ADVANCED GERIATRICS & PRIMARY CARE, LLC

MEGUMI MAGUCHI, MD

Quality care for a better quality of life.

Patient Registration Form

Demographic Information

Name_____ Soc. Sec # _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ___ M ___ F Age: _____ Birth Date: __ / ___/ _____ ___ Single ___Married __ Widowed ___Separated ___ Divorced

Home phone# (___) _____ - _____ Mobile # (___) _____ - _____ Work# (___) _____ - _____

Whom may we thank for referring you? _____

Primary Insurance Information

Person responsible for account: _____

Relationship to patient: _____ Birth Date: ___ / ____ / _____

Address (if different than patient) _____ Ph. # (____) ____ - _____

City: _____ State: _____ Zip Code: _____

Insurance Company _____

ID# _____ Grp # _____

Additional Insurance Information

Is this patient covered by additional insurance __ Yes __ No

Subscriber name _____ Relation to Patient_____ Birth Date __ / ___ / _____

Insurance Company _____

ID # _____ Grp# _____

Assignment and Release

I, the undersigned, certify that I) or my dependent) have insurance coverage with _____ and assigned directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

Responsible Party Signature: Relationship: Date: / /

I give permission for treatment of myself / my dependent to my assigned provider.

Responsible Party Signature: Relationship: Date: / /

Advanced Geriatrics Dr. Megumi Maguchi

9013 University Pkwy Ste G
Phone: 850-912-8020 Fax: 850-912-8150

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Advanced Geriatrics and Primary Care (Dr. Megumi Maguchi)

Address: 9013 University Pkwy STE G

City: Pensacola State: FL Zip Code: 32514

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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Consent Form for ePrescribe Program

ePrescribing Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Fill Status Notification**- Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up or not picked up, or partially filled.
- **Medication history transactions** – Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribe regiments, therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The Medication history information would include medications prescribed by your health care provider at the Advanced Geriatrics and Primary Care as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/ STD, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse. Genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at Advanced Geriatrics & Primary Care, LLC may request and use your prescription medication history from other healthcare providers and/ or third party pharmacy benefits payers for treatment purposes.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Advanced Geriatrics & Primary Care, LLC to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Printed Patient Name **Date of Birth**

Signature of Patient or Guardian **Date**

Disclosure to Families and Loved Ones (Emergency Contacts)

I authorize Megumi Maguchi, MD to disclose my health care information / to discuss my health care needs to those that I designate. I further authorize the release of my billing information / give these individual the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Megumi Maguchi, MD to disclose my personal health information to the following people.

Name: _____Relationship:_____ Ph# ( ) _____

Name: _____Relationship:_____ Ph# ( ) _____

Consent to Treatment for All Patients

I hereby grant authorization/consent for medical treatment and/or procedure for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for and understand that no guarantee or assurance has been made as to the results for which may be obtained. **I hereby grant authorization /consent for Dr. Megumi Maguchi to retrieve all my medical records / history of all current and past medications**.

_____

Patient Initials

Photo documentation

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical records.

_____

Patient Initials

Notice of Privacy Practices

I have received a copy of the Megumi Maguchi, MD "Notices of Privacy Practices" today and agree with these privacy policies.

_____

Patient Initials

Insurance Assignment and Financial Responsibility

I hereby authorize the offices of Megumi Maguchi, MD to release any medical information required during the course of examination/treatment to my insurance company and I permit payment to Megumi Maguchi, MD from my insurance of coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services. I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the Office visit, such labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Megumi Maguchi, MD

_____

Patient Initials

____ / _____ / _____ **_____**

Date **Signature of Patient or Guardian (if Patient is Minor)**

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NARCOTIC AGREEMENT

By signing this agreement, I am stating that I understand the risks and benefits of this class of medications as well as the policies of this practice regarding its use and agree to abide by these policies.

- I understand this agreement is essential to the trust and confidence necessary in a doctor – patient relationship and that my doctor undertakes to treat me based on this agreement.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.
- I agree to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines only from the physician listed below, unless I am already being prescribed pain medications by another physician. Additional physician prescribing narcotics. _____
- I will not use any illegal controlled substances such as marijuana and cocaine. I will not share, sell or trade my medications with anyone.
- I agree that I will use my medicine at a rate no greater that the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. If requested by my doctor, I will bring all unused pain medicine to every office visit.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written or filled will not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.
- I authorize my doctor to provide a copy of the agreement to other providers, emergency departments and pharmacies and allow pharmacies to release my prescription history. I also consent for other providers, emergency departments or pharmacies to report violations of this agreement to the prescribing provider(s).
- I authorize my doctor and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the State of Florida's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient Name: _____ DOB: _____ / _____ /_____

Patient Signature: _____ Date _____ /_____ /_____

Physician Name: ___Dr. Megumi Maguchi__ Physician Signature_____