Welcome to Impact Primary Care!

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ / _____ / _____ SS#: _____

Local Address: _____City: _____State: _____ Zip: _____

Northern Address: _____

Cell Phone #: _____ Home Phone #: _____

Email: _____

Referred by: _____ Primary Care Physician: _____

Pharmacy: _____

Pharmacy Location: _____

Pharmacy Phone # : _____

Race: ☐ African American ☐ Caucasian ☐ Asian ☐Other _____ ☐ Decline

Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline

Sex: ☐ Male ☐ Female Gender identity: ☐ Man ☐ Woman ☐ Non – Binary ☐ Gender fluid

Emergency Contact: _____ Phone #: _____

Relationship to patient: _____

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

Plan Name: _____ Group Name: _____

Group #: _____ Member ID: _____

Secondary Insurance

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

Plan Name: _____Group Name: _____

Groups #: _____ Member ID: _____

Relationship to Patient: _____

Responsible Party (If different than Patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Local Address: _____ City: _____State: ____ Zip_____

Date of Birth: _____/_____/_____ Phone: _____ Email: _____

Relationship to Patient: _____

Assignment and Authorization of Benefits: I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing. I hereby authorize Impact Primary Care to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Impact Primary Care (or the party who accepts assignment). I certify that the information I have reported concerning my insurance coverage is correct. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services provided on my behalf or my dependents. I agree to pay any reasonable collection fees, including reasonable attorney fees necessary to collect my debt.

Patient or Responsible Party Signature: _____ Date: _____

MEDICAL HISTORY

Name:_____ Date of Birth:_____Date:_____

Allergies:_____ **No Known Allergies:** ____
Reason for visit today: _____
Current Concerns: _____
_____

Cardiovascular	**Yes**	**No**
Heart Attack	**Y**	**N**
Chest Pain	**Y**	**N**
Pacemaker/ Defib	**Y**	**N**
Leg / Ankle swelling	**Y**	**N**
Palpitations	**Y**	**N**
Irregular Pulse	**Y**	**N**
Muscle pain	**Y**	**N**
Heart Murmur	**Y**	**N**
Abnormal EKG	**Y**	**N**
High Blood Press	**Y**	**N**

Ears/ Nose/ Throat		
Hearing loss	**Y**	**N**
Uncorrectable vision loss	**Y**	**N**
Fever Blisters	**Y**	**N**
Difficulty Swallow	**Y**	**N**

Blood/ Lymphatic		
Bleeding Disorder	**Y**	**N**
Anemia	**Y**	**N**
Transfusions	**Y**	**N**

Endocrine		
Diabetes	**Y**	**N**
Thyroid Problems	**Y**	**N**
Pituitary	**Y**	**N**

Respiratory	**Yes**	**No**
Recent Infect	**Y**	**N**
Asthma	**Y**	**N**
Pneumonia	**Y**	**N**
Tuberculosis	**Y**	**N**
Chronic Cough	**Y**	**N**
Shortness of Breath	**Y**	**N**
COPD	**Y**	**N**
CPAP machine	**Y**	**N**

Neurological		
Stroke/ TA	**Y**	**N**
Migraine	**Y**	**N**
Blackout Spells	**Y**	**N**
Dizziness	**Y**	**N**
Weakness/ Paralysis	**Y**	**N**
Motion Car Sickness	**Y**	**N**

Musculoskeletal		
Fractures	**Y**	**N**
Dislocations	**Y**	**N**
Joint Pains	**Y**	**N**
Arthritis	**Y**	**N**
Back Pain	**Y**	**N**
Neck Stiffness	**Y**	**N**
Neck Immobility	**Y**	**N**

Gastrointestinal	**Yes**	**No**
Hepatitis	**Y**	**N**
Jaundice	**Y**	**N**
Ulcer	**Y**	**N**
Hiatal Hernia	**Y**	**N**
Pancreatitis	**Y**	**N**
Vomiting Blood	**Y**	**N**
Colitis	**Y**	**N**
Blood in stool	**Y**	**N**
Hemorrhoids	**Y**	**N**
Change in bowels	**Y**	**N**

Genitourinary		
Bladder Infection	**Y**	**N**
Kidney Infection	**Y**	**N**
UTI	**Y**	**N**
Stone in Urine	**Y**	**N**
Incontinence	**Y**	**N**
Blockage of urine	**Y**	**N**
Prostate Problem	**Y**	**N**

Other Providers	**Yes**	**NO**
Cardiologist	**Y**	**N**
Dentist	**Y**	**N**
Family Doctor	**Y**	**N**
Gastroenterology	**Y**	**N**
Neurology	**Y**	**N**
OB/GYN	**Y**	**N**
Orthopedic	**Y**	**N**
Rheumatology	**Y**	**N**
Vascular	**Y**	**N**

Previous Surgeries / Hospitalizations: _____ Year: _____
_____ Year: _____
_____ Year: _____
Implantable Devices: _____

Family History

Please list if your father, mother, sibling, grandparent, or aunt/uncle has had any of the following conditions.

Arthritis:_____ Cancer:_____
Cholesterol:_____ Diabetes:_____
Heart Disease:_____ Hypertension:_____
Psychological:_____ Seizure/ Epilepsy:_____
Stroke:_____ Other:_____

I agree the information put on this patient information history form is accurate to the best of my knowledge.

Patient Signature: _____ **Date: _____**

Social History

What is the highest grade or level of school of highest degree you have received? _____

Do you feel stress – tense, restless, nervous, or anxious or unable to sleep because your mind is troubled all the time?

☐ Not at all ☐Only a little ☐To Some Extent ☐Rather Much ☐Very Much

☐ Prefer to not disclose

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

ALCOHOL:
How many drinks per day? _____ Per Week? _____ Per Month? _____

Recreational Drugs:
Do you currently or previously use recreational drugs? ☐Yes ☐No
If yes, how often and what route? _____

TOBACCO USE: ☐Non-Smoker ☐Current Smoker ☐Former Smoker - Year Quit _____

How many packs per day? _____ For how many years? _____

Marital Status :

☐Married ☐Widowed ☐Divorced ☐Separated ☐Never Married ☐Living with a Partner
☐Prefer to not Disclose

Occupation : _____
If retired, what was your occupation? : _____

Please check whether you have had the following preventative services- include month and year of service.

IMMUNIZATIONS	MONTH	YEAR	TESTS	MONTH	YEAR
Shingles Vaccine ☐Zostavax ☐Shingrix			☐Mammogram Screening		
Pneumonia Vaccine ☐Pneumovax 12 ☐Prevnar 13			Colorectal Cancer Screen ☐ Colonoscopy ☐ Other:		
Influenza			Chest X-Ray		
Tetanus vaccine/ Tdap			Prostate- Specific Antigen (PSA)		
Covid			Gardasil (HPV)		
Hepatitis B			Bone Density		
			Screening For Skin Cancer		

Name:_____ Date: _____

MEDICATIONS

Please list all current medications/ Supplements below in the chart, including over the counter and vitamins.

MEDICATION:	DOSAGE:	FREQUENCY:

COMMUNICATION AGREEMENT FORM

As a participant in your own care, it is your responsibility to ensure that there is a clear and open method of communication from our office to you. It is also your responsibility to make sure that this office always has a way to contact you to communicate test results and other important matters related to your medical care.

We may recommend/perform diagnostic studies that we feel are important to your well-being. These studies are to diagnose your ailment(s), define treatment strategies and to maintain your health. As with all diagnostic studies, at times we find results that, if undiagnosed or diagnosis is delayed, can result in death or a serious disability. Some of these studies will be at the time of an active issue, and other times it will be recommended for the future.

We attempt to contact every patient with results of diagnostic studies and reminders for follow-up issues. Ultimately, if you do not hear from us within 14 days about your test results, it is your responsibility to contact us.

By signing this letter, you agree to the following:

1. Call our office two weeks after any diagnostic study, if we have not notified you with results
2. Call our office again, for any issue, if we do not return your call
3. Immediately notify our office of a change of address and/or contact telephone numbers
4. Keep a written record of when your diagnostic studies are scheduled and notify our office
   If you cannot comply
5. Keep a written record of your future follow-up needs, even if it is ten years in the future
6. _____(initial) I authorize IPC to leave telephone messages that may contain medical information at the following numbers: _____
7. _____(initial) I authorize IPC to contact me at the following email address: _____
8. _____(initial) I authorize IPC to share my medical information with: _____

By signing this letter, you are agreeing that the responsibilities and obligations outlined in lines 1 through 5 are important to your future health and that you will comply with these obligations.

_____

Patient Name Printed

_____

Patient Signature

_____

Date

CONSENT FOR TREATMENT
AUTHROIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

1. CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of (PATIENT)_____ hereby consent to examination, diagnostic testing and treatment by Impact Primary Care, and its employees and agents (together, IPC). I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by IPC.

2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to IPC. I understand that this assignment of benefits does not relieve me of my obligation to pay IPC for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for, and guarantee payment of any charges incurred for the services provided to PATIENT by IPC. I further understand and agree that I will be responsible for payment of any deductible, co-payment or co- insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors.

I authorize IPC to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to patient

_____
Date

FINANCIAL POLICY

1. Payment for all co-pays, deductibles, and outstanding patient balances is due at the time of service. We accept cash, checks, and most major credit cards. There will be a minimum charge of $25.00 on all returned checks.

2. Please be advised that your insurance policy is a contract between you and your insurance company.

   We are participating providers with many insurance companies and other health plans, and we will file a claim and accept assignment of benefits on these claims. Payment will be made by the insurance company directly to Impact Primary Care (IPC).

   If we do not participate with your insurance company, you will be responsible for paying your charges at the time of service. We will, however, provide you with a superbill summary of your visit for you to submit to your insurance company. If your insurance company covers such charges, then the insurance company will pay you directly.

3. Not all insurance companies cover all services. If your insurance company determines a service to be "non covered," you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.

4. If you provide incorrect or false information that results in a denial of a claim(s), you will be responsible for any unpaid claims and/or all charges for services provided.

5. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, included but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.

6. If you cannot keep your appointment for any reason, we require 24 hours-notice for office visits.

7. If the patient or responsible party fails to pay for services rendered under standard practices, then such nonpayment will result in the patient/undersigned's provider, and all providers of IPC, terminating their provider relationship with the patient/undersigned, in accordance with applicable law. All outstanding balances for services rendered will be referred to a collection agency.

I have read and understand the IPC Financial Policy, and I agree to be bound by its terms. I also understand and agree that IPC may amend such terms from time to time.

_____ _____

Signature of Patient (or Responsible Party) Date

_____

Please Print Name of Patient or Responsible Party

Impact Primary Care

MEDICAL RECORDS RELEASE FORM

Patient Name (Please Print) _____ Date of Birth _____

I Authorize:

Physicians Name	Address	Phone Number	Fax Number

To Release To:

Impact Primary Care
722 Shamrock Blvd.
Venice, FL 34293
Ph: 941-786-1385
Fax: 941-907-8597

I request and authorize the release of my health information noted below: (Please check all that apply)

☐All Healthcare Information ***(LAST 12 MONTHS ONLY)*** ☐Lab Report(s) Dates _____

☐X-Ray Report(s) Date(s) _____ ☐Other _____

I understand that I am entitled to receive a copy of this authorization
I understand that I may withdraw this authorization in writing at any time
Unless otherwise specified below. I understand that this authorization will expire 90 days from the request date.
I request that this authorization expire on (specify date): _____

Signature: _____ Date: _____ Daytime Phone# _____

_____ _____

If Not Signed by Patient – Legal Representative's Name Legal Representative's Relationship to Patient

NOTICE OF PRIVACY PRACTICES

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of Interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

• *Law Enforcement Purposes*: Subject to certain restrictions, we may disclose information required by law enforcement officials.

• *Deaths*: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

• *Serious Threat to Health or Safety*: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• *Military and Special Government Functions*: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

• *Research*: We may use or disclose information for approved medical research.

• *Workers Compensation*: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights concerning your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a specific address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below, you also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Effective Date: The effective date of this notice is December 21, 2021

By signing this form, you are agreeing that you have reviewed IPC's Notice of Privacy Practices. If you would like a copy of Notice of Privacy Practice, please request!

Patient Signature: _____
Patient Printed Name: _____
Date : _____