SOLE HEALTH

Demographics:

Last Name: First Name: MI:

Address:

City: State: Zip:

Date of Birth: Sex: Male Female Transgender

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered

Contact Information:

Home Phone: Cell Phone:

Email Address:

Emergency Contact Name: Emergency Contact Phone:

Pharmacy:

Local Pharmacy Name: Local Pharmacy Number:

Supplemental Data Collection:

Race:

☐White	☐Hispanic	☐Black-African American
☐Asian	☐American Indian	☐Native Hawaiian
☐Other/Pacific Islander	☐Unreported/Refused to Report	☐Other-Race

Preferred Language:

☐English	☐Spanish	☐Other

How did you hear about us? _____

SOLE HEALTH

NEW PATIENT HEALTH HISTORY

Name: _____ DOB: _____

Reason for visit: select or describe:

- Established care with a new Primary Care Provider.
- _____
- _____
- _____

Past Health History:

Have you ever had any of the following medical conditions?

□ Acid reflux
□ Anemia
□ Anxiety (low blood count)
□ Anxiety / Panic attacks
□ Arthritis
□ Asthma
□ Blood clotting problems
□ Cancer (Type: _____)
□ Chronic back pain
□ Constipation
□ COPD / Emphysema
□ Dementia / Alzheimer's
□ Depression
□ Diabetes
□ Erectile dysfunction
□ Eye disorder (Specify:_____)
□ Fibromyalgia
□ Gout
□ Gynecological problems (Specify: _____)
□ Hearing loss
□ Heart disease / Heart attack
□ Heart failure
□ Heart murmur
□ High blood pressure
□ High cholesterol
□ Irregular heart beat/palpitations
□ Joint problems (Specify: _____)
□ Kidney problems (Specify: _____)
□ Liver problems
□ Migraines/Chronic headaches
□ Mobility problems
□ Osteoporosis
□ Prostate problems
□ Seasonal allergies
□ Seizures
□ Sexually transmitted disease
□ Skin condition (Specify: _____)
□ Stomach / GI problems (Specify: _____)
□ Stroke / TIA
□ Substance or alcohol abuse
□ Thyroid problems
□ Urinary tract infection
□ Urinary incontinence
□ Other: _____
□ Other: _____
□

Have you had any of the following surgeries?

☐Appendectomy
☐Back surgery
☐Biopsy
☐Breast surgery
☐Carotid artery surgery
☐Cataract surgery
☐Coronary artery bypass
☐Colon surgery
☐ C-Section(s)
☐Dilation & Curettage (D&C)
☐Gallbladder removal
☐Gastric bypass/Weight loss
☐Heart stent(s)
☐Hemorrhoids
☐Hernia repair
☐Hysterectomy
☐Joint replacement
☐Pacemaker insertion
☐Prostate surgery
☐ Tonsillectomy
☐ Skin graft
☐Other: _____

Prior Hospitalization:

Year: _____ Reason: _____
Year: _____ Reason: _____
Year: _____ Reason: _____

List Health care providers involved in your care:

_____
_____
_____

SOLE HEALTH

Name: _____ DOB:_____

Allergies: *Please include name of medication or food and type of reaction*

Name	Reaction	Name	Reaction

Current Medications: *Please include prescription medications, over-the-counter drugs, vitamins and supplements*

Name/Dose	#Tabs/Frequency	Name/Dose	#Tabs/Frequency

Family History: *Please indicate if any of the following conditions are present in your family members*

Relative	Status	Cancer (Specify)	Diabetes	Heart Disease	High Blood Pressure	Mental Illness (Specify)	Stroke	Other (Specify)
Father	□Alive □Deceased		□	□	□		□	
Paternal Grandfather	□ Alive □ Deceased		□	□	□		□	
Paternal Grandmother	□ Alive □ Deceased		□	□	□		□	
Paternal Other_____	□ Alive □ Deceased		□	□	□		□	
Mother	□ Alive □ Deceased		□	□	□		□	
Maternal Grandmother	□ Alive □ Deceased		□	□	□		□	
Maternal Grandfather	□ Alive □ Deceased		□	□	□		□	
Maternal Other_____	□ Alive □ Deceased		□	□	□		□	
Siblings _____	□ Alive □ Deceased		□	□	□		□	
Children _____	□ Alive □ Deceased		□	□	□		□	

SOLE HEALTH

Name:_____DOB:_____

Social History:

Marital status ☐ Single ☐Married ☐Divorced/Separated ☐Widowed ☐In a relationship
Highest level of Education: _____
Occupation: _____
Alcohol use: ☐None ☐Yes (Number of drinks/week:_____)
Smoking: ☐Never ☐Former smoker (Quit Date:_____) ☐Current Smoker (Number of cigs /day:_____)
Recreational drugs: ☐None ☐History of injection drug use ☐Past/Current use (Specific:_____)
Do you exercise regularly ☐No ☐Yes
Have you had a fall in the past year? ☐No ☐Yes
Have you traveled outside the country in the past 3 years? ☐No ☐Yes (Where?_____)
Do you have an Advanced Directive or Living Will ☐No ☐Yes (If yes, please make sure we receive a copy)

Preventative Health History: *Please indicate the date the following were performed*

	Date		Date
Last preventative health visit/complete physical		Stress test or EKG	
Breast cancer screening (Mammogram)		Hepatitis C screening	
Cervical cancer screening (Pap smear)		Flu Vaccine	
Colon cancer screening (Colonoscopy)		Pneumonia Vaccine	
Lung cancer screening (CT scan for high risk only)		Shingles Vaccine	
Osteoporosis screening (Bone density)		Tetanus/TDAP Vaccine	
Prostate cancer screening (PSA)		Other:_____	

SOLE HEALTH

Name: _____ DOB:_____

REVIEW OF SYSTEMS: *if you have experienced any of the following symptoms, please check corresponding box.*

GENERAL

□ Weight gain or loss over 10 pounds
□ More fatigue than usual
□ Fever, chills
□ Night sweats

SKIN

□ Changes in your skin, hair or nails
□ Dryness or changes in texture
□ Rashes
□ Itching
□ Jaundice or yellowing of the skin
□ Moles that have changed in appearance

HEAD

□ Headaches
□ Head injuries

EYES

☐ Trouble with your vision
□ Eyeglasses/contact lenses
□ Eye pain, redness, excessive tearing
□ Double vision
□ Glaucoma
□ Cataracts

EARS

□ Trouble hearing
□ Ear infections
□ Pain in ear
□ Discharge (fluid) from ear
□ Ringing in ears (tinnitus)
□ Spinning or vertigo attacks

NOSE/SINUSES

□ Trouble with nose/sinuses
□ Constant Postnasal drip
□ Significant Nasal congestion
□ Nosebleeds

MOUTH/THROAT

□ Recent change in taste
□ Any bleeding of lips, gums, tongue
□ Any bleeding in mouth or throat
□ Persistent sore throat
□ Hoarse voice

NECK

□ Swollen glands or lumps
□ Stiffness or loss of motion
□ Neck pain

BREAST

□ Breast lumps or bumps
□ Discharge from the nipple
□ Pain in the breast

CARDIOVASCULAR

□ Swelling in legs
□ Difficult or uncomfortable breathing
□ Needing to sleep upright to breathe better
□ Chest pain, pressure tightness with exertion
□ racing, pounding heart beat
□ Irregular heart beat
□ Told you had high blood pressure
□ Told you had a heart murmur

RESPIRATORY

□ Wheezing
□ Regular Coughing
□ Coughing up phlegm (mucus)
□ Coughing up blood
□ Asthma
□ Exposure to someone with TB

GASTROINTESTINAL

□ Trouble/pain with swallowing
□ Frequent Heartburn
□ Pain after eating
□ Abdominal pain/discomfort
□ Nausea/vomiting
□ Vomiting up blood
□ Excessive Gas
□ Changes in bowel habits
□ Constipation
□ Diarrhea
□ Unusual colored stools
□ Bleeding from rectum
□ Hemorrhoids
□ Groin pain with lifting or straining

GENITOURINARY

□ Difficulty passing urine
□ Frequent urination
□ Urinating more than once at night
□ Any pain or burning with urination
□ Leak urine or wet yourself
□ Urine appeared bloody, brown or reddish
□ Urinary infection
□ Passing kidney stones

FOR MEN

□ Sores on or discharge from the penis
□ Lump on the testicle
□ Pain on the testicles

FOR WOMEN

□ Sores on or discharge from the vagina
□ Menstrual cycle irregular
□ Unusual vaginal discharge or odor
□ Unexpected vaginal bleeding

SEXUAL

□ Am sexually active
□ More than one sexual partner
□ Interested in getting pregnant
□ Not using contraception
□ Worried about sexually transmitted infections
□ Problems/concerns about sexual function
□ Had unwanted sexual experience

PERIPHERAL VASCULAR

□ cramps, aches or numbness in legs while walking
□ Swollen feet or ankles
□ Fingertips change color when cold
□ Varicose Veins

MUSCULOSKELETAL

□ Pain in your joints
□ Swelling, redness, warmth in joints
□ Back or shoulder pain
□ Back stiffness
□ Disc problems
□ Weakness in muscles
□ Any bone fractures

NEUROLOGICAL

□ Dizzy spells or lightheadedness
□ Any fainting spells
□ Convulsions or seizures
□ Loss of consciousness
□ Any speech problems
□ Trouble staying alert
□ Problems with memory
□ Numbness or tingling in hands or feet
□ Weakness in particular part of body

HEMATOLOGICAL

□ Bleed or bruise easily
☐ Received any blood transfusion

ENDOCEINE

□ Do you ever feel too hot or too cold
□ Excessive thirst

PSYCHIATRIC

□ Seen a counselor/therapist or psychiatrist
□ Experience mood swings
□ Feel depressed
□ Feel frequently worried or nervous
□ Feel you should cut down on drinking

SOLE HEALTH

Consent for Treatment Authorization for Release of Information Financial Agreement and Consent for Photo ID

NAME: _____ DOB: _____

CONSENT FOR TREATMENT:

Permission is hereby given to the physicians and staff of Sole Health to provide ordinary and necessary medical examination, diagnosis and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care as well as laboratory tests, but shall not include surgery, general anesthesia, laboratory tests for which separate consent is required under the law or other extraordinary procedures. I further consent to routine immunizations for future office visits.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Sole Health providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by Sole Health or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. This authorization shall expire 24 months from the date signed below and is subject to revocation at any time except to the extent that action has been taken in reliance upon it. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Sole Health. I understand that neither Sole Health nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

FINANCIAL AGREEMENT/ASSIGNMENT OF INSURANCE BENEFITS:

I understand that I am obligated to pay Sole Health for services provided to me in accordance with the rates and terms of Sole Health, including **a "No-Show" fee of $25 for missed office visit, if I fail to appear and did not cancel at least 24 hours in advance**. In consideration for services provided or to be provided to me, I hereby assign to Sole Health all basic and major medical or other insurance benefits, including, without limitation, Medicare or Medicaid benefits, to cover such expenses. In connection with such assignment, Sole Health is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information (including, without limitation, copies of any plans, contract, or other documents defining or otherwise limiting the scope of insurance coverage by such carrier) as may be necessary to process any insurance claims related to my treatment by Sole Health. If I am not insured, I hereby authorize Sole Health to use and/or disclose my health information in order to obtain funds to cover expenses related to my treatment by Sole Health. I owe and agree to pay Sole Health for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by Sole Health to collect the balance owed. I also authorize payment directly to Sole Health or the entity providing service under the above account number that would otherwise be payable to me.

HIPAA CKNOWLEDGEMENT:

The undersigned hereby acknowledges that I have received a copy of the Sole Health Notice of Privacy Policy.

CONSENT FOR PHOTO IDENTIFICATION:

I consent to Sole Health taking a digital photograph of my face for purposes of patient identification. The digital photograph will remain with my electronic medical chart and will not be used for other purposes without my authorization.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

_____

Date Signature of Patient or Person Granting Authorization on Behalf of Patient

_____

Witness

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

Thank you for choosing SOLE HEALTH. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Sole Health strives to exceed expectations in care and service to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. To do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS: Our office is available Monday-Friday 8:30am to 5:00pm and may be reached at 954-534-7696. Our Physicians are available after hours 24 hours per day/365 days per year by calling our phone number and following the prompts**. If you need an appointment, prescription refill or test results, please call during regular business hours.**

APPOINTMENTS: To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact or insurance information. While we strive to schedule appointments appropriately, emergencies can and do occur in Primary Care. We strive to give all our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date. To ensure quality care, Sole Health, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined. We encourage you to schedule appointments for preventative health visits, physicals, pap exams, chronic medical conditions, prescription renewals and sick visits.

CANCELLATION OF AN APPOINTMENT: In order to be respectful of the medical needs of our patients please be courteous and call Sole Health promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your scheduled appointment we require that you call one (1) working day in advance

NO SHOW POLICY: A “no show” is someone who misses an appointment without canceling it within one (1) business day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a “no show”. An administrative fee of $25.00 will be billed to your account. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) “no-shows” within one (1) calendar year will result in a temporary suspension of services. To reinstate services, you will be required to meet with your Primary Care Physician within 30 days of the third no show letter to evaluate your situation. In the event you do not respond and/or schedule an appointment within 30 days, we will consider your patient status as terminated. **Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.

INSURANCE: It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

PAYMENTS: Sole Health accepts cash, MasterCard, Discover, Visa and American Express. It is the policy of Sole Health to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

FORMS/LETTERS: We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Sole Health will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow 7-10 days for completion of requested forms/letters.

MEDICAL RECORDS: Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of $0.75 per page. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

PRESCRIPTION REFILLS & PHARMACY INFORMATION: Please inform Sole Health of which Pharmacy you use and update us if this should change. Please allow one to two business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. Please note that we do not fill Narcotic Medications or order Antibiotics over the phone. Our Practice does not routinely order Narcotic Pain Medicine; therefore, you may be required to obtain these medications through Pain Management.

PHONE CALLS:All patients are encouraged to call us with any and all medical questions and concerns. Our receptionist will relay your message to the appropriate clinical staff. We will make every effort to return your call within a 48 hour period. Patients with any medical emergency should seek immediate medical attention by calling 911, going to a hospital Emergency Department, or coming to our office.

PRIOR AUTHORIZATION: Insurance companies frequently deny payment for certain non-formulary prescriptions. Our staff will make every effort to conduct a "prior authorization" on your behalf so that you can receive your medication. This process may take a few weeks. You are invited to inquire about the status of your "prior authorization" with us if your pharmacy refuses to dispense your medicine. An office visit maybe required to address "prior authorization" concerns.

_____INITIALS

SOLE HEALTH

PHONE MESSAGE CONSENT

NAME: _____ DOB: _____

Your provider or office staff will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

Please read the below and consider carefully whom you authorize to have access to protected information regarding your care.

I give Sole Health my permission to speak with and/or leave messages regarding my medical care and/or billing with the person(s) listed below. I fully understand that this consent will remain valid until revoked in writing:

My Home answering machine # _____ Initials: _____

My Cell Voice Mail (VM) #_____ Initials: _____

My Office/representative/family VM #_____ Initials: _____

SOLE HEALTH

Designation of Person Representative

NAME: _____ DOB: _____

As required by the Health Insurance Portability and Accountability Act of 1966 ("HIPPA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form, you are informing us of your wish to designate the named person(s) as your "personal representative**." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to the office**.

DESIGNATION SECTION:

I hereby appoint the following person (s) to act as my personal representative (s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

PRINT Name of Personal Representative (s)	**PRINT relation of each to Patient**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature Date

****I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:**

Sole Health LLC
7261 Sheridan Street,
Suite 100 D
Hollywood, FL 33024

Revocation Section:

I hereby revoke the designation of _____as my personal representative.

_____

Patient Signature Date

SOLE HEALTH

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: _____ DOB _____

I hereby authorize Sole Health to release/ obtain all medical information with respect to the treatment of the above referenced patient, including relating to diagnosis or treatment of mental illness or drug or alcohol abuse and/ or confidential HIV related information.

Release the Medical Records From:

Medical Group Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Fax: (If needed): _____
Phone: _____

Send the Medical Records To:

Name: SOLE HEALTH, LLC
Address: 7261 Sheridan St Suite 100 D
City: Hollywood State: FL Zip: 33025
Fax: (if needed): 954-534-7731
Phone: 954-534-7696

What is the purpose of Health Information Release

☐New Physician ☐Social Security Disability ☐Other
☐Primary Care Physician ☐Medical Ins. Claim
☐Consultation ☐Worker's Com

Describe the Health Information to be Released

Service Dates: from: _____ to: _____

☐Complete Medical Record ☐Other: _____
☐History and Physical ☐EKG's ☐Laboratory Results ☐Hospital Notes
☐Immunization Records ☐Pathology Reports ☐Radiology Reports ☐Clinical Notes
☐Hospital Discharge Summary ☐Operative Reports ☐Radiology Images ☐Billing Information

I understand that Sole Health LLC will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Sole Health LLC. I understand that I may not be able to revoke this Authorization if Sole Health LLC has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.
I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Florida State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event.

_____ _____

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

Printed Name of Person Signing (If Not the Patient) **Relationship to Patient**