Spikes Medical, LLC

Rachel Spikes, ARNP
2633 Hwy 77, Suite A
Panama City, FL 32405
Phone: 850-481-0846
Fax: 850-481-0596

Dear Patient:

Welcome to my practice. I'm honored to be your healthcare provider, and I'm committed to providing you with the best care I can. My hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. I will share my medical expertise with you, and I hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being. Few of us, myself included, have a completely healthy lifestyle, but each day we can take a step closer to a healthier life. Here are a few tips toward better health:

- Don't smoke cigarettes or use other tobacco products.
- Drink alcohol in moderation, if at all, and never drive when you've been drinking.
- Eat a diet low in fat and high in vegetables and fruits.
- Exercise at least three times a week.
- Learn about ways to deal with stress and tension.
- Discover what spirituality means to you and practice it.
- Maintain ties with your family, neighbors, co-workers or your church community.

Advanced Registered Nurse Practitioners, (ARNP's) are nurses with an advanced degree and have been providing quality care for over 45 years with a focus on health promotion, disease prevention and providing health education. In addition, ARNP's can order, perform and interpret test results, diagnose and treat illness. In accordance with state law, **we do not prescribe controlled substances**. In the event that your health requires attention that is greater than my area of expertise, you will be referred to a specialist who can better serve your healthcare needs.

It will give me great pleasure to work with you on your healthcare goals, either through my own expertise, through reading I might give you, or by referral to other health professionals.

We want everyone to be involved in our health maintenance program. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups to test for a few specific diseases.

I look forward to working with you as your healthcare provider. Please contact me whenever you'd like to talk about anything you think may be affecting your health. It's my hope that we can have a relationship where the lines of communication are open and communication goes both ways. I will listen to you at least as much as I talk. Let's work together to help you live the satisfying life that you deserve.

Sincerely,

Rachel Spikes, ARNP

SPIKES MEDICAL, LLC

Rachel Spikes, ARNP
2633 Hwy 77, Suite A
Panama City, FL 32405
Phone: 850-481-0846 Fax: 850-481-0596

PATIENT INFORMATION RECORD

Office visit date: _____

Patient's Name: _____ **DOB:** _____**SSN:**_____
(Last, First, Middle/Maiden)
Address: _____**City**_____**State**_____ **Zip**_____

Home Phone: _____ **Work Phone:** _____**Cell Phone:** _____

Parent or Guardian (for minor child):_____

Sex: Male___ **Female**___ **Single**___**Married**___**Divorced**___**Widowed**___**Separated**____

Referred by: _____ **Preferred Pharmacy**_____

Contact Preference: Home Phone___ **Cell Phone**___ **Work Phone**___ **Email**_____

Patient's Employer: _____

Employer's Address:_____

Spouse's Name: _____**Cell Phone:** _____

Spouse's Employer: _____

Employer Address: _____

PRIMARY INSURANCE:_____

Address:_____

Policy Number:_____ **Group Number:**_____

Policy Holder:_____ **Policyholder DOB:**_____

SECONDARY INSURANCE CO._____

Address:_____

Policy Number:_____ **Group Number:**_____

Policy Holder:_____ **Policyholder DOB:**_____

Person to contact in case of emergency:_____

Phone Home: _____**Cell Phone:** _____**Relationship to patient:** _____

SPIKES MEDICAL, LLC

Rachel Spikes, ARNP
2633 Hwy 77, Suite A
Panama City, FL 32405
Phone: 850-481-0846 Fax: 850-481-0596

PATIENT CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I understand that as part of my healthcare, **Spikes Medical, LLC**, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information and uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that **Spikes Medical, LLC** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

I wish to be contacted in the following manner (List / circle all that apply)
Home Phone/Cell phone _____ Can/Cannot leave message
Work Number _____ Can/Cannot leave message
Written Communication to: Home address / Work Address / Fax to:_____
Can give personal information to the following: Please list name/relationship to the patient and phone number:

_____
_____

_____ _____
Patient's Signature Date

_____ _____
Witness Date

(X) Copy of consent and Notice of Privacy Practices given to patient: ____ (initials of patient).

FOR OFFICE USE ONLY
( ) Consent received by _____ on _____
( ) Consent refused by patient, treatment refused as permitted.
( ) Consent added to the patient's medical record on _____.

SPIKES MEDICAL, LLC

Rachel Spikes, ARNP
2633 Hwy 77, Suite A
Panama City, FL 32405
Phone: 850-481-0846 Fax: 850-481-0596

PATIENT CONSENT TO OBTAIN PROTECTED HEALTH INFORMATION

I give my permission for all my current / previous healthcare providers to release my protected health information to **Spikes Medical, LLC** for the purpose of treatment. This includes (but is not limited to) hospital records, lab, X-rays, MRI's and office notes.

I understand that **Spikes Medical, LLC** will release my records to other healthcare providers who request them for the purpose of treatment.

These records may be faxed to: **850-481-0596**
If preferred, they may be mailed to: **2633 Hwy 77, Suite A, Panama City, Fl. 32405**

Previous Provider:_____ Phone:_____
Address:_____City:_____St:___Zip:_____

Patient Name:_____ DOB: _____
Signed: _____ Date: _____

Witness: _____ Date: _____

The specific information I wish to have released is: **the notes from my last visit and any recent labs.**

I understand that I may revoke this consent at any time, except where information has already been released. Unless, otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months from the date signed.

_____ _____
Signature: (Parent or Legal Guardian of Minor Child) Date:

Witness: _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.
__ I DO consent to have this information disclosed.
__ I DO NOT consent to have this information disclosed.

_____ _____
Signature: (Parent or Legal Guardian of Minor Child) Date:

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

__ I DO consent to have this information disclosed.
__ I DO NOT consent to have this information disclosed.

_____ _____
Signature: (Parent or Legal Guardian of Minor Child) Date:

Spikes Medical, LLC
Rachel Spikes, ARNP
2633 Hwy 77, Suite A
Panama City, FL 32405
Phone: 850-481-0846
Fax: 850-481-0596

POLICIES & PROCEDURES

PAYMENTS & COPAYS:

Payment for service is due when rendered.

We accept Cash, Check, Debit Cards, Visa, Mastercard, American Express and Discover for your convenience. We accept your personal check, however, there will be a $25.00 returned check fee added to your balance for NSF charges. You will be responsible for the check **PLUS** $25.00 fee. **In addition, future visits will be on a cash or credit card basis.**

If you have insurance, we will gladly file it for you. Copays and any outstanding balances are due at time of service.

APPOINTMENTS:

We appreciate the opportunity to be your healthcare provider and realize your time is valuable, as well as ours. **Broken appointments without a 24 hour notice will be subject to a $25.00 charge**.

Also, if you **NO SHOW** for an appointment three times, you will be removed from our practice.

REFILL POLICY:

Please allow 48 hours for medication refills to be sent to your pharmacy.

Refills **will not** be sent to pharmacy if you do not keep your appointment **and** have required labs. NO EXCEPTIONS.

In addition, **antibiotic meds will not be prescribed to a patient over the phone. You must be seen by the provider first.**

FORMS AND LETTERS:

Due to time constraints, there will be a $10-$25 charge for any letters or forms completed.

SIGNATURE:_____ **DATE:**_____

Spikes Medical, LLC

Rachel Spikes, ARNP

2633 Hwy 77, Suite A
Panama City, FL 32405
Phone: 850-481-0846
Fax: 850-481-0596

ASSIGNMENT OF BENEFITS

I, _____, (Patient's Name) hereby authorize_____(Patient's Insurance Company), to make medical benefits payments otherwise payable to me for services rendered by Rachel Spikes, ARNP, but not to exceed the charges of those services, payable to and mailed directly to:

Spikes Medical
2633 Hwy 77, Suite A
Panama City, FL 32405

Furthermore, I hereby IRREVOCABLY ASSIGN to _____ (Patient's Insurance Company) the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by Rachel Spikes, ARNP.

I understand that I remain fully responsible for payment to Provider for all expenses incurred for medical treatment, regardless of payment, partial or denial of payment by my insurance company.

IN WITNESS WHEREOF, the undersigned has hereunto set her hand.

_____ _____
Date (Name of Patient)

I hereby accept the above Assignment of Benefits.

_____ _____
Date Rachel Spikes, ARNP

HEALTH HISTORY QUESTIONNAIRE

Date_____ Name_____ DOB_____

Answer every question on the following two pages.

Please check any of the following medical problems that you have had.

__Abn Weight Loss
__Abn Weight Gain
__Excessive Fatigue
__Insomnia
__Anemia
__Cancer or Tumor

__Rheumatic Fever
__High Cholesterol
__Heart Failure
__Heart Attack
__High Blood Pressure

__Arthritis or Joint Pain
__Gout
__Broken Bones

__Glasses/Contacts
__Glaucoma
__Cataracts
__Other Problems w. Vision

__Hearing Loss
__Ear Problems
__Ringing In Ears

__Allergies
__Frequent Sinus Infection

__Dentures
__Dental Problems
__Recurrent Mouth Sores

__Breathing Problems
__Frequent Bronchitis
__Emphysema
__Pneumonia
__Asthma

__Heartburn
__Ulcer Disease
__Gallbladder Disease
__Blood In Stool
__Hepatitis
__Diarrhea/Constipation
__Hemorrhoids
__Abdominal Pain
__Colon Polyp

__Abn Pap Smear
__Abn Mammogram
__Breast Lump
__Last menstrual Period
__# of Pregnancies
__Live Births
__Miscarriages
__Abortions

Have you been exposed to or do you have a close family member with
__HIV/AIDS
__Hepatitis
__TB

__Angina
__Frequent Chest Pain
__Irregular Heart Beat
__Heart Murmur

__Urinary Infrequency
__Bladder Infections
__Prostate Problem
__Urinary Incontinence

__Depression
__Anxiety-Panic Attacks
__Suicide Attempt
__Physical Abuse
__Sexual Abuse
__Mental Abuse

__Diabetes
__Thyroid Disease
__STDs

__Seizure
__TIA
__Stroke
__Numbness
__Weakness
__Memory Loss
__Headaches

Other Medical Problems

_____
_____
_____
_____
_____

All Surgeries you have had

_____
_____
_____
_____
_____

List all medications, supplements, and Vitamins
Including DOSAGE and FREQUENCY.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List ALL health care providers you have seen in
In the past, or currently

_____
_____
_____
_____
_____

DRUG ALLERGIES_____

Please list the year in which you have had any of the following
Physical Exam_____ Sigmoidoscopy/Colonoscopy(Circle Which)_____ Cholesterol_____
Pap Smear_____ Stool Cards for Colon Cancer_____ Dental visit_____ Eye Exam_____
Mammogram____ Rectal Prostate Exam____ Stress test___ Testicular Exam_____

Tetanus___ Pneumonia___ Hep B Series___ Flu___ TB___ Measles/Mumps/Rubella_____

Describe your use of Tobacco Products
___None ___Cigarettes ___Smokeless Tobacco ___Pipe ___Cigars
How much do you or did you smoke per day____. For how many years_____.
Do you wish to quit? ___Now ___Soon ___Eventually ___Never
Have you quit?_____ when?_____

How much Alcohol do you drink on weekly average?_____ Do you have a problem with alcohol_____
Have you used illicit drugs: Marijuana, heroin, cocaine, LSD, etc.)_____

How much Caffeine do you drink daily (including tea, coffee, soda)_____
How much do you exercise?_____

Are you sexually active?_____ With Male_____ Female_____ Both_____
Do you use contraception?_____ Type_____

Have you ever had a blood transfusion?____ When_____ Where_____ Why_____

Is there a history of any of the following in your family?
_ Heart Disease _Diabetes _Colon Cancer _Osteoporosis _Prostate Cancer _Breast Cancer
_Ovarian Cancer _High Cholesterol _ Skin Cancer

Please fill in any <u>medical problems</u> including age and <u>if living</u>
Father_____
Mother_____
Siblings_____
Children_____

SIGNATURE_____ DATE_____