Erica L. O'Donnell D.O., P.A.
1400 Hand Ave, Suite K, Ormond Beach, FL 32174
Telephone: (386) 671-2771 Fax: (386) 671-6458

MEDICAL HISTORY

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet your healthcare needs, please fill out this form in its entirety. If you have any questions, or require assistance, please ask us – we will be happy to help.

TODAY'S DATE: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____

Primary Phone # _____ Secondary Phone # _____

E-Mail: _____

ALLERGIES: (Please mark all that apply)

Food: __ No Allergies If So, Please List: _____

Drugs: __ No Allergies If So, Please List: _____

Latex [Y/N] *(Please Circle)*

Previous Primary Care Provider: _____

Specialists: _____

_____

Reason for Establishing: _____

Preferred Pharmacy: _____ Address: _____

Phone Number: _____

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY: Please mark all that apply. Indicate relative, and if relative died from the condition.

Condition	**Relative**	**Cause of Death [Y/N]**	**Condition**	**Relative**	**Cause of Death [Y/N]**
□Asthma			□Hypertension		
□Glaucoma			□Stroke		
□Arthritis			□Heart attack		
□COPD			□Thyroid Disease □Hypo| □Hyper		
□Diabetes| Type □I □II			□Kidney Disease		
□Depression/Anxiety			□Other: _____		
□Heart Disease			□Breast Cancer		
□Blood Disorder			□Prostate Cancer		
□High Cholesterol			□Cancer Type _____		

SOCIAL HISTORY:

Do you use Tobacco products? □ I Have Never Used Tobacco □ Yes, currently: ___ packs/day

□ Former Tobacco User **Start Date: _____** □ I Use Chewing Tobacco

Quit Date: _____

*****Prior to quitting; how many packs per day were smoked? _____

Do you Consume Alcohol? □ No Alcohol □ Daily Alcohol, ___ drinks per day

Are you a social drinker? □ No □ Yes

If yes, how many drinks do you consume a week?

□ Rarely □ Occasionally □ 1-2 per week □ 3-5 per week □ More than 5 per week

Recreational Drugs? □ No □ Yes _____ OCCUPATION: _____

MARITAL STATUS:

□ Single □ Married □Married with Children □ Divorced □ Separated □ Widowed

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Please mark all that apply *(if you have ever received medication or treatment for the following conditions)*

Condition	**Condition**
□ Asthma	□ Stroke
□ COPD	□ Anemia
□ Depression	□ Blood Disorder
□ Insomnia	□ Kidney Disease
□ Heartburn	□ Arthritis □ Osteo □ Rheumatoid
□ Glaucoma	□ Seizure Disorder
□ Diabetes □Type I □Type II	□ Gout
□ High Cholesterol	□ Pregnancies # _____ □Cesarean # _____
□ High Blood Pressure	□ Cancer Type _____
□ Thyroid Disease □Hypo □Hyper	□ Other: _____
□ Heart Disease	□ Other:

SURGICAL HISTORY: Please list surgeries and dates *(Approximate date if unknown)*

Year	**Type**	**Year**	**Type**

SCREENING AND PREVENTION: Please indicate when last performed *(Approximate date if unknown)*

Procedure	**Date**	**Procedure**	**Date**
Mammogram		Colonoscopy	
DEXA/Bone Density		Flu Vaccine	
Pap		Pneumonia Vaccine	
Lab Work		Shingles Vaccine	
Prostate Cancer Screening		Other Colorectal Cancer Screening	

Patient Name: _____ Date of Birth: _____

MEDICATION LIST: *(Please include **all** prescriptions as well as over-the-counter medications, vitamins, and supplements)*

Medication	**Strength**	**Directions**	**Ordering Physician**

Patient Name: _____ Date of Birth: _____

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CONSENT TO TREAT

I hereby consent to have the physician and/or nurse practitioner render medical evaluations, treatment, and performance of diagnostic testing and other procedures according to their discretion. No guarantees have been made to me as to the results of the examination. The audio and/or video recording of any employee, including the physician, is prohibited. Violation of this policy will result in immediate discharge from the practice.

Signature: _____ Relationship to Patient: _____

Patient/Legal Representative (Print): _____ Date: _____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCOLSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Erica O'Donnell D.O., P.A.

Acknowledgement of Receipt of Privacy Policy

We are required by law to provide you with our Notice Privacy Practices. To ensure that our records are accurate, please read the attached document, sign this form, and return it to our receptionist to acknowledge that you have been provided with a copy of our notices.

I acknowledge receipt of Erica O'Donnell D.O., P.A.'s Notice of Privacy Practices

I hereby understand and accept the Notice of Privacy Policy and will abide by these policies:

Patient Signature: _____ Date: _____

Patient's Name (Print): _____

Patient Name: _____ Date of Birth: _____

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Financial Policy

Thank you for choosing Erica O'Donnell D.O., P.A. as your health care provider. We are committed to providing you with excellent health care. Please understand that payment of your bill is considered part of your treatment. We will bill insurance companies with the understanding that the insurance policy is a contract between you and your carrier. We are not a party to that contract. In the event your insurance company has not satisfactorily paid your account within 60 days of date of service, the balance will be transferred to you.

You Need to Make a Choice about Receiving Treatment

We will bill your insurance carrier for all treatment, injections, and services rendered by this office. Your insurance may not pay for all or any item or service. This does not mean that your doctor does not recommend that you receive that service. It does mean that if you choose to receive that treatment and the insurance company does not pay, you will be responsible for payment.

Listed below are some common services and treatments that may not be covered by your insurance.

Shingles Vaccine
Pap Smear & Exam
All Vaccines
Allergy Testing
Prostate Screening
Laboratory Tests
INR Testing
EKG's
General Physicals
Drug Screenings School/Sports Physicals
Pre-existing Conditions

If your account balance becomes delinquent and we find it necessary to go to collection proceedings, you will be responsible for all costs and fees associated with the collection of this debt.

Patient Name: _____ Date of Birth: _____

Financial Policy (Continued)

Please initial by the following items to show that you have read and understand the specific policies:

_____ *Prescriptions:* We require prescriptions to be written at the time of your appointment. If you need a prescription filled, you may contact your pharmacy and have them send us a "Refill Request." We require 48-hour notice on refills that are requested outside of your office visit. No refills will be issued on weekends and holidays. To provide the highest level of care, I understand Erica O'Donnell D.O., P.A. participates in E-Prescribing and Rxhub. Please see additional information on Controlled Substance Agreement.

_____ *Billing and Collections:* As a courtesy, our office will file primary insurance claims only to those insurance companies that your physician is in network with. All fees, non-covered services, co-pays, co-insurance, and deductibles **are due at the time of your visit. Financial arrangements may be made on request, please ask to speak with the Office Manager, NOT THE DOCTOR.**

_____ *Record Request:* Our office will be happy to provide you with requested copies of your medical records for a charge of $1.00 per page for the first twenty-five pages of records requested, then $0.25 for each additional page. There is also the cost of any postage if records are mailed. For your protection, if you need records from another facility that may be in your chart, you must contact that facility as we are not permitted to release any records other than our own.

_____ *Lab Requisitions:* As a patient, you are responsible for knowing and verifying which lab participates with your insurance, as well as what laboratory services are covered.

_____ *Worker's Compensation and Accidents:* Our office is not a provider for Worker's Compensation. We do not see patients for injuries resulting or related to third party accidents.

I have read and understand the policies of Erica O'Donnell D.O., P.A., I want to be treated, and I understand that I am responsible for the payment of all services.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

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NOTICE OF PRIVACY PRACTICES

Introduction:

At Erica O'Donnell D.O., P.A., we are committed to providing patient care and using health information responsibly while protecting your rights. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. This notice is effective September 01, 2019, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information:

Each time you visit Erica O'Donnell D.O., P.A., a record of your visit is made. Typically, this record contains your symptoms, examination notes, test results, diagnoses, treatment, and a plan for future care of treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were provided,
- Tool in educating health professionals,] source of data for our planning and marketing, and
- Tool with which we can access and improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Erica O'Donnell D.O., P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Rights upon request,
- Obtain an accounting disclosure of your health information as provided in 45 CFR 164.538,
- Request communications of your health information by alternative means or at alternative locations, request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
    - Request health information to be disclosed to another medical facility,
    - Revoke your health information except to the extent that action has already been taken or mandated by law.

Our Responsibilities

Erica O'Donnell D.O., P.A. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right change our practices and to make new provisions effective for all protected health information we maintain. Should our information practice change, we will post a revised notice visible in our office.

We will not use or disclose your health information without your authorization, except as described in this notice. We will no longer use or disclose your health information after we have received a written revocation of the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our office at (386) 673-0517.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Office for Civil Rights. The address for the OCR is listed below:

Officer for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person(s) designated by you for your care.

Communication from offices: We may call your home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO (Treatment, Payment, and Health Operations) such as appointment reminders, insurance items, and any other call pertaining to your medical care. We may mail to your home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. We may e-mail to your home or other designated location any items that the practice in carrying out TPO such as appointment reminder cards and patient statements.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other that you identify that we may communicate with, health information relevant to that person's involvement in your care or payment of your care.

Open treatment areas: Patient care is sometimes provided in an open treatment area. While particular care is taken to maintain patient privacy, some patient information may be overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of the Office Manager.

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information related to adverse events with respect to food, supplements, or products and produce defects. We may also disclose post-marketing surveillance information to enable product recalls, repair, and replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and have potentially endangered one or more patients, workers or the public.

IF YOU HAVE QUESTIONS REGARDING THIS POLICY, PLEASE CONTACT THE OFFICE MANAGER.

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Controlled Drug Agreement

I am aware that if a provider from Erica O'Donnell D.O., P.A. prescribes a narcotic analgesic to me to lessen the pain for my condition or any controlled drug for my diagnosis, the medication has certain risks associated with it.
These risks may include, but are not limited to, sleepiness, drowsiness, constipation, nausea, vomiting, dizziness, itching, allergic reaction, slowing of respiratory rate, slowing of reflexes and reaction time, physical addiction and dependence and mental addiction. This medication may lessen the pain but not provide complete pain relief.

In accepting the prescription for controlled medication(s), I agree with the following:

- I will make the doctor aware of all the other medications I take.
- I am aware of the possible side effects and risks of these medications and will have all recommended laboratory studies.
- I will not use any illegal or illicit substance including, but not limited to, marijuana, cocaine, etc.
- I will not seek or use any other narcotic medication(s) except for those prescribed to me by my physician at Erica O'Donnell D.O., P.A.
- I will not share or sell my medication(s)
- I will not operate heavy machinery or drive a motor vehicle while under the influence of these medications.
- I will be subject to discussing alternative, non-narcotic therapy at any interval during my treatment.
- **I understand that I am responsible for my medication. The medication is prescribed in a 30-day supply. It will not be replaced or filled early for any reason.**
- I understand that I must be seen by the prescribing physician **every 30 days.**
- I understand that I am subject to random drug screening tests, which may not be covered by my insurance, and I am responsible for balances associated with this test.
- I will not call the doctor requesting a refill, I will instead make an appointment for renewal of my medication(s)
- I understand that at any time during my treatment I may be referred to a pain management specialist for further evaluation.
- **I understand that failure to abide by this agreement could result in termination of the medication being prescribed and/or discharged from the care of the doctor.**

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Patient Name: _____ Date of Birth: _____

Erica L. O'Donnell D.O.

Board Certified in Family Practice by the American Board of Osteopathic Family Physicians

Jessica Hills ARNP

Certified by the American Academy of Nurse Practitioners

Controlled Substance Drug Screening Policy

All patients receiving a prescription for a controlled substance will be subject to random urine drug screening multiple times a year. Patients refusing or claiming that they are unable to provide a sample for a urine drug screen will not receive a prescription for a controlled drug. All patients receiving a drug screen will be charged a fee of $15.00. This charge is not covered by most insurance plans. We will be collecting the fee from the patient. If your insurance does allow the charge, we will credit your account.

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Authorization for Discussion of Medical Records

Patient Name: _____

I have been made aware of the policy and procedures of Erica O'Donnell D.O., P.A. as they relate to HIPAA Requirements.

___Yes ___No I authorize medical information to be left on the answering machine at the phone number provided by me. Phone: _____

___Yes ___No I authorize Erica O'Donnell D.O., P.A. to discuss my medical history with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact Information

Emergency Contact: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: ___ Same as Patient _____

City: _____ State: _____ Zip: _____

Patient Signature: _____ Date: _____

This authorization shall remain in effect for one year from the date signed above or until: □_____ (*Specify Date;* ***not to exceed one year***); unless revoked in writing prior to specified dates.

Patient Name: _____ Date of Birth: _____

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Frequency of Visits

All patients of the office will be seen minimally twice a year, unless otherwise dictated by the physician, to ensure that all preventative care is performed, and any preventative testing is ordered. Any person with the following diagnoses (but not limited to these diagnoses) will be seen more frequently as outlined below:

1. Patients with hypertension (high blood pressure), hyperlipidemia (high cholesterol), prediabetes, and/or hyper/hypothyroidism (thyroid disease) will be seen minimally every 6 months.

2. Patients with diabetes, patients requiring schedule 3-5 controlled medications (at the discretion of the physician), and/or patients with an extensive problem list consisting of multiple comorbidities will be seen minimally every 3 months.

3. Patients with chronic pain and/or those patients requiring schedule 2 controlled medications will be seen every month.

4. Patients being prescribed weight loss medications will be seen at least every 3 months.

5. Any patients needing any type of forms/paperwork filled out, i.e., disability, FMLA, etc. will require an appointment to complete said forms/paperwork.

_____ __/___/___
Print Name DOB

_____ _____
Patient/Legal Guardian Signature Date