STANKUS FAMILY CARE
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NEW PATIENT PAPERWORK

PATIENT INFORMATION

Last Name:_____ First Name: _____ DOB: _____

Preferred Name: _____ SSN: _____ Email: _____

Sex: _____ Sex at Birth: _____ Mailing Address: _____

City/State/Zip: _____Home #: _____ Cell #: _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Caucasian/White ☐ Asian ☐ Hispanic
☐ African American/Black ☐ Other Race

Employment Status: ☐ Full-Time ☐ Self-Employed ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Student

PRIMARY INSURANCE

Policy Holder: _____

Insurance Co: _____

Group #: _____

Member ID: _____

Policy Holder DOB: _____

SECONDARY INSURANCE (IF APPLICABLE)

Policy Holder: _____

Insurance Co: _____

Group #: _____

Member ID: _____

Policy Holder DOB: _____

CURRENT EMPLOYER

Name: _____

Address: _____

City, State, Zip: _____

Occupation: _____

Phone: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

Include emergency contact to HIPAA? ☐ YES ☐ NO

PHARMACY INFORMATION

Local Pharmacy Name: _____

Local Pharmacy Address/Phone # (if known): _____

Mail Order Pharmacy: _____

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CHIEF COMPLAINTS:

What concerns would you like to discuss during your visit today?

_____

_____

CURRENT AND/OR PREVIOUS PHYSICIANS

NAME	SPECIALTY	PHONE NUMBER	CURRENT PHYSICIAN
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

IMMUNIZATIONS

IMMUNIZATION	DATE	IMMUNIZATION	DATE
Influenza (Flu Vaccine)		TD Tetanus Diphtheria	
Prevnar-13		Tdap Tetanus (Pertussis)	
Pneumovax-23		Zostavax (Shingles)	
Covid-19		Other:	

MEDICAL HISTORY / DIAGNOSIS

_____

_____

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

MEDICATIONS (PLEASE LIST DOSAGE AND HOW OFTEN)

_____

_____

_____

_____

_____

_____

FOR FEMALE PATIENTS ONLY

Are you Pregnant? ☐ **YES** ☐ **NO**

If so, how far along? _____

Are you Breastfeeding? ☐ **YES** ☐ **NO**

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PROCEDURES

X	PROCEDURE	DATE	X	PROCEDURE	DATE
	X-Ray			Bone Density Scan	
	MRI			Flexible Sigmoidoscopy	
	Mammogram			Colonoscopy	
	Echocardiogram			Prostate Exam	
	EKG			CT Scan	

If marked **X**, please specify: _____

SURGICAL HISTORY/HOSPITALIZATION

YEAR	OPERATION OR ILLNESS	HOSPITAL NAME	CITY/STATE

FAMILY HISTORY

RELATION	Age, if living	Age, at death	Cause of death	Medical History
Father				
Mother				
Paternal GF				
Paternal GM				
Maternal GF				
Maternal GM				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

SOCIAL HISTORY

Have you ever used illicit drugs? ☐ **Yes** ☐ **No**

Tobacco: ☐ **Non-Smoker** ☐ **Current Smoker** ☐ **Former Smoker; Quit date:** _____

If you are a current or former smoker, how much and how often do/did you smoke? _____

If you drink alcohol, how much and how often do you drink? _____

CONSENT TO TREAT

By signing this consent form you are allowing **Stankus Family Care** to provide you medical treatment, file your insurance and send your medical records to your insurance company, on your behalf. Furthermore, you are responsible for paying for your share of the costs, and if the insurance company does not pay or you do not have insurance coverage on the date of service, you must pay for the cost of these services. You also understand that you have the right to refuse any medical procedure or treatment and you have the right to discuss all medical treatments with your clinician.

X _____

Patient/ Representative Signature Date

Patient Name

Date of Birth

The last 4 of Social

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Acknowledgement of Receipt of Notice of Privacy Practices and Express Consent of Communication

HIPAA & Your Protected Health Information
The use and disclosure of Protected Health Information (PHI, aka Medical Records) is regulated by the Health Insurance Portability and Accountability Act of 1995 (HIPAA). Under HIPAA, we are required to give patients our Notice of Privacy Practices for PHI. HIPAA also requires that adult patients specify to whom (if anybody) we may release their PHI.

Patient Instructions for PHI Communications
I authorize **Stankus Family Care** to leave messages, including certain medical information. By selecting "YES" below, you hereby give express consent for **Stankus Family Care**, its employees, and agents to contact you at the phone numbers listed to communicate with you about your interaction with our practice; including lab, test results, and healthcare information. You may cancel this consent at any time by completing a new form.

YES NO **You may leave messages on my answering machine or voicemail in regards to my medical care.**

May send text messages on my cell phone # at: _____

May share information with the following individuals:

Name	Phone Number	Relationship

Please read and sign next page

Express Consent of Communication
In addition, to the above-listed Authorization or Denial of Authorization, as a patient or representative of a patient, you hereby authorize **Stankus Family Care**, our employees, and/or our agents to contact you and leave messages about your appointment reminders and billing/collections. This consent also authorizes such communications to be sent by the automated dialers and messaging equipment.

Acknowledgment
I acknowledge that I have read the above paragraphs, that **Stankus Family Care** has made available to me a written copy of its Notice of Privacy Practices for me to read on behalf of myself, my family, and/or my dependent, and that I give Express Consent to Communication.

Authorization of the Release of PHI
I attest that I am the patient, legal guardian, or Power of Attorney of the patient and authorize the release of PHI to the Individual(s) listed above for the next 18 months. I understand that I may rescind this authorization at any time by completing a new form.

Signature of Patient (or guardian) _____ Date _____

To be completed by **Stankus Family Care, LLC**: We have made a good faith effort to provide thabove-nameded patient with a copy of our Notice of Privacy Practices, but were not successful for the following reasons:

☐ PATIENT REFUSED ☐ OTHER: _____

Employee Name _____ Title _____

Employee Signature _____ Date _____

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Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to providing you with the highest quality lifetime medical care, so that you may attain optimum health. The following is a statement of our financial policy, which we require that you read, agree to, and sign before any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, and credit cards.

Please Note: Returned checks will be subject to additional fees, based on your bank. If you fail to show up for a scheduled appointment or do not give 24-hour notice, a $30 no-show fee will be applied to your account.

Do You Have Insurance?

- We must emphasize that as your medical care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
  If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, or credit card at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your healthcare needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my benefits directly to my medical office. I understand that responsibility for payment for Medical Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Signature (Parent if child) _____ Date _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations		
Patient Name:	DOB:	SSN:
Office/Provider Name:	Recipient Name: **Stankus Family Care** **18743 NW 234TH ST.** **High Springs, FL 32643**	
Provider's Fax Number:	**Phone: (386) 454-0721 Fax: (386) 454-0722**	

Expiration Date or Event: This authorization will expire on the following expiration date (or) event

Date: Event: Death

Purpose of Disclosure:

Section B: Description of Information to be Used or Disclosed

Is this a request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

☐ No, then you may check as many items as you need below.

Description:	Date of Service(s):	Description:	Date of Service(s):
☐ All PHI in Medical Records ☐ Progress Notes ☐ Clinical Test(s) ☐ Medication Sheets		☐ Special Test/Therapy ☐ Itemized Bill(s) ☐ HCFA-1500 Claim(s) ☐ Other:_____	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law, such as: alcohol, drug abuse, mental health, AIDs, or HIV testing or treatment.
3. My treatment, payment, enrollment, or eligibility may not be conditioned.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I can request a copy of this form at any time, if needed.

Section C: Is the request of PHI for the purpose of marketing? YES NO

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?

☐ **NO** ☐ **YES** **If YES, describe:**

Section D: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient, Guardian, or Personal Representative:	Date signed:
Printed Name or Patient, Guardian, or Personal Representative:	Relationship to Patient: