Today's Date: _____

Kristin Harmon, MD
2623 Centennial Blvd, Suite 204
Tallahassee, FL 32308

Patient Name: _____ Date of Birth: _____

STAFF TO COMPLETE WT: _____ T: _____ HR: _____ BP: _____

PsO2: _____ BBG: _____ A1C: _____

Your Pain Level Today (circle one) 0 1 2 3 4 5 6 7 8 9 10

Chief Complaint: _____

_____

Current Primary Care Physician: _____

Referring Physician if different: _____

Current Pharmacy (Local): _____

Current Pharmacy (Mail): _____

SYMPTOMS TODAY

- ◯ General Good Health
- ◯ Weight Gain
- ◯ Weight Loss
- ◯ Excessive Fatigue
- ◯ Excessive Thirst
- ◯ Blurred Vision
- ◯ Double Vision
- ◯ Shortness of Breath
- ◯ Cough
- ◯ Palpitations
- ◯ Irregular Heart Rate
- ◯ Chest Pain
- ◯ Ankle Swelling
- ◯ Sexual Problems
- ◯ Low Sex Drive
- ◯ Nausea
- ◯ Vomiting
- ◯ Constipation
- ◯ Diarrhea
- ◯ Blood in Stool
- ◯ Abdominal Pain/Cramping
- ◯ Hair Loss
- ◯ Abnormal Hair Growth
- ◯ Change in Nails
- ◯ Excessive Sweating
- ◯ Pain in Joints
- ◯ Back Pain
- ◯ Swelling in Joints
- ◯ Recent Fractures
- ◯ Weakness
- ◯ Numbness
- ◯ Burning
- ◯ Pins & Needles
- ◯ Tremor
- ◯ Headache
- ◯ Anxiety
- ◯ Depression
- ◯ Sleep Disturbances
- ◯ Frequent Urination
- ◯ Nighttime Urination
- ◯ How Often/Night
- ◯ Blood in Urine
- ◯ Poor Urine Control

FOR WOMEN ONLY:

Are you still having periods? YES NO

If yes, are they regular? YES NO Length of cycle? _____ days

If no, age of menopause? _____

◯ Estrogen Therapy ◯ Discharge from Breast

Patient Name:_____ Patient Date of Birth:___/___/_____

Personal History: (Check all that apply and briefly explain)

- Diabetes_____
- Skin Problems: _____
- High Blood Pressure: _____
- Heart Disease: _____
- Arthritis: _____
- Thyroid Disease: _____
- Cancer:_____
- Stomach Ulcers:_____
- Kidney Disease: _____
- Heartburn: _____
- Liver Disease: _____
- Anemia: _____
- Neurologic Disease: _____
- Blood Clots: _____
- Seizures: _____
- Other Medical Problems:

_____

_____

_____

Medication History:

Drug Allergies and Reaction:

_____

_____

_____

Current Medications with Dosage and Instructions:

_____

_____

_____

_____

_____

_____

_____

Family History:

Type of Disorder: **Family Relationship:**

- Diabetes: _____ _____
- Thyroid Disease: _____ _____
- Heart Disease: _____ _____
- Hypertension: _____ _____
- Stroke: _____ _____
- Cancer: _____ _____
- Cholesterol/ Lipid Disorder: _____ _____
- Osteoporosis: _____ _____
- Abnormal Calcium: _____ _____
- Kidney Stones: _____ _____
- Pituitary or Adrenal Tumor: _____ _____
- Other: _____ _____

Mother Living:__ Yes ___ No Medical Problems: _____

Father Living: __ Yes __ No Medical Problems: _____

Past Surgical History:

_____

_____

_____

Smoking:

____ Yes ____No _____Quit/ Date you stopped

_____ Number of Cigarettes per day _____Smokeless Tobacco/ Vape

Alcohol:

___ Yes ___ No _____Quit/ Date you stopped

_____ Number of drinks per day _____Type of Alcohol

Substance Abuse:

___ Yes ___No Describe: _____

Marital Status:_____

Exercise:

___ Yes ___No _____Number of minutes per day, ____Days per week

Current Occupation:_____

Number of servings of Caffeine a day: _____ **Type of Caffeine:**_____

Describe your diet:_____

Children:_____

<u>*For Patients with Diabetes Only*</u>

- Duration of Diabetes:_____
- Age of onset:_____
- Current Treatment Regimen:
  - Oral Agents:_____
  - Insulin:_____
- Do you have a Glucose Meter or CGM: ___ Yes ___No Type:

_____

- How often do you check glucoses: _____
- Any complications with your diabetes (check all that apply):

___ Eye Problems ____ Angioplasty (Date:_____)

___ Kidney Problems ____ Foot Ulcer (Date:_____)

___ Nerve Damage ____ Bypass Surgery (Date:_____)

___ Heart Attack

- Date of Most Recent Stress Test: _____
- Date of Most Recent Eye Exam: _____

Dr. Kristin Harmon's Office Protocols

Appointment Cancellations/ No Shows:

- We require 24 hour notice for appointment cancellations so we can schedule another patient.
- No Shows and Cancellations that occur less than 24 hours before your appointment time may incur a $45 fee. If your appointment is on Monday that would require you to call the office Friday before close of business at noon.
- If you have not been able to complete your labs prior to your appointment, the provider advises you to keep your appointment.

Late Policy:

- If you arrive to your appointment more than 15 minutes late, we will try and work you back in if the schedule permits or you will have to reschedule to another day.
- We ask that patients arrive 10 minutes prior to their appointment time to check in for demographics verification and intake by the clinical staff.

Patient Portal:

We recommend that all of our patients sign up for the patient portal at www.tallahasseemedicalgroup.com

This allows you to see upcoming appointments and communicate with clinical staff.

Refill Request:

- We ask that you contact your pharmacy first for all prescription refill request.
- If you leave a voice mail we have up to 72 hours to fulfill your request. In the event the medication can't be sent in you will be notified by the clinical staff.
- If your medication requires a Prior Authorization those can take up to 5 business days to get back from your insurance company after submission.

Medications:

- As a patient in this office, you will need to have follow up appointments and lab work on a regular basis. This timeframe is established by the provider based on your diagnosis, symptoms, and medications to help you in the safest, most effective was possible. Please understand that failure to comply with labs and appointments may result in us being unable to fill medication request, this is for your safety.

MD/APRN/PA:

Dr Kristin Harmon's practice as a part of Tallahassee Medical Group uses a variety of professional healthcare providers in order to provide patients with the best and most timely care. Some of these providers include but are not limited to: Endocrinologist (MD), Advanced Nurse Practitioner (APRN), Physician Assistant (PA), registered nurse (RN), licensed practical nurse (LPN), and medical assistants (RMA, CMA). While all of these individuals may be involved in your care, all patient care is overseen by the physician. These individuals work together as a team to provide comprehensive patient care. If you join this practice as a part of Tallahassee Medical Group, your appointment may be with the APRN or PA and not the MD, but all care is collaborative even if you are not physically seeing the MD that day. If this type of practice does not work for you then Dr Kristin Harmon's practice will unfortunately be unable to meet your needs.

Patient Signature: _____ Date:____/____/_____

Patient Name (Print): _____ Date of Birth: ___/___/_____

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Medical Group ("TMG") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Medical Group prior to signing this document, and I acknowledge that the TMG Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Medical Group is also available on the website for TMG at www.TallahasseeMedicalGroup.com. I understand that my physician is a part of TMG, and that this notice applies to the protected health information that my physician, as a part of TMG, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TMG, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TMG participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.centralishealth.com is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. **I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of Centralis Health activities directly to our Privacy Officer at 1511 Surgeons Drive, Tallahassee, FL 32308.**

TMG reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseeMedicalGroup.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TMG of all benefits due by me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Medical Group. participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through Centralis Health (www.centralishealth.com)

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

Centralis Health is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction
Unless you specifically opt out as provided below your personal health information will be provided to organizations such as Centralis Health under secure methods with HIPAA compliant agreements. Tallahassee Medical Group and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation can be found at www.centralishealth.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Patient name (Please Print): _____ **Patient DOB:** _____/_____/_____

Patient Signature: _____

Patient's Communication Instructions, Patient's Release and Acknowledgement

Patient Name (PRINT): _____

Date of Birth: _____

Patient Address: _____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):

____ I would like to UPDATE or CHANGE my telephone number and/or email contact information

____ I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communications and disclosures concerning my healthcare

____ I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communications and disclosures concerning my healthcare

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Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

____ Home phone number – leave message to return call – NO particulars NUMBER:_(____)_____

____ Home phone number – leave message with particulars NUMBER:_(____)_____

____ Cell number - leave message to return call – NO particulars NUMBER:_(____)_____

____ Cell number – leave message with particulars NUMBER:_(____)_____

____ I would like to receive text message for appointment reminders NUMBER:_(____)_____

____ Email _____
(Please do not assume that email will be used by your physician for communication)

Who are you authorizing our office to discuss your health situation with? (Please list all names)

____ Discuss with no one

____ Spouse: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Child: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Child: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Sibling: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Sibling: circle AUTHORIZED or UNAUTHORIZED Name:_____

____ Other circle AUTHORIZED or UNAUTHORIZED Name:_____

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name:_____Relationship:_____Phone:_____

This authorization will expire on:_____(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

_____ _____

Signature of Patient or Legal Guardian Date

If not the patient, explain relationship and legal authority:_____