North Florida Integrative Medicine

Angeli Maun Akey, M.D., FACP · Dawn Brown, PA-C · Shawna Doran, ARNP-BC
6228 NW 43rd Street
Building 5, Suite B
Gainesville, Florida 32653-8871
Telephone 352-332-3380 · Fax 352-332-6604

Board-Certified in Internal medicine
Board-Certified in Anti-Aging and Regenerative Medicine
Board-Certified in Integrative and Holistic Medicine

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physician and healthcare practitioners to participate in your healthcare. We look forward to providing you with personalized, comprehensive healthcare focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our healthcare team consisting of Dr. Angeli Akey, nurse practitioner, physician assistant, medical assistants and office staff work closely in a “team approach” to support your patient care.

Our office is open **Monday through Thursday from 7:00am-4:00pm, Friday from 7:00am-12 Noon.** Our phones are on service daily from **12 Noon-1:00pm for lunch** and after normal business hours. Any message left on our answering service during the above times, will be returned as soon as possible. Every effort is made to see our patients for medical problems during daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care.

In addition, all office visits are scheduled in advance, and we will make **every effort** to meet your needs. It is not always possible to fit in urgent or emergency issues into our schedule. If this is the case, we encourage you to use the excellent services offered with Dr. Steven Yucht’s team at Emergency Physician Medical Centers located at:

9181 NW 39th Avenue (next to Sonny’s)
Gainesville, Florida 32606
352-727-7755
emergencypmc.com

or

2445 SW 76th Street, Suite 110
Gainesville, Florida 32608
352-872-5111
emergencypmc.com

If this is a severe or life threatening medical condition, please proceed to North Florida Regional Medical Center or call 911. (Dr. Akey is on staff at NFRMC)

Once again, we would like to thank you for choosing us as your Primary Healthcare Provider. We look forward to working with you.

Sincerely,

The Providers and Staff of North Florida Integrative Medicine

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Thank you for choosing **NORTH FLORIDA INTEGRATIVE MEDICINE** as your healthcare provider. We are **committed to fulfilling our responsibilities in your successful treatment. However, in order for our** relationship to be successful, it is important that you understand your responsibilities as a patient. They are as follows:

Patient Responsibilities

1. You need to keep your scheduled appointments, however if for some reason you cannot, it is your responsibility to give a minimum of twenty-four (24) hours' notice. Failure to do so will result in a $75 No Show fee/Late Cancellation. Repeated failure to give appropriate notice could result in ***NFIM*** discharging you from our practice.

2. It is your responsibility to give true and complete information about your health status, medical history, medications, and any other matters about your health. If you do not understand your care plan, please let us know so that our staff can clarify any questions that you may have.

3. It is your responsibility to let us know about any changes in you your care, illness, caregivers and safety concerns.

4. It is your responsibility to provide our office with your up to date/current insurance information. It is your responsibility to pay patient co-pays, deductibles and other appropriate fees at the time of service. Failure to pay previous balances could result in being sent to a collection agency.

5. It is your responsibility to follow the treatment plan established by your practitioner and you. This means going to appointments for tests, attending recommended therapies and doing home activities that have been recommended to you. Be responsible for your actions if you refuse care or don't follow your practitioner's orders. Failure to comply with your treatment plan could result in your practitioner discharging you from our practice.

6. Prescription medicine might be part of your treatment. If so, it is your responsibility to follow instructions closely. No early refills on narcotics will be provided. Prescriptions can only be refilled during work days/hours - Monday through Thursday 7:00am-4:00pm.

7. Follow practice policies and procedures. Be thoughtful of the rights of other patients. Treat the doctor, practitioners and our staff with respect and consideration. I realize that bad language or behavior is not tolerated and may be grounds for discharge from our practice.

I pledge to fulfill my responsibilities as patient:

Signature: ____Date:______________________

Witness: ____Date:______________________

PATIENT INFORMATION

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PATIENT NAME ____
LAST FIRST MIDDLE
PREFERRED NAME: ____
MALE ____ FEMALE ____ DATE OF BIRTH ____________ SOCIAL SECURITY # ____________________
SINGLE _____ MARRIED_____ DIVORCED _____ SEPARATED _____ WIDOWED _____ OTHER ______
ADDRESS 1 ____
ADDRESS 2 (LOT #, APT #) ____
CITY _______________________________ STATE ________________ ZIP______________
HOME PHONE # ______________ WORK PHONE #______________ CELL #______________
E-MAIL ADDRESS ______________________________ REFERRED BY ___________________
EMPLOYER/SCHOOL _____________________________ PHONE _______________________
DRIVER'S LICENSE # ____________________________ STATE ________________________
IN CASE OF EMERGENCY, CONTACT: NAME ____
RELATIONSHIP TO YOU ____________________________ PHONE _____________________
*IS THIS AILMENT RELATED TO YOUR EMPLOYMENT? YES _____ NO _____
ACCIDENT? AUTO ___ HOME ___ WORK ___ OTHER ______________________ NONE ______________

** Know that NFIM does not manage auto insurance or workman's compensation insurance*

PRIMARY INSURANCE INFORMATION

INSURANCE ____
INSURANCE ID/POLICY # _______________________________ GROUP # __________________
INSURED PARTY'S NAME __________________________________ DOB ___________________
RELATIONSHIP TO PATIENT _____________________ PHONE # ____________ SS# ____________
ADDRESS ____________________________ CITY ______________ STATE _____ ZIP __________
INSURED PARTY'S EMPLOYER ____
EMPLOYER'S ADDRESS _________________________ CITY ____________ STATE _____ ZIP __________

SECONDARY INSURANCE INFORMATION

INSURANCE ____
INSURANCE ID/POLICY # _______________________________ GROUP # __________________
INSURED PARTY'S NAME __________________________________ DOB ___________________
RELATIONSHIP TO PATIENT _____________________ PHONE # ____________ SS# ____________
ADDRESS ____________________________ CITY ______________ STATE _____ ZIP __________
INSURED PARTY'S EMPLOYER ____
EMPLOYER'S ADDRESS _________________________ CITY ____________ STATE _____ ZIP __________

Print Your Name_______________________ **Today's Date**____________________

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Please prioritize your most important health concerns.

1.____
2.____
3.____
4.____

Please list your healthcare team.

Physician Name and Specialty **What are you being seen for?**

1.____
2.____
3.____
4.____

Do you have any allergies to medications, environment, food, etc.? ____ (YES) ____ (NO)

Please Explain:

____
____
____

Medications and Supplements

Preferred Pharmacy Name ____

Location ____________________ ____

Phone # ____

What medications are you taking now? (Include prescription and over-the-counter medications)

Medication/Supplement	**Reason**	**When Started**	**Dosage**	**How often taken**

Do you use any of the following?

	Amount per Day	**Amount per Week**	**Never Used**
Tobacco:			

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Alcohol: ________________ ________________ ________________

Other ________________ ________________ ________________

Do you drink caffeine? _____ (YES) _____ (NO) Amount per day? ______________________________________

Do you exercise? _____ (YES) _____ (NO) What type? ____

How Often? ____

What does your diet consist of?

____

____

Vaccination History

Hepatitis A _____ (YES) _____ (NO)

Influenza (flu) _____ (Year most recent) _____ (NO)

Tetanus _____ (Year of last booster) _____ (NO)

Gardasil _____ (1st) _____ (2nd) _____ (3rd) _____ (NO)

Prevnar 13 ______ (Year)

Hepatitis B _____ (YES) _____ (NO)

Pneumonia _____ (Year most recent) _____ (NO)

Rubella _____ (Year) _____ (NO)

Shingles_____ (Year) _____ (NO)

Other ______________________________

Family Medical History

Please check all that apply with the following: (M)Mother (F)Father, (B)Brother, (S)Sister, (C)Child, (MG)Maternal Grandparent, (PG)Paternal Grandparent, (MA)Maternal Aunt, (PA)Paternal Aunt, (MU)Maternal Uncle, (PU)Paternal Uncle

Alcoholism or Substance Abuse________ Allergies________ Anxiety________ Arthritis/Joint Disease________

Blood Disorder/Anemia________ Cancer or tumors (specify type) __________ Depression________

Diabetes________ Epilepsy/Seizures________ Glaucoma________ Headaches/Migraines________

Heart Attack________ Heart Disease________ Heart Failure________ High Blood Pressure________

High Cholesterol________ Kidney or Bladder Disorder________ Liver Disease (Hepatitis etc.)________

Lung Disease (asthma, COPD etc.)________ Mental Illness________ Multiple Sclerosis________

Parkinson's________ Stomach or Intestinal Ulcer (crohns, ulcerative colitis etc.)________ Stroke________

Suicide________ Thyroid Disease________

Personal/Past Medical History (please check all that apply)

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Alcoholism or Substance Abuse________ Anemia________ Arrhythmia________ Arthritis/Joint Disease________

Blood Clots/Phlebitis________ Breast Cancer________ Chronic Sinusitis_________ Colon Cancer________

Depression________ Diabetes________ Dizziness/Fainting________ Epilepsy/Seizures________

Environmental Allergies________ Fatigue________ Fibromyalgia________ Food Allergies________ Gout________

Hay Fever________ Headaches/Migraines________ Heart Attack________ Heart Disease________

Heart Failure________ High Blood Pressure________ High Cholesterol________ History of Infertility________

Irritable Bowel Syndrome________ Kidney Infection________ Kidney Stones________ Liver Disease________

Lung Cancer________ Lung Disease (COPD) _________ Lyme Disease________ Menopausal Symptoms________

Menstrual Dysfunction________ Mental Trouble_______ Multiple Sclerosis________ Parkinson's________

Pregnancy- How Many? ________ Miscarriage(s) ________ Prostate Cancer________ Rheumatic Fever________

Serious Injury or Accident________ Sexual Dysfunction_________ Sexually Transmitted Disease_________

Shortness of Breath________ Stroke/TIA's________ Thyroid Disease________ Tuberculosis________ Ulcer or Stomach Trouble________ Urinary Difficulties________

Men (please check all that apply)

Prostate problems________ Sexual impotence________ Lack of libido (sexual desire) If so, for how long? ________

Genital discharge________ Testicular pain________ Vasectomy________ Hernia________

Testicular Cancer________ Other________

Women (please check all that apply)

On birth control________ Use to take birth control________ On HRT/ bHRT________

Use to be on HRT/ BHRT________Low libido (sexual desire) ________ Pain with intercourse________

Menopause________ Infertility________ Pregnant now________ Planning pregnancy________

Breast lump________ Abnormal mammogram________ PCOS________ Abnormal Paps________

Endometriosis________ PMS________ Hysterectomy________ Cesarean________ How long is your average menstrual cycle? ________ Absent_______ Regular_______ Irregular________ Last Menstrual Cycle _____________

Pain with menses_______ PMS_______ Bloating_______ Tender Breasts_______ Mood swings_______

Headaches_______ Nausea______

Bowel movements

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Once daily________ Twice daily________ Three daily________ >3 daily________ Every other day________

1-2 times weekly________ Other________ Stools tend to be: Loose______ Formed______ Constipated______

Alternating______ Blood in stool______ Dis-colored stools______

If you have sleep issues, please check all that apply

Problems falling asleep________ Frequent waking________ Early waking________ Wake unrefreshed________

Sleepy________ Night sweats________ Fevers________ Use medication________

Use nutritional supplements________

Hospitalizations/Surgeries: Please list any medical conditions, operations/surgical procedures, blood transfusions and major injuries with dates.

1. ____ Date: ____________________________________
2. ____ Date: ____________________________________
3. ____ Date: ____________________________________
4. ____ Date: ____________________________________
5. ____ Date: ____________________________________

Review of Symptoms (check if you are currently experiencing any of these symptoms)

Fatigue_____ Change in Weight_____ Headaches_____ Change in Vision _____ Change in Hearing _____

Ringing in Ears_____ Ear Wax Build up_____ Nasal Obstruction or Discharge_____ Hoarseness_____

Tooth Pain_____ Mouth Sores or Lesions_____ Neck Stiffness or Pain_____ Breast Lumps_____

Breast Tenderness or Swelling_____ Nipple Discharge_____ Chest Pains_____ Palpitations_____

High Blood Pressure_____ Syncope (fainting) _____ Orthopnea (difficulty breathing while laying down) _____

Edema (swelling) _____ Dyspnea (shortness of breath) _____ Wheezing or Coughing_____ Change in Appetite_____

Dysphagia (difficulty swallowing) _____ Acid Reflux_____ Abdominal Pain_____ Diarrhea_____ Constipation_____

Changes in Bowel Habits_____ Emesis (vomiting) _____ Melena (blood in stool) _____ Bleeding from Rectum_____

Abdominal Bloating_____ Indigestion_____ Urination Urgency or Frequency_____ Nocturia (frequent urination at night) _____ Dysuria (painful urination) _____ Incontinence_____

Women Only (pre-menopausal)

Dysmenorrhea (painful periods) _____ Vaginal Discharge_____ Dyspareunia (pain during intercourse) _____

Decreased Libido_____ Pelvic Pain_____ Menstrual Irregularity_____ Severe PMS_____

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Women Only (post-menopause)

Vaginal Discharge_____ Dyspareunia (pain during Intercourse) _____ Pelvic Pain_____

Men Only

Erectile Dysfunction_____ Slow Urinary Stream_____ Painful Urination_____

Men and Women

Joint Pain_____ Muscle Pain_____ Joint Swelling_____ Numbness or Tingling_____

Recent Injuries_____ Hair Loss_____ Skin Rash_____ Changing Moles_____

Pruritus (itching) _____ Generalized Weakness_____ Focal Weakness_____ Memory Loss____

Tremors_____ Balance Problems_____ Dizziness or Fainting_____ Anxiety_____

Depression_____ Insomnia_____

Preventative and Diagnostic Testing (please check all that apply, give date performed and the name of the facility where performed)

Cardiac Testing (what type) ________________________ Date__________ Where________________________________

Chest X-ray_______ Date___________ Where____

Colonoscopy_______ Date___________ Where____

CT Scan_______ Date___________ Where____

DEXA (bone density) _______ Date___________ Where____

Endoscopy_______ Date__________ Where____

Eye Exam_______ Date__________ Where____

Hearing_______ Date__________ Where____

Lab Testing_______ Date__________ Where____

Male exam (Prostate) _______ Date__________ Where____

Mammogram _______ Date__________ Where____

Pap Smear_______ Date__________ Where____

Pelvic Exam _______ Date__________ Where____

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Hormone Balance Inventory for Women

This inventory gives you and your health care provider a tool for assessing hormone imbalance. Circle the answer that best describes you.

During the past 3 months, how often have you experienced:					
Difficulty concentrating and remembering?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Hot flashes and/or night sweats?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Lack of sexual desire?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Feeling anxious?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Mood swings?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Feeling depressed, sad or unhappy?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Difficulties with sleep?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Irritability or nervousness?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Heart palpitations?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Changes in the length of your menstrual cycle?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Changes in the amount of menstrual bleeding?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Breast tenderness?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Bloating or fluid retention?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Weight gain?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Vaginal dryness?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1

Now add up each answer. A high total score (45-75) indicates a strong likelihood of hormone imbalance. However, pay attention to where you may have scored high on one, two, or three questions. This may also indicate a hormone imbalance.

A low total score with low scores on all items indicates a strong likelihood that there is no hormone imbalance.

Total: __________

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MEN ONLY

Do you have: ______ Prostate Problems _____ Testicular Cancer ______ Hernia______ Treatment for genital problems______ Vasectomy______ Discharge from penis_______ Loss of sexual activity? If so, for how long? _________

A.D.A.M

(Androgen Deficiency in the Aging Male)

Screening Questionnaire

	Check YES or NO for each of the following questions:	YES	NO
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decrease in “enjoyment of life”?		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

A.D.A.M. Interpretations
Your ADAM screen is “positive” if you answered

- Yes to question #1 or #7 or
- Yes to any three questions

A positive ADAM screen requires a bioavailable testosterone test for confirmation

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BOTH MEN AND WOMEN

Hospital Anxiety and Depression Scale (HADS)

Patients are asked to circle one response from the four given for each interview. They should give an immediate response and be dissuaded from thinking too long about their answers. The questions relating to anxiety are marked "A," and to depression "D." The score for each answer is given in the right column. Instruct the patient to answer how it currently describes their feelings.

A	3	2	1	0
I feel tense or "wound up":	Most of the time	A lot of the time	From time to time, occasionally	Not at all
I can sit at ease and feel relaxed:	Not at all	Not often	Usually	Definitely
I get a sort of frightened feeling as if something awful is about to happen:	Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
I get a sort of frightened feeling like 'butterflies' in the stomach:	Very often	Quite often	Occasionally	Not at all
Worrying thoughts go through my mind:	A great deal of the time	A lot of the time	From time to time, but not too often	Only occasionally
I feel restless as if I have to be on the move:	Very much indeed	Quite a lot	Not very much	Not at all
I get sudden feelings of panic:	Very often indeed	Quite often	Not very often	Not at all
				Total:

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D	3	2	1	0
I feel cheerful:	Not at all	Not often	Sometimes	Definitely as much
I still enjoy the things I used to enjoy:	Hardly at all	Only a little	Not quite so much	Not at all
I feel as if I am slowed down:	Nearly all the time	Very often	Sometimes	As much as I always could
I can laugh and see the funny side of things	Not at all	Definitely not so much now	Not quite so much now	I take just as much care as ever
I have lost interest in my appearance:	Definitely	I don't take as much care as I should	I may not take quite as much care	As much as I ever did
I look forward with enjoyment to things:	Hardly at all	Definitely less than I used to	Rather less than I used to	Often
I can enjoy a good book or radio or TV program:	Very Seldom	Not often	Sometimes	Often
				Total:

Scoring:

- Add the A's = Anxiety
- Add the D's = Depression
- The norms below will give you an idea of the level of Anxiety and Depression
  - 0-7 = Normal
  - 8-10 = Borderline abnormal
  - 11 – 21 = Abnormal

Reference:

Zigmond and Snaith (1983)

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CONSENT FOR PURPOSES OF: TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I consent to the use or disclosure of my protected health information by **North Florida Integrative Medicine (NFIM),** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by **NFIM.** I therefore authorize, by my signature on this document, **NFIM** to evaluate and treat my condition. I understand that diagnosis or treatment of me by **NFIM** and/or its employees may be conditioned upon my consent. I understand that Dr. Angeli Akey is a Primary Investigator for Clinical Studies in conjunction with Sarkis Clinical Trials. I understand that my health information may be given to Sarkis Clinical Trials if Dr. Angeli Akey and/or the practitioners of **NFIM** feel that the study will benefit my health. I understand that prior to my health information being released to Sarkis Clinical Trials this will be discussed with me by Dr. Angeli Akey or the staff of **NFIM.**

I understand that **NFIM** is a multidisciplinary practice and I give my health care practitioner permission to share my clinical case in weekly case conference should he/she believe it would help my care.

I give **NFIM** (Dr. Akey and/or staff) my authorization to photocopy all portions of my medical records and provide copies of those
medical records to any individual or company which requests those records if the requesting party provides this office with either: a subpoena which requires that production, a court order which requires that production, or a release or authorization which appears to be signed by the patient or the patient's court appointed representative.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **NFIM** is not required to agree to the restrictions that I request. However, if **NFIM** agrees to a restriction that I request, the restriction is binding on **NFIM** and any employee of that entity.

My "protected health information" means heath information, including any demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical, and mental health condition and identifies me, or there is reasonable basis to believe the information may identify me.

Recipients have the right to receive security breach notification; Health plans may not use genetic information for underwriting purposes; Covered entities must obtain patient authorization before using PHI for marketing purposes and before selling PHI.

I have the right to revoke this consent, in writing, at any time, except to the extent that **NFIM** has taken action in reliance to this consent.

I understand that I have the right to review **NFIM's** notice of privacy practices prior to signing this document. The notice of privacy practices has been provided to me. The notice of privacy practices is also posted in the waiting area.

NFIM reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice by called the office manager and requesting a revised copy.

______________________________	______________________________
Signature of Patient or Personal Representative	Date
______________________________	______________________________
Name of Patient or Personal Representative	Description of Personal Reps. Authority

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HIPPA AUTHORIZATION

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPPA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.50 (a)(1)(iv)a covered entity (being a health care provider as defined by HIPPA is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, ____, an individual, hereby authorize all covered entities as defined in HIPPA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath, psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization of ANY protected medical information to the persons named in this authorization.

I authorize the following person(s) full authorization and ANY protected medical information:

Name: ___________________________________
Relationship: ___________________________________
Address: ___________________________________
____

Name: ___________________________________
Relationship: ___________________________________
Address: ___________________________________
____
Telephone: ___________________________________

Name: ___________________________________
Relationship: ___________________________________
Address: ___________________________________
____
Telephone: ___________________________________

*You may leave a message on my answering machine and/or cell phone. _______ (Yes) _______ (No)

*I would like to be added to Dr. Akey's Health News Letter via email. _______ (Yes) _______ (No)

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TERMINATION

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

RE-DISCLOSURE

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPPA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

INSTRUCTIONS TO MY AUTHORIZED PERSONS

My authorized persons shall have the right to bring legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected medical information.

VALID DOCUMENT

A copy or facsimile of this original authorization shall be accepted as though it were an original document.

WAIVER AND RELEASE

I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Signed on the _______ day of ___________________ 20____

Signature: ____

Printed Name: ______________________________________

Witness:

Signature: ____

Printed Name: ______________________________________

North Florida Integrative Medicine

Angeli Maun Akey, M.D., FACP · Dawn Brown, PA-C · Shawna Doran, ARNP-BC

6228 NW 43rd Street

Building 5, Suite B

Gainesville, Florida 32653-8871

Telephone 352-332-3380 · Fax 352-332-6604

LIFETIME AUTHORIZATION

INSURANCE ASSIGNEMENTS AND AUTHORIZATIONS TO RELEASE INFORMATION FORM

I. **RELEASE OF INFORMATION –** I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. **PHYSICIAN INSURANCE ASSIGNMENT –** I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. **MEDICARE/MEDICAID** – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. **I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE ___________________________

PATIENT____

Signature

SUBSCRIBER (if different from patient) ____

Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

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MEDIGAP (SECONDARY INSURANCE) SIGNATURE

________________________________ ___________________________
NAME OF BENEFICIARY HEALTH INSURANCE COMPAY

____
MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on my behalf to _______________ __________or any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to (name of Insurance Company) _______________________________ any information needed to determine these benefits or the benefits for related services.

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Board-Certified in Internal Medicine
Board-Certified in Anti-Aging and Regenerative Medicine
Board-Certified in Integrative and Holistic Medicine

Dear Patient:

The law of Florida recognizes the right of a competent adult to make an Advance Directive regarding instructions for his or her medical care. An adult can instruct his or her physician to provide, withhold, or withdraw life-prolonging procedures (using a Living Will), or to designate another person to make those decisions for him or her if they are unable to (using a Designation of Health Care Surrogate form) should the adult be suffering from a terminal condition.

There is no requirement that our patients have an Advance Directive. The decision to have an advance directive is a personal one, and one that should be made after discussing this matter with one's family, friends, attorney, and/or spiritual advisor.

However, whether you do, or do not have an Advance Directive, we would like to document that fact in your medical record. If you do have an Advance Directive, we would like to keep a copy in your medical record.

Please contact your legal advisor or the Florida Bar Association at www.floridabar.org if you need any further information. On the website www.floridabar.org are free Advanced Care planning forms.

Sincerely,

North Florida Integrative Medicine

I have a Living Will _______ (Yes) _______ (No)

I have an Advanced Directive _______ (Yes) _______ (No)

I have a Designation of Health Care Surrogate _______ (Yes) _______ (No)