Cooper Family Medical

General Information:

Patient Last Name | First Name | MI | Date Of Birth

Home Phone Number | Cell Phone Number | E-Mail Address

Home Address | City | State | Zip

_ _ Social Security # | Male Female (Please Circle) | Single Married Divorced Widowed (Please Circle)

Employer

Pharmacy

Primary Insurance Carrier | Policy ID

HMO PPO POS OTHER (Type Of Plan) | ( ) Insurance Carrier Phone #

Primary Card Holder's Name/Relation: | **DOB:**

Second Insurance Carrier | Policy ID

HMO PPO POS OTHER (Type Of Plan) | ( ) Insurance Carrier Phone #

IMPORTANT: In case of an emergency, who would we contact?

Name | Relationship

Address (Street/City/Zip) | ( ) Home Phone

( ) Cell Phone | ( ) Work #

"I understand that I am financially responsible for all charges, whether or not paid by insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give Cooper Family Medical consent to perform medical treatment."

(Patient/Guardian Signature) | Date

Cooper Family Medical

Patient Medical History

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Date of last physical exam: _____ **Previous Physician's Name:** _____

Physician's Address: _____

Past History (Personal & Allergies)

Have you had any of the following illnesses? :

	YES	NO		YES	NO		YES	NO
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous Breakdown	☐	☐
Alcohol Overuse	☐	☐	Emphysema/COPD	☐	☐	Ostomies_____	☐	☐
Allergies (Other than medications)	☐	☐	Falls	☐	☐	Paralysis	☐	☐
			Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Seizures	☐	☐
Asthma	☐	☐	HIV / AIDS	☐	☐	Sexually Transmitted	☐	☐
Bleeding Disorder	☐	☐	Heart Attack / MI	☐	☐	Diseases		
Cancer	☐	☐	Other Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
Location: _____			(CHF / CAD)			Sleep Disorder	☐	☐
Cardiac Arrhythmias	☐	☐	Hepatitis	☐	☐	Stomach Ulcers	☐	☐
Pacemaker:	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Vascular Disease	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐		☐	☐
Depression	☐	☐	Measles / Mumps	☐	☐		☐	☐

Personal Habits:

Have you ever smoked? ☐ YES ☐ NO If yes, are you a regular smoker now? ☐ YES ☐ NO

Have you used chewing tobacco? ☐ YES ☐ NO If yes, number of yrs. ____ If no, when did you quit? _____

Do you regularly drink alcohol? ☐ YES ☐ NO If yes, how often: _____

Have you used any of the following: Marijuana LSD Heroin Cocaine Speed Other

(Please Circle)

Operations: List and indicate approximate year

_____

_____

_____

Serious Injuries: List and indicate approximate year

_____

_____

_____

Hospitalizations: (Other than operations)

List and indicate approximate year

_____

_____

_____

Diagnostic Tests/Exams:

Last Test/Exam & Date	Location/Provider
Eye Exam:	
Foot Exam:	

Immunizations: (Please give date) **Hepatitis B** _____ **Flu**_____ **Polio**_____

Typhoid_____ **Smallpox**_____ **Tetanus**_____ **Pneumococcal**_____ **Chicken Pox**_____

Cooper Family Medical

Patient Last Name: **Patient First Name:** **DOB:**

Family History	Circle Sex		If Living		If Deceased	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters	M	F				
	M	F				

Check if any blood relative has or had any of the following and indicate their relationship to you:

	Please Circle		Relationship		Please Circle		Relationship
Arthritis	Yes	No		High Blood Pressure	Yes	No	
Asthma	Yes	No		Intestinal Polyps	Yes	No	
Bleeding Tendency	Yes	No		Kidney Disease	Yes	No	
Cancer	Yes	No		Leukemia	Yes	No	
Colitis	Yes	No		Migraine	Yes	No	
Congenital	Yes	No		Nervous Breakdown	Yes	No	
Heart Disease	Yes	No		Rheumatic Fever	Yes	No	
Diabetes	Yes	No		Sickle Cell Anemia	Yes	No	
Emphysema	Yes	No		Stomach Ulcers	Yes	No	
Epilepsy	Yes	No		Stroke	Yes	No	
Goiter	Yes	No		Suicide	Yes	No	
Gout	Yes	No		Tuberculosis	Yes	No	
Hay Fever	Yes	No		Other	Yes	No	
Heart Attack	Yes	No					

Medications:

- ☐ Asthma Wheezing Medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol, or Similar Products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or Heart Medicine
- ☐ Hormones
- ☐ Insulin or Diabetic Pills
- ☐ Anemia Medication
- ☐ Laxatives
- ☐ Sleeping Pills / Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach / Digestive Medicine
- ☐ Weight-Reducing Pills
- ☐ Blood Thinners or Coumadin
- ☐ Dilantin or Seizure Medications
- ☐ Water Pills or Diuretics
- ☐ Antibiotics
- ☐ Phenobarbital / Barbiturates
- ☐ Vitamins
- ☐ Other Prescription / Over the Counter Drugs

Cooper Family Medical

Patient Last Name: **Patient First Name:** **DOB:**

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medications	Dosage	How Often?	When did you start?

Are you allergic to any medications: ☐ YES ☐ NO If yes, Please list medications & the reactions.

Medication	Reaction

Cooper Family Medical

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Social and Lifestyle History: **Primary Language:** _____

(Please Circle)

Is there someone that lives in your residence?	Yes No	If yes, please list name and relationship:
Type of Residence		Apartment Mobile Home House: One Story Two Story Assisted Living Facility: Facility Name:_____ Other: _____
Durable Medical Equipment	Yes No	Wheel Chair_____ Oxygen_____ Walker_____ Nebulizer _____ Cane_____ CPAP/BIPAP_____ Other_____
Can you afford medicines?	Yes No	Potential Referral to Patient Assistance Program
Transportation provided by?		

Nutritional History:

(Current Weight)	(Current Height)	
_____ Lbs.	_____ Ft _____ In	**Weight Changes in the past 6 months?** Yes No

Current Diet Plan:

Exercise / Activity:

Current Activity	How Often
Physical Limitations:	

Activities of Daily Living:

Do you require assistance to bathe or groom?	Yes No	**If yes, Explain:**
Do you require assistance for your toilet needs?	Yes No	**If yes, Explain:**
Do you require assistance to eat?	Yes No	**If yes, Explain:**
Do you have hearing loss?	Yes No	**Do you wear hearing aids?** Yes No Last hearing exam date: _____

Additional Comments and Notes:

Cooper Family Medical

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Preventative Service History		
Preventative Services	**Date Received**	**Findings and Recommendations**
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening		Hypercholesterolemia ☐
Cholesterol ▶	_____	Hyperlipidemia ☐
LDL ▶	_____	Other ☐ _____
EKG ▶	_____	EKG Results: _____
Colorectal Cancer Screening		
Flexible Sigmoidoscopy ▶	_____	
Barium Enema ▶	_____	
Colonoscopy ▶	_____	
Fecal Occult Blood Test ▶	_____	
Diabetic Screening		
Hg A1C ▶	_____	Cataracts ☐ Other _____
Foot Exam ▶	_____	
Eye Exam ▶	_____	
Glaucoma Screening		Glaucoma ☐
PAP and Pelvic Examination		
Prostate Cancer Screening		
Digital Rectal Exam (DRE)	_____	
Prostate Specific Antigen Test (PSA)	_____	
Mammogram Screening		
Breast Self Exam ▶	_____	
Mammogram Screening ▶	_____	

_____ **Date Reviewed**

_____ **Physician Signature**

Cooper Family Medical, PLLC

5123 4th Avenue Circle East
Bradenton, Florida 34208
T: (941)744-5510
F: (941)744-5166

Patient ID:

Physician ID:

All patients must complete our Patient Payment Registration form prior to seeing our medical providers.

Payment Policy

Thank you for choosing Cooper Family Medical, PLLC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided upon request.

All Payments Due at Time of Service

Initial This office maintains a pay at time of service policy. You will need to know your insurance policy in advance in order to be aware of the portion of your visit for which you will be responsible. If you accrue a credit balance, we will maintain that credit balance on your account and apply it to any future balance that may accumulate. If a credit balances exceeds $30.00, we will refund the credit by check to the address on your account. These policies are designed to comply with the Fair Debt Collection Practices Act and any applicable state laws. If your account goes to collections we will no longer provide medical services to you, at which that time you will then be discharged from Cooper Family Medical.

Regarding Insurance

Initial Regarding insurance plans where we are a participating provider, all payments are due including but not limited to deductibles from previous visits, copay, and/or non- covered services, and will be collected upon your arrival. Your insurance policy is a contract between you and your insurance company - we are NOT party to that contract. We cannot bill your insurance unless you provide timely clear and accurate insurance information. **If you have new insurance, or a change in insurance plans, you must provide us with clear and accurate insurance information within 30 days of your visit for your insurance to be billed.** If you are unable to provide this information within 30 days you will be responsible for any visits that may have occurred.

Statements & Claim Submission

Initial We will submit your claims and assist you in any way reasonable we can help to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. We will send you a statement should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. When you receive your explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. There will be a $35 charge for check denied by your bank and returned to the office for any reason. If your account is over 90 days past due for nonpayment, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if your account remains unpaid, we may refer your account to the three major credit bureaus which may adversely effect your credit.

Minor Patients

Initial The adult accompanying a minor and the parents(or guardian) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office visit.

Divorced Parents/ Legal Custody issues

Initial The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out BEFORE your child's appointment. If a separate parent is responsible for payment, we are not party to this arrangement. Payment is due in full at the time of service, and we will prepare a receipt of payment verification purposes.

Appointment Reminders and Missed Appointments

Initial Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. We are not able to guarantee a reminder call for each visit, but we will certainly try.

Unless canceled **AT LEAST 24 HOURS IN ADVANCE**, our policy is to charge the person who is scheduled for the appointment a missed appointment fee at the rate of $35.00. Please help up serve our entire patient population best by keeping scheduled appointments. **Patients who miss three or more appointments without notice may be dismissed and may no longer receive medical treatment at our medical practice.**

Cooper Family Medical, PLLC is committed to providing the best treatment to our patients. Our prices are a representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Printed Name of Patient/Responsible Party	Signature of Patient/Responsible Party	Date

Cooper Family Medical

HIPAA Consent Form

Patient's Name(Printed) : _____ **Date of Birth:** _____

Do We Have Permission to:

Mail medical information to your home? Yes_____ No_____

Leave a detailed message on your home/cell answering machine for:

Appointment Information? Yes_____ No_____
Billing Information? Yes_____ No_____
Other Medical Information? Yes_____ No_____

Leave a detailed message on your work answering machine for:

Appointment Information? Yes_____ No_____
Billing Information? Yes_____ No_____
Other Medical Information? Yes_____ No_____

I give permission to share information with the following person(s):

Appointment Information : _____ Relation/ Phone #: _____
Billing Information: _____ Relation/ Phone #: _____
Medical Info (Including biopsy & Lab result _____ Relation/ Phone #: _____

With my consent, Cooper Family Medical may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Cooper Family Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Cooper Family Medical use and disclosure of information according to the Notice of Privacy Practices, and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize release of any medical information necessary to all my insurance companies to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment direct to Cooper Family Medical. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize use of this form for all my insurance submissions. I authorize Cooper Family Medical to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and insurance claim for submission. Under penalty of perjury, I declare that I have read the forgoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature:_____ **Date:**_____

Witness Signature(CFM Employee):_____ **Date:**_____

Cooper Family Medical

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: _____ S.S.# _____

Date of Birth _____ Patient Phone Number(s): _____

Treatment Dates to Be Released: _____

Type of Visit: Inpatient ☐ Outpatient Surgery ☐ ER ☐ Outpatient Test ☐ Therapy ☐ Other ☐

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

_____

_____

RELEASE INFORMATION TO: (*recipient of disclosure*)

Name: Cooper Family Medical
Address: 5123 Fourth Avenue Circle East
Apt, Suite or PO #: _____
City, State, and Zip: Bradenton, Florida 34208
Phone: 941-744-5510
Fax: 941-744-5166

PURPOSE OF THE DISCLOSURE: ☐ Insurance ☐ Legal ☐ Continuing Care ☐ Personal ☐ Other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

☐ Face Sheet	☐ ER Record	☐ Physician Progress Notes	☐ Other (specify)_____
☐ Consent Form	☐ Therapy Records	☐ Physician's Orders	_____
☐ Discharge Summary	☐ Radiology Report	☐ Lab Results	_____
☐ History & Physical	☐ Mammogram	☐ Abstract of all records	
☐ Operative Reports	☐ EKG	☐ Copy of Itemized Bill	
☐ Pathology Reports	☐ Consultations	☐ Radiology disc/films	

SPECIFIC INFORMATION TO NOT BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department.. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize this medical facility and/or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release this medical facility and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

_____ _____
PATIENT'S SIGNATURE **DATE**

_____ _____
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

_____ _____
WITNESS **DATE**