First Name________________________________Last Name ___________________________

Birthdate______________Age:_______Gender: ☐ Male ☐ Female

**Relationship Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Separated

**Cultural Heritage**: ☐ American ☐ European ☐ Asian ☐ Caribbean ☐ African ☐ Latin/Hispanic

☐ Other (Specify): _________________________________________

Religion:_____________________________Preferred Language(s):____________________________

Home Address_________________________________City______________State____Zip__________

Social Security_________________Cell Phone__________________Home Phone _______________

Email________________________________________

## PRIMARY CARE DOCTOR

Doctor Name_______________________________Tel__________________Fax__________________

Address_______________________________________City______________State___Zip__________

**Preferred Pharmacy ___________________**City/Location__________________Tel_________________

**Preferred Hospital ____________________**City/Location__________________Tel _______________

## INSURANCE

Are you currently on ☐ Medicare ☐ Medicaid ☐ Long Term Care ☐ VA benefits

**Insurance Company 1:______________________________**Group number _______________

Policy or ID#___________________Phone: ______________________

**Insurance Company 2:_____________________________**Group number _______________

Policy or ID#___________________Phone: ______________________

## INSURED PERSON / PARTY

*If same person,check box and skip to next section. Complete section if insured is **different** than patient.*

First Name______________________Last Name_______________________Birthdate_______________

Address_______________________________________City______________State___Zip__________

Social Security__________________Cell Phone__________________Home Phone ________________

Email________________________________Drivers Lic#__________________________DL State_____

Relationship to Patient__________________Employer_____________________Tel _________________

## RESPONSIBLE PERSON / PARTY

*If same person,check box and skip to next section. Complete section if person is **different** than patient.*

First Name______________________Last Name_______________________Birthdate_______________

Address_______________________________________City______________State___Zip__________

Social Security__________________Cell Phone__________________Home Phone ________________

Email________________________________Drivers Lic#__________________________DL State_____

Relationship to Patient__________________Employer_____________________Tel _________________

*The information provided is complete and accurate to the best of my knowledge.*

First Name________________________Last Name_______________________Birthdate ___________

Signature of Patient/Guardian________________________________________Date__________________

## Financial Policy/Assignment of Benefits/Consent to Treatment

*This policy has been established to help us serve you better.*

It is necessary for us to make appointments to see our patients as efficiently as possible. No-shows and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late- cancellations delay the delivery of health care to other patients, some who are quite ill.

A “No Show” is missing a scheduled appointment. A “Late Cancellation” is canceling an appointment without calling us to cancel 24 hours in advance of an office visit. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

Payment for services is due at the time services are rendered. Methods of payment: Cash, American Express, MasterCard, Visa and Discover. (Returned check fee is $25.00).

We are happy to assist you in processing your insurance claim, however insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for payment of your bill.

I understand that I may be billed for any out of pocket or reasonable collection fees if my account is not paid in a timely fashion. If it becomes necessary to pursue legal action to attempt to collect any outstanding balances, I agree that I am responsible for any and all attorney fees, court costs and any and all other costs deemed reasonable and customary and/or that may be allowed by the Court.

I hereby authorize and direct my insurance company to make payment to my physicians, providers and/or associates for services rendered and acknowledge that I am financially responsible for all non-covered services. I also authorize my provider to release to my insurance company any information necessary to process my claims. A photocopy of this assignment shall be considered as effective as the original.

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor’s office of any changes in my medical status. I hereby authorize the healthcare staff to perform the necessary services I may need.*

I certify that I have read and understand the foregoing “Financial Policy/Assignment of Benefits/Consent to Treatment” and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare / Medicaid, or other benefits programs and that I am ultimately responsible for payment in full of any outstanding balances. Note:*A charge of $25.00 will be assessed for each no show or late cancellation office visit appointment if lessthan 24 hours notice is given.*

First Name______________________Last Name________________________Birthdate

Signature of Patient/Guardian_________________________________________Date___________________

Acknowledgement of policyholder/responsible party (*if other than patient*):

First Name_______________________Last Name________________________Date __________________

# Physician Questionnaire and Standing Orders Form

A **physician** must complete this form and **attach** the most recent **history, physical** & **medication list**.

| Date of Request | | Physician | |
|---|---|---|---|
| Phone # | | Fax # | |
| Participant Name | | Participant DOB | |

Do you recommend this individual for an **Adult Day Care** program? ☐ Yes ☐ No

If No, please explain: ____________________________________________

Is this individual able to **self-administer medications**? ☐ Yes ☐ No

Does this individual have a **communicable disease**? ☐ Yes ☐ No please explain: ______________

**Allergies** (provide list) ____________________ ________________ __________________

**TB**: Test date:__________Result: Negative Positive

Chest X-ray date:_________Result: Negative result for TB Positive result for TB

**Dietary Needs:** ☐ Regular ☐ No added table salt ☐ Low fat ☐ Diabetic ☐ No added sugar ☐ No raw fruits/vegetables ☐ Other: __________________________

**Dysphagia**: ☐ Yes ☐ No Requires food Chopped: Pureed:

**Thickened Liquids**: ☐ Yes ☐ No Nectar consistency Honey consistency Pudding consistency

**Primary Diagnosis:________________,__________________, _________________**

**The following orders, once signed by the physician, are effective for 1 year and must be renewed yearly.**

| Please check either Yes or No for each item below (Allowable OTC) | Yes | No |
|---|---|---|
| **Tylenol** 325 mg. 1 or 2 tablets every 4 hours as needed for pain or fever | | |
| **Ibuprofen** 200 mg. 1 or 2 tablets every 4 hours as needed for pain or fever | | |
| **Maalox** 30cc every 4 hours as needed for stomach upset | | |
| **Imodium** 2mg once daily as needed for sudden diarrhea | | |
| Over the counter **cough drop** every 2 hours as needed for cough | | |
| **Tums** 1 or 2 tablets every 4 hours as needed for indigestion/heartburn | | |
| May check **blood sugar** with finger stick testing unit as needed for s/s of hyper/hypoglycemia | | |
| **Minor wound care** as needed; cleanse w/ normal saline; apply triple antibiotic & dressing | | |
| Preliminary **urine dipstick test** for RBCs, WBCs, and Nitrates for s/s of UTI | | |

Physician Name:_______________________Signature:__________________Date __________

## Authorization for Release of Information (ROI) – Primary Care Provider

I hereby give my permission for: ____________________________

Tel:______________________ Fax:_______________________

to release a copy of the specific information/documents listed: All medical records

Drug Abuse Psychiatric/Psychological HIV/AIDS Alcohol Abuse

**Sprycare Senior Center**
**Attn: Medical Records**
☐ **Phone: 561-247-2234**
**Email:info@SprycareSeniorCenter.com**

___(Initial Here) I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

***For the purpose(s) of Alcohol & Drug abuse clients only*** (*please check one*)***:***

This is a single disclosure **or** a continuing disclosure for 90 days. Date on which consent is given (Today's Date)________________Release Expiration Date __________________

*(Consent is subject to revocation at any time)*

First Name_________________Last Name__________________Birthdate ___________
Signature of Patient/Guardian______________________________Date_____________

*To Receiving Agency: Prohibition of Redisclosure! This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.*

## Communications Consent

Your physician(s) and other staff members will, at times, need to contact you. By filling out the Information below, we will be better able to serve you. Unless we have your written permission to do so, we will **not**:

- ✓ Leave messages with anyone except the patient or legal guardian.
- ✓ Leave medical information on an answering machine.
- ✓ Leave medical information on a voice mail, send emails, SMS/texts and/or fax.

*Please read below and carefully consider whom you want to have access to your medical information.*

I give Sprycare Senior Center my permission to leave phone messages, send emails and text messages or fax anything regarding my medical care and test results, as well as any changes in location, hours of operation, appointments and/or marketing information, on the following answering systems and/or devices. I fully understand that this consent will remain in effect until I revoke it in writing.

*IMPORTANT: Initial each item and fill in each space to confirm "YES" you grant consent:*

INITIALS: My cell phone/voice mail ______________________________

INITIALS: My home phone answering machine/voice mail _______________________________

INITIALS: My office/work voice mail _______________________________

INITIALS: My personal fax _______________________________

INITIALS: My email: ___________________________________

All my medical care information may be discussed with the following individuals:

Contact Name_________________________Phone________________Relationship__________________

Contact Name_________________________Phone________________Relationship__________________

Contact Name_________________________Phone________________Relationship__________________

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First Name_______________________Last Name________________________Birthdate______________

Signature of Patient/Guardian__________________________________________Date___________________

## Notice of Privacy Practices Acknowledgement

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 (CHECK ALL):

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Sprycare Senior Center of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review in office or online at www.medflorida.com, such Notice of Privacy Practices prior to signing this consent. I understand that Sprycare Senior Center has the right to change the Notice of Privacy Practices from time to time and that I may contact this office at any time by phone or in person to obtain a current copy of the Notice of Privacy 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 healthcare operations. 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.

First Name________________________Last Name_________________________Birthdate _______________

Signature of Patient/Guardian__________________________________________Date____________________