OPĒS HEALTH

ADULT | PATIENT REGISTRATION

PATIENT NAME: (LAST)________________________(FIRST)___________________(M)__CELL: (___)_______________

HOME: (___)________________**PERSONAL E-MAIL:** (FOR PATIENT PORTAL) ___________________________________

DATE OF BIRTH: ____/_____/______AGE:_____**GENDER:** MALE FEMALE **SOCIAL SECURITY**:_______-______-______

MARITIAL STATUS: SINGLE MARRIED WIDOW(ER) OTHER ____

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO LANGUAGE:________________________________

RACE: AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN AMERICAN NATIVE HAWAIIAN OR PACIFIC ISLANDER CAUCASIAN

ADDRESS:___________________________________ APT:______CITY:______________STATE:_______ZIP:__________

MAILING ADDRESS: (IF DIFFERENT FROM ABOVE) ____APT:_____

CITY:__________________________STATE:____ZIP:_____________

EMPLOYMENT: FULL TIME PART TIME FULL TIME STUDENT PART TIME STUDENT OTHER_____________

PRIMARY CARE PHYSICIAN: ______________________PHONE: (___)______________FAX: (___)_______________

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY CARE):__________________PHONE: (___)______________

RESPONSIBLE PARTY/RELATIONSHIP: MOTHER FATHER LEGAL GUARDIAN OTHER ___________________

NAME:_____________________________DATE OF BIRTH: __________________SS:__________-_______-__________

PHONE: (___)___________________EMPLOYER NAME: ____

ADDRESS: (IF DIFFERENT FROM ABOVE) ____

PRIMARY INSURANCE: ___________________**SUBSCRIBER SSN OR MEMBER ID**:_________________________

SUBSCRIBER: (IF DIFFERENT FROM PAITENT)_________________ DATE OF BIRTH _________RELATION___________

SUBSCRIBER ADDRESS:________________________________ CITY:________________STATE:_____ZIP:__________

SECONDARY INSURANCE:______________________________SUBSCRIBER: _______________________________

IN CASE OF EMERGENCY: PLEASE LIST THE FAMILY MEMBERS OR SIGNIFICANT OTHERS, IF ANY WHOM WE MAY INFORM ABOUT YOUR MEDICAL CONDITION **NAME:**______________________**PHONE:** (____)_______________

HOW DID YOU HEAR ABOUT US?____

Preferred Television Network:____

HIPAA Consent: Please list the family members or other person, if any, who we may inform about your general health condition and your diagnosis (including treatment, payment, and health condition):

____

Restrictions: I request the following restrictions to the use or disclosure of my health information:___________________

____

Messages or Appointment Reminders: I authorize the Practice to leave a message using doctor's/practice name on the following numbers Cell Home Work

_____**Privacy Notice:** I acknowledge that I have been provided with OPĒS HEALTH'S Notice of Privacy Practices.
INITIAL

_____**Release of Results:** I understand that any and all results will not be released over the phone. I must schedule a follow up appointment in order to discuss my results and/or treatment plans.
INITIAL

ADULT | PATIENT REGISTRATION

REQUEST FOR CARE AND CONSENT FOR TREATMENT

CONSENT OF TREATMENT: I hereby grant my authorization and consent for treatment and procedures, and certify that no guarantee has been made as to the results obtained.
COMPLICATIONS: I understand it is my responsibility to return to the Practice or report any change in condition to the Practice's Doctor.
ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to OPĒS HEALTH of any insurance benefits otherwise payable to me for services, at a rate not to exceed OPĒS HEALTH'S regular charges for such services.
AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of my medical records and related information from OPES HEALTH to authorized representatives of my third party payor or physician related to my care. I authorize review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

The undersigned certifies that he/she has read the above and is the patient, guarantor or the patients representative duly authorized to execute this agreement and accept its terms.

SIGNATURE OF PATIENT/REPRESENTATIVE ______________________ DATE ______________

PRINT REPRESENTATIVE NAME ______________________ RELATIONSHIP TO PATIENT ______________

FINANCIAL RESPONSIBILITY

STATEMENT OF FINANCIAL RESPONSIBILITY
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.
NOTICE OF "NON-COVERED SERVICES"
I am aware that some services performed by the Practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.
WAIVER OF "USUAL, CUSTOMARY AND RESONABLE" CLAUSES (For patients with "Out-of-Network" Coverage)
I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for who I assume financial responsibility, may exceed the fees considered "usual, customary, and resonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.
BILL TO/PAYMENT INSTRUCTIONS
I am aware that some services performed by the Practice may be considered "non-covered by my Insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.
______ Commercial Insurance/Third Party Payor ______ Medicare ______ Medigap
INITIAL INITIAL INITIAL
FINANCIAL AGREEMENT
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay resonable collection and attorney fees for collection expenses.

Patient's Name: ______________________ **Date:** ______________

Patient (or legal guaradian's) Signature: ______________________ **Relationship to Patient:** ______________

OPĒS HEALTH

ADULT | PATIENT REGISTRATION

As your healthcare provider, we are committed to providing you with the best possible health care. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment is due at time services are rendered: We accept cash, check and credit cards.

Cancelled appointments: If you need to cancel or reschedule an appointment it must be done at least 24 hours in advance. There is a $35 fee for missed or cancelled appointments with less than 24 hours' notice.

Arriving late: Patients arriving 15 minutes late to their appointment time will need to reschedule for another day.

Returned checks: There will be a $35 charge on all returned checks.

Contracted coverage: Co-payments and deductible must be paid at the time of service. Because we are providers with insurance companies, we will file your insurance claim directly.

Medicare: You are responsible for your annual deductible and 20% of the allowable charges due at the time of service, unless you have supplementary insurance. Please bring your Medicare Explanation of Benefits (EOB) showing that you have met your deductible.

HMO/MCO: If you are required to select a PCP by your insurance carrier, then you must change your PCP prior to scheduling an appointment with our office. If this is not done and your insurance carrier declines payment you will be responsible for the office visit in full based on our fee schedule.

Financial Agreement: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

A. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

B. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

We must emphasize that as your health care provider, our relationship and concern is with you and your health, not your insurance company.

All charges are your responsibility from the date services are rendered.

Any balance on your account after 90 days, including those that insurance has not paid, may result in a collection action. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our billing staff promptly for assistance in the management of your account. We are willing to work with you on setting up a payment plan.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above referenced information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above financial policy.

Patient's Signature:____Date: ____________

Print Name:____

OPĒS HEALTH

Controlled Substance Agreement

I, ____________________________, understand that I have a medical condition, ________________, that requires use of controlled substance medication(s) because this medical condition has not been adequately controlled with non-controlled medications and that my function is limited by this medical condition. I understand that the intent of this medication is to increase my ability to do more, though the controlled substance medication is unlikely to eliminate my condition.

________ (initial) I will take the medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my doctor.

________ (initial) **(Females Only)** I understand a pregnancy test will be required by the physician prior to prescribing the medication.

________ (initial) I understand the provider will need my previous doctor's records showing I have been on this medication prior to prescribing.

________ (initial) I understand that the medication will be prescribed only by Dr. _____________ and only according to the agreed upon schedule. Prescriptions will be provided only during regular business hours. Medications will not be called in or electronically sent to the pharmacy.

________ (initial) I understand an EKG and urinalysis drug screening are both required prior to prescribing medication.

________ (initial) I will not seek or accept any additional controlled substance medications (i.e. pain, anxiety or stimulants) other than those prescribed by my doctor. This includes prescriptions from other doctors, medications borrowed or accepted from family or friends and any illicit or street drugs.

________ (initial) Medication refills will be provided as written prescriptions only. Refill requests submitted by your pharmacy will not be filled. No refills will be given prior to 30 days. I understand that I must make appointments with my doctor at least every (3) months or sooner if my doctor recommends. No refills will be given if I do not keep these appointments. Two (2) no show appointments will constitute grounds for immediate dismissal from the practice.

________ (initial) I understand that my doctor is under no obligation to provide these medications to me, and that he/she reserves the right to discontinue these medications at any time. If I refuse, I understand the medications will be stopped.

________ (initial) I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen controlled substance prescriptions.

________ (initial) I understand that my doctor may request specialist evaluation of my treatment and I agree to keep appointments. My doctor will send a copy of my medical record and care to the referred physician.

OPĒS HEALTH

Controlled Substance Agreement

________ (initial) I understand that my doctor by law is required to report all controlled substances dispensed to me to the state monitored prescription monitoring program.

In addition to the above agreements, I accept the right of my doctor's staff to terminate this agreement for any of the following reasons:

a) I seek or obtain any pain medication from a source other than my doctor.
b) I in any way attempt to forge or alter a prescription.
c) I distribute my prescribed medication(s) to any other person.
d) My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents danger to my well being or safety.
e) There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.
f) At every office visit urine will be collected. Refusal of collection is grounds for termination.

________ (initial) I agree to fill my prescriptions only at the pharmacy listed below. If I change pharmacies, I will contact my doctor's office with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time.

________ (initial) I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and immediate dismissal from my doctor and the practice.

________ (initial) I understand that if I default from this agreement and I am having a medical condition I should call 911 or go to the nearest emergency room.

Patient Name: (printed) ____

Patient Signature: ____

Date Signed: _____________________ Date of Birth: ___________________

Physician Signature: ____

Date Signed: _____________________

Pharmacy:

____

OPĒS HEALTH

GAD-7 Anxiety Scale

	Not at all	Several days	More than half the days	Nearly every day
Over the last two weeks, how often have you been bothered by the following problems?				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
TOTAL SCORE*___________=	Add Columns	_________+	_________+	_________
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people				
Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

*Score: 5 to 9 = mild anxiety; 10 to 14 = moderate anxiety; 15 to 21 = severe anxiety.

PHQ-9 Depression Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on thing, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Column Totals	_______ + _______ + _______			
Add Totals Together	______________________			

PHQ-9 score ≥10: Likely major depression

Depression score ranges:

5 to 9: mild

10 to 14: moderate

15 to 19: moderately severe

≥20: severe

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Medical Records Release

OPĒS HEALTH

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: ____

____

____

to release copies of all medical records complied during office visits and/or hospital admissions for:

Patient: ____

Date of Birth: ____

SSN: ____

Medical records including but not limited to:

Office Visit Notes   History and Physical   Nurses Notes   Labs   EKG   X-Rays

Physical/Occupational therapy notes   HIV Results   Mental Illness   Other:_________________________

Release medical records to: OPĒS HEALTH CHANNELSIDE
912 Channelside Dr. Suite 2102-2103
Tampa, FL 33602

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
This consent will expire 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Manager at the address listed above.

Note: There may be a processing fee charged to the patient of $1.00 a page to cover labor, copying, and supplies used to reproduce medical records. There is NO charge for medical records going to another healthcare provider.

Patient/Guardian Signature:_________________________________   Date:____________________

Print:____