Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

ACKNOWLEDGE OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Effective Date: January 1, 2003 Dr. _____

Thank you for choosing the Medical Center clinic for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Health Information Privacy Practices. To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

_____	_____	_____
Patient Name	MCC #	Date of Birth

_____	_____
Signature of Patient (or Legal Representative)	Date

_____	_____	_____
Signature of Staff Member	Title	Date

Comments:

Place label here

8333 N. Davis Highway • Pensacola, FL 32514
850.474.8398

PLACE PATIENT LABEL HERE

MedicalCenter/Clinic
HEALTHCARE CENTERED AROUND YOU

LIFETIME INSURANCE ASSIGNMENT AND AUTHORIZATION FORM

West Florida Medical Center Clinic, P.A. (MCC) is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

Lifetime Insurance Assignment

I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

West Florida Medical Center Clinic, P.A.
8333 North Davis Highway
Pensacola, FL 32514

for all medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MCC and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to MCC. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) MCC accepts Medicare assignment and Medicare payments will be directed to MCC and 2) Medical Center Clinic does not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim and any account balance not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures.

Authorization to Use and Disclose My Protected Health Information

I authorize MCC to use or disclose information about me for the following reasons:

Treatment: MCC may disclose information about me to my primary care physician, referring physicians, and other individuals consulted by my physician so that those involved in my treatment can manage my healthcare needs. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible and genetic conditions to such consultants and/or other healthcare personnel that may be involved in my care. X Initials of Patient or Legal Representative: _____.

Payment: MCC may use and disclose information about me to any person or corporation which is or may be liable for all or any portion of the charges incurred in connection with these services, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to any third party payors that may be responsible, in whole or in part, for payment on my behalf. X Initials of Patient or Legal Representative: _____.

Operations: MCC may use and disclose information about me as needed to support its business activities. Examples of business activities may include notification of pharmaceutical and medical device recalls, communication about health-related products or services provided by MCC, and quality improvement activities designed to assess and improve the quality and effectiveness of the healthcare and service MCC provides to its patients. If applicable, I expressly consent to MCC's use and disclosure of information regarding testing and/or treatment for HIV/AIDS, substance abuse, mental health, sexually transmissible, and genetic conditions to support its business activities.

X Initials of Patient or Legal Representative: _____.

I further agree and acknowledge that:

- My health information is stored in an Electronic Medical Record (EMR) that is shared by MCC health care professionals.
- I have the right to request that you restrict how information about me is used or disclosed for treatment, payment, or operations. I understand that you are not required to agree to these restrictions, but if you do agree, you are bound by the restrictions.
- Should I decline to sign this Lifetime Insurance Assignment and Authorization Form, I assume full responsibility for all charges incurred for services provided at MCC and that these charges are due in full at the time of service.

This Lifetime Insurance Assignment and Authorization is ongoing and will not expire until such time as written notice of revocation is provided.

_____ _____

Signature of Patient or Legal Representative Date

eye INSTITUTE℠
AT THE MEDICAL CENTER CLINIC
EXCELLENCE IN EYE CARE

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

PATIENT INFORMATION SHEET

Name: _____ Age: _____ Today's Date: _____
Last Name First Name

Family Physician/Internist: _____ Date of last visit: _____

Optometrist: _____ Date of last visit: _____

Referred by: _____ Relationship: _____

EYE HISTORY:

1. Do you wear glasses? Yes _____ No _____
2. Do you wear contact lenses? Yes _____ No _____
3. Do you have problems reading with glasses: Yes _____ No _____

4. How does your eye condition affect your daily activities? _____
_____

5. Have you ever had an eye injury or eye surgery? Please describe: _____
_____

Personal Medical History: Please **check** and **date** those that you have now and in the past:

Anemia _____	Gout _____	Liver Disease _____	Transfusions _____
Arthritis _____	Heart Disease _____	Lung Disease _____	Tuberculosis _____
Asthma _____	Hepatitis _____	Migraines _____	Ulcers _____
Cancer _____	High Blood Pressure _____	Seizures _____	Other _____
Colitis _____	High Cholesterol _____	Stroke _____	
Diabetes _____	Kidney Disease _____	Thyroid Disease _____	

Past Surgical History: Please **list** and **date** any surgeries you have had. ☐ None

_____ _____ _____
_____ _____ _____

Are you currently taking any **Medications**? Yes _____ No _____ If yes, please list below:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you **allergic** to any Medications or Dyes? Yes _____ No _____ If yes, please list below:

_____ _____ _____

*****PLEASE TURN OVER TO COMPLETE OTHER SIDE*****

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850.474.8436

Family medical history: Please **check** and **list** family relationship-**Blood relatives only**

Glaucoma _____ Retinal disease _____ Macular degeneration _____ Diabetes _____

Please give a brief statement as to the health status of the following:
Parents: _____

Brothers/Sisters: _____

Children: _____

Social History:
If employed, how many hours do you work per week? _____

If retired, former occupation? _____

Do you smoke? Yes _____ No _____ If yes, how much? _____

Do you drink alcohol? Yes _____ No _____ If so, how much? _____

Education: _____ If you are a student, name of school _____ What grade? _____

Review of Recent Symptoms: Please **circle** either yes or no.

Constitutional:		**Urinary:**		**Neurologic:**	
Unusual fatigue	yes/no	Pain or burning	yes/no	Muscle weakness	yes/no
Excessive thirst	yes/no	Urinary frequency	yes/no	Numbness/tingling	yes/no
Swollen glands	yes/no	Penile discharge	yes/no	Seizures/convulsions	yes/no
Weight change	yes/no	Blood in urine	yes/no	Fainting spells	yes/no
Cold hands or feet	yes/no			Loss of balance	yes/no
Ears, Nose, Throat, Mouth		**Bones & Joints:**		**Gastrointestinal:**	
Hearing loss	yes/no	Painful or stiff joints	yes/no	Hard to swallow	yes/no
Bleeding gums	yes/no	Swelling in joints	yes/no	Abdominal pain	yes/no
Hoarseness	yes/no			Nausea/vomiting	yes/no
Sore throat	yes/no				
Heart:		**Lungs:**		**Blood:**	
Racing or fluttering	yes/no	Breathing difficulty	yes/no	Easy bruising	yes/no
Chest discomfort	yes/no	Wheeze	yes/no	Prolonged bleeding	yes/no
Swollen feet or ankles	yes/no	Cough	yes/no		
Shortness of breath	yes/no	Coughing up blood	yes/no		
Mood:		**Skin:**			
Memory change	yes/no	Rash or hives	yes/no		
Depression	yes/no	Change in skin or moles	yes/no		
Excessive worry	yes/no				

I have seen my internist/family physician for the above problems: yes _____ no _____

For office use only—do not write below this line.

_____ _____ _____

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