Registration Form

DEMOGRAPHICS

Patient Name: ____ Date of Birth:__________________

Address: ____

City: ____________________________________ State: __________ Zip Code: ______________________

Home Phone Number:_____________________________ Cell Phone Number: ____________________________

E-mail: ____ Marital Status: ______________________________

Social Security Number: ___________________________ Race: ______________________________________

Preferred Language (If other than English): _______________________ Ethnicity: O Hispanic O Non-Hispanic O ______________

Sexual Orientation:
- O Heterosexual/Straight
- O Homosexual/Gay/Lesbian
- O Bisexual
- O Choose Not to Disclose
- O Other:_______________________

Gender Identity:
- O Male O Female
- O Transgender
- O Transgender – Female to Male
- O Transgender – Male to Female
- O Genderqueer, Neither Male nor Female
- O Choose Not to Disclose
- O Other:______________________________

EMERGENCY INFORMATION

Emergency Contact: _______________________________________Phone Number:_________________________________

Name of Person that helps provide care for you:____

Phone Number:_________________________________ Caregiver Lives: O With you O Separately

Name of Closest Relative not living with you:_________________________________ Phone:__________________________

Address:_________________________________ City:______________________ State:__________ Zip:_____________________

PHARMACY/PRIMARY CARE PHYSICIAN

Local Pharmacy Name: ____________________________________ Pharmacy Phone:_________________________________

Pharmacy Address:____

Mail In Pharmacy Name: __________________________________ Pharmacy Phone:_________________________________

Pharmacy Address:____

Name of Current or Prior Primary Care Physician:____

INSURANCE

Primary Insurance Company Name:____

Policy #: ______________________________Group:____________________ Effective Date: ____________________________

Secondary Insurance Company Name:____

Policy #: ______________________________Group:____________________ Effective Date: ____________________________

Patient Signature: ____ Date: ______________________

Legal Guardian/POA: ____ Relationship: ________________

MaxHealth

Medical History

Patient Name: ____ Date of Birth:_______________________

MEDICATIONS/PRESCRIPTIONS (including vitamins and supplements)

Drug	Dose	How Often

PAST MEDICAL HISTORY (Please check any medical conditions you have been diagnosed with in the past)

O Anxiety Disorder	O Has Pacemaker	O Mental Disease
O Asthma/Wheezing	O Epilepsy	O Osteoporosis
O Arthritis/Gout	O Gallbladder Disease	O Skin Disease
O Blood Disorder(s)	O Glaucoma/Blindness	O STD's (VD)
O Bronchitis/Pneumonia	O Heart Disease	O Stroke/TIA
O Cancer	O Hemorrhoids	O TB/TB Exposure
O Colitis	O Hepatitis or Jaundice	O Thyroid Disease
O COPD	O High Cholesterol	O Transfusion – Date:_______________
O Diabetes	O Hypertension	O Ulcers
O Drug/Alcohol Addiction	O Kidney Disease	O Other:_________________________

ALLERGIES (Please list allergy and reaction)

____

____

PAST SURGICAL/HOSPITAL

Past Surgeries/Hospitalizations	Date of Surgery/Hospitalization

FAMILY HISTORY (please list any known conditions your immediate family members had/have)

Are you adopted? : O Yes O No

Relationship	Condition

SOCIAL HISTORY

Do you use tobacco?	O YES – Pack per day ___________	O NO
Do you drink alcohol?	O YES – Drinks per day___________	O NO
Do you drink caffeine (coffee, tea, colas)?	O YES – Drinks per day___________	O NO

PREVENTATIVE HEALTH/IMMUNIZATION HISTORY

□ Measles □ Mumps □ Rubella □ Hepatitis A and/or B □ Polio

□ Tetanus Last Vaccination Date ______________________ Where ___________________________________

□ Shingles Last Vaccination Date ______________________ Where ___________________________________

□ Flu Last Vaccination Date ______________________ Where ___________________________________

□ Pneumonia Last Vaccination Date ______________________ Where ___________________________________

□ Prevnar 13 Last Vaccination Date ______________________ Where ___________________________________

□ Covid Type: □ Moderna □ Pfizer □ Jessner (Johnson & Johnson)

1st Dose Date ______________ 2nd Date ________________ Where _______________________________

Booster Date_______________ Where______________________________________

□ Bone Density Date ____________ Where ________________________

□ Eye Exam Date ____________ Where ________________________

□ Mammogram Date ____________ Where ________________________

□ Pap Smear Date ____________ Where ________________________

□ Colon Cancer Screening Date ____________ Where ________________________

Type: □ Colonoscopy □ ColoGaurd □ iFOBT (Fecal Occult Blood Test) □ Sigmoidoscopy

CIRCLE OF CARE (Please identify the specialists that you are currently seeing and provide name)

- Allergist ______________________________
- Behavioral Health ________________________
- Cardiology______________________________
- Dermatology____________________________
- Endocrinology___________________________
- Ear, Nose, Throat_________________________
- Gastroenterology_________________________
- GYN/OBGYN____________________________
- Hematology/Oncology_____________________
- Infectious Disease________________________
- Nephrology______________________________
- Neurology_______________________________
- Orthopedic______________________________
- Pain___________________________________
- Physical Therapy_________________________
- Podiatry________________________________
- Pulmonology_____________________________
- Rheumatology____________________________
- Urology________________________________
- OTHER_________________________________

ADVANCE DIRECTIVES

Do you have an Advance Directive? □ Yes □ No

Health Surrogate? Name:________________________ □ Yes □ No

Living Will? □ Yes □ No

Power of Attorney? □ Yes □ No

Authorization for Use or Disclosure of Protected Health Information

Patient Name:____ Date of Birth:______________________

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects sensitive patient health information from being disclosed without the patient's consent or knowledge. The purpose of this form is to identify the circumstances you authorize the disclosure of such sensitive information.

I hereby authorize the of release medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information as it concerns the above referenced patient as follows:

To: (check all that apply):

□ My spouse/partner — Name of spouse/partner: ____________________________________
□ My Physician/staff — Name of Physician: ____
□ My Pharmacy — Name of Pharmacy: ____
□ My parent/child(ren) — Name(s): ____
□ My Personal Representative — Name of Representative: ____________________________________
□ Other Name: ____
□ None of the above

I authorize the Practice[1]/provider to communicate via the below methods (*please circle yes or no for each method listed below*):

Yes No Leave a voicemail message at the provided phone numbers

Yes No Text me at the provided phone numbers

Yes No Email me at the provided address

Please circle yes or no for each of the below

Yes or No I authorize the Practice to use or disclose my protected health information (PHI), including my name, phone number, mailing address and email account listed below, to communicate with me about the Practice's products, services, community events or other general health information. I understand that these communications may be considered marketing communications, and that I will have the opportunity to opt-out of these communications at any time. The practice will/will not receive financial remuneration in relation to these communications. I also understand that mail, text message, and email are not secure and may be intercepted by unauthorized parties, and specifically authorize the Practice to communicate with me about products, services, community events, or other health information via phone, text message, email or regular mail. I understand that some of these communications may result in charges from my telecommunications provider.

Yes or No I further authorize the Practice to take photos, videos, and recordings to of me (or person for whom I am legal guardian), and specifically authorize the Practice to disclose such images for marketing purposes, including, on social media sites, in journals, publications or other educational materials, in marketing publications, in electronic or paper form, and in medical publications/treatment examples for other patients. I understand that by authorizing the disclosure of images of me (or persons for whom I am legal guardian), the images may be seen by members of the general public, in addition to scientists, and medical researchers that regularly use publications in their professional education, as well as use for marketing purposes including, without limitation, website marketing, newspaper and television advertising. I understand that it is possible that someone may recognize me (or person for whom I am legal guardian). I acknowledge that the Practice is the sole owner of all rights in and to the photos, videos,

[1] Practice includes Best Value Healthcare, LLC, Florida Medical Specialists, LLC, Ridge Medical Associates, LLC, RVP Medical, LLC, Southeastern Primary Care Associates, LLC, Zephyrhills Primary Care Associates LLC, Sarasota Primary Care Associates, LLC, North Ft. Lauderdale Primary Care Associates, LLC, Lakewood Ranch Primary Care Associates, LLC, Riverview Primary Care Associates, LLC, Lakeland Primary Care Associates, LLC, Palmetto Primary Care Associates LLC, Town & Country Primary Care Doctors, LLC, St. Petersburg Primary Care Associates, LLC, Celebration Primary Care Associates, LLC, New Port Richey Primary Care Associates, LLC, Primary Care Associates of Port Richey, LLC, Wildwood Primary Care Associates LLC, Summerfield Primary Care Associates LLC, Plant City Primary Care Associates LLC, WC Holding Company, LLC, Valrico Medical Clinic LLC, Yogesh Ranpariya M.D. LLC

and recordings, in whatever format they are in. The Practice has the right, among other things, to edit and otherwise alter the photos, videos, and recordings, as deemed needed or desirable. I understand that this authorization applies to any photos, videos and recordings that were taken or used by the Practice prior to the date of my signature below. I understand I will receive no compensation for the Practice's use of the photos, videos and recordings.

Are there any restrictions on PHI to be disclosed? □Yes □ No
If yes, please describe:
____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my revocation will not affect any actions taken prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 50 years from the date signed, at which time this authorization to obtain and release this protected health information expires.

____ ____________________
Patient Signature or Authorized Representative Date

____
Patient Name Printed

____
Relationship to patient if not patient

For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the patient above, and attach proof of your authority to act on the patient's behalf (other than natural parents).

MaxHealth

Patient Care Agreement

Patient Name: ____ Date of Birth: _____________________

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the medical care and treatment tendered to the patient as deemed necessary or advisable in the judgment of the MaxHealth[2] ("MaxHealth") physician or other health care provider. I understand that, prior to rendering treatment, the physician or other health care provider will explain my medical care and treatment, including an explanation of treatment alternatives and the risks associated with such treatment. I acknowledge and consent to the following:

1. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: I hereby expressly authorize MaxHealth and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to MaxHealth and all professionals providing for such care, and I hereby assign such sums to them. I understand this authorization and assignments shall remain valid unless I provide written notice of revocation to MaxHealth and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
2. NOTICES OF PRIVACY PRACTICES: I acknowledge I have received a copy of MaxHealth's Notice of Privacy Practices on or before the date signed below. A copy of MaxHealth's Notice of Privacy Practices is also located here: mymaxdoc.com.
3. CONSENT FOR COMPREHENSIVE EXAM INVOLVING PELVIS AND/OR RECTUM: I here by consent to (check box)
    - o FEMALE Gynecologic exam which may include the examination of external genitalia, a pelvic exam and a rectal exam
    - o MALE digital prostate exam including a rectal exam
4. PAYMENT FOR SERVICES: I agree to pay MaxHealth for services rendered. If I am insured by a health insurance plan in which MaxHealth participates, MaxHealth will submit a claim to my insurance carrier. I understand that my insurance coverage is a contract between me and my insurance company, and not MaxHealth. I understand that I am responsible for any charges denied by my insurance carrier along with any charges classified by my insurance carrier as a deductible, co-payment, and/or coinsurance.

By signing this document, I certify that I have read, understand and agree to its contents and that information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.

Patient/ Representative [Print]: ____

Patient/ Representative [Signature]: ____

DATE [mm/dd/yyyy]: ________________

If not signed by patient, please provide documentation of legal representative status:
Attached: [ ] Do not have copy: [ ]

[2] MaxHealth includes all legal entities Best Value Healthcare, LLC, Florida Medical Specialists, LLC, Ridge Medical Associates, LLC, RVP Medical, LLC, Southeastern Primary Care Associates, LLC, Zephyrhills Primary Care Associates LLC, Sarasota Primary Care Associates, LLC, North Ft. Lauderdale Primary Care Associates, LLC, Lakewood Ranch Primary Care Associates, LLC, Riverview Primary Care Associates, LLC, Lakeland Primary Care Associates, LLC, Palmetto Primary Care Associates LLC, Town & Country Primary Care Doctors, LLC, St. Petersburg Primary Care Associates, LLC, Celebration Primary Care Associates, LLC, New Port Richey Primary Care Associates, LLC, Primary Care Associates of Port Richey, LLC, Wildwood Primary Care Associates LLC, Summerfield Primary Care Associates LLC, Plant City Primary Care Associates LLC, WC Holding Company, LLC, Valrico Medical Clinic LLC, Yogesh Ranpariya M.D. LLC

Authorization to Release Healthcare Information

Patient Name: ____________________________________ Birth Date: ____

Previous Name: ___________________________________ Social Security: ###-##-________________________________

I request and authorize my healthcare information to be:

Release to:

MaxHealth

Fax to: 866-554-1914

Release from:

____

____

INFORMATION TO BE PROVIDED (check one or more):

☐ All Medical Records/Information
☐ Abstract
☐ Billing records
☐ Outpatient Record
☐ Diagnostic Test/Results
☐ History & Physical
☐ Discharge Summary
☐ Other: ____

Do not include:
____

Unless indicated above, I acknowledge that this request specifically includes medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information if in the possession of MaxHealth (“MaxHealth”).

Please include date(s) of service from: _______________ to _______________ (records will be provided for all service dates if left blank)

FORMAT

I request that the copy be provided (where possible/available):

☐ On paper ☐ In an electronic format ☐ Discuss my medical information only ☐ Other: _______________________

If requesting an unencrypted format, by signing below you acknowledge that you understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties. I understand there may be a fee for a copy of my health information. All fees will be in compliance with applicable law.

Patient Signature:____ Date:_____________________

THIS AUTHORIZATION EXPIRES WHEN THE PATIENT IS
NO LONGER UNDER THE CARE OF THE FACILITY REFERENCED ABOVE