NEW PATIENT QUESTIONNAIRE

Name:_____ Today's Date:_____
(Last) (First) (Middle Initial)

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐Electronic ☐Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a <u>personal</u> history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/GYN Exam in the last year
( ) Mammogram in the last 12 months
( ) Bone Density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy Removal of Ovaries
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:_____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer Type:_____ Year: _____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

FEMALE MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. ***Please mark only ONE box.***

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6.	**Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

_____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

_____

_____

FOR OFFICE USE ONLY

CHART ID:_____ **DOB:**_____ **APPT DATE:**_____

Rev Jan 2022

Freedom Family Practice

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation with Freedom Family Practice.
2. I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with Freedom Family Practice and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through Freedom Family Practice will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.
8. Telemedicine services offered through Freedom Family Practice is not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.
9. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
- That I have had the opportunity to ask questions and have had them answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ Date:_____

2929 Lakeland
Highlands Rd
Suite A2
Lakeland, FL 33803

Phone: 863-500-9279
Fax: 863-583-0499
Email: Freedomfamilypracticellc@gmail.com
Website: Https://yourfreedomfamily.com

Assignment of Benefits

I, _____, hereby assign and transfer all medical insurance benefits, if any, available under my policy to Freedom Family Practice, for services provided to me by said provider.

Insurance Company: _____

Policy Holder: _____

Policy Number: _____

Group Number: _____

Effective Date: _____

I authorize payment directly to Freedom Family Practice for medical benefits otherwise payable to me under the terms of my insurance policy for services rendered.

This assignment will remain in effect until revoked by me in writing.

Signature: _____

Date: _____

2929 Lakeland
Highlands Rd
Suite A2
Lakeland, FL 33803

Phone: 863-500-9279
Fax: 833-449-5257
Email: Freedomfamilypracticellc@gmail.com
Website: Https://yourfreedomfamily.com

Release of Billing Information Form

I, _____ authorize the release of my billing information to:

Freedom Family Practice
2929 Lakeland Highlands Rd.
Lakeland, FL, 33803

The purpose of this release is for the billing information to be released for insurance claim processing, legal purposes, personal records, etc.

Please release the following information related to my medical services:
- Itemized billing statements
- Procedure and diagnosis codes
- Payment history

I understand that by signing this authorization, I am permitting the disclosure of my billing information as governed by applicable laws and regulations.

This authorization shall remain valid until the patient determines a specific end date or "until further notice" if indefinite.

Signature: _____

Date: _____

2929 Lakeland
Highlands Rd
Suite A2
Lakeland, FL 33803

Phone: 863-500-9279
Fax: 863-583-0499
Email: Freedomfamilypracticellc@gmail.com
Website: Https://yourfreedomfamily.com

Medical Records Release Authorization

I, _____Date of Birth: _____ hereby authorize the release of my medical records from:

_____

_____

_____

To: Freedom Family Practice
2929 Lakeland Highlands Rd
Lakeland, FL, 33803
Telephone: (863) 500-9279
Fax: (863) 583-0499

Please release all medical records including but not limited to:
- Doctor's notes
- Test results
- Imaging reports
- Medication history

Please release the medical records for _____ for continuation of care, legal proceedings, personal records, etc.

I understand that by signing this authorization, I am permitting the disclosure of my protected health information (PHI) as governed by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws.

This authorization shall remain valid until further notice, or the patient determines a specific end date.

Signature: _____

Relationship to patient: _____

Date: _____

Freedom Family Practice

2929 Lakeland Highlands Rd
Suite A2
Lakeland, FL 33803

Phone: 863-500-9279
Fax: 863-583-0499
Email: Freedomfamilypracticellc@gmail.com
Website: Https://yourfreedomfamily.com

Vaccination Record Release Acknowledgment

By signing below, I acknowledge and authorize the release and sharing of my immunization and vaccination records with Florida SHOTS (State Health Online Tracking System) for the purpose of maintaining accurate public health records and ensuring proper continuity of care.

I understand that this information will be used in accordance with state and federal privacy laws.

Signature: _____

Printed Name: _____

Date: _____

Freedom Family Practice

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact the Office Manager.

Effective Date: January 11, 2024
We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **yourfreedomfamily.com**

Uses and Disclosures of Protected Health Information
We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. EXAMPLE: Your PHI may be provided to a specialist to whom you have been referred for evaluation to ensure that the specialist has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your

health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

• We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.

• We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

• We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

• Marketing

• Disclosures of for any purposes which require the sale of your information

• Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception:

we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct

along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact: Freedom Family Practice, Attn: Office Manager, 2929 Lakeland Highlands Rd, Lakeland, FL, 33803, 863-500-9279

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.
This notice was published and becomes effective on January 15,2024.