West Volusia Family and Sports Medicine
www.drjohnhillmd.com

Dear Valued Patient,

We are pleased that you have chosen to partner with us in the care for your health. However, in order to insure that you receive the best care possible and are taken care of in the most efficient way, we ask that you review the following office policies.

Healthcare Compliance

We ask that you make an effort to comply with the physician's recommendations regarding routine follow-ups, medications, specialist referrals, procedures and etc.

Pain Management

Please note that a referral will be made to a pain management specialist for chronic pain management medication at the discretion of Dr. Hill.

Prescriptions

Prior to your office visits, please make a note of any refill needed.

For refills we ask that you contact your pharmacy and have them fax us a refill request, allowing 24-48 hours for it to be processed and forwarded back to the pharmacy.

Mail-Order prescriptions can be called in to the office and then picked up from the front desk. We no longer fax prescriptions to mail-order pharmacies. Again, please allow 24 to 48 hours for processing.

Controlled substance refills require follow-up appointments every 3 months, as per prescribing regulations.

Lab/Imaging/Sleep study Follow up Policy

To go over any results for labs, imagining or sleep studies you will need to make an appointment. If no appointment is made and there are abnormal results we will contact you to make an appointment to go over the results.

Cancellations/ No Show policy

Time has been specifically reserved for your physician appointment, procedure or treatment. Please call at least 24 hours ahead to cancel your appointment. There will be a $25 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours' notice.

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By signing this Written Acknowledgment, I hereby expressly acknowledge receipt of West Volusia Family and Sport Medicine's Notice of Privacy Practices.

X______________________________________ ___________________________

Patient Signature (If under 18, parent/guardian signature) Date

X__________________________________ __________________________

Patient Printed Name Relationship to patient

Emergency Notification/Next of Kin- Someone not in the Household:

Name:_______________________

Relation to Patient: __________________ Telephone:__________________

Release of Information / Assignment of Benefits

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me; I understand and agree that regardless of my insurance status I am responsible for any balance of my account.

X____ ___________________________

Patient Signature or responsible party signature Date

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Patient Information:

Name:________________________________ DOB:______________ SS#: __________________

Mailing Address:__________________________ City:_______________ State: ______ Zip:__________

Telephone:_______________________ Cell Phone #: ______________________

Email:____

Gender: [ ] Male [ ] Female Marital Status:___________ Preferred Language:___________

Race:_______________ Ethnic Group:________________

Primary Policy Holder:

Name:__________________________________ DOB:_______________ SS#: ________________

Mailing Address:__________________________ City:_______________ State:_____ Zip:_________

Telephone: _______________ Relation to patient: __________ _________

Primary Insurance:

Company: _________________________________ Group #:__________________________

ID #: ________________________________

Secondary Insurance:

Company:______________________ ID:____________________ Group #: ___________________

Policy Holder: _________________________________ Relation to Patient:____________________

Employment Information:

Company:_______________________________________ Position: ________________________

Office Telephone: ____________________

Student Status:

( ) Part Time ( ) Full Time ( ) Not a Student

Y	N	Advance Directives Questions
		Do you have an Advanced Directive or Living Will? If yes please furnish a copy for your record.
		If you do not, would you like information on the preparations on these? If yes please ask our staff.
		Have you designated a Healthcare Surrogate? If yes, please furnish a copy of your designation for your records.
		Are you an organ donor?

Reason for visit or any health concerns/ additional information

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are protected by privacy acts under HIPPA and will become part of your medical record. Fill in the blanks or check appropriate answers.

Previous Primary Care Provider

Provider:____
Practice Name:____
Address:____
Fax Number:____
Phone Number:____

Current Specialists (Ex: Cardiologist, Pulmonologist, Endocrinologist, Nephrologist, etc)

Provider:__________________________________ Provider:__________________________________
Practice Name:_____________________________ Practice Name:_____________________________
Telephone Number:_________________________ Telephone Number:_________________________
Fax Number:_______________________________ Fax Number:_______________________________

Provider:__________________________________ Provider:__________________________________
Practice Name:_____________________________ Practice Name:_____________________________
Telephone Number:_________________________ Telephone Number:_________________________
Fax Number:_______________________________ Fax Number:_______________________________

Patient Preferences

Pharmacy Name:____________________________ Laboratory Name:___________________________
Address:__________________________________ Address:__________________________________
____ ____
Telephone Number:_________________________ Telephone Number:_________________________

Imaging Center Name:______________________ Hospital Name:_____________________________
Address:__________________________________ Address:__________________________________
____ ____
Telephone Number:_________________________ Telephone Number:_________________________

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Health History Questionnaire

All questions contained in this questionnaire are protected by privacy acts under HIPPA and will become part of your medical record. Fill in the blanks or check appropriate answers.

Personal Health History	
Childhood Illness: [ ]Measles [ ]Mumps [ ]Rubella [ ]Chickenpox [ ]Rheumatic Fever [ ] Polio	
Please indicate current vaccinations and Date received:	
[ ]Tetanus or TET/DIP- Date:	[ ]Pneumonia- Date:
[ ]Hepatitis (series of 3) Date:	[ ]Chickenpox/Shingles- Date:
[ ]Influenza- Date:	[ ]MMR(Measles, Mumps, Rubella) Date:

List any medical problems that other doctors have diagnosed or check applicable items on list.		
	[ ]High Blood Pressure	[ ] Heart Disease [ ]
	[ ]Hypothyroidism	High Cholesterol [ ]
	[ ]Diabetes II	Atrial Fibrillation [ ]
	[ ] COPD	Asthma [ ] Arthritis
	[ ] Peripheral Vascular	

Surgeries and procedures (Please fill in any that applies):		
	Date	Doctor
[ ]Carotid Endartectomy (remove plaque from neck vessels)		
[ ]Thyroidectomy		
[ ] Cardiac Catheterization. Stent		
[ ]Coronary Artery Bypass # of Vessels ___		
[ ]Pacemaker Automatic Implanted Defibrillator		
[ ]Aortic Aneurysm Repair		
[ ] Vascular Bypass (specify location):		
[ ]Breast Surgery: [ ]Mastectomy [ ]Lumpectomy [ ]Biopsy (non-cancer)		
[ ]Chest Surgery		
[ ]Kidney Surgery		
[ ] Hip Replacement : [ ] Left [ ]Right		
[ ]Knee Replacement : [ ] Left [ ] Right		
[ ]Amputations:		
[ ]Endoscopy of Esophagus/ Stomach/ Duodenum (EGD)		

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[ ]Cholecystectomy (Gallbladder Removed)		
[ ]Colonoscopy- Finding: [ ]Polyps [ ]Diverticulosis [ ]IBS [ ]Chron's		
[ ]Gastric Bypass- Type:		
[ ]Appendectomy		
[ ]Hysterectomy : [ ]Abnormal [ ]Vaginal (this is uterus only, see below)		
[ ]Ovaries and Tubes : [ ]Left [ ]Right		
[ ]Tubal Ligation (sterilization)		
[ ]Bladder (Specify what type)		
[ ]Prostate: [ ]TUNA [ ]TURP [ ]Other		
[ ]Cataracts: [ ]Left [ ]Right		
[ ]Plastic Surgery- Specify:		
[ ]Other:		
[ ]Other:		

Testing in the last two years:		
	Date	Doctors
[ ]CT (Computed Tomography) [ ]Head [ ]Chest [ ]Abdomen [ ]Pelvis		
[ ]MRI: [ ]Head [ ]Chest [ ]Abdomen [ ]Pelvis		
[ ]DEXA Bone Scan for Bone Mass		
[ ]Nuclear Medicine Scan		

Other Hospitalizations in the last 2 years		
Date	Reason	Hospital

Have you ever had a blood transfusion? [ ]Yes [ ]No	If yes, what year?
Have you ever had radiation therapy? [ ]Yes [ ]No	If yes, indicate reason:
Have you ever had a blood clot in your lungs or legs? [ ]Yes [ ]No	If yes, what year?

Allergies or intolerance to Medications?

Please list the drug and make sure you are specific about your reaction. List your prescribed drugs and over-thecounter drugs, such as vitamins and inhalers, eye drops and nasal sprays.

Name the Drug (BRAND and Generic)	Reaction You Had

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Current Medications:		
Name the Drug (Brand and Generic)	Strength/Dose/Form	How and when you take the medications:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS IN THIS SECTION ARE OPTIONAL AND WILL BE CONFIDENTIAL IN COMPLIANCE WITH PRIVACY POLICIES		
The Amount of exercise you get on a weekly basis . Please check the appropriate answer.	[ ] Sedentary (No Exercise)	
	[ ] Mild Exercise (Climb stairs, walk 3 block, golf)	
	[ ] Occasional Vigorous Exercise (Work or recreation, less then 4x / week for 30 min.)	
	[ ] Regular Vigorous exercise (Work or recreation, 4x / week or more for 30 min.)	
Are you happy with your Are you Dieting? weight? [ ]Yes [ ]No	If yes, are you on a physician prescribed diet?	[ ]Yes [ ]No
	How many meals do you eat in the average day?	[ ]Yes [ ]No
How many caffeinated drinks do you consume?	[ ]None [ ]Coffee [ ] Tea [ ] Cola [ ]Other:	
	# Of cups/cans per day?	
Do you consume alcoholic beverages? Please answer questions to the best of your ability	[ ]None [ ]Beer [ ]Wine [ ] Mixed Drinks [ ]Coolers [ ]Other:	
	How many servings per week?	
	Are you concerned about your drinking? [ ]Yes [ ]No	
	Have you ever experienced blackouts? [ ]Yes [ ]No	
	Have you considered stopping? [ ]Yes [ ]No	
	Are you prone to binge drink? [ ]Yes [ ]No	
	Do you drive after drinking? [ ]Yes [ ]No	
Do you now or have you ever smoked or chewed tobacco? Fill in the blanks	I smoke cigarettes: ____ packs per day ___#years	I quit in _____, I smoked ____ packs per day for _____ years.
	[ ]Chew-#/Day	[ ] Cigars -#/Day
	[ ] Pipe-#/Day	
	Are you interested in quitting? [ ] Yes [ ] No	

Urinary/Infectious Concerns	
	Do you have a history of recurrent urinary tract, bladder, or kidney infections?
	Do you have problems with control of urination?
	Do you feel any pain or burning with urination?
	(#) of Time you get up during the night to urinate
	Have you had any of the follow infections: HPV , Herpes, HIV, Chlamydia, or Gonorrhea
Sexual/Reproductive Health	
	Are you sexually active?
	If not trying for pregnancy, what methods are used for prevention?
	Any discomfort (pain or dryness) with intercourse?
	Any problems with frequency or loss of interest in intercourse?
Females	
	Age at Start of Menstruation
	Age at Menopause
	Date of Last Menstrual Period
	How many pregnancies?
	How many live births?
	Are you pregnant?
	Are you breastfeeding?
Males	
	Any difficulty with erection or ejaculation?
	Any testicle pain or swelling?
Questions about your health and safety.	
	Do you live alone?
	Do you have frequent falls?
	Do you wear glasses, contacts, hearing aid or dentures?

Family Health History

Relationship	Age (Present or at Death)	Health Problems
Father		
Mother		
Siblings		
Children		
Grandmother(Maternal)		
Grandfather(Maternal)		
Grandmother(Paternal)		
Grandfather(Paternal)		

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Dear West Volusia Family and Sports Medicine Patient,

If you have two or more chronic diagnosis, such as Diabetes, CHF, COPD, and/or other diagnoses you qualify for our Health Management program also known as Chronic Care Management (CCM). West Volusia Family and Sports Medicine offers this program to all **Medicare** patients. Our goal is to make sure you get the best care possible from everyone that is involved with your health. This service is at no extra cost to you the patient.

A phone call each month for this program includes:

- Discussion of symptoms and management of medications with your dedicated CCM Care Coordinator.
- Help coordinate your visits with other doctors, facilities, lab, radiology, or other testing.
- A Comprehensive Care Plan from our practice to help you understand how to care for your chronic conditions (diagnosis) so that you can be as healthy as possible.

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. 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. We look forward to helping you manage your health with our CCM program.

Our office will have a record of our time spent managing your care if you ever have a question about what we did each month. You may stop this service at any time, for any reason. Your signature is required to end CCM services, please ask staff for form.

I agree to participate in the Health Management Program (CCM): Yes _____No _____

DOB:___________ Name: _________________________________

Signature:________________________ Date___________

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Here at West Volusia Family and Sports Medicine we strive to provide exceptional care to all of our patients. Our priority is to have a safe and respectful environment for all of our patients and staff alike. We understand that receiving medical care at times can be very stressful however, it is imperative that all individuals involved adhere to a standard of conduct that promotes mutual respect and professionalism.

Instances of disrespect, verbal abuse, or threats will not be tolerated within our practice. Such behavior not only undermines the well-being of our staff but also compromises the quality of care we can provide to you and other patients. Any displays of said behavior will result in termination of your relationship with our practice.

We believe that effective communication and mutual respect are essential components between the provider-patient relationship, and we expect all interactions to reflect these principles. If you have any concerns or questions regarding your care, we encourage you to address them in a respectful and constructive manner. We value the opportunity to serve you as a patient, but we must prioritize the well-being and safety of our entire community.

Thank you for your attention to this matter.

Please acknowledge your agreeance to the above referenced information.

X ______________________________

Patient Name (Printed)

X ______________________________

Patient Signature

X ______________________________

Date

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOAURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

*****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW*****

Patient (Name and information of person whose health information is being disclosed):

Name (First Middle Last):____

Date of Birth(mm/dd/yyyy):____

Address:_______________________________ City:_________________ State:_____ Zip:________

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions if any) [see page 2 for details]

FROM WHOM: ALL Information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: West Volusia Family and Sports Medicine Phone: (386)774-0016

Address: 1590 S SR 15A, Suite 100, DeLand FL 32720 Fax: (386)774-0606

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In Addition:

- ☐ I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- ☐ I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- ☐ I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- ☐ I have read all pages of this form and agree to the disclosures above from the types of sources listed.

X____ ______________________

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

____

Print Name of Legal Representative (If Applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- o Parent of minor
- o Guardian
- o Other personal representative (explain:___________________________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOAURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": Includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All record and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to the sensitive health conditions (if any), including but not limited to:
   1. Drug, Alcohol, or substance abuse
   2. Psychological, psychiatric or other mental impairment(s) or developmental disability (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   3. Sickle Cell Anemia
   4. Birth control and family planning
   5. Records which may indicate the presence of a communicable disease or noncommunicable disease; and test for or records of HIV/AIDS or sexually transmitted disease or tuberculosis
   6. Genetic (inherited) diseases or tests
2. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. Information created before or after the date of this form.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law. Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information); instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your healthcare provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.