NEW PATIENT IN-TAKE FORM / YEARLY UPDATE FORM

In an effort to ensure all your information is correct in your file, please fill out the information below. ***PLEASE PRINT.***

Today's Date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Mar / Div / Sep / Wid
Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #:		Cell Phone #:
Street address:			Home Phone #: ( )		
P.O. Box:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer Phone:	

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Person responsible for bill:					
Occupation:	Birth date: / /	Address (if different):		Home phone #: ( )	
Is this patient covered by insurance?	Employer:				
❑ Yes ❑ No	Employer address:		Employer phone #: ( )		
Subscriber's name:	Primary Insurance:				
	❑ Medicare	❑BCBS	❑ United Healthcare	❑ Secure Horizons	❑ Aetna
❑ Tricare	❑ Humana	❑ Self-Pay	❑ Cigna	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
	Subscriber's name:		Group #:	Policy #:	

IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	❑ Self	❑ Spouse	❑ Child	Phone:	Relationship to patient:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE DR. CHET ANTHONY, D.O. OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

Signature Date

☐ I authorize Dr. Chet Anthony and the office staff to obtain my protected health information as needed from any of the following:

- *Previous Doctors/Medical Offices*
- *Urgent Care/Clinics*
- *Hospitals*
- *Pharmacies*
- *Imaging Centers*
- *Assisted Living Facilities/Nursing Homes*

____________________________________ ____________________
Print Name Date of Birth

____________________________________ ____________________
Signature Witness

Medical History

Current Medications—Including dosage and directions:
____

____

____

Allergies:____

Social history

Marital Status:__________ Children:________Lives with: ___________ Pets:________

Occupation:____________Years in FL:_______States prior to FL:__________________

Nutrition:____________________________(Poor, average, good, excellent, or vegetarian)

Exercise:_______________ Sexual Activity: ______________Contraceptive:__________

Smoking: _____If so, how many packs per day?_______Tobacco exposure:_____________

Alcohol? _________If so, how many drinks per day? _______ Seatbelt:______________

Anthony
Medical Care

Past/Recent Hospitalizations or Surgeries: **Year:**

____

____

Has it been more than a year since your last mammogram? ______________________

Has it been more than 5 years since your last colonoscopy? ______________________

Have you had recent blood work (In the past 90 days)? ______________________

Family History

Please note any family history:

Mother (alive/deceased):____

Reason for Mother's passing:____

Father (alive / deceased):____

Reason for Father's passing:____

Siblings (alive / deceased):____

Reason for Sibling's passing:____

Notice of Privacy Practices

By signing here, I hereby acknowledge that (1) I have received a copy of HIPPA privacy practices for Dr. Chet Anthony, D.O. or (2) I have been offered a copy but declined to accept a copy.

X____

( ) Home Telephone ____________________________

- ( ) Leave a message on my answering machine with detailed information
- ( ) Leave a message on my answering machine with call-back number ONLY

( ) Cellular Phone ___________________________

- ( ) Leave a voicemail message with detailed information
- ( ) Leave a voicemail message with call-back number ONLY

( ) Written Communication

- ( ) Mail to home address
- ( ) Mail to work address

At times it may be necessary to discuss medical information with someone other than yourself. In the space provided below please list anyone we might be able to discuss information with (spouse, friend, family member). If you do not wish to list anyone, please indicate "NONE" below.

Name:____ **Phone:**_______________________

Relationship to patient:____

Name:____ **Phone:**_______________________

Relationship to patient:____

Name:____ **Phone:**_______________________

Relationship to patient:____

( ) NONE

____

Patient Signature **Date**

____

Print Name **Date of Birth**

NOTICE: Uses and disclosures for TPO may be permitted without prior to consent in an emergency.

DEAR PATIENT,

As a patient, you will benefit from a new program that Anthony Medical Care is now offering. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiologists, etc.; Your insurance will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year. Some EXAMPLES of Chronic Care Management:

- Review of your in-house chart and records from other Specialists / Physicians / Hospital Records / X-rays / CT-Scans / Lab work
- Refill requests & Coordination of Care with Other Providers
- Handicapped Parking Forms / Records Requests / Home Healthcare Forms and Coordination / Referrals for Specialists
- Notification of Labs, Ultrasounds, Shots, etc. that may be due for your healthcare
- Management of Medications & Online Education on Patient Portal

Your assigned clinician in charge of your care is Dr. Chet Anthony. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.
As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
This service will "COME AT NO COST TO YOU". Although you may or may not come into the office every month, your Medicare Statement will show a charge by our office of approximately $33.00. Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.
You have a right to, after agreeing to participate below to any office notes pertaining to your case at any time. You may discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.
Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program:

Print Name____

Patient Signature ____________________________________ Date ________________

Anthony
Medical Care

Controlled Substance Contract

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

_____2.) Refills of controlled substance medications:

_____a) Will be made only during regular office hours *Monday through Friday, in person, once a month, and during a scheduled office visit.* Refills will not be made at night, weekends, or during holidays.

_____b) Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____c) I understand that I must call ahead within 72 hours to schedule an appointment.

_____3.) It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.

_____4.) I agree to comply with urine/blood drug testing and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____5.) I agree that I am not pregnant.

_____6.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____7.) I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____8.) I understand that the long-term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____9.) If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

_____10.) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____11.) I understand that if the prescribing provider or my primary care provider become concerned that there is illegal activity; he or she may notify the proper authorities including law enforcement.

_____12.) I agree that Opioid will be prescribed by only one (1) doctor and I agree to fill my prescriptions at only one (1) pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for Opioid medication or going to other pharmacies.

I have been fully informed by Dr. Chet Anthony regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

Print Patient Name: _____________________________________

Patient Signature:_____________________________________ Date:______________

Physician Signature:____________________________________ Date:______________

Due to the recent law signed by Governor Rick Scott, HB 7095, concerning controlled substances, we at Anthony Medical Care, will be instituting the following policies effective immediately.

1. All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with Dr. Chet Anthony, DO.

   ***This includes the following:**

   - All forms of hydrocodone – (Vicodin, Lorcet, Lortab)
   - All forms of oxycodone- (Percocet/Percodan, Oxycontin, Tylox)
   - Most muscle relaxers- (Valium, Soma, Etc.)
   - Duragesic, Fentanyl patches
   - Most sleeping agents- Ambien (Zolpidem), Lunesta
   - All Benzodiazepines- Klonopin (clonazepam), Restoril (temazepam), Serax (oxazepam), Xanax (Alprazolam)
   - Codeine Preparations (Tylenol # 3, Tussionex)

2. I understand that THERE WILL BE NO REPLACEMENT PRESCRIPTIONS GIVEN WITHOUT A POLICE REPORT.

3. I understand that I must bring all medication bottles and/or pills to every appointment for pill count verification.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice medicine in the safest and manner possible.

Patient Signature ____________________________________ Date ________________________

Physician Signature___________________________________ Date_________________________

Name Of Pharmacy:____

Pharmacy Phone Number:____

Location Of Pharmacy:____

24239 State Road 40
Astor, FL 32102
Ph: (352) 759 3900
Fax: (352) 759 3800

RECORDS REQUEST AUTHORIZATION

TO:____
Doctor or Hospital

Address:____

Phone: __________________________Fax: ____________________________________

__I hereby authorize you to RELEASE my complete medical record to Dr. Chet Anthony, including any psychiatric, drug and/or alcohol abuse, and HIV or AIDS testing information in my records.

__I hereby authorize you to RELEASE my records to Dr. Chet Anthony for __________________

Dates needed: From: ______________ To: ____________

Name:____

Street:____

City/State/Zip: ____

Social Security #: _________________________ DOB: ___________________________

Signature: ___________________________________ Date: ________________________

Relationship (if not patient): ____

Witness:____

IF RECORDS CONTAIN MORE THAN 20 PAGES – PLEASE MAIL – FAX ONLY PERTINENT RECORDS FROM LAST 12 MONTHS

This communication is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the recipient, you are hereby notified that any dissemination, distribution, or copying of the information is strictly prohibited. If you have received this message in error, please notify sender immediately. Thank you.

ADVANCED CARE PLANNING

Welcome to Anthony Medical Care. **The attached form only applies for our office. If you would like a legally binding form that can be used at the hospital or other facility, please ask at the front desk for the complete 5 Wishes booklet**. We also offer to notarize (not required to make it legally bound) if you would prefer as well.

The person I want to make health care decision for me when I cannot make them for myself is below. This person will serve as my health care agent if both things happen below:

(My attending or treating doctor finds I am no longer able to make health care choices, AND another health care professional agrees this is true.)

First Choice Name: ____

Address: ____

Phone: ____ Date: ____/______/ 2020

If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, this is my next choice:

Second Choice Name: ____

Address: ____

Phone: ____ Date: ____/______/ 2020

Patient Name (Print): ____

Patient Signature: _______________________________________ Date: ____/______/ 2020

IF YOU REFUSE:

Please sign below if you prefer not to discuss Advanced Care Planning with the doctor and if you are refusing to choose a health care advocate.

Patient Name (Print): ____

Patient Signature: _______________________________________ Date: ____/______/ 2020

HIPAA Notice of Privacy Practices for Chet Anthony, D.O.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, authorization or opportunity to object unless required by law. **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 352-759-3900.