

Welcome to Cooper Family Medical

Please keep this letter so you have access to this information at any time you need it.

- The doctor is available 24 hours a day for your urgent healthcare needs and will return your call. Avoid expensive emergency room co-pays and long waits.

► Please call our office at (941)744-5510 ◀

- If you have an urgent healthcare need during business hours, 8:00am-5:00pm, we will make the necessary arrangements to see you.
- **Preferred Hospital:** Your doctor has selected this hospital because of their confidence and professional rapport they have with the hospital and the specialists.

▪ **MANATEE MEMORIAL HOSPITAL** ▪

- **Preferred Laboratory:**

▪ **LAB CORP.** ▪

- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your doctor will need to see you in the office to assure your continued recovery.
- If you are a Medicare patient: your doctor encourages you to be seen at least every six (6) months. This will help both you and your doctor maximize preventative care.
- Scheduling appointments: Call our office to schedule your appointment and be sure to always bring your medication with you to each appointment. If you are unable to keep your appointment please call us at least 24 hours in advance so we can offer that appointment to someone else with a healthcare need.
- To avoid receiving a bill: Call the office before seeing a specialist or undergoing a procedure as Humana requires a referral. DO NOT GO FOR LAB TESTS, XRAYs, PHYSICAL THERAPY, ETC. UNTIL OUR OFFICE IS NOTIFIED.

Cooper Family Medical

General Information:

Date: _____

Patient Last Name _____ First Name _____ MI _____ Date Of Birth _____

Home Phone Number _____ Cell Phone Number _____ E-Mail Address _____

Home Address _____ City _____ State _____ Zip _____

Social Security # _____ - - _____
 Male Female _____
 (Please Circle) (Please Circle)
 Single Married Divorced Widowed
 (Please Circle)

Employer _____

Pharmacy _____

Primary Insurance Carrier _____ Policy ID _____
 HMO PPO POS OTHER _____ ()
 (Type Of Plan) Insurance Carrier Phone # _____

Primary Card Holder's Name/Relation: _____ DOB: _____

Second Insurance Carrier _____ Policy ID _____
 HMO PPO POS OTHER _____ ()
 (Type Of Plan) Insurance Carrier Phone # _____

IMPORTANT: In case of an emergency, who would we contact?

Name _____	Relationship _____
Address (Street/City/Zip) _____	Home Phone _____
() _____	() _____
Cell Phone _____	Work # _____

"I understand that I am financially responsible for all charges, whether or not paid by insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give Cooper Family Medical consent to perform medical treatment."

(Patient/Guardian Signature)

Date

Patient Medical History

Patient Last Name: _____ Patient First Name: _____ DOB: _____

Date of last physical exam: _____ Previous Physician's Name: _____

Physician's Address: _____

Past History (Personal & Allergies)

Have you had any of the following illnesses? :

	YES	NO		YES	NO		YES	NO
Amputation	<input type="checkbox"/>	<input type="checkbox"/>	CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Overuse	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Ostomies _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Other than medications)	<input type="checkbox"/>	<input type="checkbox"/>	Falls	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack / MI	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____			Other Heart Disease (CHF / CAD)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker:	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Deficit	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Measles / Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Visual Deficit	<input type="checkbox"/>	<input type="checkbox"/>

Personal Habits:

Have you ever smoked? YES NO If yes, are you a regular smoker now? YES NO

Have you used chewing tobacco? YES NO If yes, number of yrs. ____ If no, when did you quit? ____

Do you drink alcohol? YES NO If yes, how often: _____

Do you or have you used any of the following:(Circle) _____ Marijuana LSD Heroin Cocaine Speed Other

Have you been exposed to second hand smoke? _____ If yes, number of yrs. ____

Operations: List and indicate approximate year

Serious Injuries: List and indicate approximate year

Hospitalizations: (Other than operations)

List and indicate approximate year

Diagnostic Tests/Exams:

Last Test/Exam & Date	Location/Provider
Eye Exam:	
Foot Exam:	
Dental Exam:	

Immunizations: (Please give date)

Covid-19 _____ Shingles _____ Tetanus _____ Hepatitis B _____ Flu _____ Polio _____

Pneumococcal _____ Chicken Pox _____

Cooper Family Medical

Patient Last Name:

Patient First Name:

DOB:

Family History	Circle Sex		If Living		If Deceased	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters	M	F				
	M	F				

Check if any blood relative has or had any of the following and indicate their relationship to you:

	Please Circle		Relationship		Please Circle		Relationship
	Yes	No			Yes	No	
Arthritis	Yes	No	_____	High Blood			_____
Asthma	Yes	No	_____	Pressure	Yes	No	_____
Bleeding Tendency	Yes	No	_____	Intestinal Polyps	Yes	No	_____
Cancer	Yes	No	_____	Kidney Disease	Yes	No	_____
Colitis	Yes	No	_____	Leukemia	Yes	No	_____
Congenital	Yes	No	_____	Migraine	Yes	No	_____
Heart Disease	Yes	No	_____	Nervous Breakdown	Yes	No	_____
Diabetes	Yes	No	_____	Rheumatic Fever	Yes	No	_____
Emphysema	Yes	No	_____	Sickle Cell Anemia	Yes	No	_____
Epilepsy	Yes	No	_____	Stomach Ulcers	Yes	No	_____
Goiter	Yes	No	_____	Stroke	Yes	No	_____
Gout	Yes	No	_____	Suicide	Yes	No	_____
Hay Fever	Yes	No	_____	Tuberculosis	Yes	No	_____
Heart Attack	Yes	No	_____	Mental Illness	Yes	No	_____
				Substance Use	Yes	No	_____

Medications:

- | | |
|--|---|
| <input type="checkbox"/> Asthma Wheezing Medicine
<input type="checkbox"/> Aspirin, Bufferin, Anacin, Tylenol, or Similar Products
<input type="checkbox"/> Blood Pressure Pills
<input type="checkbox"/> Cortisone, Prednisone
<input type="checkbox"/> Cough Medicine
<input type="checkbox"/> Digitalis or Heart Medicine
<input type="checkbox"/> Hormones
<input type="checkbox"/> Insulin or Diabetic Pills
<input type="checkbox"/> Anemia Medication
<input type="checkbox"/> Laxatives | <input type="checkbox"/> Sleeping Pills / Tranquilizers
<input type="checkbox"/> Thyroid Medicine
<input type="checkbox"/> Stomach / Digestive Medicine
<input type="checkbox"/> Weight-Reducing Pills
<input type="checkbox"/> Blood Thinners or Coumadin
<input type="checkbox"/> Dilantin or Seizure Medications
<input type="checkbox"/> Water Pills or Diuretics
<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Phenobarbital / Barbiturates
<input type="checkbox"/> Vitamins
<input type="checkbox"/> Other Prescription / Over the Counter Drugs |
|--|---|

Cooper Family Medical

Patient Last Name:

Patient First Name:

DOB:

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medications	Dosage	How Often?	When did you start?

Are you allergic to any medications: YES NO If yes, Please list medications & the reactions.

Medication	Reaction

Cooper Family Medical

Patient Last Name: _____ Patient First Name: _____ DOB: _____

Social and Lifestyle History: **Primary Language:** _____

(Please Circle)

Is there someone that lives in your residence?	Yes No	If yes, please list name and relationship:
Type of Residence		Apartment Mobile Home House: One Story Two Story Assisted Living Facility: Facility Name: _____ Other: _____
Durable Medical Equipment	Yes No	Wheel Chair _____ Oxygen _____ Walker _____ Nebulizer _____ Cane _____ CPAP/BIPAP _____ Other _____
Can you afford medicines?	Yes No	Potential Referral to Patient Assistance Program
Transportation provided by?		

Nutritional History:

(Current Weight) _____ Lbs.	(Current Height) _____ Ft _____ In	Weight Changes in the past 6 months? Yes No
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Current Diet Plan:

Exercise / Activity:

Current Activity	How Often
Physical Limitations:	

Activities of Daily Living:

Do you require assistance to bathe or groom?	Yes No	If yes, Explain: _____
Do you require assistance for your toilet needs?	Yes No	If yes, Explain: _____
Do you require assistance to eat?	Yes No	If yes, Explain: _____
Do you have hearing loss?	Yes No	Do you wear hearing aids? Yes No Last hearing exam date: _____

Additional Comments and Notes:

Cooper Family Medical

Patient Last Name: _____ Patient First Name: _____ DOB: _____

Preventative Service History		
Preventative Services	Date Received	Findings and Recommendations
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening Cholesterol ▶ LDL ▶ EKG ▶	_____ _____ _____	Hypercholesterolemia <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Other <input type="checkbox"/> _____ EKG Results: _____
Colorectal Cancer Screening Flexible Sigmoidoscopy ▶ Barium Enema ▶ Colonoscopy ▶ Fecal Occult Blood Test ▶	_____ _____ _____ _____	
Diabetic Screening Hg A1C ▶ Foot Exam ▶ Eye Exam ▶	_____ _____ _____	Cataracts <input type="checkbox"/> Other _____
Glaucoma Screening		Glaucoma <input type="checkbox"/>
PAP and Pelvic Examination		
Prostate Cancer Screening Digital Rectal Exam (DRE) Prostate Specific Antigen Test (PSA)	_____ _____	
Mammogram Screening Breast Self Exam ▶ Mammogram Screening ▶	_____ _____	

Date Reviewed

Physician Signature



HIPAA Consent Form

Patient's Name(Printed) : _____ Date of Birth: _____

Do We Have Permission to:

Mail medical information to your home? Yes _____ No _____

Leave a detailed message on your home/ceii answering machine for:

Appointment Information? Yes _____ No _____

Billing Information? Yes _____ No _____

Other Medical Information? Yes _____ No _____

Leave a detailed message on your work answering machine for:

Appointment Information? Yes _____ No _____

Billing Information? Yes _____ No _____

Other Medical Information? Yes _____ No _____

I give permission to share information with the following person(s):

Appointment Information : _____ Relation/
Phone #: _____

Billing Information: _____ Relation/
Phone #: _____

Medical Info (Including biopsy & Lab results): _____ Relation/
Phone #: _____

Emergency Contact: _____ Relation/
Phone #: _____

With my consent, Cooper Family Medical may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Cooper Family Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Cooper Family Medical use and disclosure of information according to the Notice of Privacy Practices, and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize release of any medical information necessary to all my insurance companies to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment direct to Cooper Family Medical. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize use of this form for all my insurance submissions. I authorize Cooper Family Medical to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and insurance claim for submission. Under penalty of perjury, I declare that I have read the forgoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature: _____ Date: _____

Witness Signature(CFM Employee): _____ Date: _____

Cooper Family Medical, PLLC

5123 4th Avenue Circle East
Bradenton, Florida 34208
T: (941)744-5510
F: (941)744-5166

Patient ID:

Physician ID:

All patients must complete our Patient Payment Registration form prior to seeing our medical providers.

Payment Policy

Thank you for choosing Cooper Family Medical, PLLC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided upon request.

All Payments Due at Time of Service

Initial This office maintains a pay at time of service policy. You will need to know your insurance policy in advance in order to be aware of the portion of your visit for which you will be responsible. If you accrue a credit balance, we will maintain that credit balance on your account and apply it to any future balance that may accumulate. If a credit balance exceeds \$30.00, we will refund the credit by check to the address on your account. These policies are designed to comply with the Fair Debt Collection Practices Act and any applicable state laws. If your account goes to collections we will no longer provide medical services to you, at which that time you will then be discharged from Cooper Family Medical.

Regarding Insurance

Initial Regarding insurance plans where we are a participating provider, all payments are due including but not limited to deductibles from previous visits, copay, and/or non-covered services, and will be collected upon your arrival. Your insurance policy is a contract between you and your insurance company - we are NOT party to that contract. We cannot bill your insurance unless you provide timely clear and accurate insurance information. If you have new insurance, or a change in insurance plans, you must provide us with clear and accurate insurance information within 30 days of your visit for your insurance to be billed. If you are unable to provide this information within 30 days you will be responsible for any visits that may have occurred.

Statements & Claim Submission

Initial We will submit your claims and assist you in any way reasonable we can help to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. We will send you a statement should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. When you receive your explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. There will be a \$35 charge for check denied by your bank and returned to the office for any reason. If your account is over 90 days past due for nonpayment, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if your account remains unpaid, we may refer your account to the three major credit bureaus which may adversely effect your credit.

Minor Patients

Initial The adult accompanying a minor and the parents(or guardian) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office visit.

Divorced Parents/ Legal Custody issues

Initial The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out BEFORE your child's appointment. If a separate parent is responsible for payment, we are not party to this arrangement. Payment is due in full at the time of service, and we will prepare a receipt of payment for verification purposes.

Appointment Reminders and Missed Appointments

Initial Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. We are not able to guarantee a reminder call for each visit, but we will certainly try.
Unless canceled AT LEAST 24 HOURS IN ADVANCE, our policy is to charge the person who is scheduled for the appointment a missed appointment fee at the rate of \$50.00. Please help us serve our entire patient population best by keeping scheduled appointments. Patients who miss three or more appointments without notice may be dismissed and may no longer receive medical treatment at our medical practice.

Cooper Family Medical, PLLC is committed to providing the best treatment to our patients. Our prices are a representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Printed Name of Patient/Responsible Party

Signature of Patient/Responsible Party

Date

Cooper Family Medical

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: _____ S.S.# _____

Date of Birth _____ Patient Phone Number(s): _____

Treatment Dates to Be Released: _____

Type of Visit: Inpatient Outpatient Surgery ER Outpatient Test Therapy Other

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

RELEASE INFORMATION TO: (recipient of disclosure)

Name: Cooper Family Medical

Address: 5123 Fourth Avenue Circle East

Apt, Suite or PO #: _____

City, State, and Zip: Bradenton, Florida 34208

Phone: 941-744-5510

Fax: 941-744-5166

PURPOSE OF THE DISCLOSURE: Insurance Legal Continuing Care Personal Other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> ER Record | <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Consent Form | <input type="checkbox"/> Therapy Records | <input type="checkbox"/> Physician's Orders | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Lab Results | _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Abstract of all records | |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> EKG | <input type="checkbox"/> Copy of Itemized Bill | |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Consultations | <input type="checkbox"/> Radiology disc/films | |

SPECIFIC INFORMATION TO NOT BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department.. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize this medical facility and/or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release this medical facility and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

PATIENT'S SIGNATURE

DATE

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN

DATE

WITNESS

DATE