2020

Patient Information

Name:_____
Last First M.I.

Address:_____
Street City State Zip

DOB: _____/_____/_____ Sex: M/F_____ Employer: _____

SSN:_____ Email: _____

Cell Phone:_____ Home Phone: _____

Optional: Race: _____ Ethnicity: _____ Language: _____

□ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Emergency Contact

Name:_____ Relation to Patient: _____

Cell Phone:_____ Home Phone: _____

Name:_____ Relation to Patient: _____

Cell Phone:_____ Home Phone: _____

Insurance Information

Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____

2020

AUTHORIZATION TO RELEASE MY MEDICAL CARE

I _____ give Primary Care Physicians of Gainesville permission to discuss my medical care and account information with the following person(s):

_____	_____	_____
Name of authorized person	Relation	Phone
_____	_____	_____
Name of authorized person	Relation	Phone
_____	_____	_____
Name of authorized person	Relation	Phone
_____	_____	_____
Name of authorized person	Relation	Phone

You may leave detailed messages regarding my healthcare (not including lab results) on my:

☐Cell Phone ☐ Home Phone ☐ Neither

You may leave messages regarding my lab results on my:

☐Cell Phone ☐ Home Phone ☐ Neither

Cell Phone:_____ Home Phone: _____

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

STATE MANADATE REGARDING
ALL CONTROLLED SUBSTANCES

The prescribing of ANY CONTROLLED SUBSTANCE is monitored and regulated by the State of Florida. There is REAL risk for addiction and also legal issues concerning abuse and diversion. Because of these issues, the state of Florida Department of Health has laws restricting how controlled substances are prescribed. Due to these regulations, our office must implement doctor-patient agreements for **all patients** being given a controlled substance of any kind.

Accountability is necessary so as to protect our providers' licenses and maintain our liability coverage. These are STATE LAWS and violation is a criminal offense.

1. All **controlled substances must** come from one physician, or during their absence, by one of the covering physicians. Shopping refills with other providers outside of this practice violates this agreement.
2. All **controlled substances** must be obtained at the same pharmacy. Shopping pharmacies violates this agreement.
3. We retain the right to discuss all diagnostic and treatment details, including drugs prescribed, with any other health care provider so as to maintain accountability and open communication.
4. RANDOM urine drug screens WILL be requested at anytime and without notification. If you are taking or using any other medications or drugs, notify the physician PRIOR to the test being performed.
5. Maintain custody of your medications. Most controlled substances have street value and people will steal them. This can and often includes family members. To anyone without tolerance to these medications, they can be hazardous, even deadly. Treat your medication like any other valuable.
6. Medications will not be replaced if they are lost, fall into a toilet, get eaten by your dog, left at a hotel or on a plane. If your medication is STOLEN, you can obtain a replacement with a copy of the official police report at your provider's discretion.
7. Do not try to obtain your prescriptions early. Do not take your medications at a dose or frequency that will cause you to be without medication at the end of the month. Misuse of the prescription violates this agreement.
8. If you break any laws with regards to your medication, for example, if the police or Drug Enforcement Agency requests information regarding our prescriptions, we are REQUIRED to provide authorities with all pertinent information, even without subpoena.
9. The Florida Prescription Drug Monitoring Program called E-FORCSE will be verified for each patient with every prescription given by one of our providers.

Violating these policies ends with permanent cessation of controlled substances from this office and may end with your termination as a patient in this practice. Violating this contract breaks the trust built between a doctor and her patients.

2020

PRIMARY CARE
PHYSICIANS
of Gainesville

Controlled Substance Consent Form and Management Agreement

I, _____ have read or have had the above form read to me and understand all of it. I have had a chance to have all my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment with controlled substance.

DESIGNATED PHARMACY:_____

DATE_____

_____ _____

Witness Patient signature

_____ _____

Witness printed Patient printed

_____

Physician signature/printed

2020

Primary Care Physicians

3780 NW 83rd Street
Gainesville, FL 32606
Phone: 352-377-2022
Fax: 352-377-9113 or 352-377-9574

Records Release

Patient Name:

_____ DOB: _____

TO BE FILLED OUT BY OFFICE STAFF ONLY	
Previous Physician/Office Name:	
Specialty:	
Phone:	Fax:
City:	State:

I hereby authorize and release the custodian of my/my dependent's medical records to Primary Care Physicians of Gainesville, including physical examination reports, laboratory reports, immunizations, diagnostic imaging reports, reports including HIV/AIDS, STD records, mental health records, and substance abuse reports. _____

Patient Initials

Release to: Primary Care Physicians of Gainesville □ Elizabeth Sanders, DO □ Abigail Eley, DNP, ARNP

3780 NW 83rd Street, Gainesville, FL 32606 Fax: 352-377-9113 or 352-377-9574

If records exceed 15 pages we request that they be mailed.* *No computer disk records.

-I understand that all medical, surgical, psychiatric and psychological information is confidential and that the patient records are the property of Primary Care Physicians of Gainesville and its related corporate entities. I will not hold Primary Care Physicians of Gainesville, its employees, staff or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.

-I understand that my authorization for release may be revoked at any time by written request to Primary Care Physicians of Gainesville, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Primary Care Physicians of Gainesville to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest your coverage.

-I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release Primary Care Physicians of Gainesville, its employees, its staff, and representatives from all liability relating to or arising out of this release of information contained Primary Care Physicians of Gainesville records.

-I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from Primary Care Physicians of Gainesville. However, if the only purpose for providing the service is to obtain in formation in order to release information to myself or a third party, then I understand that I might sign the authorization in order to receive the service.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified. Expiration Date or Circumstance: _____

Patient Signature: _____ Date: _____

Relationship to Patient if Not Self: _____

Witness: _____

Requested By: _____ Date: _____