Midway Primary Care, LLC.
Suzan E Zimmer, D.O.
Tracy Britcher, ARNP
3255 S US Hwy 1
Fort Pierce, FL 34982

Telephone (772) 742-9271 Fax (772) 742-9278

Missed Appointment Policy

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments. A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients.

I have read and understand the policy stated above.

Signature:_____ Date:_____

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Patient Name:_____
(LAST) (FIRST) (MIDDLE)

Phone:(____) ____-____

SS#:_____ Date of Birth:_____

Guarantor (If patient is a child):_____

Fl. Address:_____ Apt#:_____

City:_____ State:_____ Zip Code:_____

Secondary Address:_____

Marital Status:_____ Drivers License #:_____

Employer:_____ Occupation:_____

Address:_____ Phone number:(____) ____-____

Emergency Contact:_____ Phone number:(____) ____-____

Contacts address:_____

City:_____ State:_____ Zip Code:_____

Insurance Information

Primary Insurance:

Name of Insured:_____ SS# of Insured:_____ DOB:_____

Secondary Insurance:

Name of Insured:_____ SS# of Insured:_____ DOB:_____

Assignment of Benefits

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to Midway Primary Care, LLC. who accepts assignment of Benefits.

_____ Date:_____
(Patient or Authorized Person's Signature)

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Consent for Treatment

I voluntarily consent to the rendering of medical care by Midway Primary Care, LLC. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry out the instructions of each physician(s).

Statement of Financial Liability

I guarantee payment of any and all bills rendered for said patient which are not covered or allowed by insurance. This office will file the bill with my insurance company providing I supply the proper insurance information to the office.

Authorization to Release Information

I authorize Midway Primary Care, LLC. to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, Worker's Compensation or Medicare benefits payments.

Non-Covered Services

I acknowledge that procedures and services not covered by my insurance company will be my responsibility and payment will be submitted immediately.

Medicare Patients

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of medical and other information held by this office to the Social Security Administration or its intermediaries or carriers required for the submission of claims and reimbursement for services rendered.

Date: _____

Signature of Patient: _____

I consent to the use and disclosure of my protected health information by Midway Primary Care, LLC. for the purpose of diagnosing or providing treatment to me, obtaining payments for my health care bills or to conduct healthcare operations of Midway Primary Care, LLC.. I understand that diagnosis or treatment of me by Midway Primary Care, LLC. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Midway Primary Care, LLC. is not require to agree to the restrictions that I am request. However, if Midway Primary Care, LLC. agrees to a restriction that I request, the restriction is binding on Midway Primary Care, LL..

I have the right to revoke this consent in writing at any time, except to the extent that Midway Primary Care. LLC. has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information collected from me and created or received buy my physician, another healthcare provider and health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify.

I understand that I have the right to review Midway Primary Care, LLC.'s Notice of Privacy Practices prior to signing this document. Midway Primary Care, LLC.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payments of my bills or in the performance of health care operations of Midway Primary Care. LLC.. The Notice of Privacy Practices for Midway Primary Care, LLC. is also provided at the front waiting area. The Notice of Privacy Practices also describes my rights and Midway Primary Care, LLC.'s duties with respect to my protected health information.

Midway Primary Care, LLC. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name of Patient or Personal Representative Date

_____

Personal Representatives Authority

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HealthCare Advanced Directives
The Patient's Right to Decide

All adult individuals in health care facilities such as hospitals, nursing homes, hospices, home health agencies and health maintenance organizations have certain rights under Florida law.

You have a right to fill out a paper known as an Advanced Directive. The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions - conditions that would stop you from telling your doctor how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment?

What is an Advance Directive?

An advance directive is a written or oral statement which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made. Two forms of advance directives are:

* A Living Will and
* A Health Care Surrogate Designation.

And advance directive allows you to state your choice about health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions about your future medical treatment.

What is a Living Will?

A Living Will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes affect while you are still living. Florida law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wished will be understood.

What is a Health Care Surrogate designation?

A Health Care Surrogate designation is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you, if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form for designation of a health care surrogate. You may use it or some other form. You may wish to name a second person to stand in for you, if your first choice is not available.

Which is Better?

You may wish to have both or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you should you be unable to make decisions for yourself.

Do I have to write an Advance Directive under Florida law?

No, there is no legal requirement to complete an advanced directive. However, if you have not made an advance directive or designated a health care surrogate, health care decisions may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a proxy.

Can I change my mind after I write a Living Will or designate a Health Care Surrogate?

Yes, you may change or cancel these documents at any time. Any changes should be written, signed and witnessed. You can also change an advance directive by verbal statement.

What if I have filled out an Advance Directive in another State and need treatment in a health care facility in Florida?

An advance directive completed in another state, in compliance with the other state's law, can be honored in Florida.

What should I do with my Advanced Directive if I choose to have one?

Make sure that someone such as your doctor, lawyer or family members know that you have an advance directive and where it is located.

Consider the following:

*If you have designated a health care surrogate, give a copy of the written designation form or the original to the person.
* Give a copy of your advance directive to your doctor for your medical file.
* Keep a copy of your advance directive in a place where it can be found easily.
* Keep a card or note in your purse or wallet which states that you have an advance directive and where it is located.
* If you change your advance directive, make sure your doctor, lawyer and/or family member has the latest copy.

For further information, ask those in charge of your care.

_____ I HAVE read and understand the above information.
_____ I HAVE executed an advance directive.
_____ I HAVE NOT executed a advance directive.
_____ I understand that provision of medical care to me will not be based on whether or not I have executed an advance directive.

Patient:_____ Date:_____

Witness:_____ Date:_____

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Prescription Medication Consent Form

The providers at Midway Primary Care, LLC, use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescribing connection (RxHub) which improves the timely and secure transmission of your medication information.

To optimize the use of this electronic capability, and coordinate your care between us and your specialists, we ask that patients allow us to access their medication history through the RxHub.

Please check only one of the following:

_____ I consent to allow my provider to access all of my medication history.

_____ I consent to allow my provider to access only my medication history for medications prescribed in this office.

_____ I DO NOT consent to my provider accessing any of my medication history.

_____

Signature

_____

Printed Name

_____

Date

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Privacy Policy Acknowledgement

I have received a Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date of Birth: _____

Signature:_____

Date:_____

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To:_____
_____
_____

Authorization of Release of Medical Records

Name of Patient:_____

Social Security: _____

I authorize the release of my medical records specifically to include the following:

_____ Complete medical Records
_____ Lab Reports
_____ Consultations
_____ Medications
_____ Other

This medical record may contain information about drug abuse, substance abuse, mental health treatment and HIV/AIDS information. Separate consent must be given to release this information.

_____ I DO consent to having this information disclosed.

_____ I DO NOT consent to having this information disclosed.

The purpose of this request is for diagnosis and treatment.
These records are to be sent to the above address.
This authorization will expire 90 days from the date of signing.
I have the right to revoke this authorization at any time in writing except to the extent of information that has already been released.

I have reviewed this authorization. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

Date: _____

_____
Signature of Patient or Personal Representative

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Medication List

Patient Name:_____ Date of Birth_____

Medication Name	Dosage

PLEASE BRING ALL MEDICATION BOTTLES ON YOUR FIRST VISIT.

MEDICAL HISTORY

☐ ANEMIA	☐ DIVERTICULITIS	☐ HEPATITIS/LIVER	☐ SUICIDE ATTEMPT
☐ ASTHMA	☐ EMPHYSEMA / COPD	☐ HIGH CHOLESTEROL	☐ THYROID PROBLEMS
☐ ANXIETY	☐ EPILEPSY / SEIZURES	☐ BLOOD PRESSURE	☐ OTHER: _____
☐ CANCER: _____	☐ GERD / PEPTIC ULCERS	☐ KIDNEY PROBLEMS	_____
☐ DIABETES TYPE I / II	☐ GOUT	☐ PNEUMONIS	☐ OTHER: _____
☐ DEPRESSION	☐ HEART DIEASES / MI	☐ STROKE / TIA	_____

SURGERIES:

☐ CHECK HERE IF NO SURGERY HISTORY

- ☐ APPENDECTOMY
- ☐ C-SECTION # _____
- ☐ GALLBLADDER REMOVAL
- ☐ GASTRIC BYPASS / BANDING
- ☐ HERNIA REPAIR: _____
- ☐ HYSTERECTOMY (PARTIAL / TOTAL)
- ☐ ORTHO SURGERY: _____
- ☐ TONSILLECTOMY
- ☐ OTHER: _____
- ☐ OTHER: _____

HOSPITALIZATIONS:

☐ CHECK HERE IF NO HOSPITAL HISTORY

_____

_____

_____

_____

FAMILY HISTORY

☐ CHECK HERE IS UNKNOWN OR ADOPTED

DAUGHTER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
FATHER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
SON:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
SPOUSE:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
MOTHER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
PATERNAL GF:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
PATERNAL GM:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
MATERNAL GF:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
MATERNAL GM:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK
OTHER:	☐ CANCER	☐ DIABETES	☐ HYPERTENSION	☐ HEART DISEASE	☐ LIPIDS	☐ UNK

SIBLING? NO / YES → NUMBER OF SIBLING(S): _____ SISTER(S) _____ BROTHER(S)

CHILD? NO/ YES → NUMBER OF CHILDREN: _____ DAUGHTER(S) _____ SON(S)

SOCIAL HISTORY

MARTIAL STATUS	SINGLE	MARRIED	SEPERATED	DIVORCED	WIDOWED
RELATIONSHIP	HAPPY	SATISFIED	AVERAGE	NOT HAPPY	UNSTABLE
STRESS LEVEL	NONE	MILD	MODERATE	HIGH	VERY HIGH
ALCHOL USE	NONE	SOCIALLY	WITH DINNER	HABITUALLY	QUIT: _____YR
TOBACCO USE	NEVER	QUIT# ____YR AGO	CURRENT# _____	PER DAY FOR # YEARS: _____	
AEROBIC EXERCISE	NONE	OCCASIONALLY	1-2 TIMES WEEK	3-4 TIMES WEEK	5-6 TIMES WEEK
STRENGTH TRAINING	NONE	OCCASIONALLY	1-2 TIMES WEEK	3-4 TIMES WEEK	5-6 TIMES WEEK
VEGETABLE INTAKE	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
FRUIT INTAKE	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
MEAT INTAKE	NONE	1 SERVING/DAY	2 SERVINGS/DAY	3 SERVINGS/DAY	4+ SERVINGS/DAY
FAST FOOD	NEVER	1 -2 TIME A WEEK	3-4 TIME A WEEK	1-2 X A MONTH	3-4 X A MONTH

REVIEW OF SYMTOMS

Please check any symptoms that you experience. For any checks, please provide a brief description.

CONSTITUTIONAL	GASTROINTESTINAL
☐WEIGHT LOSS / GAIN - HOW MANY POUNDS? ____	☐ABDOMINAL PAIN
☐WEAKNESS	☐BLOATING / GAS
☐LOSS OF APPETITE	☐BLOOD IN STOOL
☐FEVER / CHILLS	☐CONSTIPATION # OF BOWEL MOVEMENTS: _____
☐EXCESS FATIGUE - HOW LONG? _____	☐DIARRHEA
☐INSOMNIA / LIGHT SLEEP	☐HEARTBURN
ALLERGIES	☐DIFFICULTIES SWALLOWING
☐ITCHY EYES	☐RECTAL BLEEDING
☐RUNNY NOSE	**HEMATOLOGY / LYMNHATICS**
☐SINSUS CONGESTION - SEASONAL? YES / NO	☐EASY BRUISING
☐SCRATCHY THROAT	☐SWOLLEN GLANDS
EYES / EAR / NOSE / THROAT	**DERMATOLOGY**
☐BLURRY VISION	☐RASH
☐EYE DRAINAGE	☐DRY SKIN
☐LOSS OF VISION - OPHTHALMOLOGY EVAL?	☐ACNE
☐HEADACHES / MIGRAINES	☐WRINKLES
☐COUGH	☐ITCHING
☐SORE THROAT / HOARSENESS	☐PIGMENTATION / SCARRING
☐GERD	☐EXCESSIVE / ABNORMAL HAIR GROWTH
☐RINGING IN EARS	**PSYCHOLOGY**
☐HEARING LOSS	☐DEPRESSED
CARDIOVASCULAR	☐FEELING ON EDGE / STRESSED
☐CHEST PAIN: HISTORY OF MI or HEART DISEASE	☐NERVOUSNESS
☐PALPITATION	☐THOUGHTS OF SUICIDE (ATTEMPTED? YES / NO)
☐DIZZINESS	☐ANXIOUS
☐LEG SWELLING	**ENDOCRINE**
☐PAIN IN LEGS WHILE WALKING	☐INTOLERANCE TO COLD / HOT
RESPIRATORY	☐EXCESSIVE THIRST #_____GLASSES OF FLUIDS DAY
☐SHORTNESS OF BREATH	☐HAIR LOSS
☐WHEEZING	☐SWEATING
☐COUGHING	☐CHANGE IN APPETITE
☐PAINFUL BREATHING	**UROLOGY**
MUSCULOSKELETAL	☐FREQUENCY – HOW OFTEN PER DAY _____
☐MUSCLE or JOINT PAIN	☐BLOOD IN URINE
☐STIFFNESS	☐DIFFICULTY or PAINFUL URINATING
☐LOSS OF RANGE MOTION	☐INCONTINENCE
☐MUSCLE CRAMPS	☐CHANGES IN URINARY STRENGTH
NEUROLOGY	**HORMONAL**
☐LOSS OF MEMORY	☐DECREASED LIBIDO
☐NUMBNESS / TINGLING	☐DIFFICULTY WITH EJACULATION / ERCTILE
☐PARALYSIS	☐ABNORMAL VAGINAL BLEEDING - MENOPAUSAL YES/NO
☐GAIT ABNORMALITY	☐HOT FLASHES
☐CONCENTRATION	☐PRE-MENSTRUAL SYMPTOMS
☐SEIZURES	☐VAGINAL DRYNESS
☐DIZZINESS / FAINTING	☐BREAST PAIN / DISCHARGE / LUMP

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PATIENT SIGNATURE: _____