Doctors Direct, LLC

Katherine Grelle, MD, FAAFP ✞ 175 Main St #173 Destin, FL 32540 ✞ doctorsdirectvisits.com ✞ Ph: (850) 861-3949

Student:_____
Birthday: ____ / _____ / ____ Age:_____
Address:_____
City: _____ State: _____ Zip: _____
Phone #: _____
May we leave a detailed message: □ Yes □ No
Email: _____
Sex: Male / Female

Parent/Guardian Information:
Name:_____
Address:_____
City: _____ State: _____ Zip: _____
Phone #: _____
May we leave a detailed message: □ Yes □ No
Email:_____

Emergency Contact:
Name: _____
Phone #: _____
Relationship: _____

Social History:
Currently smoke? □ Yes □ No
Previously smoke? □ Yes □ No Year Quit: _____
Drink alcohol? □ Yes □ No
Frequency: _____Type: _____
Exercise: □ Daily □ Weekly □ Rarely □ Never
Are you on a special diet? □ Yes □ No
Describe: _____
Any current drug use? □ Yes □ No Type: _____
Who do you live with? _____

Medical History: Please list all medical problems:

_____

_____

Previous Head Injuries/Concussions? □ Yes □ No

Current Medications:

_____

_____

Allergies: □ No Known Drug Allergies

_____

Previous Surgeries: Year_____

_____

_____

Family History:
Has anyone in your immediate family been diagnosed with the following disease? If yes, please indicate which family member.

Heart Disease	□ Yes	□ No	_____
High Blood Pressure	□ Yes	□ No	_____
Diabetes	□ Yes	□ No	_____
Cholesterol	□ Yes	□ No	_____
Sudden Death	□ Yes	□ No	_____
Cancer	□ Yes	□ No	_____
Other	□ Yes	□ No	_____

Are you currently having problems with any of the following? If yes, please describe:

Fatigue/Weakness	□ Yes	□ No	_____
Weight Gain/Loss	□ Yes	□ No	_____
Headaches	□ Yes	□ No	_____
Dizziness	□ Yes	□ No	_____
Vision Changes	□ Yes	□ No	_____
Cough	□ Yes	□ No	_____
Wheezing	□ Yes	□ No	_____
Shortness of Breath	□ Yes	□ No	_____
Chest Pain	□ Yes	□ No	_____
Irregular Heart Beats	□ Yes	□ No	_____
Leg Swelling	□ Yes	□ No	_____
Abdominal Pain	□ Yes	□ No	_____
Joint Pain	□ Yes	□ No	_____
Muscle Cramps	□ Yes	□ No	_____
Mood Changes	□ Yes	□ No	_____
Passing Out	□ Yes	□ No	_____
Urine or Stool	□ Yes	□ No	_____

Signature: _____

Date: _____ /_____ / _____

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (from this point on referred to as PHI) to carry out treatment, payment, or health care operations for other purposes. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example: we would disclose your PHI, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include collections agencies.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. We may also call you by your full name when speaking with you on the phone. We may use or disclose your PHI, as necessary, to contact you by telephone or email.

We may use or disclose your PHI in the following situations without your authorization:

○ As Required by Law	○ Food & Drug Administration Requirements		○ Organ Donation	○ Workers' Compensation
○ Public Health Issues	○ Legal Proceedings	○ Research	○ Inmates	○ Criminal Activity
○ Communicable Diseases	○ Law Enforcement	○ Required Uses	○ Health Oversight	○ Coroners
○ Military Activity	○ Required Disclosures	○ Abuse or Neglect	○ Funeral Directors	○ National Security
○ National Security	○ Under the law we must make disclosures to you and when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with the requirements of Section 164.500.			

Other Permitted & Required Uses & Disclosures will be made only with your consent, authorization, or opportunity unless required by law.

You have the right to inspect & copy your PHI: Under federal law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to obtain a copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You may have the right to have your physician amend your PHI: If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health & Human Services if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. Your signature below is an acknowledgment that you have received this Notice of Privacy Practices.

Patient Name: _____ DOB: ___ /___ / _____

Guardian Signature: _____ Date: ___ /___ / _____

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Authorization for Release of Medical Records:

By providing this authorization, I understand the authorization is voluntary and is being done at the request of the patient, parent, or guardian. I understand that I may refuse to sign this authorization without my treatment and/or payment obligations being affected. I understand that the health information to be obtained and released may be subject to redisclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Doctors Direct of Destin, LLC in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of revocation. I understand that this authorization is valid until otherwise specified.

I hereby authorize Doctors Direct of Destin, LLC to use or disclose my health information to the following:

Name: Destin Middle School Other Entity:_____

Assignment of Benefits & Guarantee of Account:

I acknowledge full financial responsibility for any charges incurred on my behalf as a patient, my family member who is a patient, or on behalf of the patient whom I have agreed to be the responsible party. I understand that all payments are due at the time of service. The cost of the visit and any procedures done are my financial responsibility. Doctors Direct accepts payment via cash, credit, or venmo. In the event my account is turned over to a collection agency, I agree to pay all costs, including but not limited to, collection fees and/or attorney's fees and all court costs, if any. I further agree to pay the outside agency an additional 30% on the outstanding portion of my account and hereby waive all rights of exemption under the Constitution and laws of the State of Florida in which my care was performed.

Policy Acknowledgement:

● **Appointments:** Please plan to be ready to be seen 10 minutes prior to your appointment time. It is our goal to have each patient taken care of as quickly as possible without compromising the level of care each patient receives. Having all paperwork completed prior to your appointment time will assist in keeping wait times as minimal as possible.

● **Payment:** The cost of the visit is due at the time you are seen. This includes the visit fee, fees for any injections, suturing, EKGs, test swabs or other procedures performed.

● **Test Results:** Dr. Grelle will discuss your lab work and/or test results with you personally at your visit. You are welcome to and encouraged to receive copies of any lab work results and/or test results in order to keep a personalized health file at home.

● **Hours of Operation:** Regular business hours are 9:00 am to 3:00 pm, Monday through Friday. Outside of normal office hours we defer care to the local urgent care centers or emergency rooms.

● **Callbacks:** In the event you are unable to reach us during normal business hours, please leave a detailed message or send a text. Our policy is to return all messages within 72 business hours. If for some unforeseen reason your message is not returned within 72 hours, we encourage you to reach out to us again then.

● **Consent for Treatment:** I consent to necessary treatment including lab tests, x-rays, procedures, administration of medication and/or other studies that may be needed to diagnose or treat any illness that I present with.

Patient Name: _____ DOB: ___ /___ / _____

Guardian Signature: _____ Date: ___ /___ / _____