MEDICAL INFORMATION

DATE:

You can REGISTER ONLINE at www.acutespot.com ⇨ "CLICK" at "APPOINTMENTS TAB"

NAME: MIDDLE NAME: LAST NAME:

DOB:

CEL. PHONE (SMS TEXT): E-MAIL:

REASON OF YOUR VISIT: ☐ ESTABLISH CARE ☐ ACUTE VISIT ☐ OTHER

RELEVANT PAST MEDICAL HISTORY

LIST OF MEDICATIONS & INDICATE IF YOU NEED MEDICATION REFILL:

PHARMACY NAME, ADDRESS & PHONE NUMBER ☐ I DON'T HAVE A PREFERED PHARMACY

ENROLLMENT FORM

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT INFORMATION

FIRST NAME________________________ **MIDDLE INITIAL** ________ **LAST NAME**________________________

ADDRESS ____

____

CITY ____________________ STATE _____ ZIP ________

SSN____

DATE OF BIRTH ________/_______/_______SEX __________

EMAIL ____

HOME / **CELL PHONE**________________________________

ETHNICITY ☐ DID NOT SPECIFY ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

RACE ☐ DID NOT SPECIFY ☐ ASIAN ☐ WHITE
☐ BLACK/AFRICAN AMERICAN
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

PREFERRED LANGUAGE________________________________

PREFERRED
PHARMACY & LOCATION ________________________________

____

MARTIAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

OCCUPATION____

EMPLOYER____

NEXT OF KIN____

RELATIONSHIP____

CONTACT NUMBER____________________________________

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO ⇨ *IF NO PLEASE COMPLETE THIS SECTION*

RELATIONSHIP____________________________ SEX______

FIRST NAME________________________MIDDLE__________

LAST NAME____

ADDRESS____

CITY________________________ STATE______ ZIP________

CONTACT NUMBER____________________________________

EMAIL____

EMPLOYER____

ADDRESS____

CITY____________________ STATE______ ZIP________

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

INSURANCE COMPANY________________________________ INSURED’S DOB________________________

INSURANCE/CARD HOLDER’S NAME________________________________RELATIONSHIP____________________

ID#____________________________ GROUP #______________________EFFECTIVE DATE____________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY________________________________ INSURED’S DOB________________________

INSURANCE/CARD HOLDER’S NAME________________________________RELATIONSHIP____________________

ID#____________________________ GROUP #______________________EFFECTIVE DATE____________________

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN____DATE__________________

PRINTED NAME____

PATIENT RESPONSIBILITIES & AUTHORIZATIONS

PLEASE READ AND INITIAL EACH LINE.
IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST FOR ASSISTANCE

____ I understand that my co-payment is due at each visit. Cash, check, Mastercard, American Express and Discover cards are acceptable methods of payment. We also accept payments through PayPal and Venmo.

____ I understand that I am financially responsible for the charges not covered by my insurance, such as: deductibles, coinsurance.

____ I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account.

____ I understand that I will be charged $30.00 for any missed appointments without 24hr notice prior to the appointment time.

____ I understand as a new patient by completing and signing this form I am subject to be charge as a regular patient if I miss an appointment.

____ I understand that I could be discharged from the practice for failing to provide notice of cancellation for two or more appointments.

____ I understand that I will be charged $30.00 for any returned check.

____ I understand that I may be responsible for charges related to the completion of certain forms and letters. The cost for such forms or letters varies from $ 30.00 to $ 300.00 depending of the complexity of these medico legal forms.

____ I understand that I am responsible for any collection and/or attorney fees should my account be turned over to a collection agency.

____ I authorize payment of insurance benefits to the physician or supplier for all services rendered.

____ I understand the physician / provider will see you to determine if will undertake the case.

____ I authorize the release of any medical or other information necessary to process the insurance claim(s).

____ I authorize payment directly to the billing office of this physician/clinic for the medical and/or surgical benefits, if any, otherwise payable to me for services.

I UNDERSTAND AND ACCEPT THE ABOVE RESPONIBILITES AND AUTHORIZATIONS.

SIGNATURE OF PATIENT OR GUARDIAN____DATE_____________________

PRINTED NAME____

CONSENT TO PHOTOGRAPH

HEALTHY LIVING CLINIC, LLC and/or his associates are authorized to take medical photographs before, during, and/or after a procedure or treatment for the professional purpose of documentation. These digital photos will be at your electronic medical record.

☐ **YES, I GIVE MY CONSENT TO BE PHOTOGRAPHED** ☐ **NO,** I do not consent to being photographed.

SIGNATURE OF PATIENT OR GUARDIAN____DATE_____________________

PRINTED NAME____

CONSENT TO BE CONTACTED BY TEXT MESSAGES (SMS) OR BY WHATSAPP AND BY E-MAIL

Healthy Living Clinic, LLC and/or his associates are authorized to contact you via e-mail as well as by using SMS or message over the internet (WhatsApp, Telegram, Signal, etc.), Since our e-mail/text communications are not encrypted, it is the policy of Healthy Living Clinic, LLC not to use e-mail/text or other digital media for sharing confidential information.

☐ **YES, I GIVE MY CONSENT TO BE CONTACTED BY SMS / WhatsApp, etc. / E-mail** ☐ **NO,** I do not consent

SIGNATURE OF PATIENT OR GUARDIAN____DATE_____________________

PRINTED NAME____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT'S NAME____ DATE OF BIRTH _______/_________/_________

ADDRESS ____ PHONE NUMBER_________________________

CITY _________________________ STATE _____ ZIP _________ SSN___________________________________

DATE OF REQUEST____

☐ I AUTHORIZE HEALTHY LIVING CLINIC, LLC **TO RELEASE INFORMATION TO:**	**OR**	☐ I AUTHORIZE HEALTHY LIVING CLINIC, LLC **TO OBTAIN INFORMATION FROM:**
NAME OF PROVIDER OR FACILITY		NAME OF PROVIDER OR FACILITY
ADDRESS		ADDRESS
CITY, STATE, ZIP		CITY, STATE, ZIP
PHONE NUMBER		PHONE NUMBER
FAX NUMBER		FAX NUMBER

PURPOSE FOR THIS REQUEST____

TYPE OF RECORDS REQUESTED:

☐ ENTIRE RECORD
☐ TREATMENT SUMMARY (INCLUDES HISTORY/PHYSICAL, LABS, XRAYS, OPERATIVE REPORTS, PATHOLOGY)
☐ LASTS MEDICAL VISITS INCLUDING LAST NOTES, X RAYS OR LABORATORY TESTS

☐ SPECIFIC INFORMATION
☐ PROCEDURE REPORT ☐ HISTORY & PHYSICAL ☐ PHYSICAL THERAPY ☐ LAB RESULTS
☐ XRAY REPORTS ☐ OTHER____

AUTHORIZATION VALID FOR:

ALL AUTHORIZATIONS ARE VALID FOR ONE YEAR UNLESS SPECIFICALLY REQUESTED DIFFERENTLY BY THE PATIENT OR BY THE FACILITY THAT WE ARE REQUESTING RECORDS.

☐ This authorization is valid only until ______________________.

I UNDERSTAND THAT:

I may cancel this authorization at any time by submitting a **written** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

SIGNATURE OF PATIENT OR GUARDIAN____DATE____________________

PRINTED NAME____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this document is available upon request.

I have received a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR GUARDIAN____DATE______________________

PRINTED NAME____

Please list the names of anyone who the office staff may release information to on your behalf. If they are not on this list, no information will be released regarding your care or condition.

NAME		
RELATIONSHIP TO YOU		
CONTACT INFORMATION		
COMMENTS		

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

- ☐ Individual refused to accept Notice
- ☐ Individual refused to sign Acknowledgment
- ☐ Individual was unable to sign
- ☐ Other:
- ☐ An emergency situation prevented us from obtaining acknowledgment

PATIENT PRIVACY RIGHTS

A copy of this document is available upon request

You Have the Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions for the amount of medical information which we disclose. Your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy if this notice by printing it or with a written request directed to our office. A copy of this notice will be given with all new patient packets.

We May contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of this privacy notice and an opportunity to review and understand it.

Our Responsibilities under HIPPA:

- We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that this notice has been changes and the effective date of the change, copies will be made available.
- You can submit a complaint about our privacy policy or its execution either verbally or in writing to our Privacy Officer at our office.

Initial ________   Signature ________________________   Date   /   /