

Secondary Insurance

Insurance Company Name

Policy #

Group #

Claims Mailing Address

City, State, Zip Code

()

(Area Code) Insurance Phone Number

Guarantor Name

Pharmacy Information

Name of Pharmacy

()

Phone

Address

City, State, Zip

Others Authorized to Discuss Medical Records

Name

()

(Area Code) Contact Phone#

Relationship

Name

()

(Area Code) Contact Phone#

Relationship

Name

()

(Area Code) Contact Phone #

Relationship

Name

()

(Area Code) Contact Phone #

Relationship

Complete ONLY If Related to an Automobile Accident

Insurance Company Name

Claims Mailing Address

City, State, Zip Code

Claim Representative

Insurance Phone Number

Date of Accident

Policy Holder

Relationship

Policy Number

Claim Number

Attorney Name and Phone #

Financial Responsibility

I understand that I am responsible for the payment of this account and hereby assume and guarantee prompt payment of all expenses incurred. I understand that, as a courtesy, PrimaCare Health Centers will directly bill my insurance company and that I am ultimately responsible for payment of my account.

Payment of Benefits

I direct payment to the undersigned medical provider of the surgical and /or medical benefits, if any, otherwise payable to me for services as described but not to exceed the reasonable and customary charge for those services.

Release of Information

I hereby authorize the medical providers to release any information acquired in the course of examination or treatment to my insurance company in order to process payment or other health care providers for referral purposes.

Notices of Privacy Practices

I acknowledge that I have been provided with PrimaCare Health Center's Notice of Privacy Practice that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practice prior to signing this statement. Pimacare Health Centers will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request.

I acknowledge that I have read and understand all of the above information.

Signature

Date

Social History

Please answer the following:

Living Situation: Single Married Divorced Widow(er) Roommate

Children? No. Yes. How many? _____

Occupation: _____

Smoke cigarettes? No. Yes. How much? _____

Drink alcohol?: No. Yes. How much? _____

Use Street Drugs? No Yes. How Much? _____

Family Medical History

Please answer the following:

Has anyone in your immediate family had the following medical problems? If yes, then who had the problem.

High Blood Pressure: No. Yes. If yes, Who? _____

Heart Attack: No. Yes. If yes, Who? _____

Diabetes: No. Yes. If yes, Who? _____

Stroke: No. Yes. If yes, Who? _____

Cancer: No. Yes. If yes, Who? What type? _____

Prescribed Medications (Rx)

_____ Name of medication	_____ Strength	_____ Directions
_____ Name of medication	_____ Strength	_____ Directions
_____ Name of medication	_____ Strength	_____ Directions
_____ Name of medication	_____ Strength	_____ Directions
_____ Name of medication	_____ Strength	_____ Directions
_____ Name of medication	_____ Strength	_____ Directions
_____ Name of medication	_____ Strength	_____ Directions

Over-The Counter (OTC) Products:

(Vitamins, Pain Killers, Muscle Relaxers, Cold, Sinus, etc)

_____ Name of medication	_____ Strength	_____ Direction
_____ Name of medication	_____ Strength	_____ Direction

Allergies to Medication: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: _____

I authorize: _____

(Company / Medical provider)

(Address)

(Phone and Fax number)

To release information from the medical record of: _____
(Patient's full name)

Reason for request: _____

To: **PRIMACARE HEALTH CENTERS, INC.**
3236 Dr. Martin Luther King Jr. St N.
St. Petersburg, FL 33704
PH: (727) 823-4848 FAX: (727) 823-4880

For the purpose of review/examination, I authorize you to provide the following information.

_____ COMPLETE COPY OF MEDICAL RECORD
_____ DISCLOSURE LOG
_____ SPECIFIC INFORMATION

I give permission to release any information related to:

_____ SUBSTANCE ABUSE
_____ PSYCHIATRIC/MENTAL HEALTH INFORMATION
_____ HIV/AIDS INFORMATION

This authorization will expire sixty (60) days from the date signed. I understand that I may revoke this authorization, in writing at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

Patient's or Legal Guardian's Signature _____

Relationship to the Patient: _____

Witness: _____ Practice: _____

Identifying Information:

Name at time of treatment, if other than above: _____

Date of Treatment: _____

Date of Birth: _____ SS#: _____