HEALTHY LIVING CLINIC

ENROLLMENT FORM

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT INFORMATION

FIRST NAME_____ MIDDLE INITIAL _____ LAST NAME_____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

SSN_____

DATE OF BIRTH _____/_____/_____ SEX _____

EMAIL _____

CELL PHONE_____

HOME PHONE_____

ETHNICITY ☐ DID NOT SPECIFY ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

MARTIAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE ☐ DID NOT SPECIFY ☐ ASIAN ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

OCCUPATION_____

EMPLOYER_____

PREFERRED LANGUAGE_____

PREFERRED METHOD OF COMUNICATION_____

NEXT OF KIN_____

RELATIONSHIP_____

PREFERRED PHARMACY & LOCATION_____

CONTACT NUMBER_____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO **IF NO PLEASE COMPLETE THIS SECTION**

RELATIONSHIP_____ SEX_____

FIRST NAME_____MIDDLE_____

LAST NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

CONTACT NUMBER_____

EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

INSURANCE COMPANY_____ INSURED'S DOB_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

ID#_____ GROUP #_____EFFECTIVE DATE_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____ INSURED'S DOB_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

ID#_____ GROUP #_____EFFECTIVE DATE_____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

HEALTHY LIVING CLINIC

PATIENT RESPONSIBILITIES & AUTHORIZATIONS

PLEASE READ AND INITIAL EACH LINE.
IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST FOR ASSISTANCE.

____ I understand that my co-payment is due at each visit. Cash, check, Mastercard, and Discover cards are acceptable methods of payment.

____ I understand that I could be discharged from the practice for failing to provide notice of cancellation for three or more appointments.

____ I understand that I will be charged $25 for any returned check.

____ I understand that I am financially responsible for the charges not covered by my insurance, such as: deductibles, coinsurance.

____ I authorize the release of any medical or other information necessary to process the insurance claim(s).

____ I authorize payment directly to the billing office of this physician/clinic for the medical and/or surgical benefits, if any, otherwise payable to me for services.

____ I understand that I will be charged $25 for any/all missed appointments without 24 hour notice of cancellation prior to the appointment.

____ I understand that I may be responsible for charges related to the completion of certain forms and letters. The cost for such forms or letters is $25

____ I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account.

____ I understand that I am responsible for any collection and/or attorney fees should my account be turned over to a collection agency.

____ I authorize payment of insurance benefits to the physician or supplier for all services rendered.

I UNDERSTAND AND ACCEPT THE ABOVE RESPONIBILITES AND AUTHORIZATIONS.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

CONSENT TO PHOTOGRAPH

Dr. Erich Arias, M.D. and/or his associates are authorized to take medical photographs before, during, and/or after a procedure or treatment for the professional purpose of documentation. We also may take pictures of prescriptions, laboratory tests using a “Phone App” that will be uploaded to your medical record. Everything photographed is under secure environment following HIPAA compliance regulations.

☐ **YES,** I give my consent to be photographed. ☐ **NO,** I do not consent to being photographed.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this document is available upon request.

I have received a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

Please list the names of anyone who the office staff may release information to on your behalf. If they are not on this list, no information will be released regarding your care or condition.

NAME		
RELATIONSHIP TO YOU		
CONTACT INFORMATION		
COMMENTS		

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

[__] Individual refused to accept Notice
[__] Individual refused to sign Acknowledgment
[__] Individual was unable to sign
[__] Other:
[__] An emergency situation prevented us from obtaining acknowledgment

HEALTH HISTORY & INFORMATION

CHIEF COMPLAINT (WHY YOU ARE HERE TO SEE THE PHYSICIAN):

_____

_____

_____

YES	NO	MEDICAL HISTORY	YES	NO	MEDICAL HISTORY	OTHER, PLEASE SPECIFY:
☐	☐	DIABETES	☐	☐	VENEREAL DISEASE (STD)	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEREDITARY DEFECTS	
☐	☐	CANCER	☐	☐	RENAL DISEASE	
☐	☐	STROKE	☐	☐	RHEUMATOLOGICAL DISEASE	
☐	☐	HEART DISEASE	☐	☐	THYROID DISEASE	
☐	☐	BLEEDING DISORDER	☐	☐	INFECTIOUS DISEASE	
☐	☐	COPD	☐	☐	NEUROLOGICAL DISORDER	

FAMILY MEDICAL HISTORY

MEDICATION ALLERGIES & REACTIONS

IMMUNIZATIONS

SOCIAL HABITS

ALCOHOL	TOBACCO	RECREATIONAL DRUGS
☐ NEVER ☐ RARELY ☐ MODERATE ☐ DAILY	☐ NEVER ☐ CURRENTLY ☐ QUIT DATE:_____	☐ NEVER ☐ CURRENTLY ☐ QUIT

SEX

☐ SEXUALLY ACTIVE ☐ PREGNANT OR TRYING ☐ INTERCOURSE DISCOMFORT ☐ USE CONTRACEPTIVE(S)	ANY CONCERN REGARDING YOUR SEX LIFE? Y or N

PREVENTATIVE SCREENINGS
(Check all that apply &
Please indicate date of last exam)

☐ ENDOSCOPY
☐ COLONOSCOPY
☐ DEXA SCAN
☐ MAMMOGRAM
☐ PAP SMEAR
☐ LUNG CANCER SCREEN

☐ OTHER, PLEASE SPECIFY:

PAST SURGICAL HISTORY

DATE	REASON	HOSPITAL/DOCTOR

PREVIOUS PRIMARY CARE PHYSICIAN (PCP)

NAME & PHONE NUMBER:

PLEASE LIST ALL MEDICATIONS INCLUDING ANYTHING OVER THE COUNTER- (Please ask receptionist for additional paper if necessary)

PHARMACY NAME & PHONE NUMBER:

NAME	DOSE	FREQUENCY TAKEN	PRESCRIBED BY

CARE TEAM – PLEASE LIST ANY OTHER DOCTORS YOU SEE, THEIR SPECIALTY, AND WHAT YOU ARE BEING TREATED FOR

NAME	SPECIALTY	CONDITION(S) BEING TREATED

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PHONE: (321) 549-2273 FAX: (321) 549-2066
1300 Florida Avenue, Rockledge, Florida 32955

PATIENT'S NAME_____ DATE OF BIRTH _____/_____/_____

ADDRESS _____ PHONE NUMBER_____

CITY _____ STATE _____ ZIP _____ SSN_____

DATE OF REQUEST_____

☐ I AUTHORIZE HEALTHY LIVING CLINIC, LLC **TO RELEASE INFORMATION TO:**		☐ I AUTHORIZE HEALTHY LIVING CLINIC, LLC **TO OBTAIN INFORMATION FROM:**
NAME OF PROVIDER OR FACILITY		NAME OF PROVIDER OR FACILITY
ADDRESS	**O R**	ADDRESS
CITY, STATE, ZIP		CITY, STATE, ZIP
PHONE NUMBER		PHONE NUMBER
FAX NUMBER		FAX NUMBER

PURPOSE FOR THIS REQUEST_____

TYPE OF RECORDS REQUESTED:

☐ ENTIRE RECORD
☐ TREATMENT SUMMARY (INCLUDES HISTORY/PHYSICAL, LABS, XRAYS, OPERATIVE REPORTS, PATHOLOGY)
☐ LASTS MEDICAL VISITS INCLUDING LAST NOTES, X RAYS OR LABORATORY TESTS

_____

☐ SPECIFIC INFORMATION
- ☐ PROCEDURE REPORT ☐ HISTORY & PHYSICAL ☐ PHYSICAL THERAPY ☐ LAB RESULTS
- ☐ XRAY REPORTS ☐ OTHER_____

AUTHORIZATION VALID FOR:

ALL AUTHORIZATIONS ARE VALID FOR ONE YEAR UNLESS SPECIFICALLY REQUESTED DIFFERENTLY BY THE PATIENT OR BY THE FACILITY THAT WE ARE REQUESTING RECORDS.

☐ This authorization is valid only until _____.

I UNDERSTAND THAT:

I may cancel this authorization at any time by submitting a **written** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____