Julie Ann Floyd, MD
2784 N. Roosevelt Blvd.
Key West, FL 33040
(305) 292-4970

PATIENT INFORMATION

PATIENT'S NAME:_____ PHONE:( )_____DATE OF BIRTH:_____
FIRST MI LAST
ADDRESS:_____ CITY, STATE, ZIP:_____

SS#:___-____-_____MARITAL STATUS:_____ SEX:___M ___F BIRTHPLACE:_____

PATIENT'S EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____ PHONE NUMBER:( )_____

SPOUSE'S NAME:_____ DATE OF BIRTH:_____ SS#:___-____-___

SPOUSE'S EMPLOYER:_____ PHONE NUMBER:( )_____

EMERGENCY CONTACT NAME: _____ PHONE NUMBER:( )_____

REFERRED BY:_____ FAMILY PHYSICIAN:_____

****IF THE PATIENT IS A MINOR:
MOTHER'S NAME: _____PHONE NUMBER:( )_____
EMPLOYER:_____ WORK PHONE NUMBER:( )_____
FATHER'S NAME: _____PHONE NUMBER:( )_____
EMPLOYER:_____ WORK PHONE NUMBER:( )_____

INSURANCE INFORMATION

PRIMARY INSURANCE GUARANTOR: _____DATE OF BIRTH:_____

PRIMARY INSURANCE COMPANY:_____
POLICY, GROUP, AGREEMENT NUMBER:_____
GUARANTOR SOCIAL SECURITY NUMBER:_____

SECONDARY INSURANCE GUARANTOR: _____DATE OF BIRTH:_____

SECONDARY INSURANCE COMPANY:_____
POLICY, GROUP, AGREEMENT NUMBER:_____
GUARANTOR SOCIAL SECURITY NUMBER:_____

WORKMAN'S COMPENSATION INFORMATION

WORK RELATED INJURY? _____YES _____NO DATE OF INJURY:_____

PLACE OF INJURY: _____
DID YOU RECEIVE A PAYMENT FROM WORKMAN'S COMPENSATION? _____YES _____NO

AUTO LIABILITY INFORMATION

AUTO RELATED INJURY? _____YES _____NO DATE OF INJURY:_____

AUTO INSURANCE INFORMATION: _____

Patient History

Your name:_____ Age:_____ Today's date_____

Current problem:_____

Height:_____ Weight:_____

What treatment have you received for this problem?_____

Have X-rays or MRIs been taken? _____ Where were they taken?_____

What physicians have you seen for this problem?_____

What are your current medications and doses?

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Medical History

Please circle all that apply:

Asthma, COPD	Thyroid Disease	Seizures
Cancer (Type-)	Heart Disease, Heart Arrack	Blood Transfusion
High Blood Pressure	HIV Positive	Stroke
Kidney Disease	Diabetes	Stomach Ulcers
Liver Disease	Hepatitis	Heart Pacemaker
Eye Problems	Ear Problems	Neck Injury
Osteoporosis	Skin Disorders	Depression

Allergic to medications: _____Yes _____No

Which medications:_____

Previous surgeries:_____

Family medical problems:_____

Smoke cigarettes; chew tobacco: _____Yes _____No Drink alcohol:_____

I certify that all information listed above is, to the best of my knowledge, true and correct:

Patient signature:_____ Date:_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Julie Ann Floyd, M.D., to release any and all medical information requested by the insurance companies, other third-party payers, or their reviewing agencies.

Signature: _____

Date:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign to Julie Ann Floyd, M.D., all professional benefits due under the provisions of all third party policies. I hereby direct these insurers to pay benefits directory to Julie Ann Floyd, M.D.

Signature: _____

Date:_____

COMPLETE ONLY IF MEDICARE PATIENT

MEDICARE RELEASE OF INFORMATION AND ASSIGNMENT

I request that payment of authorized Medicare benefits be made to Julie Ann Floyd, M.D., for any services furnished to me. I authorize any holder of medical information about me to release to Dr. Julie Ann Floyd, MD/Tropical Wellness any information needed to determine these benefits or the benefits payable for related services.

Signature: _____

Date:_____

Witness:_____

Date:_____

Your signature below indicates you understanding your financial responsibility of all charges, whether covered or not covered by insurance.

_____ _____

Responsible Party Signature Date

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosers of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections about this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review out privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature:_____ Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to out employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.