THIS PATIENT PACKET MUST BE COMPLETED BEFORE YOUR APPOINTMENT. IF IT IS NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.

IF YOU NEED ASSISTANCE PLEASE CALL BEFORE YOUR APPOINTMENT (352) 205-4302

Welcome to Rivers Family Medicine!

Our Providers:

Steven J. Rivers, M.D. moved to The Villages in July 2004. He was born and raised in West Chester, Pennsylvania. He completed both his undergraduate degree and medical degree at the University of Iowa located in Iowa City, IA. Embracing a warmer climate he completed his internship, and residency at the Florida Hospital Family Practice Residency located in Orlando, FL. He has been licensed in Florida since 2003, and is board certified in Family Medicine. Dr. Rivers is devoted to providing quality, compassionate, medical care with a focus on preventive medicine. He is aggressive in educating the patient, and involving them in the decision making process. Services include, but are not limited to: comprehensive medical care, health maintenance, minor surgical procedures, skin care, and preventive services.

Patricia L. Cheston, PLC, PAC graduated from Hillsborough Community College, Tampa FL in 1976 and George Washington University, Washington DC in 1987. She is certified by the National Commission on Certification of Physician Assistants and a longstanding member in the American Academy of Physician Assistants and the Florida Academy of Physician Assistants. Patricia has practiced Family Medicine, Rural Urgent Care Medicine and Emergency Medicine for over 24 years in Florida. She has worked at Munroe Regional Medical Center, Leesburg Regional Medical Center, Spring Hill Regional Hospital and Citrus Memorial Hospital in the ED. During her off time, Patricia served as Coordinator of Equine Rescue and Adoption for the Humane Society, SPCA of Sumter County from 1998-2011, Board of Directors Sumter County Youth Charities and Heart of Florida Girl Scouts Group Leader for City Force-Future Focus at South Sumter Middle School. She is presently a member in the Florida Cracker Horse Association, Florida Native Plant Society and her local church. She resides at her farm with her four horses, two dogs and five cats.

Julio Ugarte M.D. grew up in Miami, FL. He completed his undergraduate degree at the University of North Carolina at Chapel Hill. He then completed medical school at The University of South Florida in Tampa, FL. He also completed both his internship and residency at the Florida Hospital Family Medicare Residency in Orlando, FL and is board certified in Family Medicine. He relocated to The Villages area in 1993. He thoroughly enjoys partnering with his patients to strive for optimal health and disease prevention. He uses both conventional and functional medicine is his integrated practice.

Erin Dariano D.O. has been practicing Family Medicine in Lima Ohio at Lima Memorial Hospital for the past 7 years. She completed her undergraduate degree at Bowling Green State University, and her medical degree at Ohio University College of Osteopathic Medicine. She is a board certified D.O., Doctor of Osteopathic Medicine. Dr. Dariano and her husband Michael have two daughters and two dogs. They recently relocated to escape the cold winters of Ohio. They enjoy spending time outdoors and are very excited to explore everything central Florida has to offer. She is committed to providing thorough, compassionate, mindful care for her patients.

Office Hours:

Are by appointment only

Monday through Thursday from 8:30 am to 5:00 pm.
Friday from 8:30 am to 12:00 pm.

Lab Hours:

Monday through Thursday from 7:00 am to 11:30 am & 1:30 pm to 3:00 pm

No labs on Friday

If you have a medical emergency dial 911 or go to the nearest emergency room. Please notify the attending ER physician that you are a patient of Rivers Family Medicine. If you require admission we have dedicated hospitalists to assist in your care. If you have an urgent medical need we reserve appointments daily for work-in appointments and we will do our best to accommodate our patients.

RIVERS FAMILY MEDICINE P.A.

1503 Buenos Aires Blvd, Bldg 110, The Villages, FL 32159
Phone: 352-205-4302 Fax: 352-430-0468

DIRECTIONS TO OUR OFFICE:

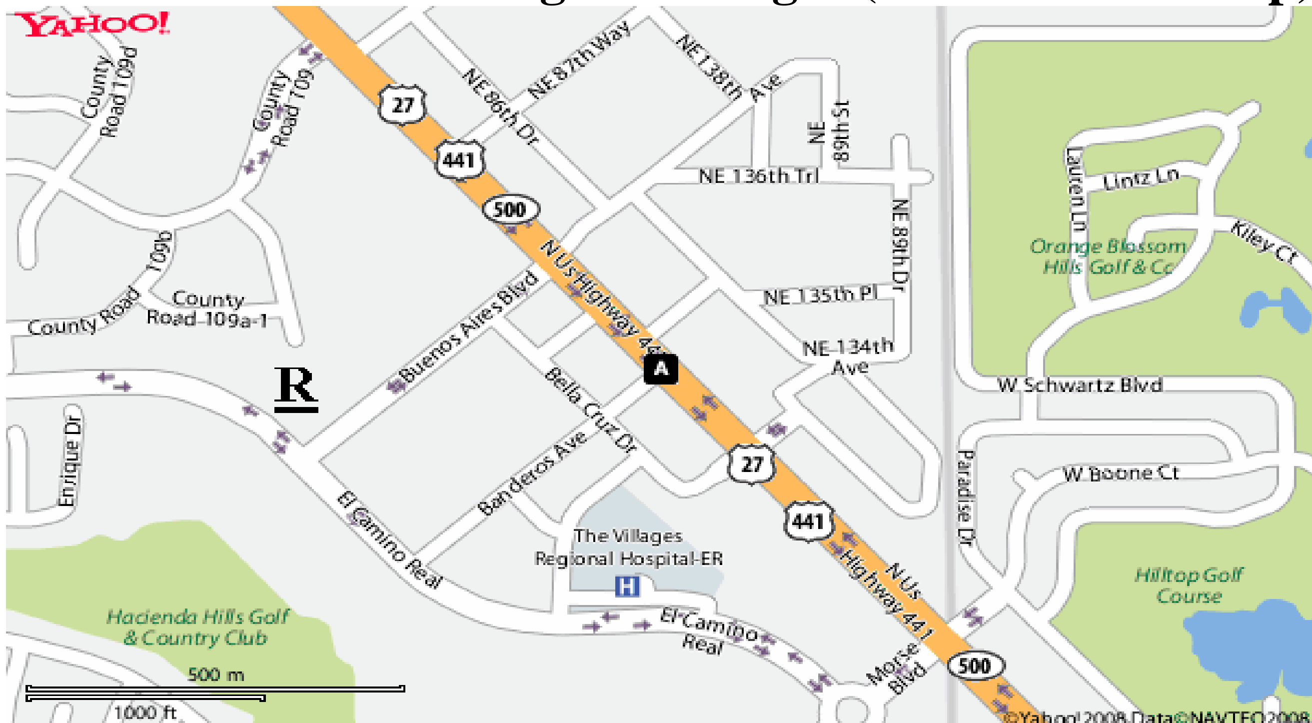
If you are heading north on Highway 441 then turn LEFT onto Buenos Aires Blvd

If you are heading south on Highway 441 then turn Right onto Buenos Aires Blvd

Turn RIGHT onto El Camino Real

Make the first RIGHT into Buenos Aires Plaza

We are the first building on the right (bold R on the map).



DEMOGRAPHICS

Name:____

Home Address:____

City:__________________________________ State:___________________ Zip:___________

Home Phone:_____________________________ Cell Phone:_____________________________

Work Phone:______________________________ D.O.B:________________________________

E-mail address: ____

Social Security Number:____________________ Marital Status:________________ Sex: M or F

Employment/Student status:_________________ Employer:______________________________

Preferred Pharmacy:_______________________ Pharmacy Phone:________________________

Pharmacy Address:____

Primary Insurance:____

Insurance ID#:________________________ Group #:_____________ Effective Date: ___________

If you are not the primary insured then please complete the following:

Primary Insured's Name:___________________________________ D.O.B:__________________

Social Security Number:____________________ Sex: M or F

Home Address:____

City:__________________________________ State:________________ Zip:_______________

Home Phone:_____________________________ Relationship:____________________________

Secondary Insurance:________________________ Insured's Name:_________________________

Secondary ID#:____________________________ Group #:________________________________

Prescription Coverage: _____________________________ ID#: _________________________

Emergency Contact: ____

Address:____________________________ City:_____________ State:________ Zip:___________

Phone:______________________________ Relationship:_________________________________

Patient Acknowledgment: I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. "Advance Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- ☐ I Have Not executed an Advanced Directive
- ☐ I Have executed an Advanced Directive Location of Form:____
  - ☐ Living Will
  - ☐ Durable Medical Power of Attorney
  - ☐ Do Not Resuscitate (DNR) order
  - ☐ Designation of health care surrogate form Designatee/Guardian:_______________________________

Signature:_____________________________________ Date:______________________________________

RIVERS FAMILY MEDICINE P.A.

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The Patient Bill of Rights and Responsibilities

The goal of Rivers Family Medicine is to provide all patients with high quality health care in a manner that clearly recognizes an individual's needs and rights. We also recognize that in order to accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. As a result, the following patient rights and responsibilities were written.

AS A PATIENT YOU HAVE THE RIGHT:

- To receive considerate care that is respectful of your personal beliefs and cultural and spiritual values.
- To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment.
- To appropriate assessment and management of your symptoms, including pain.
- To know the contents of your medical records through interpretation by the provider.
- To know who it is that is interviewing and examining you.
- To have explained to you ways that you can prevent your medical problem from recurring.
- To refuse to be examined or treated by health practitioners and to be informed of the consequence of such decisions.
- To be assured of the confidential treatment of disclosures and records and to have the opportunity to approve or refuse the release of such information except when release of specific information is required by law or is necessary to safeguard you or the community.
- To participate in the consideration of ethical issues that arise in the provision of your care.

AS A PATIENT YOU HAVE THE RESPONSIBILITY:

- To provide Rivers Family Medicine with information about your current symptoms, including pain.
- To provide Rivers Family Medicine with information about past illnesses, hospitalizations and medications.
- To ask questions if you do not understand the directions or treatment being given by a provider.
- To keep appointments or telephone the office at least 24 hours ahead if you need to cancel.
- To be respectful of others and others' property while in our facility.
- To keep an up to date list of all medications, and to contact the office if there are any changes.
- To monitor prescription refill status and to initiate the refill process with a minimum of one week of medication remaining
- To treat all staff members with common courtesy whether in office or through other means of communication.

Signature of Patient or Legal Guardian: ______________________________

Patient's Name: ______________________________ **Date:** ______________

Print Name of Patient or Legal Guardian: ______________________________

RIVERS FAMILY MEDICINE P.A.

1503 Buenos Aires Blvd, Bldg110, The Villages, FL 32159
Phone: 352-205-4302 Fax: 352-430-0468

Office Financial Policy

I. As a courtesy, we will file your primary and secondary insurance. It is your responsibility to make sure that your insurance company has your most recent address and contact information.

II. We are required to make a copy of your insurance cards for verification purposes.

III. We will collect your deductible, co-payment and non-covered service fees at the time of service. Payment methods are: cash, check, MasterCard, and Visa.

IV. There is a $25 charge on all returned checks and a $25 charge for scheduled appointments canceled without 24 hour prior notice or failure to show up for a scheduled appointment.

V. Your insurance will send you an Explanation of Benefits that explains what they have paid to our office. This is a record that you **MUST** keep on file. If you do not agree with their payment, please contact the insurance company directly.

VI. If payment is not received within 30 days of the filing date with your insurance, you will be notified that payment is due.

VII. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.

VIII. There will be a minimum of a $25 charge for completion of all forms. This is not billable to your insurance. Payment due prior to release of forms.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT'S AND AUTHORIZATION TO RELEASE INFORMATION

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 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 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 their 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 carries 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 AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS 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 the deductible amount, co-insurance, or any other balance not paid for by insurance or third 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.

Signature of Patient or Legal Guardian:____

Patient's Name:______________________________ **Date:**____________________

Print Name of Patient or Legal Guardian:______________________________________

RIVERS FAMILY MEDICINE P.A.

1503 Buenos Aires Blvd, Bldg 110, The Villages, FL 32159
Phone: 352-205-4302 Fax: 352-430-0468

Prescription Refill Policy

Refills for current medications can be accomplished by:

1. Requesting through your patient portal account*
2. Calling your pharmacy and they will transmit a request
3. Keeping an up to date list and requesting at the time of your appointment

Please Note:

1. Refill requests received through the patient portal will be accomplished within **24 business hours**.

2. Refill requests received from a pharmacy will be accomplished within **48 business hours**.

3. Please do not leave multiple requests for the same medication

4. **If you are completely out of a medication you can contact your pharmacy for an emergency refill** (typically 3-4 days worth of the medication).

5. Drop in and call in requests for prescription refills will be manually entered into the system at the end of the business day and subject to a **72 business hour** wait period from that time.

6. Your physician will **not** be pulled out of a room while seeing a patient to refill any medications as this is not fair to patients with scheduled appointments.

Signature of Patient or Legal Guardian:____

Patient's Name:______________________________ **Date:**____________________

Print Name of Patient or Legal Guardian:____

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.

If you have any questions about this notice, please contact the Privacy Official for
Rivers Family Medicine P.A.
352-205-4302

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Rivers Family Medicine P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit Rivers Family Medicine P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Rivers Family Medicine P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Rivers Family Medicine P.A. is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Rivers Family Medicine P.A., reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.
Examples of How Rivers Family Medicine P.A., May Use or Disclose Your Health Information

For Treatment: Rivers Family Medicine P.A., may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: Rivers Family Medicine P.A., may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: Rivers Family Medicine P.A., may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business Associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Rivers Family Medicine P.A., may use and disclose information about you as required by law. For example, Rivers Family Medicine P.A., may disclose information for the following purposes:

For Judicial and Administrative Proceedings Pursuant to Legal Authority;
To report information related to victims of abuse, neglect or domestic violence; and
To assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Official.

Rivers Family Medicine P.A.
1503 Buenos Aires Blvd, Bldg 110
The Villages FL 32159
Phone: 352-205-4302
Fax: 352-430-0468

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Rivers Family Medicine P.A. is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Rivers Family Medicine P.A.

____
Name of Patient (PRINT)

____ ______________________
Signature of Patient or Authorized Representative Date

RIVERS FAMILY MEDICINE P.A.

1503 Buenos Aires Blvd, Bldg 110, The Villages, FL 32159
Phone: 352-205-4302 Fax: 352-430-0468

I acknowledge and agree that Rivers Family Medicine P.A. may: (CHECK ALL THAT APPLY)

❑ Leave a message regarding upcoming appointments

❑ Leave a message regarding lab results/imaging studies/medication refills on my home answering machine

❑ Leave a message regarding billing questions on my home answering machine

I acknowledge and agree that Rivers Family Medicine P.A. may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

____
Print name, relationship, and phone number

____
Print name, relationship, and phone number

____
Print name, relationship, and phone number

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose, and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Date: ______________________

____
Signature of Patient or Authorized Representative

____
Please Print Name

HISTORY SHEET INSTRUCTIONS

1. PLEASE READ OVER THE CHOICES CAREFULLY
2. FOR EACH POSITIVE RESPONSE THE BOX MUST BE COMPLETELY DARKENED IN (example □ should be filled in to look like ■)
3. FOR EACH NEGATIVE RESPONSE LEAVE THE BOX BLANK
4. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE PLEASE CALL THE OFFICE AT 352-205-4302

AFTER YOU HAVE COMPLETED THE FOLLOWING SHEETS IF YOU HAVE ADDITIONAL MEDICAL OR SURGICAL HISTORY PLEASE ENTER IT HERE:

ADDITIONAL PAST MEDICAL HISTORY:

ADDITIONAL PAST SURGICAL HISTORY:

PATIENTS NAME: ____

Patient's Name: ____________________________

PATIENT HISTORY SHEET

PAST MEDICAL HISTORY:

☐ ABDOMINAL AORTIC ANEURYSM
☐ ABNORMAL PAP SMEAR (female)
☐ ATTENTION DEFICIT DISORDER
☐ ADOPTED
☐ ALLERGIC RHINITIS
☐ ANEMIA
☐ ANXIETY
☐ ASTHMA
☐ ATRIAL FIBRILLATION
☐ BACK PAIN
☐ BLOOD TRANSFUSION
☐ BENIGN PROSTATIC HYPERTROPHY
☐ BREAST LUMP
☐ BRONCHITIS
☐ CANCER: BLADDER
☐ CANCER: BONE
☐ CANCER: BREAST
☐ CANCER: COLON
☐ CANCER: LEUKEMIA
☐ CANCER: LUNG
☐ CANCER: LYMPHOMA
☐ CANCER: MELANOMA
☐ CANCER: MOUTH
☐ CANCER: OVARIAN (female)
☐ CANCER: PROSTATE (male)
☐ CANCER: RENAL CELL
☐ CANCER: SKIN
☐ CANCER: TESTICULAR (male)
☐ CANCER: THYROID
☐ CANCER: UTERINE (female)
☐ CARDIOMYOPATHY
☐ CARPAL TUNNEL
☐ CATARACTS
☐ CVA (STROKE)
☐ CHRONIC BLADDER INFECTIONS
☐ CHRONIC DIARRHEA
☐ CHRONIC PANCREATITIS
☐ CIRRHOSIS
☐ COLOSTOMY
☐ CONGESTIVE HEART FAILURE (CHF)
☐ COPD (Chronic obstructive pulmonary disease)
☐ CORONARY ARTERY DISEASE
☐ CONSTIPATION
☐ DEPRESSION
☐ DIABETES
☐ DIVERTICULITIS
☐ DIVERTICULOSIS
☐ DNR (DO NOT RESUSCITATE)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ EDEMA
☐ EMPHYSEMA
☐ GALLBLADDER DISEASE
☐ GERD
☐ GOUT

☐ HEAD OR NECK RADIATION
☐ HEADACHE
☐ HEART DISEASE
☐ HEART MURMUR
☐ HYPERTENSION (High blood pressure)
☐ HERNIA
☐ HYPOTHYROIDISM
☐ HYPERLIPIDEMIA (High cholesterol)
☐ INSOMNIA
☐ MACULAR DEGENERATION
☐ MIGRAINE HEADACHE
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPENIA
☐ OSTEOPOROSIS
☐ PALPITATIONS
☐ PNEUMONIA
☐ POLIO
☐ PULMONARY NODULE
☐ PULMONARY EMBOLUS
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ SEIZURES
☐ THYROID NODULE
☐ TIA (Transient ischemic attack aka mini-stroke)
☐ ULCERS
☐ URINARY INCONTINENCE
☐ UTERINE PROLAPSE (female)
☐ VARICOSE VEINS

SOCIAL HISTORY:

DO YOU SMOKE? ☐ YES ☐ NO

IF YES, PACKS PER DAY: ☐ ONE ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU USE CAFFEINE? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

MARITAL STATUS:

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

Patient's Name: ___________________________

FAMILY HISTORY:

MOTHER:

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
☐ CANCER
☐ COPD (Chronic obstructive pulmonary disease)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

FATHER:

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
☐ CANCER
☐ COPD (Chronic obstructive pulmonary disease)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

SIBLINGS:

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
☐ CANCER
☐ COPD (Chronic obstructive pulmonary disease)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

CHILDREN:

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
☐ CANCER
☐ COPD (Chronic obstructive pulmonary disease)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

Patient's Name: ___________________________

REVIEW OF SYSTEMS:

Which of the following symptoms have you had in the past **2 weeks**?

- ☐ FEVERS OR SWEATS
- ☐ VISION WORSENING
- ☐ HEARING LOSS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ BLOOD IN STOOL
- ☐ BLOOD IN URINE
- ☐ JOINT SWELLING
- ☐ IRRITATED MOLES
- ☐ CONVULSIONS
- ☐ LACK OF PLEASURE/FUN
- ☐ HOT FLASHES
- ☐ BRUISING EASILY
- ☐ WHEEZING
- ☐ SEX LIFE COULD BE BETTER
- ☐ UNDESIRED WEIGHT LOSS
- ☐ DOUBLE VISION
- ☐ DIFFICULTY SWALLOWING
- ☐ CHEST HEAVINESS
- ☐ COUGHING UP BLOOD
- ☐ VOMITING BLOOD
- ☐ URINARY DISCHARGE
- ☐ MUSCLE WEAKNESS
- ☐ CHANGING MOLES
- ☐ FALLING
- ☐ THOUGHTS OF SUICIDE
- ☐ CAN'T TOLERATE HOT/COLD TEMP
- ☐ BLEEDING FREQUENTLY
- ☐ NASAL CONGESTION
- ☐ SNORING

RIVERS FAMILY MEDICINE P.A.

1503 Buenos Aires Blvd, Bldg 110, The Villages, FL 32159
Phone: 352-205-4302 Fax: 352-430-0468

MEDICATION LIST

Patient Name:	**Date of birth:**
Pharmacy:	**Pharmacy phone#:**
Allergies to medications:	

Date prescribed	**Medication**	**Dose**	**Quantity**	**Frequency**

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____ ______________ ________________________
Patient Name: LAST   FIRST   MI   Date of Birth   Social Security Number

I hereby authorize Rivers Family Medicine P.A. to OBTAIN my medical records from:

Name:____

Street
Address:____

City:____________________________________ State:____________ Zip:_______________

Phone:___________________________________ Fax:____

INFORMATION TO BE DISCLOSED: ( ) Complete chart, ( ) Records from ___/___/___ to ___/___/___
( ) Other - please specify:____
PURPOSE OF DISCLOSURE: ( ) Continuing Care, ( ) Payment of Claim, ( ) School, ( ) Legal,
( ) For Personal Use, ( ) Other - please specify:____

I specifically authorize the release of information relating to: (for consent initial by each option)
_____ Substance abuse (including alcohol/drug use)
_____ Behavioral Health
_____ HIV related information (AIDS related testing)
_____Communicable diseases

ACKOWLEDGEMENT OF UNDERSTANDING:
- I understand the expiration date of this authorization is one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
by the recipient and no longer protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I have a right to receive a copy of this form after I have signed it.
- I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

____ _______________ _______________
Signature of patient, parent of minor, or personal representative   Relationship   Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RIVERS FAMILY MEDICINE, P.A.
1503 Buenos Aires Blvd, Bldg. 110
The Villages, FL 32159
Telephone 352-205-4302
Facsimile 352-430-0468

RFM NPI # 1821211335

Consent to Obtain External Prescription History

I,____, whose signature appears below, authorize Rivers Family Medicine, and its affiliated providers, to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at Rivers Family Medicine, and it may include prescriptions that have been dispensed for several years prior to my visit here.

____

Patient signature Date

____

Date of birth

____

Witness Date