Family Doctors of Pasadena

6800 Gulfport Blvd. S., Unit 101, South Pasadena, Fl 33707
Phone: (727) 328-3324 Fax 877-592-0792
FamilyDoctorsofPasadena.com

Preparing for Your First Visit

To help us provide you with the best possible care from the very beginning, we ask that new patients complete their paperwork in advance and return it to our office prior to their appointment.

This allows our team time to review your information, request any necessary medical records, and ensure your visit is as thorough and efficient as possible.

If a section does not apply to you, simply write “N/A.”

What to Bring to Your First Appointment

In addition to submitting your paperwork in advance, please bring the following with you:

- All current medications and supplements in their original containers
- A list of any doctors you have seen in the past two years (including names and phone numbers)
- Your preferred pharmacy name and phone number
- Your current insurance card (this is updated annually)

Need Help?

If you have any questions about the paperwork or need assistance completing it, please contact our office—we are happy to help.

Thank you,

Family Doctors of Pasadena

FAMILY DOCTORS
OF PASADENA

Healing
Through Caring
Family Medicine

In order to properly thank your friends and acquaintances, please check all that apply:

How Did You Hear About Us?

_____ Friend or Relative _____ Name
_____ Letter or Postcard
_____ Newspaper Ad
_____ Online Advertisement
_____ Humana.com
_____ Medicare.gov
_____ Insurance Agent _____ Name
_____ Billboard
_____ TV or Radio Ad
_____ Community Newsletter

If you are a Humana member, how did you enroll?

_____ Agent _____ Online _____ Educational Talk _____ Telephone _____ Called Medicare

If you enrolled with an agent, what is his/her name? _____

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New Patient Verification

Welcome to Family Doctors of Pasadena. If you need any assistance, please let the receptionist know.

Patient_____
Last Name First Name Middle initial

SS#_____ Birth date_____

Home Phone #_____ Cell #_____

E- Mail: _____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Significant other ☐ Yes ☐ No Name: _____

Are you employed? ☐ Yes ☐ No Full Time Part Time Retired Occupation: _____

Do you have any specialist appointments scheduled? ☐ Yes ☐ No

- Where & When _____

Insurance: _____
_____
_____

Prior Doctor and Phone Number:

_____

_____

_____

Office Use Only:

Availity Done ☐ Yes ☐ No

ID/License Scanned ☐ Yes ☐ No

Med Records Requested ☐ Yes ☐ No

Labs: _____

Dr:_____

Family Doctors of Pasadena

MY MEDICATION LIST

Name:	Birth Date:
Pharmacy:	Pharmacy Phone:
Allergies:	

Latex Allergy	☐ Yes ☐ No **PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT. Nitrile Gloves are available.**
Iodine Allergy	☐ Yes ☐ No

Name of Medication	Strength (ex. mg, units …)	How to Take (ex. Take 1 tablet by mouth 2 times daily)	When to take medication

Provider Signature: _____ Date_____

Family Doctors of Pasadena

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Primary Language:	**Interpreter Needed?** ☐ Y ☐ N
Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**
EMERGENCY CONTACT: **Contact #:**	
Can we send you our newsletter? ☐ Y ☐ N	**Email:**
Can you afford your medicine? ☐ Y ☐ N ☐ Potential referral to assistance program _____	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Influenza	☐ Chickenpox	☐ Shingles
	☐ Hepatitis	☐ Pneumonia	☐ MMR *Measles, Mumps, Rubella*	

HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES?

Amputation	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Alcohol Overuse	☐ Yes	☐ No
Allergies (Other than Medications)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Location:		
Cardiac Arrhythmias	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No

CVA/TIA	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema/COPD	☐ Yes	☐ No
Falls	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Heart Attack/ MI	☐ Yes	☐ No
Other Heart Disease (CHF/CAD)	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No

Migraine Headaches	☐ Yes	☐ No
Nervous Breakdown	☐ Yes	☐ No
Ostomies	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Sleep Disorder	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Vascular Disease	☐ Yes	☐ No

OPERATIONS, SERIOUS INJURIES, HOSPITALIZATIONS AND DIAGNOSTIC TESTS/EXAMS (PLEASE LIST REASONS AND APPROXIMATE YEAR)

		OTHER:

Durable Medical Equipment? ☐ Yes ☐ No ☐ Wheelchair ☐ Oxygen ☐ Walker/Cane ☐ Nebulizer ☐ CPAP/BIPAP ☐ Other:_____

Provider Signature: _____ Date_____

Family Doctors of Pasadena

FAMILY HISTORY-HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING AND THEIR RELATIONSHIP

ILLNESS	YES/NO		RELATIONSHIP
Arthritis	☐ Yes	☐ No	
COPD	☐ Yes	☐ No	
Bleeding Tendency	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Colitis	☐ Yes	☐ No	
Congenital Heart Disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Heart Attack	☐ Yes	☐ No	

ILLNESS	YES/NO		RELATIONSHIP
High Blood Pressure	☐ Yes	☐ No	
Intestinal Polyps	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Leukemia	☐ Yes	☐ No	
Nervous Breakdown	☐ Yes	☐ No	
Stomach Ulcers	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Suicide	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Other:			

PREVENTATIVE SERVICE HISTORY-HAS THE FOLLOWING TESTING: NEVER BEEN DONE (NO), OR, HAS BEEN DONE (YES). IF YES, YOUR BEST ESTIMATE OF THE MONTH/YEAR THE TEST WAS PERFORMED AND THE RESULT.

Preventative Service	YES/NO		Month/Year	Result
Bone Mass Measurement (Bone Density)	☐ Yes	☐ No		
Bloodwork	☐ Yes	☐ No		
Colorectal Cancer Screening: Colonoscopy	☐ Yes	☐ No		
Colorectal Cancer Screening: Fecal Occult Blood Test (Stool Card)	☐ Yes	☐ No		
Vision Screening: Eye Exam	☐ Yes	☐ No		
Female Screening: PAP & Pelvic Examination	☐ Yes	☐ No		
Female Screening: Mammogram	☐ Yes	☐ No		
Male Screening: PSA – Prostate Specific Antigen	☐ Yes	☐ No		
Other:	☐ Yes	☐ No		

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)	☐ Mild exercise	☐ Occasional exercise	☐ Regular vigorous exercise
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Alcohol /Drugs	Do you drink alcohol? ☐ Y ☐ N - #/day		Do you use the following? ☐ CBD ☐ Marijuana	
	Do you use drugs? ☐ Y ☐ N	☐ Cocaine ☐ Meth ☐ LSD ☐ Ecstasy/MDMA ☐ Other_____		
Sex	Are you sexually active?		☐ Yes	☐ No
	Any discomfort with intercourse?		☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?		☐ Yes	☐ No
Personal Safety	Do you live alone? [ ] Apartment [ ] Mobile Home [ ] House [ ] Asst. Living [ ] Ind. Living		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Do you have problems with speech?		☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?		☐ Yes	☐ No

Provider Signature: _____ Date_____

Family Doctors of Pasadena

MINI NUTRITIONAL HEALTH ASSESMENT (MNA)

Sex (Circle One): Male Female **Age:** **Weight:** **Height:**

A. Has food intake declined over the last 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? 0 = Severe decrease in food intake 1= Moderate Decrease in food intake 2= No decreases in food intake	=
B. Weight loss during the last 3 months? 0= Weight loss greater than 6.6lbs (3kg) 1= Do not know 3= Weight loss between 2.2-6.6lbs (1-3kg) 3= No Weight loss	=
C. Mobility 0= Bed or chair bound 1= Able to get out of bed/chair but do not go out 2= go out	=
D. Suffered Stress in the past 3 months? 0= Yes 2 =No	=
E. Neuropsychological problems 0= Severe Dementia or Depression 1= Mild Dementia 2= No psychological problems	=
For Physician Use Only	
F1. Body Mass index (BMI) (Weight in KG/Height in M^2). 0= BMI less than 19. 1= BMI >19 less than 21 2= BMI >21 less than 23 3= BMI 23 or greater *If BMI is not available replace question F1 with F2. Do not answer F2 if F1 is already answered.	=
F2. Calf Circumference (CC) in cm. 0= CC less than 31 1= CC 31 or greater	=
Screening Score (Max 14 points) **12-14 = Normal Nutritional Status 8-11 = At Risk of Malnutrition 0-7 = Malnourished**	

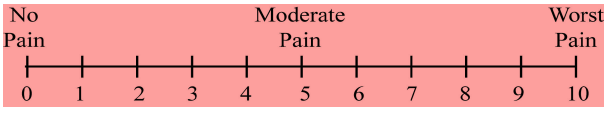
Functional Status Assessment: Activities of Daily Living (ADL) and Activities of Instrumental Living (IADL):

Please check the appropriate category that best fits you:

Activity	Independently	With Assistance	Dependent
Bathing			
Dressing			
Eating			
In and out of Chairs			
Toileting			
Walking			
Taking Medication			
Driving			
Use of Public Transportation			
Use Phone			
Meal Prep			
Housework			
Handling Finances			

If needed, who helps you with your activities:_____

Pain Screening: How would you rate your pain on a scale from 0-10 or use the scale:



Pain 0 to 10: _____

Location:_____

Quality (Sharp, Dull, etc…):_____

Provider Signature: _____ Date_____

Family Doctors of Pasadena

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
Several days (#) _____ x 1 = _____
More than half the days (#) _____ x 2 = _____
Nearly every day (#) _____ x 3 = _____

Total score: _____

Provider Signature: _____ Date_____

Family Doctors of Pasadena

Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by said 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 Family Doctors of Pasadena consent to perform medical treatment.

Prescription Renewal Policy

Family Doctors of Pasadena physicians are available for emergencies 24 hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with a Medical Assistant during normal business hours of Monday thru Friday.

Insurance Authorization, Assignment and Guarantee of Payment

I request that payment of authorized Medicare / Other Insurance company benefits be made on my behalf to Family Doctors of Pasadena for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration a healthcare administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permitted copy of this authorization to be used in place of the original comma and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security act and 31 U.S.C. 3801 – 3812 Provides penalties for withholding this information).

I request that payment under the Medicare or other medical insurance program(s) be made to Family Doctors of Pasadena for as long as I continue to receive services from them. If I were to receive any checks/payments intended as a payment for services rendered by Family Doctors of Pasadena from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Family Doctors of Pasadena.

I understand that I am responsible for payment of all charges and fees to Family Doctors of Pasadena that they are entitled to collect that they're not paid for by Medicare or other insurance.

_____ _____

Patient Name Printed Date of Birth

_____ _____

Patient Signature Date

Family Doctors of Pasadena

For HUMANA HMO Patients ONLY

Understanding your insurance and the referral process:

If the insurance plan you have selected is a HMO/managed care plan.

1. Your Primary Care Physician (PCP) will be able to see the total picture of your overall health. This allows your provider to make the best decisions in managing your health and wellbeing.

2. While your Primary Care Provider (PCP) can provide most of your care, if you do need a specialist your PCP manages the care you receive from these healthcare specialists within the network.

3. Your Primary Care Physician (PCP) needs to issue a referral for you before you see any specialist.

4. Your Primary Care Provider (PCP) will choose a specialist that will best suit your needs within your HMO Network.

5. Within the HMO there are a select number of Providers that have demonstrated outstanding care and improved outcomes.

6. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

7. The referral process serves as a way for your PCP and your specialist to communicate with each other. When a referral is issued for you to see a specialist, your PCP will inform the specialist of the reason(s) for the referral as well as the goal(s) for the visit. In other words, your PCP will help coordinate your visit; the referral helps ensure you receive the proper care when seeing a specialist.

Thank you for joining our practice!

_____ _____

Signature Date

Family Doctors of Pasadena

Privacy Policy

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of *protected health information* (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, our physicians and staff have the necessary medical and PHI to provide the highest quality of medical care possible. Our facility will always protect the confidentiality of the PHI of our patients to the highest degree possible. Our patients should not be afraid to provide information to our practice, its physicians and staff for purposes of *treatment, payment and health care operations* (TPO).

To that end, our practice, its physicians and our staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patients covenants and/or authorizations, as appropriate. Our practice, its physicians and staff will not use or disclose PHI for uses outside of our practice's TPO; such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us to not to do so.
- Recognize that PHI collected about the patients must be accurate, timely, complete and available when needed.
- Our practice and its physicians and staff will implement reasonable measure to protect the integrity of all PHI maintained about patients.
- Recognize that patients have the right to privacy. Our practice, its physicians and staff respect the patient's individual dignity at all times. Our practice, its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential information. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements. Not disclose PHI data unless the patient has properly authorized the release or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. This may generate a bill according to Rule 64B8-10.003, Florida Administrative Code. In addition, patients have a right to request an amendment to his/her medical record if they believe his/her information is inaccurate or incomplete.

Family Doctors of Pasadena

Privacy Policy Contd.

- Permit our patient access to their medical records when their written request is approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site health care professional review the patient's appeal,
- Provide the patient an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPPA rules. We will provide this list to the patient upon request, as long as the request is in writing.
- All physicians and staff in our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, in accordance with our practice rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy. As always, the privacy policy will be made available to patients upon request.

Effective 2016

Family Doctors of Pasadena

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Family Doctors of Pasadena's privacy practice notice.

_____ _____

Signature of Patient Date

Family Doctors of Pasadena

Patient authorization for use and disclosure of protected health information (PHI) for purposes requested by the practice.

(HIPAA Release of information)

Name: _____ Date of Birth: _____/_____/_____

(Please Print)

By signing this authorization, I authorize Family Doctors of Pasadena to release/ disclose my medical information, medical history; progress notes with diagnosis; laboratory data; imaging studies and claims information. "Only as permitted or required by Federal or State Law", we may use your protected healthcare information to do the following:

- To disclose, as may be necessary, your heath information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: Referrals to or consultation with, other health care professionals, laboratories, hospitals etc.) or to others as may be required by law or a court order concerning your treatment, payment and or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care or treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individuals for payment of our services and treatment we provide for you.
- To discuss your healthcare payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your health care treatment or payments.
- To leave appointment reminders or other minimum necessary information related to your health care or health care payments on your answering machine, mobile voicemail or text mail, email or with a household family member.

[ ] **Please check here if you do not want us to leave messages on your answering machine or with a household family member.**

[ ] Please check here if you do not want us to leave a voice/text message on your mobile device.

[ ] Please check here if you authorized to send your health care information by email (please understand the email may be an unsecured medium of transmission and is potentially accessible by others). In addition to checking the box, we reserve the right to require you to authorize in reading the transmission of your health care information to you by unsecured email.

- You may request a copy of an you have the right to read our notice of patient privacy practices prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

This information may be released to:

[ ] My Spouse/Partner_____
Name(s) Phone #

[ ] My Child(ren)_____
Name(s) Phone #

[ ] Other_____
Name(s) Phone #

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to **Family Doctors of Pasadena 6800 Gulfport Blvd. S., Unit 101, South Pasadena Fl 33707**. This practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Family Doctors of Pasadena. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed By: _____ Date_____/_____/_____

Signature of Patient or Legal Guardian

Family Doctors of Pasadena

Dr. Randy Shuck

6800 Gulfport Blvd. S., Suite 101, South Pasadena, Fl 33707

Phone: (727) 328-3324 Fax: 1-877-592-0792

FamilyDoctorsofPasadena.com

Release of Medical Information

I, _____, with a date of birth,_____, give my permission for
(Patient name) (Patient's DOB)

_____to give my medical records (as described) to the above referenced doctor
(Doctor's or hospital name that has records)

and /or organization so that he/she can better understand my condition and continuity of my healthcare.

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

(Please Initial *ALL* Lines)

_____ My mental health,
_____Transmittable disease I may have like HIV/AIDS,
_____Genetic records, and/or
_____Drug and alcohol records.

I understand that:

- **I do not have to give my permission to share these records.**
- **If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.**

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other _____

Patient's Full Name_____
(Please Print)

Patient's Social Security Number_____ Date Of Birth: _____

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____

FAMILY DOCTORS
OF PASADENA

ADVANCED DIRECTIVES FAQS

What is an advanced directive?

It is a written or oral statement about how you want medical decisions made should you not be able to. Some people put their wishes into writing while they are healthy, often as part of their estate planning. Other people make advance directives when they are diagnosed with a life-threatening illness

Types of advance directives are:

A Living Will

A Health Care Surrogate Designation

What is a living will?

It is a written or oral statement of the kind of medical care you want or do to want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to you health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have no made an advance directive, decisions about your health care may be made for you by your wife or husband, your adult child, your parent, your adult sibling, an adult relative, a close friend or a court-appointed guardian.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney.

An advance care directive needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or blood relative.

Where can I find advance directive forms?

They are available at your provider's office. Please inquire and we will provide one to you.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated.

ADVANCED DIRECTIVES FAQS continued

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

If you designate a health care surrogate and an alternate surrogate, be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.

Provide a copy of your advanced care directives to your primary care provider.

Make sure your health care provider, attorney, and the significant people in your life know that you have an advance directive and where it is located. You also may want to give them a copy.

If you change your advance directive, make sure your health care provider, attorney, and the significant people in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant people in your life.

FAMILY DOCTORS
OF PASADENA

Patient Name: _____

DOB: _____

LIVING WILL DECLARATION

I, _____, being of sound mind, and after careful consideration, make this declaration that if I should become unable to make or communicate my own health care decisions, I direct my provider, my health care surrogate, and my family to honor this living will as my legal right. I understand that this living will only becomes effective when two providers have determined that I have any of the below:

- Have a terminal or end-stage condition or condition with little or no chance of recovery.
- Am in a persistent vegetative state and 2 providers have determined that there is no reasonable probability of recovery

I state the following instructions:

Cardio-pulmonary resuscitation (CPR) if my heart or breathing stops.	○ Yes, I do want	○ No, I do NOT want
A breathing machine if I am unable to breathe on my own.	○ Yes, I do want	○ No, I do NOT want
Nutrition and fluids through tubes in my veins, nose or stomach.	○ Yes, I do want	○ No, I do NOT want
Aggressive medical care such as kidney dialysis or surgery.	○ Yes, I do want	○ No, I do NOT want
Medications that can prolong my dying.	○ Yes, I do want	○ No, I do NOT want
I want comfort care.	○ Yes, I do want	○ No, I do NOT want

Other points that are important to my end of life wishes are: _____

_____

_____

I have read and understand this Living Will and designation of a Healthcare Surrogate, and I am freely and voluntarily signing it on ___/___/_____ in the presence of witnesses. At least one of these witnesses is not a spouse or blood relative.

Signed: _____

Street Address: _____

County: _____ City, State: _____

Patient Name: _____

DOB: _____

APPOINTMENT OF MY HEALTH CARE SURROGATE

I, _____, appoint the following as my Heath Care Surrogate:

Name: _____

Address: _____

Phone: _____

If my surrogate is unable or unwilling my next choice (alternate Health Care Surrogate) is:

Name: _____

Address: _____

Phone: _____

I authorize my Health Care Surrogate to:

___ (initials) Receive any necessary health information, whether oral or recorded in any form or medium, that is created or received and relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

___ (initials) Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift.

___ (initials) Specific instructions or restrictions: (if none put N/A)

_____

_____

_____

Patient Name: _____

DOB: _____

While I have decision-making capacity, my wishes are controlling and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my Health Care Surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

This Health Care Surrogate Designation is not affected by my subsequent incapacity except as provided by law.

I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation
2. Physically destroying this designation through my own action or by thtat of another person in my presence and under my direction
3. Verbally expressing my intention to amend or revoke this designation
4. Signing a new designation that is materially different from this designation.

My Health Care Surrogate's authority become effective when my primary provider determines that I am unable to make my own health care decisions unless I initial either or both of the following:

If I initial here ___, my Health Care Surrogate's authority to receive my health information take effect immediately.

If I initial here ___, my Health Care Surrogate's authority to make health care decisions for me take effect immediately except that any instructions or health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict made by me.

(At least one of these witnesses cannot be a spouse or blood relative)

WITNESSES:

1. Printed Name: _____ Signature: _____

2. Printed Name: _____ Signature: _____