☐
Calambres	☐	Incontinencia	☐	Frecuentes Vaginitis	☐
Endometriosis	☐	Displasia cervical	☐	Micoplasma/Ureaplasma	☐
Fibromas	☐	Sifiilis	☐	Tricomoniasis	☐
Gonorrea	☐	PMS	☐		

Historial Sexual:
Esta usted sexualmente activo? ☐ Si ☐ No Siente usted dolor cuando tiene relaciones íntimas? ☐ Si ☐ No

Historia de infertilidad: (Completar solo si aplica)
Por cuanto tiempo ha estado usted tratando de quedar embarazada? _____
Por cuanto tiempo le ha tomado sin un método anticonceptivo? _____

Por favor indique los exámenes/ tratamientos/diagnósticos que usted ha hecho:
_____
_____

Historial de embarazos: ☐ N/A
Números de embarazos _____ Embarazo Termino complete _____ Nacimiento premature _____
Terminación temprana _____ Perdidas _____ Embarazo Ectópico _____

Perdidas tempranas de embarazo: Por favor indique la fecha y cuanto duro el embarazo (menos de 20 semanas)

FECHA PERDIDAS/#SEMANAS ABORTO SELECTIVO/#SEMANAS HOSPITAL/DR.

_____

_____

_____

NACIMIENTOS: Por favor indique la fecha y cuanto duro el embarazo (menos de 20 semanas)

FECHA #SEMANAS VAGINAL/CESAREA SEXO/PESO HOSPITAL/DR. COMPLICACIONES

_____

_____

_____

Historial familiar: ☐ Adoptado

Cuál de los miembros de la primera generación en su familia tienes los siguientes problemas:
Problemas con anesthesia _____
Enfermedades cardiovasculares _____
Cáncer de seno _____
Presión arterial alta _____
Cáncer de colon _____
Cáncer de ovario _____
Diabetes_____
Otro tipo de cáncer _____

7. Problemas Generales

Por favor indique si usted tiene o ha tenido alguna de las siguientes:

HEENT	PRESENTE	PASADO	N/A
Migrañas	☐	☐	☐
Dolores de cabeza crónicos	☐	☐	☐
Cambios en la visión	☐	☐	☐
Sorderas	☐	☐	☐
Mareos	☐	☐	☐
CARDIOVASCULAR			
Dolor en el pecho	☐	☐	☐
Tos crónica	☐	☐	☐
Placa del pecho anormal	☐	☐	☐
Inflamación de las piernas	☐	☐	☐
Soplos en el Corazón/defectos cardiacos	☐	☐	☐
Toma antibióticos para algún trabajo dental	☐	☐	☐
Palpitaciones/ronquido en el pecho	☐	☐	☐
GASTROINTESTINAL			
Hemorragias abdominales crónicas	☐	☐	☐
Nausea/vómitos	☐	☐	☐
Estreñimiento crónico	☐	☐	☐
Diarrea persistente	☐	☐	☐
Sangre en las escreta	☐	☐	☐
Hemorroides	☐	☐	☐
Acidez	☐	☐	☐
RESPIRATORY			
Tos	☐	☐	☐
Falta de aire	☐	☐	☐
Congestion	☐	☐	☐

NEUROLOGICO	PRESENTE	PASADO	N/A
Desorden neurologico	☐	☐	☐
Perdida del conocimiento	☐	☐	☐
adormecido	☐	☐	☐
Debilidad	☐	☐	☐
Cabeza/nervio lastimado	☐	☐	☐
Ansiedad/ Depresión	☐	☐	☐
SENOS			
Quiste en los senos	☐	☐	☐
Senos endurecidos	☐	☐	☐
Secreción en los senos	☐	☐	☐
Goteos en el pezón	☐	☐	☐
Implantes mamarios	☐	☐	☐
URINARY			
Infección en la orina	☐	☐	☐
Sangre en la orina	☐	☐	☐
Dolor al orinar	☐	☐	☐
Piedras en los riñones	☐	☐	☐
HEMATOLOGIA			
Frecuentes moraduras	☐	☐	☐
Cortadas que no dejan de sangrar	☐	☐	☐

Por favor, explique: _____

West Coast Primary Care, LLC

Reset Form

Account#_____

PATIENT INFORMATION

Patient Name: _____ **DOB:** ___/___/_____ **SS#:** _____-_____-_____ **Sex: Male** ☐ **Female** ☐

Address: _____ **City:** _____**State:** _____**Zip:** _____

Phone#: (_____)_____ **Cell#** (_____)_____

☐ **Check this box if we may use this cell # for text and/or robocall appointment reminders**

Nationality: ☐**African American/Black** ☐**American Indian or Alaska Native** ☐**Asian** ☐**Native Hawaiian or Other Pacific Islander** ☐**White**

Ethnicity: ☐**Hispanic** ☐**Non-Hispanic** ☐**Declined**

Marital Status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Seperated**

Email:_____

Pharmacy :_____ **Pharmacy Phone:** (_____) _____-_____

Smoker? ☐**Current Smoker** ☐**Former Smoker** ☐**Never Smoked**

Primary Language:_____ **Preferred method of contact: Email Phone Cell Phone Text**

(Please Circle One)

Whom may we thank for referring you:_____

Employer Status: ☐**Employed** ☐**Self-Employed** ☐**Retired** ☐**Disabled** ☐**Unemployed** ☐**Student**

Occupation:_____**Employer**_____

Employer Address_____ **Work Phone:** (_____)_____

EMERGENCY CONTACTS

#1. Name: _____ **Relationship:** _____ **Phone#:** (_____) _____-_____

#2. Name: _____ **Relationship:** _____ **Phone#:** (_____) _____-_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ **Policy#**_____**Group#**_____

Policyholder's Name: _____ **Date of Birth**_____

Policyholder's SS#:: _____ **Relationship to patient:** _____

Claims Address: _____ **City:** _____**State:** _____**Zip:** _____

Eligibility Phone# (_____) _____-_____

Secondary Insurance Carrier: _____ **Policy#**_____**Group#**_____

Policyholder's Name: _____ **Date of Birth**_____

Policyholder's SS#:: _____ **Relationship to patient:** _____

Claims Address: _____ **City:** _____**State:** _____**Zip:** _____

Eligibility Phone# (_____) _____-_____

West Coast Primary Care, LLC

REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider, which may include but are not limited to labortory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services endered to the patientunder the general and special instructions of thepatient's physician. West Coast Primary Care, LLC has the right to refuse to you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Patient Signature_____**Date**_____

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to West Coast Primary Care, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.
I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Patient Signature_____**Date**_____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient Signature_____**Date**_____

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West Coast Primary Care

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD.

Regarding Insurance
Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Regarding insurance plans where we are not a participating provider: You are responsible for payment of your first office visit in full. We may accept assignment of insurance benefits after your second visit. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges.

We bill secondary insurance carriers as a courtesy to our patients.

Usual and Customary Charges
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed upon.

Interest
We reserve the right to charge interest in the amount of 18 % per year as provided by state law on past due accounts.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

Missed Appointments
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $30.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

Returned Checks
If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $30.00. Payment must be made prior to your return to the office and we may not accept any more personal checks.

Billing Questions
Please address all billing questions to Fountainhead Practice Management Solutions at 727-456-3288 or toll free 866-343-3288.

Collections
You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

_____ _____
Signature of Responsible Party Date

_____ _____
Witness Date

Reset Form

West Coast Primary Care

Patient Consent for Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations, Per HIPAA Regulations

I understand that as part of my healthcare, the practice originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered

A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff
I have been provided with a "*Notice of Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following and privileges:

- The right to review the "*Notice*' prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

Please Print

Restrictions;
I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s), friends or caregivers (name(s))

_____

_____

Messages or Appointment Reminders
May we leave a message at your home using doctor's /practice name: ☐ Yes ☐ No
May we leave a message at your work using doctor's /practice name: ☐ Yes ☐ No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and ☐ accept ☐ decline the information of this consent.

_____ _____
Patient/ Guardian Signature Date

_____
Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No

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West Coast Primary Care

Influenza/Pneumococcal Vaccination Consent Form

Please Print

Patient Last Name	Patient First Name	Date of Birth

P Number	Chart Number	Physician

Complete Assessment:

Yes _____ No _____ 1. Are you allergic to eggs or egg products?

Yes _____ No _____ 2. Have you ever had an anaphylactic reaction to the Influenza vaccine?

Yes _____ No _____ 3. Have you ever had Guillain-Barre Syndrome?

Yes _____ No _____ 4. Are you allergic to latex?

Yes _____ No _____ 5. Are you sick with a fever?

Yes _____ No _____ 6. Are you pregnant?

I have read, or had explained to me, the information sheet about the Influenza vaccine (flu shot) and the Pneumococcal vaccine. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefit and risks of the vaccination as described. I request that the Influenza vaccine and/or the Pneumococcal vaccine be given to me (or the person above for whom I am authorized to make this request).

I assume the responsibility for any payment not covered by my insurance carrier.

I would like the Influenza shot: Yes _____ No _____

I would like the Pneumonia shot: Yes _____ No _____

Signature of the person to receive the vaccine: _____ Date _____

Signature of the legal representative (if different then the recipient) _____

Date_____

For clinic use only

Vaccine Given	*Date*	*Manufacturer*	*Lot No.*	*Site*	*Administered by*
Influenza					
Pneumococcal					

***This information has been documented in the EMR. Initials of employee*_____

West Coast Primary Care, LLC
Authorization for Release of Information

Reset Form

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: _____-_____-_____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize _____Provider Phone#_____
(Print Name of Provider)
to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:
❑ History and physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-ray reports	_____
❑ Other: _____	_____

I specifically authorize the release of information relating to:
- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)
- ❑ Genetic Testing

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation
❑ Other (please specify): _____

1. I understand that this authorization will expire on _____ (Print the Date this Form Expires) days after I have signed the form.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of:
   _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that _____ (Print Name of Provider) ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

5. I understand that in compliance with _____(Print the State Whose Laws Govern the Provider) statute, I will pay a fee of $_____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____