Patient Information

Last Name: ______________________ First: ___________________ Middle ____________

Male/Female Date of Birth __________ Age ____ Social Security # __________________

Single/married/divorced/widowed

Race: Caucasian/African American/Hispanic/Native American/ Other _____________

Address ____

Home Phone ________________ Work __________________ Cell ____________________

Email address ____

Primary Care Physician_____________________ Referring Physician ____________________

Insurance Information

Primary Insurance ______________________________ Policy/ID #_______________________

Policy Holder __________________________________

Secondary Insurance ____________________________ Policy/ID# _______________________

Policy Holder ____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Private insurance, or any other Health/Auto Insurance plans to IDC of Volusia. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary (including photocopies of medical records) to secure payment (see notice of privacy practices.) Also, by signing below I am attesting that I have received a copy of the privacy practices for this office (available from receptionist.)

Patient/Guardian ________________________________ Date ______________________

If under the age 18, please print guardian's name __________________________________

*It is the patient's responsibility to be aware of their individual plans, policies, and benefits. The filing of claims for you does not guarantee payment from your insurance provider, nor should it be considered a binding agreement of payments and/or benefits from your insurance provider. As a patient of IDC of Volusia, you are responsible for the entire bill of services should your insurance provider deny payment for any reason. By signing this statement as a guarantor, you agree to pay for all services and/or supplies that are deemed patient responsibility by IDC of Volusia or your insurance provider.

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Dr. Reba Isaac

Latoya Moody, ARNP

Personal Healthcare Confidant

I, ______________________________, elect the following person/people, listed below as my personal Healthcare confidant(s). **I give permission to the above named physician and her office staff to release any and all information regarding my medical treatment to my elected personal Healthcare confidant(s).** I understand that should I choose to change or remove an elected person, I must do so in writing in the presence of the staff, or by sending my notarized request in the mail.

Elected Person	**Relationship**
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________

May we leave messages on your answering machine or voice mail regarding your health (including but not limited to labs, radiology reports, and appointments)

Yes **No**

Patient Signature ____________________________ Date______________

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Reba K. Isaac, M.D.

Latoya Moody, ARNP

Name ____ DOB____________________

Past Medical History

____Diabetes ____High blood pressure ____Coronary Artery Disease ___Lung Disease

___Emphysema ___Asthma ___Kidney disease ___Liver disease ___Thyroid disease
___Vascular disease ___Stroke ___Heart attack ___Angina ___Bleeding problems
___Ulcers ___seizures ___Heart murmur ___Back Injury ___Rheumatic Fever

___Cancer (Type) ____

___Other medical problems____

Allergies:

Allergen/Reaction	Allergen/Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Surgical History:

Procedure	Date
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

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Reba K. Isaac, M.D.

Latoya Moody, ARNP

Name: ______________________________ DOB________________

Family History:

___Heart Disease (____________________) ___Diabetes (____________________)

___High Blood Pressure (________________) ___Cancer (____________________)

___Stroke (________________________) ___Lung Disease (________________)

___Kidney Disease (____________________)

Children? ____ How Many? ____________ Ages? ______________________________

Social History:

___Current Smoker, Packs per day__________ ____Past Smoker Quit__________

___Never smoked ____Recreational drug use Specify________________________

___Alcohol use Type______________________________

Amount/how often________________________________

___Never drink

___Pets Type/vaccinated____

Occupation: ____

Have you had recent tests done? Where? ________________________________

Current symptoms:

___Pain (specify) __________________ ___swelling ___Drainage ___Night Sweats ___Chills ___Fever ___Thrush ___Increase/Decrease appetite ___Weight gain/loss ___Nausea/Vomiting ___Diarrhea ___Frequent urination ___Pain while urinating ___Foul odor while urinating.

Are you currently or recently taken antibiotics? ______________________________

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Reba K. Isaac, M.D.

Latoya Moody, ARNP

Name: ______________________________ DOB ____________________

Pharmacy: ____

Location: ____

Phone: ________________________

Medication List

Medication	Strength	Frequency

Please be sure to list vitamins and supplements as well

Next page

General Office Policies

Missed Appointments

We require 24hours notice if cancelling an appointment. This allows us to offer that appointment to someone else who may need it. You may be billed a $20 missed appointment fee. This fee is not covered by insurance.

Returned Check Fees

There will be a $20 fee on all returned checks, in addition to any bank fees assessed.

Prescription Refill Policy

We ask that you contact your pharmacy directly for any prescription refills written by either Dr. Reba Isaac or Latoya Moody, ARNP. If the prescription is expired, the pharmacy will contact us directly for renewal. Prescriptions will not be filled on the weekends. Be sure to contact your pharmacy Monday through Friday (early on Friday.)

****This applies to all insurances except Florida Health Care****

Please allow two business days for refill requests
Prescriptions will only be filled during business hours.
Prescriptions will not be filled on weekends

***By signing the document below, I agree to the above terms and conditions of this office and understand that non-compliance of the terms may result in termination from the practice.**

Printed Name: ______________________________

Signature of Patient: ______________________________

Date: ______________________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________________

Phone: H) ______________________ **Phone: W)** ______________________

Address: ______________________ **City/State/Zip:** ______________________

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ______________________ **Facility Phone:** ______________________

Facility Address: ______________________ **Facility Fax:** ______________________

City, ST, Zip: ______________________

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: ______________________
☐ Specific Information Requested:
____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other ______________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ______________________

Address: ______________________

City, State, Zip: ______________________ ☐ **Please mail records.**

Fax: ______________________ **Phone:** ______________________ ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** ______________. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X______________________ ______________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

______________________ ______________________

Printed name of Authorized Representative

Relationship / Capacity to patient

____

Address and telephone number of authorized representative