Patient Information for Medical Records

Please fill out all applicable areas

Today's Date: _____

Patient's Name: _____

DOB: _____ SS#: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____

_____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Guardian 1 Name: _____

DOB: _____ SS#: _____ Marital Status: ☐Married ☐Divorced ☐Single

Address: _____

_____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Employer: _____ ☐ Full Time ☐ Part Time

Guardian 2 Name: _____

DOB: _____ SS#: _____ Marital Status: ☐Married ☐Divorced ☐Single

Address: _____

_____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Employer: _____ ☐ Full Time ☐ Part Time

Emergency Contact Name: _____

Phone #: _____ Relationship to Pt: _____

Primary Care Physician: _____ Phone _____ Last Seen: _____

Referring Physician: _____ Phone: _____ Last Seen: _____

Other Physician(s)/Therapist(s) Involved in Your Care:

1. _____ Last Seen: _____
2. _____ Last Seen: _____
3. _____ Last Seen: _____

Has the patient been evaluated by a Psychiatrist this year? ☐ Yes ☐ No If yes, when? _____

Medications (prescriptions, over the counter, and herbal): _____

_____

Medication Allergies: _____

Insurance Information

We are in network with CHP only but as advised during intake, we will be happy to file an electronic claim on your behalf so that your insurance company may reimburse you.

Primary Carrier: _____

Address: _____

Phone #: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

DOB: _____

Secondary Carrier: _____

Address: _____

Phone #: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

DOB: _____

I, _____, give permission for Connie L. Speer, M.D. to provide me/my minor

child _____with services. I also assign directly to Connie Speer, M.D. all medical benefits for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the physician or therapist to release all information necessary to secure payment for benefits. I also authorize a release of information between my physician/therapist and my referring/primary physician regarding my treatment.

_____ _____

Patient or legally authorized signature | Printed name if on behalf of the patient

_____

Relationship (parent, legal, guardian, personal representative)

Please read and initial each of the following:	**Initial**
All payments/co-payments are due at the time of services.	_____
Failure to give 24-business hour notice will result in a "no show" fee.	_____
Please do not leave children unattended in the building.	_____
Prescription requests for controlled substance require 72-hour notice.	_____
Prescriptions outside of regular appointments/lost prescriptions will result in a $25 replacement fee.	_____
Patients on controlled substances must be seen (minimum – Dr.'s discretion) every three months.	_____
Requests for a call from the Doctor will result in a phone consultation fee.	_____
There is a charge (depending on size and difficulty) for letters, paperwork etc.	_____
Requests for a change of medication (type or dosage) or adding a medication require an appointment.	_____
A copy of the custody agreement will be required for all children of divorced parents.	_____
Children under the age of 18 must have a parent or legal guardian present during appointments.	_____

Acknowledgement of Receipt of Notice of Privacy Policies

I acknowledge that I have received a copy of the Providers Notice of Privacy Polices with the effective date of April 4, 2003 (attached).

_____ _____

Signature of Parent/Patient representative | Date

_____

Relationship to patient

CONNIE L. SPEER, M. D.
1407 M. D. LANE, SUITE A
TALLAHASSEE, FL 32308
(850) 877-0635 Option 3
FAX# 850-877-8215

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Name When Treated (if different from above): _____

Social Security Number: _____ Treatment Dates: _____

I. My Authorization

Please release the following information: (check all that apply)

- ☐ HIV/AIDS Testing and/or Treatment
- ☐ Alcohol and/or Drug Treatment
- ☐ Medical Evaluation
- ☐ Medical Progress Notes
- ☐ Laboratory Test Results
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Progress Notes
- ☐ Psychotherapy Notes
- ☐ Summary of Care
- ☐ Financial Information
- ☐ Medication Information

You may disclose this information to:

Name (or title) and organization: _____

Address _____City_____State_____Zip_____

Phone _____ Fax _____

The reason for this authorization is: _____

This authorization ends when revoked by the patient or the patient's representative in writing.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. This authorization may be revoked by writing a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship to patient

Connie L. Speer, MD
1407 M.D. Lane, Suite A
Tallahassee, FL 32308
(850) 877-0635 Option 3
Fax No. (850) 877-8215

Dear Patients:
The following is to remind our current patients and inform out new patients of **current office policies.** Please note that all fees for prescriptions, telephone consultations, and letters/forms/medical records, etc. will be due in full at the time of the pick-up or service.

PRESCRIPTION POLICY
All prescription and refills are now sent to your pharmacy electronically. So please make sure we have your pharmacy on file. Additionally, when prescribing some controlled substances, there is a federal requirement that the clinician see the patient at least once every three months. If you have not been seen within that time frame, your refill request for a controlled substance may be denied.

APPOINTMENT CANCELLATION POLICY
We would like to remind all our patients that cancellations require a one-business day notice **(at least 24 hours**) to avoid the **$40 missed appointment charge**. We understand that occasionally an emergency may occur that may prevent proper notice. In those cases we will not charge subject to the approval of your provider.

LETTERS, FORMS AND PAPERWORK POLICY
There is a fee for all letters/forms/paperwork completed in our office and most documents take anywhere from 30 minutes to 90 minutes to complete. All letters/forms/paperwork are completed at Dr. Speer's discretion. The charges are not covered by insurance and are as follows:
-Tier I, Standard…$25.00
-Tier II, Above Standard…price will be quoted

TELEPHONE CONSULTATIONS
There will be a fee for telephone consults requiring physician/clinician intervention. To facilitate timeliness and maintain confidentiality the doctor or the nurse may communicate recommendations to you. These fees may or may not be covered by your insurance, so please contact your insurance provider if you would like to know if your plan will reimburse you for the cost. The base fee begins at $80 and will increase according to the complexity/length of the call.

We thank you for your patience, understanding, and cooperation in this matter.