Precision Healthcare Specialists, LLC
13691 Metro Parkway Ste. 300
Fort Myers, FL 33912
Phone: (239) 291-6970
Fax: (239) 522-4288

PATIENT REGISTRATION FORM

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Sex: _____ SSN: _____

Home Phone: _____ Mobile Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Employer: _____ Work Phone: _____

Marital Status: _____ Spouse is: ☐ Working ☐ Retired

Spouse Name: _____ Spouse DOB: _____

Spouse SSN: _____ Spouse Phone: _____

Primary Care Physician: _____

Referring Provider: _____

Alternate Address: ☐ I do not have an alternative address.

Alternate Address: _____

City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance: _____

Plan ID: _____ Group #: _____ Phone #: _____

Secondary Insurance: _____

Plan ID: _____ Group #: _____ Phone #: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship to Contact: _____ Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred method of contact (check all that apply): ☐ Home ☐ Cell ☐ Email ☐ Portal ☐ Decline

PATIENT SIGNATURE (I confirm all the information provided is correct): _____

PRECISION HEALTHCARE SPECIALISTS
Head & Neck Surgery

PATIENT MEDICAL HISTORY

Name:
DOB:
Age:

Pharmacy: _____ Pharmacy Address: _____ Pharmacy Phone: _____

Medical History (check all that apply): ☐None apply

☐ Asthma	☐ Diabetes Mellitus	☐ Hearing Loss	☐ Kidney Disease	☐ Sleep Apnea
☐ Bladder Disease	☐ Emphysema	☐ Heart Disease	☐ Prostate Disease	☐ Stomach Ulcers
☐ Bleeding Problems	☐ Glaucoma	☐ Hepatitis	☐ Reflux	☐ Thyroid Disorder
☐ Chronic Bronchitis	☐ Hay Fever	☐ HIV	☐ Seizures	☐ Tuberculosis
☐ Cancer / Cancer Type:_____		☐ Other:_____		

Family History (include relationship to you): ☐None apply

☐ Asthma:	☐ Diabetes:	☐ Hearing Loss:
☐ Bleeding Problems:	☐ Hay Fever:	☐ Tuberculosis:
☐ Cancer (what kind):		☐ Malignant Hyperthermia:

Social History:

Smoking history?	☐ Never	☐ Former Smoker	☐ Sometimes	☐ Daily
What do you smoke?	_____		# of packs/day:_____	
Other than tobacco?	What kind? _____		How much? _____	
Alcohol history?	☐ Never	☐ Sometimes	☐ Daily	# per week? _____

Current Medications (include dose frequency & strength): _____

_____

_____

Surgical History: _____

_____

_____

Allergies (with reaction):_____

_____

_____

Please select all that apply:

GENERAL	☐ Appetite Loss	☐ Dietary Changes	☐ Fever	☐ Weight Loss
	☐ Chills	☐ Fatigue	☐ Night Sweats	☐ Weight Gain
SKIN	☐ Bruising	☐ Hair Loss	☐ Rash	
	☐ Changes in wart/mole	☐ Hives	☐ Skin Color Changes	
	☐ Excessive Sweating	☐ New Lesions	☐ Ulcer	
GASTROINTESTINAL	☐ Abdominal mass pain	☐ Diarrhea	☐ Heartburn	☐ Nausea
	☐ Bloody Stool	☐ Dysphagia/Difficulty Swallowing		
	☐ Constipation	☐ Food Intolerance	☐ Indigestion	
CARDIOVASCULAR	☐ Abnorm Blood Press.	☐ Fainting/ black outs	☐ Leg pain / swelling	☐ Shortness of Breath
	☐ Chest Pain	☐ Heart Stent	☐ Murmur	☐ Snoring
	☐ Edema	☐ Leg Cramps	☐ Palpitations	☐ Swelling of Extremities
NEUROLOGIC	☐ Difficulty Speaking	☐ Fainting	☐ Numbness	☐ Stroke
	☐ Dizziness	☐ Headaches	☐ Paresthesia	☐ Trouble Walking
HEENT	☐ Blurred Vision	☐ Ear Pain	☐ Neck Stiffness	☐ Vertigo
	☐ Deafness	☐ Headaches	☐ Neck Swelling	☐ Visual Disturbances
	☐ Double Vision	☐ Head Injury	☐ Runny Nose	☐ Visual Loss
	☐ Ear Discharge	☐ Hearing Loss	☐ Swollen Glands	
	☐ Ear Infection	☐ Neck Pain	☐ Tinnitus/ringing in ear	
HEMATOLOGIC	☐ Abnormal Bleeding	☐ Enlarged Lymph Nodes	☐ Nose Bleeds	
	☐ Blood Clots	☐ Gland Problems		
MUSCULOSKELETAL	☐ Back Pain	☐ Muscle Cramps	☐ Swelling of extremities	
	☐ Joint Pain	☐ Physical Disability		
ENDOCRINE	☐ Appetite Changes	☐ Excessive Thirst	☐ Thyroid Problems	
	☐ Cold Intolerance	☐ Heat Intolerance		
RESPIRATORY	☐ Chronic Cough	☐ Difficulty Breathing	☐ Wheezing	
GENITOURINARY	☐ Blood in Urine	☐ Hesitancy	☐ Painful Urination	
	☐ Flank Pain	☐ Increased Frequency	☐ Urinary Retention	
PSYCHIATRIC	☐ Anxiety	☐ Insomnia	☐ Suicidal Ideation	
	☐ Depression	☐ Memory Loss		

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Patient Name:
DOB:
Age:
ID:
Physician:

QUALITY OF CARE INFORMATION

For patients 66 and older: Have you received a pneumonia vaccination on or after your 60th birthday?

☐ Yes ☐ No

Do you have a health care proxy in the event you are unable to make your own decisions?

☐ Yes ☐ No If yes, complete the following:
Designee's name: _____
Designee's phone number: _____

Do you have a living will?

☐ Yes ☐ No

Which of the following statement(s) best reflects your wishes on advanced care recommendations?

☐ Do not Intubate: I do not wish to have a breathing tube, even if its necessary to save my life.

☐ Do not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

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Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service,
Unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Advocate Radiation Oncology LLC medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Precision Healthcare Specialists, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Precision Healthcare Specialists on behalf of myself and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient / Responsible Party Signature Date

_____ _____
Witness Date

PRECISION
HEALTHCARE SPECIALISTS
Head & Neck Surgery

Patient Name:
DOB:
Age:
ID:
Physician:

HIPAA Patient Disclosure Form for Health Information

We understand that health information about you is personal, and we are committed to protecting your information. We create a record of the care and services you receive at Precision Healthcare Specialists. We need this record to provide care, for payment of care provided, for health care operations, and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

The Health Insurance Portability & Accountability Act of 1996 S160.103, also known as HIPAA, defines individual personal health information (PHI) as information, including demographic information collected from an individual and to include information that is:

1) Created or received by a health care provider, health plan, employer, or healthcare clearing house.
2) Related to the past, present or future physical, mental health and/or condition of an individual past, present or future payment for provision of health care to an individual.
3) The information, therefore, that identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.
4) Uses or disclosure to a personal representative assigned by patient.
5) Disclosure to the parents or persons acting in loco to parents to unemancipated minor.
6) For case management, care coordination for the individual, to direct or recommend alternative treatments or therapies, health care providers or health care selling.

The PHI can only be disclosed through a permitted disclosure (S164.502) and used by a health care provider in the following manners:

- For treatment: We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- For payment: We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment for your health plan to agree to pay for that treatment.

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Patient Name:
DOB:
Age:
ID:
Physician:

- For health care operations: We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

I _____am a patient of Precision Healthcare Specialists, LLC and understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time by myself. This disclosure becomes effective the date it is signed and will continue until it is cancelled, changed, altered, or amended by myself or my appointed legal representative. This facility has notified me that they have a listing of all the persons and agencies or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility.

I HAVE READ THE PERMITTED DISCLOSURE FORM AND I UNDERSTAND IT.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature _____ Date _____ Signature of Witness _____

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Name of Guardian/Representative Legal Relationship Date Witness

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Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Guardian:_____

Patient Name: _____ Date:_____

Valid for 1 year from date of signature

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TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT

Communication with our patients is a key aspect in providing high quality health care services. Precision Head and Neck Surgery desires to communicate timely information regarding health care services to you in the most efficient means possible, including telephone and text messaging. Federal law requires that we obtain your consent prior to communicating with you via these means. Please read and sign below so that we can establish this communication process with you.

I (patient name), authorize the use of my personal information, provider information, appointment information, and other limited information for the purpose of notifying me of any health care related function. I consent to receiving multiple messages from my health care provider, if needed, and I consent to allowing messages being left on my voicemail, answering system or with another individual, if I am unavailable at the number provided by me.

I also authorize any of Precision Head and Neck Surgery independent contractors, agents and/or affiliates to contact me through the use of any equipment, an artificial voice or pre-recorded voice or other messaging system, at any telephone number associated with my account including cellular telephone numbers, provided by me or found even if I am charged for the call, as well as through any other personal contact information supplied by me. I understand that charges may apply to certain calls or text messages depending on my cellular plan.

Signature of Patient/Person Legally Responsible

Date

Relationship to Patient (if signed by person legally responsible)

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RELEASE OF PATIENT INFORMATION

Patient Name:

DOB:

Phone Number:

Address:

1) I authorize the use or disclosure of the above named individual's health information.
2) The following individual or organization is authorized to make the disclosure to **Precision Healthcare Specialists, LLC d/b/a Precision Head and Neck Surgery**:
   ****Please indicate provider info for us to obtain your records****

   Provider Name: _____ Phone:_____
   Address:_____
   City:_____ State:_____ Zip: _____
3) This disclosure may include:

   Laboratory reports and specimens, radiology reports and images (CT scans, ultrasounds, PET scans, etc.)

   Prescription records and drug information related to these records.

   Office notes, clinical chart reports, treatment plans, hospital records, discharge summaries and test results.
4) I understand that the information in my health records may include information related to behavioral or mental health services and treatment for alcohol and drug abuse. It may also include information about sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
5) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management team. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that the disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact a clinic representative at the Precision Head and Neck Surgery site.

_____ _____ _____
Signature of patient or legal representative Printed name and relationship to patient Date

PRECISION
HEALTHCARE SPECIALISTS
Head & Neck Surgery

Patient Name:
Patient DOB:
Patient Age:
Patient ID:
Patient Provider:

Release of Patient Information to Individuals

At Precision Head and Neck Surgery, we know that communication regarding your healthcare is important. By signing this form, you consent for us to discuss your healthcare with the individuals listed below and/or give us permission to leave messages.

I am aware that I can update or cancel this information at any time by notifying Precision Head and Neck staff.

I give consent for providers and staff to discuss medical, insurance, and billing information with the individuals below and I understand that proper judgement will be used when discussing such information.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

_____ _____ _____

Signature (patient or authorized representative) Date Time

_____ _____ _____

Printed (patient or authorized representative) Date Time

_____

Relationship to Patient