PATIENT CONSENT FOR TREATMENT AND FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I authorize medical treatment as deemed necessary and appropriate by the physicians of *South Tampa Immediate Care* and their employees participating in my care.

With my consent, *South Tampa Immediate Care* may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the South Tampa Immediate Care's **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

With my consent, *South Tampa Immediate Care*, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, *South Tampa Immediate Care* may relay any items that assist the practice in carrying out treatment, payment or healthcare operations such as appointment reminders, insurance items, statement reminders and any information pertaining to my clinical care, including laboratory results among others, to:

With my consent, I authorize *South Tampa Immediate Care* to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that *South Tampa Immediate Care* restrict how it uses or discloses my PHI to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to *South Tampa Immediate Care*. I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment, co-pay, deductible, all other charges determined to be patient responsibility or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize *South Tampa Immediate Care* to submit a claim to the insurance company on my behalf and/or release pertinent information to my health insurance companies required in the course of my examination or treatment.

I understand that it is my responsibility to report any change in my condition and/or return to *South Tampa Immediate Care*.

I authorize *South Tampa Immediate Care* to down load my medication history from a pharmacy clearinghouse.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, *South Tampa Immediate Care* has the right to decline to provide treatment to me.

I understand that if labs are needed to be performed, I will receive a separate bill from the outside lab for those services. I understand it is my responsibility to know what laboratory that is preferred.

By signing this form, I am consenting *South Tampa Immediate Care's* use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

Patient OR Legal Guardian Signature _____ **Date** _____

Printed Name of Patient OR Legal Guardian _____ **Relationship to the Patient** _____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at **South Tampa Immediate Care**, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with **South Tampa Immediate Care** to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date

South Tampa Immediate Care
602 S. Howard Ave
Tampa, FL 33606

Date: _____

Reason for Visit: _____

Is this a Work-related problem?___YES __NO or AUTO ACCIDENT related? ___YES __NO

Last Name: _____ First Name: _____ M.I. ____

Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Age: _____ Sex: _____ Social Security # _____

Cell Number: _____ **Home Numbers:** _____

Race:_____ Primary Language: _____ Hispanic: YES NO

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Employer: _____ Occupation: _____

Primary Insurance: _____ Member ID #: _____

Secondary Insurance:_____Member ID #: _____

Patient's Relationship to Insurance Subscriber (please circle one): Self Spouse Dependent Other

Subscriber Name (if different from patient): _____Subscriber Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Telephone: _____

PLEASE LIST A PHARMACY OR CHECK ONE FROM THE LIST PROVIDED BELOW
NOTE: Please keep in mind the hours of the pharmacy when making your selection.

Pharmacy Name: _____ City: _____

Cross Roads: _____

Pharmacies in the area:

□ Walgreens Henderson/Swann	□ CVS Howard/Swann	□ CVS Henderson/Lois	□ Walgreens Platt St	□ Publix S Dale Mabry/Neptune

PLEASE LIST PERSON(S) THAT WE CAN SPEAK WITH ON YOUR BEHALF
(PLEASE LIST BOTH PARENTS OR GUARDIANS FOR MINOR PATIENTS)

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

South Tampa Immediate Care

Patient Health History

Patient Name:_____ DOB:_____ Date:_____

Reason for visit: _____

Current Symptoms:

Fever/Chills	Yes No	Rash/Itching	Yes No	Change in vision	Yes No	Abnormal Heartbeat	Yes No
Chest Pain	Yes No	Shortness of Breath	Yes No	Weight Loss/Gain	Yes No	Abdominal Pain	Yes No
Diarrhea	Yes No	Nausea/Vomiting	Yes No	Muscular Pain	Yes No	Urinary Frequency	Yes No
Headache	Yes No	Joint Pain	Yes No	Joint Swelling	Yes No	Urinary Urgency	Yes No
Cough	Yes No	Sore Throat	Yes No	Swollen Glands	Yes No	Burning on Urination	Yes No
Change in Hearing	Yes No	Sinus Congestion	Yes No	Ringing in Ears	Yes No	Vaginal/Penile Discharge	Yes No

Any Allergies to Medications: Yes [ ] No [ ] _____

Patient History:

Stroke	Yes No	Heart Trouble/Disease	Yes No	High Blood Pressure	Yes No	Diabetes	Yes No
Arthritis	Yes No	Gout	Yes No	Seizures/ Epilepsy	Yes No	Mental Health Illness	Yes No
Kidney Trouble/Stones	Yes No	Cancer	Yes No	Bleeding Disorder	Yes No	Alcoholism	Yes No
Serious Injuries	Yes No	Lung Disease	Yes No	Tuberculosis	Yes No	Heartburn	Yes No
Anemia	Yes No	Stomach Ulcers	Yes No	ADHD	Yes No	Thyroid Trouble	Yes No
HIV	Yes No	Hepatitis	Yes No	Osteoporosis	Yes No	Autoimmune Disease	Yes No
Asthma	Yes No	Hearing Trouble	Yes No	Anxiety/Depression	Yes No	Gastrointestinal Disorder	Yes No
Seasonal Allergies	Yes No	High Cholesterol	Yes No	Migraines	Yes No	Chronic Back Pain	Yes No

Explain Yes answers:

_____

_____

*Current Medications/Vitamins:*_____

_____

*Previous Surgeries:*_____

_____

[ ] Married [ ] Single [ ] Divorced [ ] Widowed Number of Children:_____ Presently Living Alone: [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No How many packs?_____ Alcohol: [ ] Never [ ] Occasionally [ ] Moderate to Heavy

Do you use recreational drugs? [ ] Yes [ ] No Female Patients Only: LMP:_____

Vitals: *For Medic Use Only*

Height_____ Weight_____ Temp_____ RR_____ HR_____ BP_____ O2_____

CC:_____

_____