North Florida Integrative Medicine
Angeli Maun Akey, MD, FACP, ABIHM, ABAARM
Dawn Brown, PA-C
Shawna Doran, MSN, ARNP-BC

6228 NW 43rd Street Suite B
Gainesville, Florida 32653
Telephone: (352) 332-6680
Fax: (352) 332-6604

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 7:30am-4:30pm, Friday from 7:30am-12:00pm. Our phones are on service daily from 12:00pm-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 Gainesville, Florida 32606 (next to Sonny's)
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,

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.

Patient Responsibilities:
Please initial by each statement.

_____ I need to keep my scheduled appointments. However, if for some reason I cannot attend, it is my responsibility to give a minimum of twenty-four (24) hours' notice. I understand that 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 me from the practice.

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

_____ It is my responsibility to make NFIM aware of changes in my care, illnesses, caregivers and safety.

_____ It is my responsibility to provide the front office with my up to date/current insurance information. It is my responsibility to pay patient co-pays, deductibles and other appropriate fees at the time of service. I understand that failure to pay previous balances could result in being sent to a collection agency or being discharged from NFIM.

_____ It is my responsibility to follow the treatment plan established by my practitioner and me. This includes attending appointments for tests, following recommended therapies and completing home activities recommended to me. I am responsible for my actions if I refuse care or do not follow my practitioner's orders. I understand that failing to comply with my treatment plan could result in my practitioner discharging me.
_____ Prescription medicine might be part of my treatment. If so, it is my responsibility to follow instructions closely. I understand that no early refills on narcotics will be provided and that prescriptions can only be refilled during work days/hours: Monday through Thursday 7:30am-4:30pm.

_____ I will follow practice policies and procedures. I will be thoughtful of the rights of other patients and will 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: _____
Patient's Name:_____
Patient's DOB:_____

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Your New Patient appointment with *(please circle)***:**

Shawna Doran ARNP-BC / Dawn Brown PA-C / Angeli Maun Akey MD **is scheduled for:**

_____ at *(please circle)***: _____** *AM / PM***.**
(MM/DD/YYYY)

Please bring this completed paperwork to your appointment, along with your insurance card and photo identification. Please arrive 30 minutes prior to your appointment to ensure your paperwork is completed and processed. Failure to arrive 30 minutes prior to your appointment can result in your appointment being delayed or rescheduled.

If you are unable to keep this New Patient appointment, you must cancel 48 hours prior to your scheduled appointment time. Failure to cancel 48 hours in advance will result in a "No Show" or "Late Cancellation" fee of $150.00.

Print Name: _____

Signature: _____

Date: _____

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PATIENT INFORMATION (THIS PAGE MUST BE COMPLETED IN FULL)**:**

PATIENT NAME (LAST FIRST MIDDLE): _____
PREFERRED NAME: _____
SEX AT BIRTH: MALE ____ FEMALE ____
DATE OF BIRTH: _____
MARITAL STATUS: SINGLE_____ MARRIED_____ DIVORCED_____ SEPARATED_____ WIDOWED____ OTHER_____
EMPLOYER/SCHOOL:_____ PHONE:_____
SOCIAL SECURITY:_____
DRIVER'S LICENSE:_____ STATE:_____

ADDRESS LINE 1_____
ADDRESS LINE 2 (LOT #, APT #)_____
CITY_____ STATE_____ ZIP_____
HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____
E-MAIL ADDRESS:_____

IN CASE OF EMERGENCY, CONTACT:
NAME:_____ PHONE:_____
RELATIONSHIP TO YOU: _____

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 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 ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

**IS THIS AILMENT RELATED TO YOUR EMPLOYMENT? YES_____ NO_____*
**ACCIDENT? AUTO___ HOME___ WORK___ OTHER_____*
**NFIM does not manage auto insurance or workman's compensation insurance.*

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Name (Print): _____

How did you hear about our practice? _____

Patient Concerns

What are you here to discuss today?

1._____
2._____
3._____
4._____
5._____

Past Medical History

Check beside all that apply.

Alcoholism/Substance Abuse_____ Anemia_____ Arrhythmia_____ Arthritis/Joint Disease_____
Blood Clots/Phlebitis_____ Breast Cancer_____ Chronic Sinusitis_____ Colon Cancer_____
Depression_____ Diabetes_____ Epilepsy/Seizures_____ Environmental Allergies_____
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 Stones_____
Liver Disease_____ Lung Cancer_____ Lung Disease (COPD)_____ Lyme Disease_____
Menstrual Dysfunction_____ Multiple Sclerosis_____ Parkinson's_____ Prostate Cancer_____
Rheumatic Fever_____ Serious Injury or Accident_____ Sexually Transmitted Disease_____
Stroke/TIA's_____ Thyroid Disease_____ Tuberculosis_____ Ulcer_____
OTHER (please specify): _____

Past Surgical History

Please list any surgeries/operations or major injuries that you have had at any point in your life, along with the year it was performed, and if there were any complications that resulted as a result from your surgery.

1._____
2._____
3._____
4._____
5._____

Health Care Team

Please list any other doctors you are seeing for any other medical problem. Make sure to list the doctor's name, phone number, and their specialty.

1._____
2._____
3._____
4._____
5._____

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Medications and Supplements

**Preferred Pharmacy Name:* _____

**Address:* _____

**Phone Number:* _____

What medications are you currently taking? Please include both prescriptions and over-the-counter drugs.

Medication/Supplement/OTC	Reason for Taking	Date Started	Dosage per Day
1.			
2.			
3.			
4.			
5.			

Allergies

Do you have any allergies, to medications, foods, or environmental causes?

Drug allergies:_____ Reaction:_____

Food allergies:_____ Reaction:_____

Environmental allergies:_____ Reaction:_____

Family Medical History

Fill all that apply with the following initials: (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 below) _____ Depression_____
Diabetes_____ Epilepsy/Seizures_____ Glaucoma_____ Headaches/Migraines_____
Heart Attack_____ Heart Disease_____ Heart Failure_____ High Blood Pressure_____
High Cholesterol_____ Liver Disease (Hepatitis etc.)_____ Lung Disease (asthma, COPD etc.)_____
Mental Illness_____ Multiple Sclerosis_____ Parkinson's_____ Stroke_____
Stomach or Intestinal Ulcer (Crohn's, ulcerative colitis etc)_____ Suicide_____
Thyroid Disease_____ Other:_____

Cancer/tumor types:

_____

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Vaccination History

For year, please provide most recent year of injection.

Childhood Vaccinations: up to date _____ refused_____
Influenza (flu): (Year) _____ (NO) _____
Hepatitis B: (YES) _____ (NO) _____
Tetanus: (Year) _____ (NO) _____
Gardasil: (1st) _____ (2nd) _____ (3rd) _____ (NO) _____
Shingles: (Year) _____ (NO)_____
Pneumovax: (Year) _____ (NO)_____
Prevnar 13: (Year) _____(NO)_____

Preventative and Diagnostic Testing

Please list any preventative or diagnostic testing that you have had done, along with the date it was performed, the location or ordering physician, and indicate whether the testing results were normal or abnormal.

Testing	Date	Location	Normal or abnormal results?
Colonoscopy			
Endoscopy			
Mammogram			
Pap Smear			
Prostate Exam			
DEXA (bone density scan)			
CT Scan/Imaging			
Cardiac Testing			
Chest X-Ray			
Lab Testing/Blood work			
Eye Exam			
Hearing Exam			

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Social History

Do you use any of the following?

TOBACCO: (YES) _____ (NO) _____
If yes: how many cigarettes/week _____ or how many packs/day_____
If no: Never used _____ or Former smoker: Year quit _____

ALCOHOL: (YES) _____ (NO) _____
If yes: about how many drinks per week_____

RECREATIONAL DRUGS: (YES) _____ (NO) _____
If yes: about how many times per week _____

Current employer (or indicate if retired): _____
Who currently lives in your household? _____

Nutritional History

Exercise and diet.

What do you do for exercise? _____ How many times per week?_____

What type of diet do you follow? _____ Any restrictions?_____

How much caffeine do you have per day? _____

Review of Symptoms

Circle if you are currently experiencing any of these symptoms.

GENERAL: (-) fatigue, (-) weight change.
HEENT: (-) headache, (-) change in vision, (-) change in hearing, (-) nasal obstruction, (-) nasal discharge, (-) hoarseness, (-) tooth pain, (-) mouth sores/lesions, (-) ringing in ears.
NECK: (-) stiffness, (-) pain.
BREAST: (-) lumps, (-) tenderness, (-) swelling, (-) nipple discharge.
CV: (-) chest pain, (-) palpitations, (-) fainting, (-) swelling of hands/arms/feet/ankles/legs.
LUNGS: (-) shortness of breath, (-) wheezing, (-) cough.
ABDOMEN: (-) change in appetite, (-) acid reflux, (-) pain, (-) diarrhea, (-) constipation, (-) bowel habit changes, (-) difficulty swallowing, (-) vomiting, (-) dark stools, (-) bright red blood around rectum, (-) bloating, (-) indigestion.
GU: (-) urgency, (-) frequency, (-) painful urination, (-) nighttime urination, (-) incontinence.
MUSCULOSKELETAL: (-) joint pain, (-) muscle pain, (-) joint swelling, (-) recent injuries.
SKIN: (-) rash, (-) changing moles, (-) itching.
NEURO: (-) generalized weakness, (-) localized weakness, (-) tremor, (-) memory loss, (-) balance problems.
PSYCH: (-) depression, (-) anxiety, (-) insomnia.

WOMEN ONLY:

GYN: (-) painful periods, (-) vaginal discharge, (-) painful intercourse, (-) decreased sexual desire, (-) pelvic pain, (-) menstrual irregularity, (-) severe PMS (-) postmenopausal - at what age? _____.

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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 statement. 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." Instruct the patient to answer how it currently describes their feelings.

Anxiety	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

Depression	3	2	1	0
I still enjoy things I used to enjoy.	Hardly at all	Only a little	Not quite so much	Definitely as much
I feel as if I am slowed down.	Nearly all the time	Very often	Sometimes	Not at all
I can laugh and see the funny side of things.	Not at all	Definitely not so much now	Not quite so much now	As much as I always could
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	I take just as much care as ever
I look forward with enjoyment to things.	Hardly at all	Definitely less than I used to	Rather less than I used to	As much as I ever did
I can enjoy a good book or radio or TV program.	Very seldom	Not often	Sometimes	Often

Total: Anxiety _____ Depression _____

0-7 = Normal
8-10 = Borderline abnormal
11-21 = Abnormal

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WOMEN ONLY

Hormone Balance Inventory

This inventory is 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

Add up each answer. A high total score (45-75) indicates strong likelihood of hormone imbalance. However, pay attention to where you may have scored high on certain 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_____

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. Interpretation:

Your ADAM screen is "positive" if you answered:

- Yes to question #1 or #7
- Yes to any three questions A positive ADAM screen requires a bioavailable testosterone test for confirmation

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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 NFIM, by my signature on this document, 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 I have the right to request a restriction on 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 restrictions that I request. However, if NFIM agrees to a restriction I request, the restriction is binding on NFIM and any employee.

My "protected health information" means health 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 ental 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: _____
Name of Patient or Personal Representative: _____
Date: _____
Description of Personal Reps. Authority: _____

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HIPAA AUTHORIZATION

STATEMENT OF INTENT

I understand that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") 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 HIPAA 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 HIPAA, 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: _____
Telephone: _____

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 Newsletter 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 HIPAA. 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 FOR 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 _____ year_____

Signature: _____

Printed Name: _____

Witness Signature: _____

Witness Printed Name: _____

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LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS 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.**

V. This assignment will remain in effect until revoked by me in writing.

VI. 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.

VII. 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 SIGNATURE (if different from patient):_____

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

_____	_____	_____
MEDIGAP POLICY NUMBER	**NAME OF BENEFICIARY HEALTH**	**INSURANCE COMPANY**

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.

North Florida Integrative Medicine
Angeli Maun Akey, MD, FACP, ABIHM, ABAARM
Dawn Brown, PA-C
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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)_____