# West Coast Primary Care, LLC

*Account#*_____ *PATIENT INFORMATION*

Patient Name: _____ DOB: ___/___/_____ SS#: _____-_____-_____ Sex: Male ___ Female ___

Address: _____ City: _____ State: _____ Zip: _____

Phone#: (_____)_____ Cell# (_____)_____

☐ Check this box if we may use this cell # for text and/or robocall appointment reminders

Nationality: ☐African American/Black ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Declined

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Email:_____

Pharmacy :_____ Pharmacy Phone: (_____) _____-_____

Smoker? ☐Current Smoker ☐Former Smoker ☐Never Smoked

Primary Language:_____ Preferred method of contact: Email Phone Cell Phone Text
(Please Circle One)

Whom may we thank for referring you:_____

Employer Status: ☐Employed ☐Self-Employed ☐Retired ☐Disabled ☐Unemployed ☐Student

Occupation:_____ Employer_____

Employer Address_____ Work Phone: (_____)_____

## *EMERGENCY CONTACTS*

#1. Name: _____ Relationship: _____ Phone#: (____) _____-_____

#2. Name: _____ Relationship: _____ Phone#: (____) _____-_____

## *INSURANCE INFORMATION*

Primary Insurance Carrier: _____ Policy#_____ Group#_____

Policyholder's Name: _____ Date of Birth_____

Policyholder's SS#:: _____ Relationship to patient: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Eligibility Phone# (_____) _____-_____

Secondary Insurance Carrier: _____ Policy#_____ Group#_____

Policyholder's Name: _____ Date of Birth_____

Policyholder's SS#:: _____ Relationship to patient: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Eligibility Phone# (_____) _____-_____

Apr-15

# West Coast Primary Care, LLC

## REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's physician. West Coast Primary Care, LLC has the right to refuse to you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Patient Signature_____Date_____

## ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to West Coast Primary Care, LLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made

Patient Signature_____Date_____

## OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient Signature_____Date_____

# West Coast Primary Care, LLC

## Patient Consent for Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations, Per HIPPA Regulations

I understand that as part of my healthcare, the practice originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered

A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff
I have been provided with a "*Notice of Patient Privacy Practices*" that provides a more complete description of information uses and disclosures. I understand that I have the following and privileges:

- The right to review the "*Notice*' prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

**Please Print**

Restrictions:
I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s), friends or caregivers (name(s))

_____

_____

Messages or Appointment Reminders
May we leave a message at your home using doctor's /practice name: ☐ Yes ☐ No
May we leave a message at your work using doctor's /practice name: ☐ Yes ☐ No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and ☐ accept ☐ decline the information of this consent.

_____ _____
Patient/ Guardian Signature Date

_____
Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No

# West Coast Primary Care, LLC

## *OUR FINANCIAL POLICY*

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
**WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD.**

***Regarding Insurance***
Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Regarding insurance plans where we are not a participating provider: You are responsible for payment of your first office visit in full. We may accept assignment of insurance benefits after your second visit. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges.

We bill secondary insurance carriers as a courtesy to our patients.

***Usual and Customary Charges***
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed upon.

***Interest***
We reserve the right to charge interest in the amount of 18 % per year as provided by state law on past due accounts.

***Minor Patients***
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

***Missed Appointments***
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $30.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

***Returned Checks***
If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $30.00. Payment must be made prior to your return to the office and we may not accept any more personal checks.

***Billing Questions***
Please address all billing questions to Fountainhead Practice Management Solutions at 727-456-3288 or toll free 866-343-3288.

***Collections***
You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

_____ _____
Signature of Responsible Party Date

_____ _____
Witness Date

*GREGORY NESTOR, M.D.* *DEBORAH NOLAN, A.R.N.P.*

NAME_____ AGE_____ SEX_____ S M W D_____

ADDRESS_____ PHONE_____ DATE_____

NEXT OF KIN_____ ADDRESS_____

OCCUPATION_____ REFERRED BY_____

MEDICARE OR OTHER INSURANCE I.D.#_____ D.O.B._____

WHAT MEDICAL DOCTOR DID YOU LAST SEE?_____ WHEN_____

1. What childhood illnesses have you had? _____
_____

2. Did you have any unusual or severe illnesses prior to age 18? _____
_____

3. Give the year or your age if you have had any of the following operations:

| | | |
|---|---|---|
| Tonsillectomy_____ | Hysterectomy_____ | Ear Operation_____ |
| Cataract Operation_____ | Prostate Operation_____ | Lung Operation_____ |
| Gall Bladder Removal_____ | Vein Operation_____ | Hernia_____ |
| Stomach Operation_____ | Appendectomy_____ | Artery Operation_____ |
| C-Section_____ | Eye Operation_____ | Heart_____ |
| Breast Surgery_____ | Hemorrhoidectory_____ | Others_____ |

4. If you have any of the following problems, please mark with an X:

| | | |
|---|---|---|
| Diabetes_____ | High Blood Pressure_____ | Prostate Problems_____ |
| Anemia_____ | Heart Trouble_____ | Lung Trouble_____ |
| Cancer_____ | Kidney or Bladder Trouble_____ | Stomach or Bowel |
| Arthritis_____ | Female Problems_____ | Trouble_____ |
| Depression_____ | Thyroid Problems_____ | |

5. If you have had any broken bones, whether right or left, and the year in which the injury occurred:_____
_____
_____

6. Give the years and reason if you have been hospitalized for anything besides injuries or operation:_____
_____
_____

7. Except as noted above, for what have you been treated by physicians during the past ten years other than common colds and the like: _____
_____
_____
_____

8. What medicines do you now take and how often do you take them: _____
_____
_____
_____

9. Have you ever had a blood transfusion? _____ When? _____ How Many? _____

10. List any medicines to which you are allergic: _____
Have you ever had asthma or hay fever? _____

(OVER)

11. Women Only: At what age did your periods commence?_____
At what age did they stop?_____
What if any trouble do you have with your periods?_____
_____
How many living children have you had? _____ How many still births? _____
How many miscarriages?_____

12. a. Occupation _____ Are you retired?_____
b. What is your spouse's age?_____
c. Do you consider him/her to be in good health? _____ If not, why not? _____
_____
d. In what year were you married? _____ How many beers, shots, cocktails and highballs do you consume in an average week?_____
e. How many pipes, cigars, or packs of cigarettes do you smoke per day, on the average?_____
_____
f. How many cups of coffee do you drink per day?_____ Tea _____
g. In what state were you born?_____ If foreign born, at what age did you come to this country? _____ In what state did you live most of your life?_____
h. Do you generally sleep well?_____
i. What are your principal hobbies or recreational activities?_____
j. If you were in the Armed Services, what branch and years? _____

13.

| | LIVING | | | DECEASED | | |
|---|---|---|---|---|---|---|
| | Age | State of Health | Chronic Diseases | Age at Death | Cause of Death | Other Illnesses |
| Father | | | | | | |
| Mother | | | | | | |
| Brothers | | | | | | |
| Sisters | | | | | | |
| Children | | | | | | |

Except as noted, have any close blood relatives had cancer? _____
_____
High Blood Pressure?_____
Diabetes?_____
Tuberculosis?_____
Any disease that run in the family? _____

HOSPITAL DATA:

Admission Date:_____ Admission Diagnosis: _____
Lab data:_____
_____
_____