Tenet Florida Physician Services II, LLC
901 45th St. Kimmel Bldg., West Palm Beach, FL 33407-2413
Office: (561) 844-5255 Fax: (561) 844-5245

Please review and update the information below to the best of your ability.

PATIENT REGISTRATION

Visit

Reason for Visit:

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City:_____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Mobile Phone:_____
Sex:_____
Date of Birth:_____
Social Security No.:_____
Patient email: _____
Required by government mandate [although you may refuse]:
Language:_____
Race:_____
Ethnicity: _____
Marital Status:_____

OTHER

Patient Referred by: _____
Primary Care Provider: _____
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email
How did you hear about us?
____Web Search ____Social Media ____Referred by Family or Friend
____Other *(Please Specify)* _____

GUARANTOR INFORMATION *(to whom statements are sent)*

Name: _____
Address: _____
City:_____ State: _____ Zip: _____
Relationship to patient: _____
Date of Birth:_____
Social Security No.:_____
Phone:_____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship to patient: _____
Phone:_____
Mobile Phone:_____

EMPLOYER INFORMATION

Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone:_____

PHARMACY INFORMATION

Name: _____
Crossroads:_____
Phone:_____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____
Policy ID #: _____
Group #: _____
Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth:_____ Sex (please circle): **M** or **F**
Employer Name: _____
Patient's relationship to policy holder:_____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____
Policy ID #: _____
Group #: _____
Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth:_____ Sex (please circle): **M** or **F**
Employer Name: _____
Patient's relationship to policy holder:_____

To the best of my knowledge the above information is complete and accurate.

Signed _____Date: _____

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MEDICAL HISTORY FORM

Name:_____ Birthdate:_____ Occupation:_____

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
2.				
3.				
4.				

PHARMACY NAME: _____ PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS:_____

PAST SURGICAL HISTORY

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			

ALLERGIES/SENSITIVITIES TO MEDICATIONS / REACTION

_____

_____

PAST MEDICAL HISTORY

Have you ever been told you had one of the following? Please check Yes if you have now, or have had in the past.

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	DM 1	☐	☐	Lung Disease	☐	☐
Anemia	☐	☐	DM 2	☐	☐	Mental Illness	☐	☐
Anxiety	☐	☐	Diabetic Complications	☐	☐	Movement Disorder	☐	☐
Arthritis	☐	☐	Endocrine Disease	☐	☐	Nerve Disease	☐	☐
Asthma	☐	☐	Eye Problems	☐	☐	Osteopenia / Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	Gastritis / Ulcer	☐	☐	Overweight / Obesity	☐	☐
Back / Neck Pain	☐	☐	GERD / Acid Reflux	☐	☐	Pneumonia	☐	☐
Blood Disorder	☐	☐	Headaches / Migraine	☐	☐	Prostate Disorder	☐	☐
Bowel Disease	☐	☐	Hearing Loss	☐	☐	Spine Disease	☐	☐
CAD	☐	☐	Heart Rhythm Disorder	☐	☐	Stroke / TIA	☐	☐
COPD	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Hypertension	☐	☐	Tuberculosis / Pos PPD	☐	☐
Dementia	☐	☐	Hyperlipidemia	☐	☐	Urinary Problems	☐	☐
Developmental	☐	☐	Kidney Disease / Stones	☐	☐	Viral Disease	☐	☐
Depression	☐	☐	Liver	☐	☐	Other:_____		

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FAMILY HEALTH HISTORY

	RELATION	AGE OF ONSET	SIGNIFICANT HEALTH PROBLEMS
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Education:

☐ Less than 8th grade ☐ High School ☐ 2 year college
☐ 4 year college ☐ Post graduate ☐ Other: _____

Tobacco:

Do you currently use tobacco? ☐ Yes ☐ No
Did you use tobacco in the past? ☐ Yes ☐ No
How long? _____
☐ Cigarettes ___/day ☐ Chew ___/day ☐ Cigars ___/day

Alcohol Intake:

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Caffeine:

☐ None ☐ Occasional ☐ Moderate ☐ Heavy
cups / cans per day? _____

Drugs:

Do you currently use recreation or street drugs? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Are you interested in being screened for STD's? ☐ Yes ☐ No

Advanced Directive:

Do you have an Advanced Directive or Healthcare Proxy? ☐ Yes ☐ No

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY:

Last PAP Smear Date: _____
Last mammogram Date: _____
Date of last menstrual period or menopause: _____
Number of pregnancies: _____

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A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may contact you via telephone, text, or email.

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including bu not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated call may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text massages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt-out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

*** Minors or Users Requiring Caregivers – Acknowledgment of Consent to Contact**

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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Financial Policy and Authorizations

We are happy that you selected TENET FLORIDA PHYSICIAN SERVICES II, LLC for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients mus provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

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Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to any family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from y0our account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: Hereby authorize the physicians, mid-level providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a “no show” and may be subject to a “no show” charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them.

Patient or Parent/Guardian if Minor	Date of Birth	Date

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PATIENT COMMUNICATION PREFERENCES

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE	OK TO LEAVE VOICEMAIL?	PHONE NUMBER
HOME PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
CELL PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
WORK PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
ALTERNATE PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
PATIENT PORTAL & SECURE EMAIL	☐1 ☐2 ☐3 ☐4 ☐5	EMAIL ADDRESS:	
☐None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to disclose your PHI to the following individuals (check all that apply):

Name: ______________________________ **Relationship to Patient:** ____________________

Telephone: (   ) ______________________ **Email:** ______________________________

Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other: ______________

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ______________

Name: ______________________________ **Relationship to Patient:** ____________________

Telephone: (   ) ______________________ **Email:** ______________________________

Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other: ______________

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ______________

Name: ______________________________ **Relationship to Patient:** ____________________

Telephone: (   ) ______________________ **Email:** ______________________________

Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other: ______________

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: ______________

☐ None of the above

Signature: ______________________________ **Date:** ______________________________

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NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient	Signature of Patient/Date Signed
Name of Patient's Personal Representative	Signature of Patient's Personal Representative/ Date Signed

FOR INTERNAL USE ONLY

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to disclose your PHI to the following individuals (check all that apply):

Name of Employee:_____ Signature of Employee:_____

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.

☐ Patient refused to sign.

Other:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE3 DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality or your medical information, and are required by law to do so. This notice describes how we may use your medical information at TENET FLORIDA PHYSICIAN SERVICES II, LLC and how we may disclose it to others outside of TENET FLORIDA PHYSICIAN SERVICES II, LLC. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

Permissible Uses and Disclosures without Your Written Authorization

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care.

For example, we will allow other physicians treating you to have access to your Practice medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. During visits with family members and other visitors, let your physician and Practice personnel know if you do not want them to disclose your medical information during the visit.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

Practice Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the Practice. We may use your medical information to conduct quality improvements activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by Practice personnel, your doctors, or other health care professionals.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

Required by Law: Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

Victims of Abuse, Neglect or Domestic Violence: Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the Practice. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a government agency that oversees the Practice or its personnel, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the Practice's compliance with state and federal laws.

Coroners, Medical examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the department of Veterans Affairs. The practice may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: The Practice may disclose medical information if the Practice is ordered to do so by a court or if the Practice receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Uses and Disclosures for Which Your Authorization is Required: With limited exceptions, the Practice must obtain your written authorization before it may disclose your medical information in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is teated differently than other types of medical information. For those types of information, the Practice is required to get your permission before disclosing that information to others in many circumstances.

Other Uses and Disclosures Requiring Authorization: If the Practice wishes to use or disclose your medical information for a purpose that is not discussed in this Notice, the Practice will seek your written authorization. If you give your authorization to the Practice, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify the Practice Manager in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, write to the Practice Office. Federal and state laws permit a reasonable cost-based fee to be charged for the copying of patient records. You will be notified in advance what this copying will cost. You can look at our record at no cost.

Right to Request Amendment of Medical Information You Believe is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, write to the Practice Manager.

Right to Get a List of Disclosures of Your Medical Information: You have the right to request a list of the disclosures we make of your medical information. If you would like to receive such a list, write to the Practice Manager. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How the Practice Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request the Practice from making uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the Practice. In many cases, the Practice is not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. However, the Practice must agree to your request not to disclose to your health plan any medical information about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want the practice to notify your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment or visit.

Right to Revoke Your Authorization: you may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice Office.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Practice Manager. At your request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our website, at https://13023-2portal.athenahealth.com/, or you may obtain a paper copy of the notice from the Practice Manager.

HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name: _____ Date: _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own mean?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Devices use for Dressing (button hook, zipper pull, etc.)
☐ Built up or special utensils
☐ Crutches
☐ Cane
☐ Wheelchair
☐ Special or built up chair
☐ walker

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as a vacuuming or yard work?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Raised toilet seat
☐ Bathtub bar
☐ Long-handled appliances for reach
☐ Bathtub seat
☐ Long-handled appliances in bathroom
☐ Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene
☐ Reach
☐ Gripping and opening things
☐ Errands and chores

Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
☐	☐	☐	☐	☐

Your PAIN: How much pain have you had IN THE PAST WEEK?

On a scale of 0-100 (where zero represent “no pain” and 100 represents “severe pain”), please record the number below.

Your HEALTH: Please rate how well you are doing on a scale of 0-100 (0 represents “very well” and 100 represent “very poor” health), please record the number below.

Tenet Florida Physician Services II, LLC
901 45th St. Kimmel Bldg., West Palm Beach, FL 33407-2413
Office: (561) 844-5255 Fax: (561) 844-5245

RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
First Middle Last

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes:

☐ Discharge Summary	☐ Progress/ Physician Notes	☐ X-Ray Report	☐ Pathology Report
☐ History & Physical	☐ Nurses Notes	☐ EKG/EMG/ EEG Report	☐ Consult Report
☐ Emergency Report	☐ Laboratory Report	☐ Operative Report	☐ Entire Record

☐ Other: _____

Records for the period (dates) from_____to_____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/ or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about mental health or mental retardation services
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

RELEASE information TO: _____

Name: _____

Address: _____

City: State: Zip Code: _____

Telephone: Fax: _____

RELEASE Information From: _____

Name: _____

Address: _____

City: State: Zip Code: _____

Telephone: Fax: _____

TERM: This Authorization will remain in effect:

- ☐ From the date of this authorization until the _____ day of _____, 20_____.
- ☐ Until TENET FLORIDA PHYSICIAN SERVICES II, LLC fulfills this request.
- ☐ Until the following event occurs: _____
- ☐ Other:_____

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PURPOSE: I authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization].

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once TENET FLORIDA PHYSICIAN SERVICES II, LLC discloses my health information to the recipient, TENET FLORIDA PHYSICIAN SERVICES II, LLC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that TENET FLORIDA PHYSICIAN SERVICES II, LLC may, directly or indirectly, receive remuneration from a third party in connection with the use of disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at TENET FLORIDA PHYSICIAN SERVICES II, LLC; except, however, if my treatment at TENET FLORIDA PHYSICIAN SERVICES II, LLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case TENET FLORIDA PHYSICIAN SERVICES II, LLC may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to TENET FLORIDA PHYSICIAN SERVICES II, LLC's Privacy Office at the address listed below. The revocation will be effective immediately upon TENET FLORIDA PHYSICIAN SERVICES II, LLC's receipt of my written notice, except that the revocation will not have any effect on any action taken by TENET FLORIDA PHYSICIAN SERVICES II, LLC in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact TENET FLORIDA PHYSICIAN SERVICES II, LLC's Privacy Office at:

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to use or disclose my health information in the manner described above.

Signature:_____ Date:_____

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures.

Signature of Authorized Personal Representative	Relationship to Patient	Date