FOREST HILL
MEDICAL GROUP

New Patient Registration

Last Name: _____ First Name: _____ MI ____

Street Address: _____ Apt/Suite #: ____ City/State/Zip_____

Date of Birth: _____ Sex: Male/Female Social Security No: _____

Cell Phone:( )_____ Home Phone: ( )_____ Email: _____

Employer Name: _____ Work Phone: _____

Employment Status: [] Full Time [] Part Time [] Unemployed [] Retired [] Military [] Student

Marital Status: [] Single [] Married [] Divorced [] Widowed [] Other_____

Race: _____ Ethnicity: _____ Language: _____

Emergency Contact Information

Name of Emergency Contact: _____ Contact Number: _____
Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ Member ID: _____
Secondary Insurance: _____ Member ID: _____

Pharmacy

Preferred Pharmacy: _____ Pharmacy Address: _____
Pharmacy Phone Number: _____

Other Information

Have you signed an Advanced Health Directive? [] Yes [] No
May we send you information regarding **Forest Hill Medical Group** events, health news updates and insurance announcements? [] Yes [] No
Who should we thank for this referral? _____

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Consent for Treatment

I _____ hereby authorize **Forest Hill Medical Group,** the attending physician, or the physician designated by him and other center employees to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the physician including but not limited to, the taking of x-rays, medications, blood samples, urine samples and other therapies. I am aware that the practice of medicine is not an exact science and I acknowledge that there has been no guarantee or assurance implied to me as to the results that may be obtained by examination and treatment. I understand that the physical examination may include a medically appropriate examination of my pelvic area, and I consent to such examination.

I hereby certify that I understand the above authorization.

_____ _____/_____/_____

Patient Signature Date of Birth

_____ _____

Person Authorized Consent Date

_____

Relationship to Patient

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Financial Policy/Assignment Information/Release of Information

By signing below, I authorize the release of any information acquired during treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person who account I am acting as guardian or representative. I authorize (assign) any insurance or Medicare benefits to be paid directly to **Forest Hill Medical Group** or its assignees. I agree that I am responsible for any non-covered services, supplies, co-payments or deductibles**.** I agree that I am responsible for knowing how my insurance plan works and have requested medical services for this office. I understand that diagnosis or treatment of me by Princeton Medical Group of Boca Raton, LLC may be conditioned upon my consent as evidenced by my signature of this document. I agree to provide **24 hours** advance notice should I need to cancel or reschedule an appointment. I understand and agree that a **$25** fee will be charged for any broken appointment for which I do not provide 24 hours advance notice.
The acceptance and assignment will be in force for all future services by practitioners from this office.

Acknowledgement of Notice of Privacy Practices

By signing below, I understand that as part of my health care, **Forest Hill Medical Group** originates and maintains paper and electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine healthcare operations such as assessing quality.

I understand that **Forest Hill Medical Group** maintains a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. The most recent version of this Notice is available from the receptionist. I understand that **Forest Hill Medical Group** reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this notice at any time.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclose.
- The right to revoke my consent to use or the disclosure of my protected health information by notifying **Forest Hill Medical Group** in writing of such revocation.

I have had an opportunity to receive and review the Notice of Privacy Practices of **Forest Hill Medical Group**.

Signature of Patient or Guardian/Representative_____ Date: _____

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Patient Consent for Pelvic Examination

A **Pelvic Examination** is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____authorize and direct

(Print Patient's Name)

Forest Hill Medical Group and my treating health care provider, the employed and/or contracted medical personnel of **Forest Hill Medical Group** as deemed necessary by my treating physician, and the medical students and/or students receiving training as a health care provider who may be involved in my care, to perform a pelvic examination, including vaginal sonography, as described above. I understand that a pelvic examination may be needed while receiving medical care from **Forest Hill Medical Group** in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider, medical student, or student receiving training as a health care provider employed by and/or contracted with **Forest Hill Medical Group** unless I revoke this consent in writing by hand delivering a copy of the revocation to **Forest Hill Medical Group.** By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

_____ _____

Patient/Legal Representative Signature Printed Name and Date

_____ _____

Witness Signature Printed Name and Date

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Patient History

Patient Name: _____Patient DOB: _____

Social Security #: _____ Date of Last Exam: _____

Which of the following conditions are **you currently being treated/have been treated** for: (Please circle all that apply)?

-Heart Disease/Murmur/Angina
-High Blood Pressure/Low Blood Pressure
-Depression/Anxiety
-Thyroid Problems
-Shortness of breath/Asthma
-Lung Problems/Cough
-Liver Problems/Hepatitis
-Psychiatric Care
-Sinus Problems/Allergies
-Eye Disorder/Glaucoma
-Neurological problems
-Swollen Ankles
-Headaches/Migraines
-Anemia or Blood Problems
-Cancer
-Stroke
-Seizures
-Tonsillitis
-High Cholesterol
-Diabetes
-Kidney/Bladder Problems
-Heartburn(reflux)
-Ulcers/Colitis
-Ear Problems
-Other: _____

Please answer the following questions to the best of your ability.

Have you ever been tested for **Hepatitis A, B, or C?** Yes/No Which virus? A/B/C
Have you been vaccinated for **Hepatitis A?** Yes/No If yes, date vaccine series completed _____
Have you been vaccinated for **Hepatitis B?** Yes/No If yes, date vaccine series completed _____
Last **Tuberculosis (TB) Screening? _____** Result of screening: [] Positive [] Negative
If **Positive** TB screening, date of last chest X-ray: _____ Result of X-Ray **Positive/Negative**
Have you had a **Sexually Transmitted Disease**? Yes/No If Yes, Diagnosis: _____
Have you ever been hospitalized? Yes/No If yes, what for? _____
Please describe any current or past medical treatment not listed above:
_____
_____

Past Medical Gynecological History (Females)

How many times have you been pregnant? _____ Date of last Pap Smear _____
Have you had any abnormal Pap Smears? Yes/No If yes, Diagnosis? _____
Date of last Mammogram _____ Mammogram Results _____

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Patient History Continued

Please list your Past Surgeries (Year/Surgery Type)

Please list your current Medications:

Please list any previous/current Allergies:

Are you allergic to penicillin or any other drugs? Y/N Please list others.

Social History (Please circle if you have had any of the following, if yes provide the exam date):

Influenza Vaccine (Flu) **Yes/No** _____ Pneumonia Vaccine **Yes/No** _____
Chest X-Ray **Yes/No** _____ Colorectal Screening **Yes/No** _____
Echocardiogram **Yes/No** _____ EKG **Yes/No** _____

Do you exercise daily/weekly? **Yes/ No**
Do you currently smoke or chew tobacco? **Yes/No** Have you in the past? **Yes/No** How many per day? _____
Do you drink alcohol, beer or wine? **Yes/No** Have you in the past? **Yes/No** How many per week?
Do you currently drink coffee and or tea **Yes/No** How many per day? _____
Do you use seatbelts while driving? **Yes/No** Do you wear a helmet while riding a bike **Yes/No**

Family History

Father	Alive/Deceased	Diabetes Yes/No	Hypertension Yes/No	Heart Yes/No	Mental Yes/No	Cancer Yes/No
Mother	Alive/Deceased	Diabetes Yes/No	Hypertension Yes/No	Heart Yes/No	Mental Yes/No	Cancer Yes/No
Siblings	Alive/Deceased	Diabetes Yes/No	Hypertension Yes/No	Heart Yes/No	Mental Yes/No	Cancer Yes/No

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is completed, true and accurate.

Patient/Legal Guardian Signature _____Date_____

FOREST HILL
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Patient Responsibility Agreement for Controlled Substance Prescriptions

Controlled substance medications (i.e., narcotics, tranquilizers, benzodiazepines, and barbiturates) are especially useful for controlling both acute and chronic pain but have a high potential for misuse and are therefore, tightly controlled by local, state, and federal governments. They are intended to relieve pain, thus improving quality of life, function and/or the ability to work. If my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions.

Treatment Goals

I understand that the main treatment goal is to reduce pain to a bearable level and improve the quality of my life. This includes the ability to function and/or work. I understand that in many cases the pain may not be eliminated. In consideration of this goal, and because I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

Patients' Responsibility

[ ] I am responsible for the controlled substance medications prescribed to me. If my prescription is **lost, misplaced, or stolen or if I "run out early",** I understand that it will **NOT** be replaced.

[ ] I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposed of maintaining accountability. This includes a copy of this contract.

[ ] I will use **ONLY one pharmacy** for all my prescription refill. I will register the name and phone number of this pharmacy with my physician.

[ ] I am aware that telephone refills are **NOT allowed**. Calls or faxed from pharmacies to refill medications will not be authorized.

[ ] I agree to **bring the bottles of all the medications prescribed by pain management** to each visit. Medications will be **counted, and number of refills checked.**

[ ] I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is **my** responsibility to comply with the laws of the State while taking the prescribed medications.

Initials_____

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Controlled Substance Agreement Cont.

[ ] At any time while I am receiving controlled substance medications, it may be deemed necessary by my doctor that I see a medication-use specialist. I understand that if I do not attend such an appointment, my medications will be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications may be tapered to completion.

[ ] I will comply with random **PILL COUNTS.** These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the pain staff.

[ ] I agree to undergo **random urine drug testing** at the discretion of the pain staff. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal.

[ ] **I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medications from pain management. I will not give, share or sell my medications to any other person.**

[ ] I also understand that I must maintain a primary care physician while being cared for in pain management. He/She will be used to care for my other medical needs and in special cases used to write prescriptions if/when the pain management physician may be unavailable.

Refills of Medications

[ ] Refills will be made **ONLY** during regular office hours Monday through Friday, in person. This will be done wither monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.

[ ] Refills will **NOT** be made if I "run out early", or "lose a prescription", or "spill or misplace my medication", or "they are stolen". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.

[ ] Refills will **NOT** be made as an "emergency" such as on a Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 24 hours in advance to schedule an appointment for refills.

Initials_____

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Risks of Chronic Opioid Use

[] I understand that **the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined.** My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate.

[] I am aware that tolerance to analgesia means that I many require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to opioids may force my doctor to choose another form of treatment.

[] (Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

[] I have been fully informed by **Forest Hill Medical Group** or the staff regarding the potential for psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are use inappropriately.

Termination of Care

[] I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be **terminated immediately,** without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. **I am responsible** for any withdrawal syndrome that may occur to do my misuse of the narcotic medications and/or termination of my care.

[] I have read this contract and the same has been explained to me by **Forest Hill Medical Group**. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Patient Name_____ Patient Signature_____

Patient DOB _____ Todays Date _____

Witness_____

[] Copy given to patient [] Patient refused copy

FOREST HILL
MEDICAL GROUP

HIPAA Release Form

Name: _____ Date of Birth: _____

Please check one of the boxes below:

[] I authorize the release of my information, including the diagnosis, records, examinations rendered to me and claim information. This information may be released to: (Please print names clearly)
Spouse _____
Child(ren)_____
Other _____

[] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by the patient in writing.

Communication

Please call my [] Home [] Work [] Cell

If unable to reach me, you may:

[] Leave a detailed message.

[] Leave a message to return call.

Signature: _____Date: _____