

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