**PLEASE DO NOT LEAVE FIELDS BLANK**

Date

## PERSONAL INFORMATION

| Legal First Name | Middle Initial | Last Name | Preferred Name |
|---|---|---|---|
| | | | |

| Street and Apt # | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Primary Telephone | Birth Date | Social Security Number |
|---|---|---|
| | | |

**E-mail:**

**Marital Status**

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Dependent
- ☐ Widow

**Race**

- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian or Alaska Native

**Ethnicity**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer Not to Disclose

**Gender**

- ☐ Male
- ☐ Female

| Emergency Contact Full Name | Relationship | Phone # |
|---|---|---|
| | | |

## BILLING INFORMATION

| PRIMARY INSURANCE | |
|---|---|
| **Insurance Company** | |
| **Subscriber Name** | |
| **Birthdate** | |
| **Group #** | |
| **ID #** | |
| **Subscriber's Employer** | |

| SECONDARY INSURANCE | |
|---|---|
| **Insurance Company** | |
| **Subscriber Name** | |
| **Birthdate** | |
| **Group #** | |
| **ID #** | |
| **Subscriber's Employer** | |

**BILLING CONTACT** | Complete *only if* the person responsible for the bill is *not the patient*.

| First Name | Middle Initial | Last Name | Relationship |
|---|---|---|---|
| | | | |

| Street and Apt # | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Primary Telephone | Employer | Employer Phone # |
|---|---|---|
| | | |

Employer Address

# Advanced Mobile Medical Services

## MEDICATION LIST/ALLERGIES/PHYSICAN & PHARMACY INFORMATION

| Medications/Supplements | Dosage/Frequency | Condition/Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Allergies (Medication, Food, Cosmetics, Etc.) | Cause/Nature of Reaction |
|---|---|
| | |
| | |
| | |

| Provider and Pharmacy Information | |
|---|---|
| **Primary Care Provider (**Name/Phone/Fax): | **Preferred Pharmacy** (Name/Phone/Fax): |
| **Referring Provider** (Name/Phone/Fax):<br>❑ Same as PCP | **Other Provider to send records to** (Name/Phone/Fax): |
| Specialty: | Specialty: |
| **Other Provider to send records to** (Name/Phone/Fax): | **Other Provider to send records to** (Name/Phone/Fax): |
| Specialty: | Specialty: |

# Advanced Mobile Medical Services

## FAMILY & SOCIAL HISTORY

| Family History: **Mother** | Family History: **Father** | Family History: **Siblings** | Family History: **Children** |
|---|---|---|---|
| ❑ Alive ❑ Deceased<br>❑ Unknown<br><br>❑ Heart Disease<br>❑ Diabetes<br>❑ Cancer (Type):<br>❑ Other: | ❑ Alive ❑ Deceased<br>❑ Unknown<br><br>❑ Heart Disease<br>❑ Diabetes<br>❑ Cancer (Type):<br>❑ Other: | ❑ Alive ❑ Deceased<br>❑ Unknown<br><br>❑ Heart Disease<br>❑ Diabetes<br>❑ Cancer (Type):<br>❑ Other: | ❑ Alive ❑ Deceased<br>❑ Unknown<br><br>❑ Heart Disease<br>❑ Diabetes<br>❑ Cancer (Type):<br>❑ Other: |

| Do you drink **Alcohol**? | Do you **Smoke**? | Do you use recreational **Drugs**? |
|---|---|---|
| ❑ Never<br>❑ Yes. I drink:<br>❑ wine ❑ beer ❑ liquor<br>❑ I have_____drink(s) per week<br>❑ I used to drink but quit in _____(year) | ❑ I have never smoked<br>❑ Yes. I smoke:<br>❑ cigarettes ❑ cigars ❑ pipes.<br>❑ I currently smoke and I don't want to quit<br>❑ I currently smoke but I'm ready to quit.<br>❑ I smoke_____pack(s) per day for _____ years<br>❑ I used to smoke but quit in _____(year)<br>❑ I use chewing or smokeless tobacco | ❑ Never<br>❑ No, but I have used _____<br>❑ Yes, I use _____ |

| Do you eat or drink foods containing **Caffeine?** | Have you taken any **Advil, Aleve, Aspirin** (NSAIDs) in the last 7 days? |
|---|---|
| ❑ Yes<br>❑ No | ❑ Yes (if so, what medication?) _____<br>❑ No |

| Do you **Exercise**? | **If yes, how often and what type?** |
|---|---|
| ❑ Yes<br>❑ No | |

| Date of most recent flu shot (13yrs +) | Date of most recent pneumonia shot (age 65+): |
|---|---|
| | |

# Advanced Mobile Medical Services

## PERSONAL HEALTH HISTORY

Have you EVER HAD, or do you have, any of the following? Circle yes or no.

| | | | | | |
|---|---|---|---|---|---|
| 1. Chicken pox or shingles | Yes | No | 25. Broken bones | Yes | No |
| 2. Measles | Yes | No | 26. Bone or joint problems | Yes | No |
| 3. Mumps | Yes | No | 27. Arthritis/gout | Yes | No |
| 4. Skin problems or chronic rash | Yes | No | 28. Back pain/injury | Yes | No |
| 5. Eye problems | Yes | No | 29. Numbness/tingling legs or feet | Yes | No |
| 6. Hearing loss or ear problems | Yes | No | 30. Knee pain/injury | Yes | No |
| 7. Chronic cough | Yes | No | 31. Foot pain/injury | Yes | No |
| 8. Asthma | Yes | No | 32. Neck pain/injury | Yes | No |
| 9. Shortness of breath | Yes | No | 33. Loss of limb | Yes | No |
| 10. Lung problems | Yes | No | 34. Severe headaches | Yes | No |
| 11. Tuberculosis or positive TB test | Yes | No | 35. Dizziness or fainting | Yes | No |
| 12. Chest pain | Yes | No | 36. Epilepsy or seizures | Yes | No |
| 13. Heart trouble/attack | Yes | No | 37. Severe weakness or tiredness | Yes | No |
| 14. Palpitations/irregular heartbeat | Yes | No | 38. Depression or anxiety | Yes | No |
| 15. Heart murmur | Yes | No | 39. Emotional or psychiatric problems | Yes | No |
| 16. High blood pressure | Yes | No | 40. Drug or alcohol dependency | Yes | No |
| 17. Stroke or paralysis | Yes | No | 41. Eating disorder | Yes | No |
| 18. Stomach or intestinal problem | Yes | No | 42. Bleeding or blood disorder | Yes | No |
| 19. Liver disease/hepatitis | Yes | No | 43. Immune suppression | Yes | No |
| 20. Kidney disease | Yes | No | 44. Chronic/recurrent infection | Yes | No |
| 21. Weight Change | Yes | No | 45. Tumor/cancer | Yes | No |
| 22. Thyroid problems | Yes | No | 46. Anemia | Yes | No |
| 23. Shoulder/elbow/wrist/hand pain | Yes | No | 47. Diabetic | Yes | No |
| 24. Numbness/tingling or arms or hands | Yes | No | 48. Any other illness not listed | Yes | No |

# Advanced Mobile Medical Services

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how *Advanced Mobile Medical Services* may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by *Advanced Mobile Medical Services*, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

**We may use or disclose your protected health information in the following situations without your authorization:** as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your provider or has *Advanced Mobile Medical Services* taken an action in reliance on the use or disclosure indicated in the authorization.

## NOTICE OF PRIVACY PRACTICES (*continued*)

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

*Advanced Mobile Medical Services* is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

**You may have the right to have *Advanced Mobile Medical Services* amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law** to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our administrative team at 813-710-9555.

**Associated companies with whom we may do business**, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

**We welcome your comments:** Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

# Advanced Mobile Medical Services

## PATIENT PORTAL /PHONE/E-MAIL

I understand that my healthcare information at *Advanced Mobile Medical Services(AMMS)* is protected and I have received a copy of their Notice of Privacy Practices. In order for AMMS to leave detailed messages on my voice-mail or answering machine, I need to give permission to AMMS to do so.

## Consent for Leaving Messages/Access to Patient Portal

**By signing below**, I consent to information regarding my lab test results or appointment reminders/ instructions be left on my voicemail or answering machines. I also consent to have access to the patient portal. This includes receiving emails where I will be able to confirm, schedule, and cancel appointments. I understand that "sensitive" information as noted below will be excluded unless specifically requested by myself or my medical power of attorney.

IF **NOT**,
INITIAL HERE → *I **do not** give consent for AMMS to leave messages* initials _____

Would you like access to our **patient portal** and to receive lab notifications on-line? Yes/No

## Consent for Shared Information with Family & Friends

By signing below, I wish family members or friends to have access to my healthcare information. The name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the judgment of my provider or his/her designee to release any "sensitive" information. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

| Family/Friend Name | Relationship | Phone # | E-mail |
|---|---|---|---|
| | | | |
| Family/Friend Name | Relationship | Phone # | E-mail |
| | | | |

I understand that some information is "sensitive". I understand that **I must check** the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Diseases
- ☐ Pregnancy Information

IF **NOT**,
INITIAL HERE → *I **do not** give consent for AMMS to share information with family/friends* initials _____

| Patient Name (PRINT) | Date of Birth |
|---|---|
| | |

| Signature of Applicant | Date |
|---|---|
| | |

**This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.**

# Advanced Mobile Medical Services

## HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

### FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

**I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance to be paid directly to my provider. I also authorize my provider or insurance company to release any information for processing my claims.**

| | |
|---|---|
| Patient Name (PRINT) | Date of Birth |
| Signature of Applicant | Date |

## CO-PAYMENTS

**Co-payments are due at the time of service.** These payments are part of your contracted benefits with your insurance company. We are happy to accept your payment in the form of cash, credit card, or check.

## BILLING

We make every effort to file the appropriate code(s) encountered and documented in your medical record. Our office is given Service Codes and guidelines to follow to prevent inappropriate charges being billed to you and your insurance company. We are unable to bill for services other than those documented in your medical record. We cannot change a code after a visit, as this can be construed as fraud by the insurance company.

As a courtesy, *Advanced Mobile Medical Services* will file a claim with your primary insurance on your behalf. Any questions regarding your benefits and coverage should be directed to your insurance carrier. Our goal is to ensure your clinic bill is processed correctly and in a timely manner. Please make sure you notify us of any changes to your insurance coverage.

If you are self-pay/noninsured; payment for your visit is due at time of service.

**By signing below, I acknowledge receipt of the Notice of Clinic Policies.**

| | |
|---|---|
| Patient Name (PRINT) | Date of Birth |
| Signature of Applicant | Date |

# Advanced Mobile Medical Services

## HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our administration team.

**By signing below, I acknowledge receipt of the Notice of Privacy Practices.**

| | |
|---|---|
| Patient Name (PRINT) | Date of Birth |
| Signature of Applicant | Date |