

# GULF COAST HEALTHCARE SYSTEMS, INC.

## **PATIENT INFORMATION:**

**Today's Date:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip code

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Sex: M F (Please circle) Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Patient Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip code

### **If insurance coverage is under spouse, please list the following information:**

Spouse Name: \_\_\_\_\_

Spouse Date of Birth: \_\_\_\_\_

Spouse Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### **IN CASE OF AN EMERGENCY, PLEASE CONTACT**

\_\_\_\_\_

Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

### **ATTORNEY:**

Do you have an attorney representing you regarding your illness/injury? YES NO

Name of Attorney: \_\_\_\_\_

Address of Attorney: \_\_\_\_\_

Phone ( ) \_\_\_\_\_

### **PATIENT CONDITION**

Have you ever had any surgery? If so, what type or surgery and date(s)?

\_\_\_\_\_

\_\_\_\_\_

Please list current medications: \_\_\_\_\_

\_\_\_\_\_

# GULF COAST HEALTHCARE SYSTEMS, INC.

## PATIENT CONDITION CONT.

Reason for visit: \_\_\_\_\_

Are you currently receiving any home health services?    YES            NO

Is the condition getting progressively worse?            YES            NO

Rate the severity of your pain on a scale of 1 (least) to 10 (severe Pain) \_\_\_\_\_

### **Circle type of pain?**

Sharp            Dull            Throbbing    Numbness  
Aching            Shooting    Burning        Tingling  
Cramps            Stiffness    Swelling        Other

How often do you have this pain? \_\_\_\_\_

Is this pain constant, or does it come and go? \_\_\_\_\_

Does it interfere with your: (circle)    Work            Sleep            Daily Activity            Recreation

Activities or movements that is painful to perform: (circle)  
                          Sitting            Standing            Walking            Bending            Lying Down

### **Circle if you have any of the following conditions:**

Angina    Chemical Dependency    Heart Attack            Metal Implants    Parkinson's Disease  
Arthritis    High Blood Pressure    Diabetes            MS            Sprains – Strains  
Asthma    Emotional / Depression    Osteoporosis            Stroke            Emphysema  
Cancer    Joint Replacement            Kidney Disease            Pace Maker            Thyroid

### **ASSIGNMENT AND RELEASE:**

I, the undersigned, certify that I (or my dependent) have insurance coverage with

And assign directly with Gulf Coast Healthcare Systems, Inc., all insurance benefits. Otherwise services rendered will be payable by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Gulf Coast Healthcare Systems, Inc to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Today's Date**

**I understand that, if for any reason, this account is placed with a collection agency; the collection fee will be added to the account!**

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Today's Date**

### **AUTHORIZATION AND CONSENT**

I, the undersigned, authorize and consent to treatment from Gulf Coast Healthcare Systems, Inc. for treatments that were developed by my Doctor per my Plan of Care.

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Today's Date**

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

**I hereby acknowledge receipt of a written notice of my privacy rights and,**

I consent to GULF COAST HEALTHCARE SYSTEMS using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that GULF COAST HEALTHCARE SYSTEMS reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to MICKEY JONES, C/O GULF COAST HEALTHCARE SYSTEMS, P.O. BOX 1747, Lehigh Acres, FL 33970.

I understand that I have the right to restrict how GULF COAST HEALTHCARE SYSTEMS uses or discloses my protected health information to carry out treatment, payment of health care operations; that GULF COAST HEALTHCARE SYSTEMS is not required to agree to the restrictions and; that GULF COAST HEALTHCARE SYSTEMS is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

\_\_\_\_\_

\_\_\_\_\_

I have the right to revoke this consent by notifying GULF COAST HEALTHCARE SYSTEMS in writing, except to the extent that GULF COAST HEALTHCARE SYSTEMS has taken action in reliance on my consent.

\_\_\_\_\_

Signature of patient or patient's representative

\_\_\_\_\_

Date

\_\_\_\_\_

Printed name of patient or patient's representative

\_\_\_\_\_

Relationship to patient or Representative's authority to act for the patient

**GULF COAST HEALTHCARE SYSTEMS, INC.  
PATIENT'S RIGHTS AND RESPONSIBILITIES**

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what rule and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning planned course of treatment, alternatives, risk, and prognosis.
- A patient has the right to refuse treatment, except as otherwise provided by law.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to express grievances regarding any violations of his or her rights, as stated in Florida law, through and grievance procedure to the health care provider.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, must notify the health care provider.

A patient is responsible for his or her actions if he or she refused treatment or does not follow the health care provider's instructions

\_\_\_\_\_

Patient's Signature

\_\_\_\_\_

Date