



NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ALLERGIES: \_\_\_\_\_

**List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** (Please circle all that apply)

- |                                   |                     |                             |                      |
|-----------------------------------|---------------------|-----------------------------|----------------------|
| ADHD                              | COPD/ Emphysema     | High Cholesterol            | Rheumatoid Arthritis |
| Alcoholism                        | Dementia            | HIV                         | Seizure Disorder     |
| Allergies, Seasonal               | Depression          | Hepatitis                   | Sleep Apnea          |
| Anemia                            | Diabetes: 1 or 2    | Irritable Bowel Syndrome    | Stroke               |
| Anxiety                           | Diverticulitis      | Lupus                       | Thyroid Disorder     |
| Arrhythmia (irregular heart beat) | DVT (Blood Clot)    | Liver Disease               | Ulcerative Colitis   |
| Arthritis                         | GERD (Acid Reflux)  | Macular Degeneration        |                      |
| Asthma                            | Glaucoma            | Neuropathy                  |                      |
| Bipolar                           | Heart Disease       | Osteopenia/Osteoporosis     |                      |
| Bladder Problems / Incontinence   | Heart Attack (MI)   | Parkinson's Disease         |                      |
| Bleeding Problems                 | Hiatal Hernia       | Peripheral Vascular Disease |                      |
| Cancer: _____                     | High Blood Pressure | Peptic Ulcer                |                      |
| Headaches                         | Kidney Stones       | Psoriasis                   |                      |
| Crohn's Disease                   | Kidney Disease      | Pulmonary Embolism (PE)     |                      |

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date: _____	Normal Abnormal
Mammogram	Yes/No Date: _____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date: _____	Normal Abnormal
Pap	Yes/No Date: _____	Normal Abnormal

**Other medical problems not listed above:**

\_\_\_\_\_

**Surgical History:** Please list all prior surgeries and approximate dates performed.

\_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL / CULTURAL HISTORY:**

Education Level:  Elementary  High School  Vocational  College  Graduate / Professional

Are there any vision problems that affect your communication?  Yes  No

Are there any hearing problems that affect your communication?  Yes  No

Are there any limitations to understanding or following instructions (either written or verbal)?  Yes  No

Current Living Situation (Check all that apply):

- Single Family Household  Multi-generational Household  Homeless  Shelter  Skilled Nursing Facility  Other: \_\_\_\_\_

Smoking/ Tobacco Use:  Current  Past  Never Type: \_\_\_\_\_ Amount/day: \_\_\_\_\_ Number of Years: \_\_\_\_\_

Alcohol:  Current  Past  Never Drinks/week: \_\_\_\_\_

Recreational Drug Use:  Current  Past  Never Type: \_\_\_\_\_

\_\_\_\_\_ Are you sexually active?  Yes  No

Are there any personal problems or concerns at home, work, or school you would like to discuss?  Yes  No

Are there any cultural or religious concerns you have related to our delivery of care?  Yes  No

Are there any financial issues that directly impact your ability to manage your health?  Yes  No

How often do you get the social and emotional support you need?

Always  Usually  Sometimes  Rarely  Never

Comments (Please feel free to comment on any answers marked "yes" above):

**FAMILY HISTORY:**

**FATHER:** Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____ COPD/	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	Emphysema	DVT (Blood	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Clot) Heart	Migraines	
		Disease		

Other: \_\_\_\_\_

**MOTHER:** Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____ COPD/	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	Emphysema	DVT (Blood	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Clot) Heart	Migraines	
		Disease		

Other: \_\_\_\_\_

**SIBLINGS:**

**List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# SandBay

PRIMARY + URGENT CARE

## HIPAA

### PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT LIMITED AUTHORIZATION & RELEASE FORM

**PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:**  
(This includes your spouse, children, step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITY IN THE FUTURE.

### NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the Notice of Privacy Practices of Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Provider. The Notice of Privacy Practices for Provider is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

### E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

Initial: \_\_\_\_\_

Date: \_\_\_\_\_



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## Policies

### APPOINTMENT POLICY:

- ✓ 24-hour notice is required to reschedule or cancel appointment. NOTE: If the proper notice is not given to cancel or reschedule an appointment, there is a "NO-SHOW" fee of \$30.00 for a follow-up appointment and \$10.00 "NO-SHOW" fee for blood work.
- ✓ Patients who arrive late for an appointment will be asked to wait to see the doctor until there is sufficient time to complete the visit/ appointment or the Patient may be asked to reschedule the appointment.

### OFFICE FEES FOR MEDICAL RECORDS: COPIES/FORMS/REPORTS

- ✓ \$1.00 per page for copies up to 25 pages, \$0.25 per page per copy for 26 pages and more.
- ✓ Request of medical records/forms a minimum of 5 business days is required.

### TELEPHONE MESSAGE POLICY

- ✓ If necessary telephone messages will have a 48 hour response time.

### PRESCRIPTION REFILL POLICY

- ✓ Approved prescription refills require a 3-5 business days notice.

### REFERRAL POLICY

- ✓ Referrals require a seven business days notice.
- ✓ Appointments are required for a referral request.  
I understand that I am responsible for all charges incurred whether or not paid by the Insurance Company. I agree and understand that I may be also charged a 1.5% interest fee per month on any unpaid balances, and that I also responsible for any costs incurred in collection of the said balance should collection become necessary. I have read and understand the above information and agree to comply

### Consent for Treatment

In this document, "I" and "my" refer to the patient, and "Provider" refers to SandBay.

I consent to the use or disclosure of my protected health information by Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Provider. I understand that analysis, diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing



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## ADVANCE DIRECTIVE QUESTIONNAIRE

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

SandBay Primary & Urgent Care would like to encourage all patients to have an Advance Directive on file with our office.

Under the Patient Self-Determination Act of 1990, each individual has the right to determine the course of his/her medical care and treatment. You make these choices now so that when you become unable, your decisions are known. Advance Directives only take effect if, in the future, you lose the capacity to speak for yourself. It has no effect on your current health care as long as you are able to speak for yourself.

### Advance Directives for Health Care consist of three parts:

**Health Care Proxy:** Designates another person to make medically related decisions for you.

**Living Will:** Designates your future health care treatment choices.

**Other Wishes:** Designates your wishes regarding Death, Organ Donation and Autopsy.

You may, at any time, complete any section and our office will keep a copy of your wishes on file for you. If you are not ready today please ask at any time for the form. We will review this annually with you.

### Circle One

Do you have a living will?	YES	NO
Do you have a Health Care Proxy?	YES	NO
If no, would you like the form to fill out?	YES	NO
If yes, would you like to have a copy in our chart for you?	YES	NO

I am not ready to fill out this form. Please ask me about this in the future. \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date