Gulf Coast Holistic and Primary Care Inc
Raquel Skidmore, MD

Patient Information

Dr.___ Mr.___ Mrs.___ Ms.___ Jr.___ Sr.___ Date of Birth: ___/___/___ Social Security Number: _____

Last Name: _____ First Name: _____ Middle Name: _____

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

Phone Numbers Home: _____ Work: _____ Cell: _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Male: _____ Female: _____

Employment Status: Employed _____ Self Employed _____ F/T Student ____ P/T Student _____ Unemployed _____ Retired _____

Fmplovers/Self Employee Business Name: _____

Emergency Contact Name: _____ Phone Number: _____ Relation to Patient: _____

Responsible Party Information

Last Name: _____ First Name: _____ Middle Name: _____

Social Security Number: _____ Date of Birth: ___/___/___ Phone Number: _____

Primary Insurance Information

Name of Insured: _____ Relation to Insured: _____

Insured Employers Name: _____ Phone Number: _____

Insurance Company: _____ Phone Number: _____

Subscriber ID/Policv Number: _____ Group ID: _____

Insured Date of Birth: ___/___/___ Insured's Social Security Number: _____ Co-pay Amount: _____

Secondary Insurance Information

Name of Insured: _____ Relation to Insured: _____

Insured Employers Name: _____ Phone Number: _____

Insurance Company: _____ Phone Number: _____

Subscriber ID/Policy Number: _____ Group ID: _____

Insured Date of Birth: ___/___/___ Insured's Social Security Number: _____ Co-pay Amount: _____

Pharmacy Name: _____ Phone Number: _____

How did you hear about our office? _____

Who can we thank? _____

New Patient Health Questionnaire

Parti

Name:_____ ___ Dale:_____

DOB:_____ Age:_____ New Patient_____ Established__

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person except when yon have authorized as to do so.

What medical concerns bring you to our office?_____

Marital Status: *(circle)* S M D W Occupation: *(if retired, previous occupation)*_____

If disabled, check here:____ Nature of disability_____ Birthplace:_____

Do you exercise routinely? *(circle)* No Yes If *Yes,* what exercise/how often?_____

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If *Yes:* #cigarettes/day_____ #yrs._____

If you have never smoked, skip this question: Do you still smoke now? *(circle)* No Yes If *No,* when did you quit?_____

Have you completed Advanced Directives or do you have a Living Will? *(circle)* No Yes Which?_____

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day_____

Tell us a little about your home environment *(e.g. live alone, with family, single parent, house, apt, etc.)*

_____

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which?_____

Medical Information

Allergies: Are you allergic to any drugs? *(circle)* No Yes Please list_____

Medications *(list all medications you are taking regularly. Include over the counter**;** herbal or natural remedies.)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Illnesses or Conditions *(list any chrome conditions which you have been diagnosed to have)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have yon ever had or been diagnosed to have: *(check box by all that apply)*

Cataracts		Heart Disease		Ulcos		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent infection	
Asthma		High Blood Pressure		Hemorrhoids		Boor or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease					
Stroke		TB/Lung Disease		Kidney Stonc(s)		German Measles		High Cholesterol	
Seizures/Epilepsy		Pleurisy		Diabetes or PreDiabetES		Rheumatic Fever		Prostate Fnlaigp-mwit	
Heat Attack or Angina		Jaundice or Liver Disease				Chicken Pax			
				Thyroid Disease		Syphilis			

Operations:
Please list any surgery and approximate year

Year	Surgery

Hospitalizations:
Other than operations

Year	Reason	Hospital

Family Medical History	Age	Health *(list significant illness)*	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Has any blood relative ever had? *(check if Yes and indicate relationship)*

___Alzheimer's_____ __ Heart Attack before age 55. ____ ___ Alcoholism _____
___ Tuberculosis_____ ___Bleeding Disease_____ ___ Mental Disorder _____
___Diabetes_____ ___ Stroke_____ ___ Allergies_____ _____
___ High Blood Pressure_____ ___Seizures_____ ___ Asthma_____ _____
___ Heart Disease_____ __ Depression/Suicide_____ ___ Cancer_____ _____

Immunizations *(check if Yes and indicate year of last injection)*

__ Influenza_____ _____Pneumonia_____ ____ MMR_____
__ Tetanus_____ _____Hepatitis A or B_____ ____ Other_____

Transfusions: Have you ever had a blood or plasma transfusion *(circle)* No Yes

Weight: What is your weight now?_____ One year ago?_____ Maximum?_____ When?_____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of last menstrual period?_____

New patient questionnaire

Please continue to the next page

'"New Patient Health Questionnaire

Part 2

Name:_____ **DOB/ED:**_____ ____

Systems Review: Please indicate those items that have been a recurrent or a recent significant change.

Yes No

Constitutional Symptoms

___ ___ Good health lately
___ ___ Recent significant weight change
___ ___ Unusual fatigue or weakness
___ ___ Frequent headaches

Eyes

___ ___ Change in vision
___ ___ Blurred or double vision
___ ___ Eye disease or injury
___ ___ Wear glasses/contact lenses?

E^i^/Nose/Moiith/Throat/Neck

___ ___ Do you wear hearing aids?
___ ___ Hearing loss or ringing in ears?
___ ___ Earaches or drainage?
___ ___ Chronic sinus problems or runny nose
___ ___ Nose bleeds
___ ___ Mouth sores
___ ___ Bleeding gums
___ ___ Sore throat/hoarseness or voice change
___ ___ Lumps or swollen glands in neck
___ ___ Difficulty swallowing
___ ___ Neck pain or stiffness

Cardiovascular

___ ___ Heart trouble
___ ___ Chest pain or angina pectoris
___ ___ Palpitations
___ ___ Shortness of breath with walking or lying flat
___ ___ Swelling feet, ankles or hands
___ ___ Waking at night with shortness of breath

Respiratory

___ ___ Chronic or frequent cough
___ ___ Coughing or spitting up blood
___ ___ Shortness of breath
___ ___ Asthma or recurrent wheezing

Gastrointestinal

___ ___ Loss of appetite
___ ___ Change in bowel movements
___ ___ Nausea or vomiting
___ ___ Painful bowel movements or constipation
___ ___ Frequent diarrhea
___ ___ Rectal bleeding or blood in stool
___ ___ Stomach/abdominal pains or heartburn
___ ___ Black or tarry stools

Comments:_____ ___ __

_____

_____

Yes No

Genitourinary

___ ___ Frequent urination
___ ___ Burning or pain on urination
___ ___ Blood in urine
___ ___ Change in force or strain when urinating
___ ___ Incontinence or dribbling of urine
___ ___ Sexual difficulties
___ ___ Men: Testicular pain
___ ___ Women: Painful periods
___ ___ Irregular periods
___ ___ Recurrent vaginal discharge

Number of pregnancies (including miscarriages):_____ __

_____ # Deliveries _____ #Miscarriages

Method of birth control (if applicable)_____ __

Menopausal, since when:_____ __

Date of last menstrual period:_____ __

Date of last pap smear_____ __

Date of last mammogram:_____ __

Yes No Musculoskeletal

___ ___ Joint pain(s)
___ ___ Joint stiflhess/swelling or warmth
___ ___ Weakness of muscles or joints
___ ___ Muscle pain or recurrent cramps
___ ___ Back pain
___ ___ Cold hands or feet
___ ___ Difficulty in walking

Integumentary (Skm/Breast)

___ ___ Rashes or itching
___ ___ Change in skin color or moles
___ ___ Change in hair or nails
___ ___ Varicose veins
___ ___ Breast pain
___ ___ Breast lump
___ ___ Breast discharge or rash

Neurological

___ ___ Frequent, recurring or increasing headaches
___ ___ Light-headedness or dizziness
___ ___ Convulsions, seizures or spasms
___ ___ Numbness or tingling sensations
___ ___ Tremors
___ ___ Paralysis
___ ___ Stroke
___ ___ Head injury

Please complete other side of form: *Over please*

Yes	No		Yes	No	
		Psychiatric			**Allergic / Immunologic**
___	___	Memory loss or confusion	___	___	History of skin reaction or other adverse reaction to:_____
___	___	Nervousness			
___	___	Insomnia	___	___	Penicillin or other antibiotic: describe reaction:_____
___	___	Depression			
			___	___	Morphine, Demerol or other narcotics reaction:_____
		Endocrine			
___	___	Glandular or hormone problem	___	___	Novocain or other anesthetics **reaction:**_____
___	___	Heat or cold intolerance			
___	___	Excessive skin dryness	___	___	Aspirin or other pain remedies reaction:_____
___	___	Excessive thirst or urination			
___	___	Change in hand or glove size	___	___	Tetanus antitoxin or other serums
			___	___	Iodine, methiolate or other antiseptic
		Hematologic / Lymphatic	___	___	Other medications:_____
___	___	Slow to heal after cuts or wounds	___	___	Other known food allergies_____
___	___	Bleeding or bruising tendency			
___	___	Recurrent anemia			_____
___	___	Swelling, warmth or tenderness of veins or history of phlebitis			

Comments:_____

Patient signature:._____ Reviewed by:._____

Date:_____ Date:_____

Hx:_____

Physician Signature:._____ Date:_____

New patient questionnaire

Controlled Substance Prescribing Treatment Protocol

The intent of this protocol is to establish a comprehensive and routine approach to the care of any patient who is prescribed a Schedule 2, 3, or 4 medication. The objective of this policy is to determine level of adherence to both pain and general medical management plans (medications, physical therapy, lifestyle interventions, etc.) and to evaluate for appropriate boundaries in a therapeutic relationship.

To ensure understanding and universal terminology below are a few general definitions to utilize while following this protocol:

New Patients: Any patient who is new to Gulf Coast Holistic Primary Care or is returning the practice after a time frame of more than three years.

Established Patients: Any Patient who has been treated for any reason at Gulf Coast Holistic Primary Care within the last three years.

Controlled Substance: Any medication that is classified by law as a schedule 2, 3, or 4 medication.

Long-Term Controlled Substance Prescribing: Treatment with controlled substances for any condition considered Non-Malignant pain in excess of 90 days.

Controlled Substance Agreement: An agreement between the Patient, Provider, and Practice to comply with the law and prevent misunderstanding regarding the prescribing and use of controlled substances.

Disruptive and/or Disorderly Behavior: Any patient who becomes verbally or physically abusive to staff and/or any other patients, any patient who calls the office in a harassing manner.

Buddy Visits: When you are seeing a scheduled patient who has a friend or relative accompanying them and that person may be a patient of the practice or they may be a Non-patient but they are asking to have medications filled or prescriptions given during this time.

Addictive Behaviors: Those patients who exhibit a need for increase dosages and/or seek additional prescription coverage due to taking more frequently than prescribed.

New patients- It is required that prior to prescribing a controlled substance providers record an accurate and detailed history of the patient's long-term controlled substance use as well as a general medical history. The documentation of this history must include but is not limited to the following; detailed relevant medical records from previous provider (must be submitted from medical office directly, no hand carried records shall be accepted) records must include proper diagnostic testing to assess condition, if proper diagnostic testing is not evident then testing must be ordered and results must be reviewed to assess expected outcome and proper treatment. Initial drug screening must be performed and instant read results must be reviewed, report must be generated using the centralized data base in place in the state of Florida, patient and provider must sign controlled substance agreement.

General Visits - Effective immediately all patients' whether established or not must undergo any portion of the New Patient protocol that cannot be found in their medical record at Gulf Coast Holistic Primary Care. In addition to the parameters mentioned for new patients there are additional rules that must be upheld when treating patients with controlled substances. They are as follows;

- The maximum amount of medication that any patient can be given at one interval cannot exceed a 90 day supply, additionally no posted dated or "hold until or fill on ..." prescriptions may be issued.
- Any patient prescribed more than 2 controlled substances for the treatment of pain or discomfort for more than a 90 day period must be referred for a comprehensive pain management evaluation, consult, and/or pain management specialist.
- **ALL** patients must be seen at least every 90 days.
- No refills will be issued for controlled substances at any point without an office visit and evaluation by a FPA-OP Provider, no exceptions.
- No Controlled prescriptions will be called in to a pharmacy.
- All controlled prescriptions will be printed, signed, and scanned into EMR with provider signature.
- For all prescriptions, controlled and non-controlled - only the provider, under their login, will execute the print, fax, and e-prescribe within the EMR.
- Any prescription that is printed in error and/or a duplicate print will be voided by writing directly on the prescription and indicating the reason for the reprint and scanned into the EMR. The voided duplicate paper copy will be submitted to the Clinical Supervisor immediately for reconciliation.
- Any prescription, controlled and non- controlled, written outside of the EMR must be copied and given to the Clinical Supervisor for documentation and tracking.
- Functional goals will be established and pain response to treatment will be assessed. Other modalities may be required to help reach treatment goals (physical therapy, consultation with appropriate specialist including interventional pain management).
- Considerations for referral to comprehensive pain management center will be made if patient fails to reach functional goals despite adherence to the treatment plan.
- Patients who exhibit addictive behaviors or exhibit cognitive functional deficits will be referred to a specialist as deemed appropriate.
- Annual review of treatment plan will be conducted. Functional progress, treatment plan, medication management, and other modalities will be determined as indicated.
- Routine/ Random Urine Drug screens are required. All new patients must submit an initial urine drug screen prior to the initial prescription of a controlled medication. All established patients must undergo urine drug screening a minimum of two screenings per calendar year, or as indicated for therapy compliance. One screening should occur randomly between January-June and a one should occur between July-December.
- Any violation of the conditions in the controlled substance agreement will result in discharge from the practice with a 30 day written notice. Prescriptions for controlled medications will cease immediately.
- If patients are routinely treated by a Physician Assistant or Nurse Practitioner the requirements are the same as well as the applicable practice act of the professional will be observed. The signing Physician is ultimately responsible for the controlled substances provided.
- Patient should be thoroughly educated on the potential risks associated with long-term use of controlled substances and documented in the medical record.
- There will be no replacement of lost, stolen, or misplaced prescriptions.

Effective July 1, 2011, the Florida Department of Health, signed by Governor Rick Scott: Patients that are prescribed controlled substance medication will have regular follow up appointments every three (3) months order to be prescribed and continue use of controlled substances.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

___1.1 **am responsible for the controlled substance medications prescribed to me.** If my prescription is, misplaced, stolen, or if "I run out early", I understand that this **medication will not be replaced.**

___2. Refills of controlled substance medications:

___a. Will be made only during regular office hours **Monday through Friday, in person, once a month, and during a scheduled office visit.** Refills will not be made at night, weekends, or during holidays.

___b. Will not be made if "I lost my prescription", ran out early, or misplacement of medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

___c. I understand that I must call ahead within 72 hours to schedule an appointment.

___3. **I** agree to **use a single pharmacy in the State of Florida,** as listed below, for all of my controlled substance prescriptions. In the event my prescribed medication is unavailable at the pharmacy indicated below, I will immediately notify Gulf Coast Holistic Primary Care prior to filling my prescription at a different pharmacy.

_____Pharmacy located at_____ Telephone Number_____

__4. I will not share, sell, or trade my medication with anyone.

__5. It may be deemed necessary by my doctor that I see a medication-use specialist at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.

__6.1 agree to comply with random urine drug testing, documenting the proper use of any medications and that it is my responsibility to comply with the laws of the state while taking prescribed medications. I understand if my drug testing results reveal medication that is not prescribed to me, including but not limited to illicit drugs, or absence of medication that is prescribed to me, is a violation of this agreement.

__7.1 understand if I violate any of the conditions in this agreement, my prescriptions for controlled medications will be terminated immediately and I will be given a 30 day notice of discharge from the practice. If the violation involves obtaining these medications from another individual, or combining use of non-prescription illicit (illegal) drugs, including but not limited to marijuana, cocaine, etc., I may also be reported to all my physicians, medical facilities, pharmacies, and the appropriate authorities.

__8. I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

__9.1 understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances and that my physician will advise me of advances in the field and will make necessary treatment changes.

- There will be no early refills.
- There shall be no "buddy visits" for any reason.
- Any patient who becomes disruptive, disorderly, harassing, loud or abusive to other patients, staff or medical providers will be asked to leave the premises and security measure will be taken. Displays of such behavior will be grounds for termination from medical treatment service and ultimately the practice.

Our goal is to provide quality patient care in the most therapeutic, conducive and effective manner possible. **Any Provider or Staff Member who identifies suspicious activity indicating non compliance to this protocol is to report their findings to their supervisor immediately.**

Monitoring Process

Periodic Random compliance reviews of the Controlled Substance Prescribing Treatment Protocol will be conducted to assure protocol compliance.

Review to include but is not limited to:

- Prescription Log Report from EMR
- Medical Record to assure appropriate documentation and documented treatment plan, as well confirming regular visits and appropriate urine drug screening intervals are completed in accordance to protocol.
- Florida Centralized Database report
- Physician Peer Review as necessary

Failure to follow and comply with this protocol will result in disciplinary action up to and including termination of employment.

By signing below I attest that I have read and the above protocol has been reviewed with me, I verbalize understanding of the same. If at any point clarification is needed I will consult my supervisor prior to proceeding and/or the Practice manager, and/or the Clinical Supervisor.

Print:_____

Sign:_____

Date:_____

According to Florida State Law (893.13) Section 7, it is illegal for persons to see multiple physicians to obtain controlled substance medications or a prescription for a controlled substance medications. To do so is in clear violation of Florida laws regarding drug abuse and can result in arrest. We, at Gulf Coast Holistic Primary Care will assist the sheriffs office in all aspects regarding this law.

I give my consent to Gulf Coast Holistic Primary Care and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Gulf Coast Holistic Primary Care. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by Gulf Coast Holistic Primary Care without order of clerk of court.

I have been fully informed by Gulf Coast Holistic Primary Care regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and that is a risk of becoming physically dependent on the medication. This will occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, 1 must do so slowly and under medical supervision, or I may have withdrawal symptoms.

I have thoroughly read this agreement and the same has been explained to me by my doctor at Gulf Coast Holistic Primary Care. In addition, I understand the consequences of violating this agreement.

Date: _____

Patient Name: _____

Patient Signature: _____

Provider Name: _____

Provider Signature: _____

Gulf Coast Holistic and Primary Care Inc.
Raqticl Skidmore, MD

219 Forest Park Circle, Panama City, FL

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, a patient of this practice may be used and disclosed and how you have access to this information. Please review this notice carefully.

Our Commitment to Privacy
Gulf Coast Holistic and Primary Care Inc. is dedicated to maintaining the privacy of its patients protected health information (PHI). We are required by law to maintain the confidentiality of this health information. We are also required by law to provide you with the notice of our legal duties and the privacy practices that wc maintain in our practice concerning PHI. We reserve the right to amend our Notice by Federal and State Law. we must follow the terms of the notice of Privacy Practices that wc have in effect all the time.

Use and Disclosure of PHI
Our practice may use and disclose PHI for the purpose of treatment, payment and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes
•Treatment * Payment *Health Care Operations * Release or Sharing of Information ‘Research Purposes
•The Rights of Minor's and Personal Representatives *Rclcasc of Information to Business Associates *Marketing Purposes
•Release of Information Required by Law

Your Health Information Rights
•Requesting Restrictions on PHI •Inspection and Copies of PHI •Amendment of PHI * Accounting or Disclosures
•Right to a Paper copy of this Notice ‘Right to File a Complaint ‘Right to Provide Authorization of Other Uses/Disclosures

If you have questions regarding the notice or our health information privacy policies, please contact Dr Raqucl Skidmore at 850-640-1530.

AUTHORIZATION FROM TO SHARE "PROTECTED HEALTH INFORMATION”

Purpose:
To permit Dr. Raqucl Skidmore to respond to patient inquiries regarding Protected health Information

Section I
Patient who's Protected Health Information may or may not be disclosed
Name:_____ Date of Birth:_____

Section II
Identify the pcrson(s) with whom your information may be shared and their relationship to you.
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Section III
How would you like your information to be left if we are unable to speak with you (check all that apply)?

( ) Home Telephone:_____ ( ) Written Communication
( ) Ok to leave message with detailed information ( ) Ok to mail to my home address
( ) Leave message with call back number only ( ) Ok to mail to my work address

( ) Work Telephone:_____

( ) Ok to leave message with detailed information
( ) Leave message with call back number only

Section IV
This Authorization will expire on:_____

_____ _____
Signature of Patient and/or Legal Representative Date

GULF COAST HOLISTIC AND PRIMARY CARE

219 Forest Park Circle, Panama City, FL

Office: 850-215-9418, FAX: 850-215-9419

I,_____, acknowledge that I have been informed that Gulf Coast Holistic and Primary Care,

Dr. Raquel Skidmore MD, does not carry medical malpractice insurance.

Patient Name (print)._____

Patient Signature__ _____

Date_____

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Name:_____ Date of Birth:_____ _____

Address:_____City:_____ State:_____ Zip: _____

Phone Number:_____

From: 1_____ _____

Address_____ _____

Phone/fax # _____

From:2_____ _____

Address_____ _____

Phone/fax #_____ _____

Information to be Released:

( ) Office Note(s)
( ) X-Ray Report(s)
( ) Laboratory Report(s)
From:_____ To:_____

( ) Entire Record
( ) Hospital Record(s)
( ) Other (specify)_____
_____

Please release the above information to:
Raquel Skidmore, MD/Gulf Coast Holistic and Primary Care Inc.

219 Forest Park Circle, Panama City, Florida 32405
Phone Number: (850) 215-9418
Fax Number: (850) 215-9419

Purpose of Disclosure
_____Further Medical Treatment _____ Changing Physician
_____Other (specify)_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this information to be used or disclosed as provided in CFR 164.524

Signature of Patient or Legal Representative _____ Date _____

Relationship to Patient if signed by other than patient _____ Witness _____

DISCLOSURES & CONSENTS

(Please read the following, initial each one, sign and date at the bottom)

CONSENT FOR TREATMENT, PAYMENT & OPERATIONS

Dr. Raquel Skidmore is committed to protecting your health information related to your medical treatment, payment for your treatment, and/or health care operations related to your treatment. Our "Privacy Notice" is posted in the waiting room for review.

____Initial I hereby consent to evaluation, testing and treatment as directed by Gulf Coast Holistic & Primary Care Inc. healthcare provider or his/her designee.

____ Initial I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my Protected Health Information may be shared with the people listed and that they may not be required to comply with federal health information privacy laws and may use and further is close any of my Protected Health Information they receive. I am also signing below that I have received a copy of the Privacy Notice.

CONSENT FOR TREATMENT OF A MINOR CHILD (PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE)

__ __Initial As the parent or legal guardian of the minor patient_____ (patient's name), I hereby give consent to evaluation, testing and treatment as directed by my Gulf Coast Holistic & Primary Care Inc. healthcare provider or his/her designee.

INSURANCE. ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

___Initial I, the undersigned, certify that I (or my dependent) have insurance coverage with the carricr(s) stated and assign directly Dr. Raquel Skidmore all insurance benefits, if any. otherwise payable to me for services rendered in Medicare assigned cases, the responsible for the deductible, coinsurance and/or non-covered services. I hereby authorized Dr. Raquel Skidmore to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___ Initial I hereby assign to Gulf Coast Holistic & Primary Care Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that Gulf Coast Holistic & Primary Care Inc. has the right to refuse or accept assignment of such benefits. If these benefits arc not assigned to Gulf Coast Holistic & Primary Care Inc. I agree to forward to Gulf Coast Holistic & Primary Care Inc. all health care insurance and other third party payments that I receive for services rendered to me immediately upon receipt

MEDICARE/CHAMPUS/TRICARE INSURANCE BENEFITS

___ Initial I certify that the information given by me in applies for payment under these programs is correct. I authorize the release of any of my medical records that these programs may request. I hereby direct that payment of my benefits be made directly to Gulf coast Holistic & Primary Care Inc.. Raquel Skidmore. MD on my behalf.

INJECTIONS'LAB/X-RAY/DIAGNOSTIC SERVICES

___ Initial I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are no reimbursed by my insurance for whatever reason.

PAYMENT

___ Initial Claims not paid within a timely manner (90 days) by my insurance company, become my fully responsibility.

___ Initial Full payment for all co-pays deductible and non-covered services are expected at the time of the appointment. Cash patients are responsible for the entire charge of their visit at the time of service.

____ Initial Past due balances, prescriptions will not be administered to any patient who has a past due balance of 90 days or more.

___ Initial There will be a S30 charge for any returned checks. If there is a history of 2 returned checks all visits will require cash or credit card payment.

APPOINTMENTS/MISSED VISITS

___ Initial It is the patient's responsibility to know the date and time of his/her appointment. We do not make appointment reminder calls. There will be a $20 charge for all missed visits unless there is a 24 hour notice for appointment cancellations.

REFILLS

__ __Initial All prescription refills require an office visit. We do not call in or fax in refills . All patients must be seen. Please keep this in mind while visiting our provider. Sometimes our pharmacy will give you enough "courtesy" meds until your appointment time, p-lease check with your pharmacy if your appointment is within 1 -2 days of your prescription running out.

Patient Signature:_____ Date:_____

If someone else is signing this authorization form on behalf of the patient, please provide the following information:
Representative Signature:_____ Date:_____
Relationship to the Patient:_____

Right to Revoke

I understand that I may cancel my authorization at any time by giving written notice to the office. I further understand that cancellation of my authorization will not affect any action taken by Dr. Raquel Skidmore prior to receiving my written notice of cancellation.

Signature of Patient/Legal Guardian:_____