We need to know your Medical History

How did you hear about us:_____
Who is your Primary Care Physician (PCP)?_____
Reason for visit:_____

Have you been outside the US in the past 30 days? _____
*****If yes, when and where did you travel to?** _____
Do you have any of the following symptoms? Please check ALL that apply:

_____Fever _____Headache _____Diarrhea _____Vomiting
_____Stomach Pain _____Muscle Pain _____ Unexplained Bleeding or Bruising

Mark conditions you need to discuss with the provider. (Please check all that apply)

__Dizzy spells __Fainting __Eye Problems __Irregular Pulse __Joint Pain __Cramps __Nose/ Sinus Problems
__Chest Pain __Wheezing __Rashes __Chronic Cough __Difficulty-Swallowing __Constipation/Bloody Stools
__Diarrhea __Weight Loss or Gain __Cold Intolerance __Feelings of Guilt __Shortness of Breath
__Vaginal Bleeding __Numbness/Tingling __Prostate Problems

Rate the severity of your pain on a scale of 1 to 10; with 1 being the least and 10 being severe:_____
Please Describe your pain:_____
What makes you feel BETTER?_____
What makes you feel WORSE?_____

Is the condition getting progressively worse?	**YES**	**NO**
Is this related to a Motor Vehicle Accident?	**YES**	**NO**
****If YES, is it a WORK RELATED motor vehicle accident?**	**YES**	**NO**
Is this a Worker's Compensation Injury?	**YES**	**NO**

Surgical History: _____

List any medications you are currently taking: _____
_____

List ALL ALLERGIES: _____

Name Pharmacy You Prefer To Use: _____

Social History (How often do you….)
Drink Alcohol: __None __Regularly __Occasionally ___Socially
Diet: ___ADA __Regular __High Protein __Low Fat __Low Calorie ___ Low Salt
Illicit Drugs: __No Usage __Marijuana __Cocaine __Other:_____
Caffeine Usage: ___None ___Coffee, # of cups_____ ___Soda, # of cups_____ ___Tea, # of cups_____
Marital Status: __Single __Married __Divorced __Widowed __Significant Other __Has Children
Smoke: __None __Actively __Quit __2nd Hand Exposure
Work Status: _Full-Time _Part-Time _Student/Working _Part-Time Student _Full-Time Student _Retired _Homemaker

Family History:

	Mother	Father	Other
Heart Disease	○	○	○
Diabetes	○	○	○
Cancer	○	○	○
High Blood Pressure	○	○	○
Cholesterol Issues	○	○	○
Other_____	○	○	○

Other Significant Information:_____
_____
_____
_____
_____
_____

Do you suffer from any of the following conditions? (Please mark all that applies):
__Angina __Arthritis __Cancer __Chemical Dependency __High Blood Pressure __Asthma __Depression
__Heart Attack __Diabetes __Osteoporosis __ Kidney Disease __Joint Replacement __ Stroke __Blood Clot
__MS __Seizures __Thyroid __Pace Maker __Emphysema __Pregnant: # of wks___ Breast Feeding: Yes No

Patient or Guardian Signature: _____ **Date:** _____
Print Patient Name: _____

Scanned into Chart?

Yes_____ No _____

PATIENT INFORMATION

Date:_____

Name:_____

Address:_____ City/Zip:_____

_____ State:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Sex: ☐**M** ☐**F** Date of Birth:_____ Age:_____

Marital Status:_____ Patient's Social Security Number:_____

Occupation:_____ Employer:_____

IF YOUR COVERAGE IS NOT UNDER YOUR NAME, PLEASE FILL IN THE FOLLOWING INFORMATION

Name:_____ Date of Birth:_____

_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:_____ Phone:_____

_____ Relationship:_____

ATTORNEY:

Do you have an attorney representing you regarding your illness/injury? ☐**Y** ☐**N**

Name of Attorney:_____ Address of Attorney:

Phone:_____ _____

_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____

And assign directly with Gulf Coast Healthcare Systems, Inc, all insurance benefits. Otherwise services rendered will be payable by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Gulf Coast Healthcare Systems, Inc to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party's Signature Today's Date

I understand that, if for any reason, this account is placed with a collection agency there will be a collection fee added to the account.

_____ _____

Responsible Party's Signature Today's Date

Authorization and Consent

I, the undersigned, authorize and consent to treatment.

_____ _____

Responsible Party's Signature Today's Date

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I hereby acknowledge receipt of a written notice of my privacy rights, and

I consent to Gulf Coast Healthcare Systems using and disclosing my protected health information to carry out treatment, payment, or healthcare operations.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that Gulf Coast Healthcare Systems reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to:

MICKEY JONES, C/O GULF COAST HEALTHCARE SYSTEMS,
P.O. BOX 1747
LEHIGH ACRES, FL 33970

I understand that I have the right to restrict how Gulf Coast Healthcare Systems uses or discloses my protected health information to carry out treatment, payment of healthcare operations; that Gulf Coast Healthcare Systems is not required to agree to the restrictions; and that Gulf Coast Healthcare Systems is bound by restrictions to which it agrees.

I request the following restrictions to how my healthcare information is used or disclosed:

_____

_____

I have the right to revoke this consent by notifying Gulf Coast Healthcare Systems in writing, except to the extent that Gulf Coast Healthcare Systems has taken action in reliance on my consent.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN IF PATIENT IS A MINOR **TODAY'S DATE**

_____ _____

PRINTED NAME OF PATIENT OR GUARDIAN IF PATIENT IS A MINOR **RELATIONSHIP TO PATIENT**

PATIENT'S RIGHTS AND RESPONSIBILITIES

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given information concerning planned course of treatment, alternatives, risk, and prognosis by the health care provider.
- A patient has the right to refuse treatment within the confines of the law.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges.
- A patient has the right to receive a copy of a reasonably clear and understandable itemized bill; and upon request to have the charges explained.
- A patient has the right to express grievances regarding any violations of his or her rights, as stated in Florida and Federal statutes, to the healthcare provider.
- Patients are responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health
- A patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
- A patient is responsible for following the treatment plan recommended by the healthcare provider.
- A patient is responsible for keeping appointments; when unable to do so, it is their responsibility to notify the health care provider.
- A patient is responsible for their actions if he or she refused treatment or does not follow the healthcare instructor's instructions.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN IF PATIENT IS A MINOR **TODAY'S DATE**

Consent for Billing

I request that payments of benefits be made on my behalf to Gulf Coast Healthcare Systems, Inc (GCHS), for any services rendered to me. I authorize the release of medical information to my insurance carrier if it is needed to determine benefits payable.

To our Medicare patients: I request that payment of authorized benefits be made on my behalf to Gulf Coast Healthcare Systems, Inc for any services rendered to me by the physician(s). I hereby authorize Gulf Coast Healthcare Systems, Inc (and/or any holder of medical information about me) to be released to the Healthcare Financing Administration or its Intermediaries/agents. I understand that I am responsible for any deductible, co-insurance, or non-covered services.

This authorization may **only** be revoked in writing.

Financial Arrangements and Medical Insurance

Gulf Coast Healthcare Systems, Inc is committed to providing you with the best possible care. If you have medical insurance, we will submit the claim on your behalf. It is important that you notify our office of any changes regarding your insurance coverage.

Payment for all office services is due at the time services are rendered unless payment arrangements have been approved in advance. Any charges for returned checks may be passed along to you. We accept cash, checks, credit cards (VISA, Mastercard, Discover, and American Express). We will file claims to your insurance carrier for reimbursement.

It is important that you understand the following:

1. Accepting Assignment does not mean we will not bill you for amounts that are deemed to be patient responsibility such as deductibles, co-insurance, co-pays, and any non-covered services. If we are participating with your insurance carrier or the network your insurance carrier utilizes, we have a negotiated contract with the carrier, and agree to accept their fee schedule and they will mail the payments directly to us. The balance after our negotiated rate is your responsibility. Depending on your plan, it may be a co-insurance amount, a co-pay amount, a deductible, or a combination thereof.
2. Depending on your insurance policy, medical services may require a pre-authorization. It is your responsibility to obtain the appropriate authorization if it is required for your visit. GCHS will help you in your request for an authorization from your primary care physician or PCP.
3. There may be times when your insurance carrier requests information from you, as the patient, that we cannot provide. It is extremely important that you provide this information to your carrier, as they may deny the claims for payment. Therefore, the balance becomes patient responsibility.

The undersigned hereby obliges him/her to pay the account for the medical services rendered. If this account is referred to a collection agency, the undersigned agrees to pay collection expenses.

By signing below, I acknowledge that I have read and understand this form.

SIGNATURE OF PATIENT OR GUARDIAN IF PATIENT IS A MINOR **DATE**

GULF COAST HEALTHCARE SYSTEMS, INC

Dr. Axel Ruiz-Tellez

2724 5th St W. Suite C., Lehigh Acres, FL 33971
PHONE: (239) 303-9296 FAX: (239) 303-9296
www.urgentandconvenientcare.com

PATIENT MEDICAL RECORDS RELEASE

Patient Name: _____ Date: _____

D.O. B: _____ Chart #: _____ Phone Number: _____

I hereby authorize the release of Medical information to:

Dr. Axel Ruiz-Tellez
Gulf Coast Healthcare Systems, Inc.
2724 5th St. W., Suite C. Lehigh Acres, FL 33971 FAX: 239-303-9296

OR

Please send all confidential medical information to:

_____

_____

INFORMATION REQUESTED/INFORMATION SENT:

____OFFICE NOTES **ALL DATES FROM** _____ **TO** _____

____ PATHOLOGY REPORTS ____ LAST NOTE ____ LAB REPORTS ____ XRAYS

____ COMPLETE MEDICAL RECORDS ____ OTHER: _____

THE INFORMATION WILL BE USED OF DISCLOSED FOR THE FOLLOWING PURPOSE:

- **AT THE REQUEST OF THE PATIENT**
- **FOR MEDICAL CARE**
- **FOR INSURANCE UNDER WRITING PURPOSES**

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____