Families First Primary Care, Inc.
2888 Mahan Drive Suite 3
Tallahassee, FL 32308-5465
Phone: (850) 402-6210, Fax: (850) 325-6015

Thank you for choosing to become a patient at Families First Primary Care. **Please complete the enclosed paperwork and return to our office, before we can schedule your initial appointment**. On the day of your appointment please bring your insurance card and picture I.D. as well as any payment due at the time of service We ask our new patients to arrive 10 minutes prior to the scheduled appointment time to allow time for check-in and preregistration with our clinical staff. We would also like to advise you of our policy regarding appointment changes. When changing an appointment, we do ask for a minimum of 24 hours notice. As a courtesy, we call and text to remind you of your appointment, in order to give you ample time to make changes. Excessive no shows, same day cancellations or rescheduling your appointment with less than 24 hours notice could result in a **$25.00 charge or discharge** from our practice. Your cooperation with this matter is greatly appreciated. Should you have any further questions or concerns, please do not hesitate to contact my office at (850) 402-6210.

PLEASE PRINT:

Patient Name:_____DOB:_____

Address:_____

Phone#_____Email:_____

Insurance Name:_____

ID Number:_____Group:_____

YOUR HEALTH IS OUR PRIORITY

Terreze Gamble, MD

Board Certified Family Physician

2888-3 Mahan Drive, Tallahassee, Florida 32308

Tel: (850) 402-6210 Fax: (850) 325-6015

Date:_____

Patient's Personal History

First Name:_____MI:_____Last Name:_____Suffix:_____

Date Of Birth:_____Age:_____

Gender: Female Male Other:_____ Race/Ethnicity:_____

Language Spoken Most Often:_____Do You Need An Interpreter? yes____No____

Current Health: Excellent _____Good _____Fair _____Poor _____ Other:_____

Chief Complaints:_____

Medical History: Please list all chronic and major medical conditions you have had and the year of diagnosis (ie; Alcoholism, cancer, diabetes etc,)

_____ _____ _____

_____ _____ _____

Women: Please indicate the number of Pregnancies _____ Deliveries _____ Miscarriages/Abortions _____

Please indicate the date of your last:

Eye exam:_____ Pap Smear:_____ Flu Shot:_____

Dental Exam:_____ Mammogram:_____ Pneumonia Shot:_____

Psychical Exam:_____ Dexa Scan:_____ Tetanus Shot:_____

Surgical History: Please list all surgeries with the date (year) of the procedure:

_____ _____ _____

_____ _____ _____

Medications: Please list all medications you are taking including prescriptions, over the counter, and herbal/supplements

Name of medication	**Dose**	**Frequency**	**Name of medication**	**Dose**	**Frequency**

Allergies: Please list all medications allergies and their associated reactions:

_____

Family History: Please list ALL medical conditions in your family (examples: alcoholism, asthma, cancer, diabetes, heart disease, high blood etc)

Father:_____ Paternal Grandfather_____ Children: _____

Mother:_____ Paternal Grandmother_____ Children: _____

Sibling_____ Maternal Grandmother_____ Children: _____

Sibling_____ Maternal Grandfather_____ Other: _____

Social History:

Marital Status:

____ Single ____ Married _____ Separated

_____ Divorced _____ Widow _____ Other

Spouse/Partner's Name: _____

Children: (Names and Birthdates)

_____

_____

_____

Who lives in your home with you?_____ Faith/Religion_____

Are you a student? _____Yes _____ No What school do you attend?_____

Occupation:_____ Employer:_____

Describe your diet:_____

Exercise: __Yes ___No How many minutes per day?_____ How many days per week?_____

Caffeine: __Yes ___No How many drinks per day?_____

Tobacco: __Yes ___No How many packs per day?_____ For how many years?_____

Do you want to quit _____ When did you quit? _____

Alcohol: __Yes ___No How many drinks per day?_____ How many days per week? _____

Drug use: __Yes __No Describe:_____

Have you ever been sexually active? __Yes ___No Are you currently? __Yes __No

Male_____ Female_____ Both_____

Birth control method: _____ Routinely wear a seatbelt? ___Yes ___No

Routinely wear a helmet? ___Yes ___No

Preferred Pharmacy:_____ Lab:_____

Pharmacy Address:_____

I authorize the release of medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered. I understand I am financially responsible for services rendered by Families First Primary Care.

_____ _____

Patient or Guarantor Signature Date

_____

Printed name (if other than patient)

Patient Name_____

REVIEW OF SYSTEMS – PLEASE CHECK ALL SYMPTOMS THAT APPLY TO YOU

CONSTITUTIONAL
- ___ FEVER
- ___ CHILLS
- ___ NIGHT SWEATS
- ___ WEIGHT LOSS
- ___ WEIGHT GAIN
- ___ DIFFICULTY SLEEPING
- ___ FATIGUE

INTEGUMENTARY
- ___ RASH
- ___ HIVES
- ___ CHANGING MOLES
- ___ HAIR LOSS

HEENT
- ___ VISION CHANGE
- ___ DRY EYES
- ___ EAR PAIN
- ___ DECREASED HEARING
- ___ SINUS PROBLEMS
- ___ ALLERGIES
- ___ DIFFICULTY SWALLOWING
- ___ DRY MOUTH
- ___ SEVERE HEADACHE

NECK
- ___ NECK PAIN
- ___ NECK MASS/SWELLING

PULMONARY
- ___ CHRONIC COUGH
- ___ COUGHING UP BLOOD
- ___ WHEEZE
- ___ SHORTNESS OF BREATH
- ___ SNORING

BREAST
- ___ LUMP
- ___ NIPPLE DISCHARGE

CARDIOVASCULAR
- ___ CHEST PAIN
- ___ IRREGULAR HEART BEAT
- ___ PALPITATIONS
- ___ LOW EXERCISE TOLERANCE
- ___ DIFFICULTY BREATHING ON EXERTION
- ___ DIFFICULTY BREATHING LYING DOWN
- ___ LEG SWELLING

GASTROINTESTINAL
- ___ HEARTBURN
- ___ NAUSEA
- ___ VOMITING
- ___ VOMITING BLOOD
- ___ ABDOMINAL PAIN
- ___ DIARRHEA
- ___ CONSTIPATION
- ___ CHANGE IN BOWEL HABITS
- ___ BLOOD IN STOOL
- ___ BLACK TARRY STOOL

GENITOURINARY
- ___ PAINFUL URINATION
- ___ FREQUENT URINATION
- ___ FREQUENT NIGHTTIME URINATION
- ___ BLOOD IN URINE
- ___ POOR URINE CONTROL
- ___ SEXUAL CONCERN

MEN
- ___ LUMP IN TESTICLE
- ___ PENILE DISCHARGE

WOMEN
- ___ IRREGULAR MENSTRUAL PERIODS
- ___ HEAVY PERIODS
- ___ PAINFUL PERIODS
- ___ VAGINAL DISCHARGE

MUSCULOSKELETAL
- ___ JOINT PAIN
- ___ JOINT SWELLING
- ___ JOINT STIFFNESS
- ___ MUSCLE PAIN
- ___ MUSCLE WEAKNESS
- ___ LEG CRAMPS
- ___ BACK PAIN

NEUROLOGIC
- ___ DIZZINESS
- ___ UNSTEADY GAIT
- ___ NUMBNESS
- ___ MEMORY LOSS
- ___ WEAKNESS
- ___ FAINTING
- ___ SEIZURES

ENDOCRINE
- ___ COLD INTOLERANCE
- ___ HEAT INTOLERANCE
- ___ EXCESSIVE THIRST
- ___ HOT FLASHES

HEMATOLOGIC
- ___ ABNORMAL BLEEDING

LYMPHATIC
- ___ SWOLLEN GLANDS

PSYCHIATRIC
- ___ ANXIETY
- ___ DEPRESSION
- ___ SUICIDAL THOUGHTS

Over the past 2 weeks, how often have you been bothered by...	**Not at all**	**Several days**	**Over half the days**	**Nearly every day**
Little interest or pleasure in doing things?	0	1	2	3
Feeling down depressed or hopeless?	0	1	2	3

Patient Name:_____ D.O.B._____

Email address:_____

Please assist us in updating your record by completing the information below. It is being required nationally for all records to be updated with the information below. Thank you

Primary Language:_____

Race: American Indian or Alaska Native

Asian

Black/African American

White/Caucasian

More than one race

Native Hawaiian

Other Pacific Islander

Refuse to report/Unreported

Ethnicity: Hispanic or Latino

Not Hispanic or Latino

Refuse to report/unreported

We also now have available a summary of your visit with us. We have it available for you within 3 business days of your visit. You may choose to pick it up from our office or receive it through a secure email (The patient portal). You may create an account on our Patient portal by going to https://www.myprivia.com/ and clicking on the patient portal in the upper right hand corner. You may also request an appointment, ask a nurse a question, or receive test/lab results.

Please circle your choice below:

Patient Portal Pick up at Office

Families First FFPC Primary Care

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code | **Any Other Names Used**

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

2. Be sent to the following person / entity at the address listed below:

Name Terreze M. Gamble M.D.

Address ~~2888-3 Mahan Dr.~~ Tallahassee, FL. 32038

Telephone (850) 402-6210

Fax or Email Address for Delivery (850) 325-6015

City State Zip Code

3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only:

_____ to _____ ☐ Specific Information Only:

NOTES

1. INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED.
2. IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.☐ PLEASE *EXCLUDE* THE FOLLOWING INFORMATION:**

_____ **Signature:**_____

3. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; **or** ☐ other (please specify)_____.
4. If I have requested records be sent **un**encrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
5. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.
7. I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
8. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify)_____.
10. This authorization expires on _____ ____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.

_____.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient | **Date of Patient's Signature** | **Patient's Date of Birth**

If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate | **Date of Legal Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

PRIVIA HEALTH

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name:_____ **Date of Birth:**_____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____

- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Cell Phone:**_____

- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Work Telephone:**_____

- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Written Communication:**_____

- ☐ **OK to mail to my home address**
- ☐ **OK to mail to my work/office address**

☐ **Other:**_____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

•Name:_____**Telephone:**_____**Relationship:**_____

•Name:_____**Telephone:**_____**Relationship:**_____

•Name:_____**Telephone:**_____**Relationship:**_____

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVIA HEALTH

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete, and current, and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider. I authorize my provider, or any holder of medical information about me or the patient named below, to release to my health insurance plan such information needed to determine the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary; however, I may refuse any treatment or procedure at any time.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in the telehealth visit, and I may terminate the visit at any time.

My consent shall cover medical examinations, procedures and testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (such as stitches), cast application/removals, and vaccine administration. My consent shall also cover treatment by care center staff acting under my provider's supervision and direction. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain. My consent shall also cover the use of internal recording devices for the purpose of scribing and clinical documentation improvement. All internal recording adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of

Consent For Services Of A Minor Child

In almost all cases, Families First Primary Care (FFPC) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services in our office for a minor child under the age of 18. All parent(s) or guardian(s) are encouraged to attend all medical appointments at Families First Primary Care, but we understand that isn't always possible. To avoid having to reschedule an appointment when a parent(s) or guardian(s) is unable to attend, this consent form authorizing FFPC and its medical professional to provide medical care must be signed by the appropriate person.

I,(WE)_____ and_____
do hereby state that I am (we are) the parents or legal guardians of (childs name)
_____, of minor age born on _____.

Please Initial options below

_____ (I)We authorize and consent to all professional services provided at or arranged within the primary care office, and their ancillary departments.

_____ (I)We authorize and consent to any medically necessary treatment within the primary care office only and not any ancillary departments.

_____ (I)We do not give consent for_____(list specific test/services)services.

Patient Acknowledgement, Consent With Insurance Certification And Assignment, And Treatment Authorization

The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parents:

Initial:_____Name:_____Relationship:_____

Initial:_____Name:_____Relationship:_____

Initial:_____Name:_____Relationship:_____

Consent expires on:_____ (if not dated then it will expire one year from the signed date)

Print Name:_____Sign:_____

Parent/legal guardian name (if patient is a minor)

Print:_____ Sign:_____

Date:_____ Relationship to Patient: _____

PRIVIA HEALTH

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out. You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork

and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!