PATIENT INTAKE: SOCIAL/FAMILY HISTORY

Patient Name_____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married / in long-term relationship _____Times Married _____Times Divorced_____

Children? ( )N ( )Y Current ages(list)_____

Residing with you? ( )N ( )Y If no, where?_____

Where are you currently living? _____

Do you have family nearby? ( )N (Please describe)_____

Education (check most recent degree):

( ) Graduate School ( ) College ( ) Professional or Vocational School ( ) High School Grade___

Are you currently employed? ( )N Where(if "no" where were you last employed?)_____

What type of work do/did you do?_____ How long have/did you work(ed)there?___

Have you ever been arrested or convicted? ( )N

( ) DWI ( ) Drug related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

Have you ever attended:

AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? ( ) N (please describe) _____

PATIENT INTAKE: MEDICAL HISTORY

Name_____

Address_____

Phone (W)_____(H)_____(C)_____

DOB _____Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____Phone _____

Primary care physician _____ Phone _____

Date of last physical _____Have you ever had an EKG? ( ) N Date_____

Current or past medical conditions (Check all that apply)

( ) Asthma/respiratory	( ) Cardiovascular (heart attack, high cholesterol, angina)	
( ) Hypertension	( ) Epilepsy or seizure disorder	( ) GI disease
( ) Head trauma	( ) HIV/AIDS	( ) Diabetes
( ) Liver problems	( ) Pancreatic problems	( ) Thyroid disease
( ) STDs	( ) Abnormal Pap smear	( ) Nutritional deficiency

Other (Please describe)_____

_____

_____

If there is a family history of any of the illnesses above, please print an "F" next to that illness

Is there a family history of anything NOT listed here? (please explain)

_____

_____

_____

Have you ever had surgery or been hospitalized? (please describe)

_____

_____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or your family ever been diagnosed with psychiatric or mental illness? (please describe) _____

_____

Have you ever taken or been prescribed antidepressants? ( ) N For what reason_____

Medication(s) and dates of use_____ Why stopped_____

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day) DO NOT include medications you may be currently misusing (that information is needed later)_____

_____

Please list all current herbal medicines, vitamin supplements, etc. And how often you take them

_____

_____

Please list any allergies you have (penicillin ,bees,peanuts)

_____

_____

PATIENT TREATMENT CONTRACT

Patient Name_____ **Date**_____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by the office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse of appeal.
7. I agree that my medication/prescription can only be given to me at the regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place, I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medication from any doctor, or pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I also recognize that several deaths have occurred among person mixing byprenorphines and benzodeiazepines (especially if taken outside the care of a physician, using routes of administration other then sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medications as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

12. I understand that medication alone is no sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).
14. ***I agree to provide random urine samples at office visits or in-between office visits when called, and have my doctor test my blood alcohol level.***
15. ***I understand that violations of the above may be grounds for termination of treatment.***

Signature:_____ Date:_____

Lake Howell Health Center
Consent/HIPPA Form

Financial Policy/Authorization to release inform to insurance company

I, Undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to LLHC understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Lake Howell Health Center (LHHC) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

Signature **X**_____Date:_____

Are you the Guarantor? Yes____No____ If not please see the receptionist.

Consent for Treatment & Release information to pharmacy/consulting physician/hospitals

Having voluntarily presented myself (or my dependent) LHHC I acknowledge recognition of the fact that the evaluation and treatment received, I also give LHHC permission to discuss RX history, advised or deemed necessary, to be the judgment of the physician.

Signature **X**_____Date:_____

Acknowledgement of receipt of privacy notice (HIPPA)
Health Insurance Portability and Accountability Act

By signing this form, you acknowledge that LHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in a various situations. We must attempt to have you sign this form on you first date of service with us after April 2003. This includes the situation where your first date of service occurred electronically. If our first date of service with us was an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

- ☐ I have received a copy of the Privacy Notice of LHHC
- ☐ LHHC has offered me a copy of the Privacy Notice with I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature **X**_____Date:_____

Additional Person(s) Authorized to make the use or disclosure of my PHI

We at LHHC value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant other with our written consent). If you want anyone other than your referring physician to have access to your medical information please list their name(s), and relationship(s) below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name_____Relationship_____

Name_____Relationship_____

Signature X_____Date:_____

Witness Signature

The Staff of LHHC complete this section of Acknowledgement Form is not signed by the Patient:

1. Does the Patient have a copy of the Privacy Notice? Y or N

trying to obtain the Patient signature:_____

Employee Signature:_____Date_____

Lake Howell Health Center
406 Lake Howell Road
Maitland, FL 32751
Phone: (407)691-3960
Fax: (407) 691-3961
www.lakehowellhealthcenter.com

Controlled Substance Agreement

The doctors are being held accountable by the DEA for prescribing controlled substances. Patient non-compliance can no longer be tolerated. It is the patient's responsibility to manage their appointments and medication refills in a timely manner. Responsibility is a part of recovery. We are here to help you with your recovery.

I understand that I have the following responsibilities/guidelines for treatment under Lake Howell Health Center. Please read and initial each line and sign at the bottom of the page.

☐ 1. I will take medication at the dose and frequency prescribed and will not increase or change how I take my medications without the approval of my doctor.

☐ 2. I will schedule my doctor appointments in a timely manner prescribed by my doctor during regular office hours preferably with a 2 week notice. **I will not ask for refills or partial refills earlier then agreed, after hours or on holidays and weekends.**

☐ 3. I will not request any other medications for my diagnosis from any other health care providers and will inform all physicians what I am taking and who is monitoring medication.

☐ 4. **I will protect my prescriptions and medications. I understand that lost, stolen or misplaced prescriptions will not be replaced. If I go into withdrawal I will not hold my physician responsible.**

☐ 5. I will keep all follow-up appointments.

☐ 6. I understand that my doctor may stop prescribing the medications if:
   a. If I do not show any improvement in my diagnosis.
   b. I develop rapid tolerance or loss of improvement from the treatment.
   c. I develop significant side effects.
   d. My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from the practice.

Signature-

Date-

Family Member		Living or Deceased	Present Age or Age of Death	Major Illness and/or cause of death
Father				
Mother				
Siblings (Name)	Circle M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
Children (Name)	Circle M F			
	M F			
	M F			
	M F			
	M F			

Spouse/ partner's name (if applicable):_____

Who referred you to us, or how did you hear about our practice? _____

Do you smoke cigarettes/ use tobacco? _____ How many years? _____ #per day _____

If applicable, when did you quit smoking? _____

How much alcohol do you drink on an average daily, weekly, or monthly basis? _____

List all surgeries you have had and there approximate dates: _____

List all medications you are allergic to or have had reactions to: _____

List all medications you are currently taking with dosages: _____

_____

_____

What major medical problems have you had in your lifetime? (I.e. cancer, diabetes, high blood pressure)

_____

Name_____ Signature _____date _____

Patient Registration Form

Today's Date_____Social Security#_____Email_____

Last Name_____First Name_____Middle Initial_____

Street Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Age_____Date of Birth_____Marital Status_____Gender M or F

Race (circle one): Black White Asian Hispanic American Indian Other Refuse

Employer_____Occupation_____

Employer Address_____

EMERGENCY CONTACT

Name_____Relationship_____

Home phone_____Work Phone_____Cell Phone_____

INSURANCE INFORMATION

Primary Insurance company_____Phone_____

Insurance company Address_____

Insurance company City_____State_____Zip_____

Insured Name (if other than self)_____Relationship_____

Insured Social Security #_____Insured Date of Birth_____

Policy/Member #_____Group #_____

Employer Providing Insurance_____Employer Phone_____

Secondary Insurance company_____Phone_____

Insurance company Address_____

Insurance company City_____State_____Zip_____

Insured Name (if other than self)_____Relationship_____

Insured Social Security #_____Insured Date of Birth_____

Policy/Member #_____Group #_____

Employer Providing Insurance_____Employer Phone_____

Pharmacy

_____

Signature_____Date_____

FINANCIAL POLICY

The doctors and staff at Lake Howell Health Center would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current—accordingly, all self pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard or Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for you original appointment.
- A returned check will result in a $25 service charge and all future payment being required in the form of cash or credit card.

If you have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your healthcare benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibilities from the date of services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. IF you have any questions about the above information please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	X_____	_____
Patient Name (please print)	Patient Signature	Date
_____	X_____	_____
Patient Name (please print)	Responsible Signature	Date

(if other than patient)

Lake Howell Health Center
Kent S. Hoffman D.O., P.A.
Kathleen L. Todd, D.O., P.A.
406 Lake Howell Road • Maitland, FL 32751
407-691-3960 Fax: 407-691-3961

Lab Draw Convenience Agreement

For patients who desire LHHC to draw blood at the office, there will be a charge of twenty dollars ($20.00) convenience fee each time they have blood drawn in our office.

It is understood that this convenience fee is not considered a "covered service" by your insurance company. Therefore, this fee is not reimbursable by your insurance company.

You are free at anytime to request a written prescription to have your labs drawn at a lab draw station or elsewhere.

By signing this you are aware of this policy:

I have read and agree to abide by the office policy as stated above.

_____ _____

Patient Signature Date

Patient Waiver for Addiction/Pain Management

Patient's Name_____ Date_____

Dr. Hoffman and Dr. Todd do not bill insurance for Addiction/Pain Management treatment. Even if your addiction/pain management diagnosis is a "covered service" through your insurance plan, we do not file for Addiction/Pain Management Treatment. The treatment here is a "self pay service" that we provide for you. If you want your insurance to be filed, you will need to find a different physician and go elsewhere. Dr. Todd and Dr. Hoffman are only contracted with the insurance companies for Family Practice medicine.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive Addiction/Pain Management services here at Lake Howell Health Center.

I acknowledge that I have been informed in advance of receiving treatment, that Dr. Hoffman and Dr. Todd will not file my insurance and or give me the information needed to file to my medical insurance on my own with the intent of getting reimbursed for my Addiction/Pain Management Treatment.

Patient Signature_____ Date_____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

PRIOR AUTHORIZATION AGREEMENT

Name_____ Date_____

Your physician has been put in a difficult situation, due to the overwhelming burden it takes to get a prior authorization from insurance companies. They now have to ask you to call your insurance company and find out what is covered without a prior authorization or we can go through the process of getting a prior authorization for you. There will be a charge of $15.00 for each prior authorization.

We understand the inconvenience and cost it comes to you. However, we do not have a relationship with your insurance company. It can take up to 15 days and hours of staff time to get just one authorization completed. We do not condone the fact that the insurance company is dictating what medication is prescribed for you. We feel you and your physician should make that decision.

Please keep in mind this does not guarantee the insurance company will approve/authorize the medication your physician prescribed.

Please initial _____