Patient Registration

Demographic Information:

Last Name:_____ First Name: _____ MI: _____

Date Of Birth: _____ (MM/DD/YYYY) Sex: _____ Race: _____

Address: _____ City: _____ State: _____ Zip:_____

Martial Status: Single ____ Married ____ Partner ____ Divorced ____ Widowed ____

Whom may we thank for referring you to our practice?_____

Contact Information:

Home Phone:_____ Work Phone: _____ Ext: _____

Cell Phone: _____ Email: _____

Emergency Contact:

First Name: _____ Last Name: _____

Preferred Phone: _____ Alt Phone: _____

Relationship to patient: _____

(*Optional*) Permission to verbally discuss my medical care. My healthcare provider and staff may discuss my medical care with the following individuals.

Name & Relation: _____ Phone: _____

Name & Relation: _____ Phone: _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/ Guardian _____ Date: _____

JOHNSON RIVERSIDE FAMILY PRACTICE

43 Avenue J SW, Moore Haven, FL 33471
Office 863.946.0284 Fax 863.946.0794

PATIENT INTAKE AND HISTORY FORM

Name: _____ **Date of Birth:** _____

Preferred Local Pharmacy: _____
(Address/City)

*****Should your information change, please report these changes in your address, phone contact numbers, insurance, or emergency contact, information to the front desk upon check in at future visits*****

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

___ Abdominal Pain
___ Abnormal Vaginal Bleeding
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Back Pain
___ Cancer
___ Colitis, Ulcerative
___ COPD
___ Crohn's
___ Deep Vein Thrombophlebitis
___ Dementia
___ Depression
___ Diabetes
___ Diverticulitis
___ Dizziness
___ ED (erectile dysfunction)
___ GI Bleed
___ GERD
___ Gout
___ Headaches, Chronic
___ Heart Disease
___ Heart Murmur
___ Heart Palpations
___ Hemorrhoids
___ Hepatitis
___ High Blood Pressure
___ Incontinence
___ Irritable Bowel
___ Kidney Stone(s)
___ Measles
___ Migraines
___ MRSA Infection
___ Mumps
___ Osteoporosis
___ Polio
___Guillain Barre Syndrome
___ Prostate Disease
___ Rash
___ Rheumatic Fever
___ Rubella
___ Scarlet Fever
___ Seasonal Allergies
___ Seizure
___ Sinusitis
___ Sleep Disorder
___ Somnolence
___ Stroke
___ Tendinitis
___ Thyroid Disorder
___ Tuberculosis
___ Ulcer
___ Urinary Frequency
___ Urinary Pain
___ Vascular Disease, Peripheral

List any other important **medical condition**(s) and **or Surgeries** you have had (do not include common colds or flu). Include date or age of initial diagnosis/surgery if possible: (continue on back if necessary)

Problem/Previous Diagnosis *Date(s) or Age*

_____

_____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP:_____

BUSINESS PHONE # : _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

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43 Avenue J SW, Moore Haven, FL 33471
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Allergy History:

List known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes below:

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

Medication History:

List any medications and vitamins/minerals/herbs that you are currently taking.
Ensure to **include Name, Dose, and Frequency of medication(s).** or Bring Medication Bottles or Completed List with you to appointment.

☐ No Current Meds

Social History:

Do you use tobacco products? ☐Never used ☐Former use ☐Current use ☐Unknown How often? ☐Rare ☐Social ☐Daily

What type? ☐Cigarettes ☐Chewing Tobacco ☐Cigars

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

Do you drink beverages with caffeine? ☐Yes ☐No

What type? ☐Coffee ☐Tea ☐Carbonated Beverages

Do you drink beverages with alcohol? ☐Yes ☐No

How often? ☐Occasional use ☐Moderate use ☐Heavy use

What type? ☐Beer ☐Hard Liquor ☐Wine

INFORMED CLIENT CONSENT
TO DISPENSE COMPOUNDED PRODUCT

Client/Paitent Information

Client Information:	
Name:	
Address:	
Phone/Fax/ Email:	

Description of the Compounded Product

Description of the compounded product:
Applies to any compounded drug recommended by provider- Check Pt Chart
If applicable:
Pharmacy that prepared the product: Varies

Declaration of Consent

I hereby acknowledge that my provider, **Jennifer Johnson, APRN**, has advised me of and explained the following (check off as each item is discussed):

- ❑ I understand the proposed compounded product is not approved by FDA and consequently may be associated with greater risk. This product has not undergone rigorous testing for efficacy and stability.
- ❑ I understand the reasons for utilizing the compounded product, its potential risks and benefits, other alternative treatment(s) and the probable consequences, which may occur if the proposed medication is not administered.
- ❑ I understand the risks associated with handling the product.

My questions have been answered, I have read or had explained to me and fully understand the information on this form and declare that I agree that the compounded product as described above is appropriate for myself. This consent is valid until I revoke it or conditions change to the point that all risks and benefits are significantly different.

Signed: _____ Date: _____
❑Signature of Patient

Signed_____ Date: _____
❑Signature of Provider

Johnson Riverside Family Practice

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation with Johnson Riverside Family Practice.
2. I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with Johnson Riverside Family Practice and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through Johnson Riverside Family Practice will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.
8. Telemedicine services offered through Johnson Riverside Family Practice are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.
9. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
- That I have had the opportunity to ask questions and have had them answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ DATE _____

Johnson Riverside Family Practice
Anchored and Committed

Office Policies and Procedures

Thank you for choosing Johnson Riverside Family Practice. We realize that you have a choice in medical providers and are pleased you have chosen to seek care with us. The staff at Johnson Riverside Family Practice strive to exceed expectations in care and service to make your experience with us comfortable and as stress-free as possible. Our goal is to provide quality medical care in a timely manner. To do so, we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS

Our office is available Monday 8am till 6pm Lunch 12pm-1pm
Tuesday, Wednesday and Thursday 8am till 5pm Lunch 12pm-1pm
Friday 8am till 4pm Lunch 12pm-1pm
We may be reached at 863-946-0284.
If you need an appointment, prescription refill, or have any other questions please call during business hours.

APPOINTMENTS

Johnson Riverside Family Practice is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up dates. We strive to give all our patients the time they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment day.
To ensure quality care, Johnson Riverside Family Practice, does not treat patients we have not seen (i.e., we will not call-in prescriptions or offer medical advice for patients prior to their initial visit). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined. We encourage you to schedule appointments for preventative health visits, physicals, chronic medical conditions, prescription renewals, and sick visits.

CANCELLATION OF AN APPOINTMENT

To be respectful of the medical needs of our patients please be courteous and call Johnson Riverside Family Practice promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs treatment. This is how we can best serve the needs of our patients.

If it is necessary to cancel your scheduled appointment, we require that you call 24hrs in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timey medical care.

NO SHOW POLICY

A "no show" is someone who misses an appointment without canceling it within 24hrs. n advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of **$25.00** will be billed to your account. Three (3) "no-shows" with-in one (1) calendar year could result in a termination of services.

**Please note that NO-SHOW charges are patient responsibility and will not be billed to your insurance.

INSURANCE

Johnson Riverside Family Practice accepts most insurance plans. If you have specific questions regarding your insurance, please first contact your insurance provider. It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.

Patients are responsible for co-pays at the time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

PAYMENTS

Johnson Riverside Family Practice accepts cash, Mastercard, Visa, Discover and American Express. (**Cards have a 3.6% service charge**). Payment is due at time of service. It is the policy of Johnson Riverside Family Practice to make all reasonable attempts to collet outstanding balances should they accrue. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

FORMS AND LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Johnson Riverside Family Practice will be happy to complete forms and write medical letter as necessary upon request. However, because this can be time consuming, please allow 7-10 business days for completion of the requested forms/letters. There is a **$25.00** charge for the first 10 pages then $1.00 per page thereafter.

MEDICAL RECORDS

Per HIPPA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost **of $0.75** per page. The law allows medical offices

30 days to complete request for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

PRESCRIPTION REFILLS AND PHARMACY INFORMATION

Please inform Johnson Riverside Family Practice which pharmacy you use and update us if this should change. **Please allow one to two business days for refill requests**. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed.

REFUND POLICY

All sales are final. Once patient makes a purchase, they will **NOT** be able to return any items or be refunded for services provided.

Signature of insured/guardian_____Date_____

Patient name_____