COASTAL PRIMARY CARE
INTERNAL MEDICINE | FAMILY PRACTICE
4995 South US Highway 1, Fort Pierce, Florida 34982
Tel: (772) 465-3225; Fax: (772) 465-7687

INDIVIDUAL PATIENT AUTHORIZATION

THIS FORM IS TO CONFIRM ***MY*** AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PEOPLE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT'S SIGNATURE_____ DATE _____/_____/_____

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To: _____
_____
_____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

Re: Name of Patient _____

Social Security # _____/_____/_____ DOB: _____/_____/_____

I authorize the release of my medical records to be sent to COASTAL PRIMARY CARE for diagnosis and treatment, specifically to include the following:

_____ Complete Medical Records
_____ Lab Reports
_____ Consultations
_____ Medications
_____ Other:

This medical record may contain information about drug abuse, substance abuse, mental health treatment and HIV/AIDS information. Separate consent must be given to release this information.

_____ I DO consent to having this information disclosed
_____ I DO NOT consent to having this information disclosed

I have the right to revoke this authorization at any time in writing except to the extent of information that has already been released.

I have reviewed this authorization. I understand that any information disclosed pursuant to his authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

DATE: _____/_____/_____

_____
Signature of Patient of Personal Representative

_____
Description of Personal Representative

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PATIENT'S NAME _____
(LAST) (FIRST) (MIDDLE)

PHONE # (_____)-_____-_____ ALTERNATE PHONE # (_____)-_____-_____

SS# _____/_____/_____ DATE OF BIRTH _____/_____/_____

GUARANTOR (IF PATIENT IS A MINOR) _____

FLORIDA ADDRESS: _____ APT# _____

CITY _____ STATE _____ ZIP _____

SEASONAL ADDRESS: _____

MARITAL STATUS: M S W D DRIVER'S LICENSE # _____

EMAIL ADDRESS: _____ PHARMACY: _____

EMERGENCY CONTACT: _____ PHONE# (_____)_____-_____

CONTACT'S ADDRESS: _____ APT# _____

CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURED: _____ SS# _____/_____/_____ DOB ____/____/____

SECONDARY INSURED:_____ SS# _____/_____/_____ DOB ____/____/_____

ASSIGNMENT OF BENEFITS

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to **MAUREEN A. ZELINKA, MD dba COASTAL PRIMARY CARE**, who accepts assignment of benefits.

_____ DATE _____/_____/_____
(Patient or Authorized Person's Signature)

REFERRING PHYSICIAN INFORMATION

NAME _____ PHONE# (_____)-_____-_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES FOR ***COASTAL PRIMARY CARE***.

NAME: _____ DOB: _____/_____/_____

SIGNATURE: _____

DATE: _____/_____/_____

HOW DID YOU HEAR ABOUT US? _____

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PRESCRIPTION MEDICATION CONSENT FORM

The providers at Coastal Primary Care use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information.

To optimize the use of this electronic capability and coordinate your care between us and your specialists, we ask that patients allow us to access their medication history through the Rx Hub.

Please check only one of the following:

_____ I consent to allow my provider to access all of my medication history

_____ I consent to allow my provider to access only my medication history for medications prescribed in this office.

_____ I DO NOT consent to my provider accessing any of my medication history.

I am aware that COASTAL PRIMARY CARE has 48 hours (not including weekends) to refill any and or all of my prescriptions. ANY prescription refill requests after 12:00 noon on Fridays will be addressed the next business day.

_____
Patient's Printed Name

_____
Patient's Signature

_____/_____/_____
Date

Health Care Advance Directives
The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?
It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Two types of advance directives are:
A Living Will
A Health Care Surrogate Designation

What is a living will?
It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?
It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?
Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?
Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You may also want to give them a copy.
Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

_____ I have read and understand the above information
_____ I have executed an advance directive
_____ I have not executed an advance directive
_____ I understand that provision of medical care to me will not be based on whether or not I have executed an advance directive.

PATIENT: _____ DATE: _____/_____/_____

WITNESS: _____ DATE: _____/_____/_____

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CONSENT FOR TREATMENT

I voluntarily consent to the rendering of medical care by Coastal Primary Care. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

STATEMENT OF FINANCIAL LIABILITY
I guarantee payment of any and all bills rendered for said patient which are not covered or allowed by insurance. This office will file the bill as a courtesy with my insurance company providing I supply the proper insurance information to this office.

AUTHORIZATION TO RELEASE INFORMATION
I authorize Coastal Primary Care to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, Worker's Compensation or Medicare benefit payments.

NON-COVERED SERVICES
I acknowledge that procedures and services not covered by my insurance company will be my responsibility and payment will be submitted immediately.

MEDICARE PATIENTS
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of medical and other information held by this office to the Social Security Administration or its intermediaries or carriers required for the submission of claims and reimbursement for services rendered.

_____ _____/_____/_____

SIGNATURE OF PATIENT **DATE**