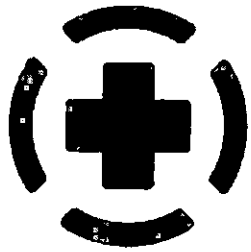

PRONTO MEDICAL CARE

CARLOS H. FERNANDEZ PA-C

1. THIS MEDICAL CLINIC DOES NOT PRESCRIBE CONTROLLED SUBSTANCES FOR CHRONIC CONDITIONS.
2. IF YOU HAVE A MEDICAL PROBLEM, CHECK IN. PLEASE DO NOT TRY TO SOLVE MEDICAL CONDTIONS OR SYMPTOMS OVER THE PHONE WITH NURSE OR THE RECEPTIONIST.
3. FOR SAFETY REASONS, IF YOU NEED REFILLS ON A MEDICATION WE PRESCRIBED, ASK YOUR PHARMACIST TO FAX US A REQUEST. KINDLY GIVE US A 48 HOURS TO RESPOND.

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE

_____	_____
WITNESS	DATE

515 AIRPORT RD. PANAMA CITY, FL 32405
P.O. BOX 16223 PANAMA CITY, FL 32406
(850) 481-0894

Patient's Information

Patient's Name:(Last)_____(First)_____(M.I)_____

Address:_____

City, State:_____ZIP:_____ Sex: Female Male

Date of Birth:_____Email Address:_____

Home Phone:_____Mobile Phone:_____Work Phone:_____

Are you Single/Married/Divored/Widowed/Seperated?_____

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander African American White Declined

Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined Language: English Spanish Other:_____

Parent or Guardian (For Minor Child)

Name:(Last)_____(First)_____

Home Phone:_____Mobile Phone:_____

Emergency Contact

Name:(Last)_____(First)_____

Home Phone:_____Mobile Phone:_____Work Phone:_____

Emergency Contact Relationship to Patient:_____

Address:_____

City, State:_____ZIP:_____

Insurance

Primary:

Insurance Company:_____Policy Number:_____

Name of Insured:_____Insured's DOB:_____

Patient Relationship:_____Group ID:_____

Secondary:

Insurance Company:_____Policy Number:_____

Name of Insured:_____Insured's DOB:_____

Patient Relationship:_____Group ID:_____

Patient's Signature:_____Date:_____

Consent for Treatment and Payment Agreement

I hereby authorize **Pronto Medical Care/Carlos Fernandez PA-C**, to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to, **Pronto Medical Care/Carlos Fernandez PA-C** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Pronto Medical Care/Carlos Fernandez PA-C all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient initial: _____

MEDICARE LIFETIME AUTHORIZATION I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services Pronto Medical Care/Carlos Fernandez Pa-C. **Patient Initial: _____**

I request this authorization also apply to all other insurance. **Patient Initial: _____**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Parent Signature:_____Date_____

Pronto Medical Care Patient HIPPA Acknowledgement and Consent Form

I understand that as part of my healthcare, **Pronto Medical Care** originates and maintains paper/and or electronic records describing my heath history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information, uses, and disclosures. I understand that I have the following rights:

The right to review the notice prior to signing this consent
The right to object to the use of my health information for directory purposes
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that Pronto Medical Care is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance.thereon. I also understand that by refusing to sign this consent form or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Patient's Signature:_____Date:_____

Disclosure to Friends/and or Family Members

I give permission to designate a family member or other individual whom with the provider/or medical staff may discuss my medical conditions, communicating results, findings and care decisions.

Name	Relationship	Contact Number

PATIENT HISTORY/MEDICATION LIST

Patient's Name:(Last)_____(First)_____(M.I)_____

Date of Birth:_____Date:_____

History of Present Illness:

What are you coming in for today?_____

Severity of Pain? 1 2 3 4 5 Duration:_____

(5 being the worse) (How long have you had this problem)

Signs/Symptoms:_____

Past Medical History: Circle any previous medical conditions you have had/have.

Headaches	Migraine Headaches	Hepatitis_____	Amnesia
Collagen Vascular Disease	High Blood Pressure	Osteoporosis	Bladder Infections
Chronic Sinus Infection	Diabetes	Epilepsy	Glaucoma
Obstructive Sleep Apnea	Mumps	Red Measles	Hemorrhoids
Carpel Tunnel Syndrome	Rheumatic Fever	Scarlet Fever	Bronchitis
Seizures, Convulsions	Polio	Asthma	Thyroid Disease
Kidney Disease	Encephalitis	Lupus	Mitral Valve Prolapse
Rheumatoid Arthritis	Nervous Breakdown	HIV/AIDS	Persistent Cough
Gait Abnormality	Tuberculosis	Psychosis	Fibromyalgia
Alcoholism	Hiatal Hernia	Psoriasis	Obesity
Trigeminal Neuralgia	Pneumonia	Polymyositis	Heart Disease
Depression/Anxiety	Substance Abuse	Shingles	Diabetes
Reiter's Disease	Chronic Neck Pain	Low Back Pain	Ulcer
	Crohn's Disease	Bipolar	Stroke
	Cancer_____		Chicken Pox

Past Surgical History:(list any previous surgeries)_____

_____

Allergies?: YES or NO If yes, please list:_____

_____

LIST OF MEDICATIONS:_____

_____

Use of Alcohol: Never Rarely Moderate Daily

Use of Tabacco: Never Previously, but quit _____ Current packs per day _____

Use of Drugs: Never Type/Frequency:_____

Family History: Adopted No Family History Known Please List Diseases/Conditions

Mother:_____Father:_____

Siblings:_____Children:_____

Patents' Signature:_____Date:_____