Compton Care

11974 CR 101, STE 101 The Villages, FL 32162

(P) : 352-391-9467 (F) : 352-391-9468

- Please send the following to our billing department

⇒ **Comptonchiro@yahoo.com**

⇒ **Or Fax to (352) 391-9468**

- Picture of **Drivers License and Insurance Cards (front and back)**
- **Completed Intake Paperwork**

- **Recent lab work, imaging, or other testing** please send report.

⇒ **Please send copies all reports to Comptonchiro@yahoo.com**

Please contact the office if you have any questions

352-391-9467

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Legal Name: _____ Prefers: _____ Gender: M / F

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Social Security #: _____ Birthdate: ____/_____/_____ □ Married □ Single □ Widowed □ Divorced

Emergency Contact : _____ Contact Number : _____

SPECIALIST CONTACT INFORMATION :

Name	**Office Phone**
Cardiologist -	
Urologist -	
Neurologist -	
Other :	

Consent to Treat

_____ **Initials** I hereby voluntarily consent to all healthcare services ordered/provided by Compton Care. The health care service may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and test; x-rays and other imaging studies; administration of medications; and alternative healthcare prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services. I consent to examinations, treatments, procedures and blood test ordered by the healthcare provider, which may include blood test for diseases such as hepatitis and HIV AIDS. I understand that if this consent is being signed on behalf of a minor, I may be required to sign a separate paternal consent form in order for the minor to receive family planning services. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and ask me to complete a new consent form.

Consent Provisions

_____ **Initials** My initials on this form indicate that: 1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true. 2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity. 3. I understand that Resident Physicians may be involved in treatment and I consent thereto. 4. I understand that midlevel providers (Physicians Assistants and Advanced Practice Registered Nurses) may be involved in treatment and I consent thereto. 5. I understand that I may be asked to sign a separate informed consent form for certain treatment (s) that require such. 6. I hereby voluntarily give my consent to treatment at Compton Care.

Consent to Bill Insurance and Collect Payment

_____ **Initials** I understand and agree that health, dental or behavioral health insurance coverage is an agreement between the insurance carrier and myself. I understand that Compton Care will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized will be paid directly to Compton Care. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I authorized Compton Care to furnish information to insurance carriers concerning my illness and treatments. I acknowledge my responsibility to pay for that care according to the fees established. In the event that the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein. HIPAA Acknowledgement of Privacy Practices I have received a copy of Compton Cares "Notice of Client

_____ Patient Name _____ Patient Signature _____ Date

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Office Policies

It is our mission to efficiently provide high-quality, comprehensive, medical care to you—our valued patient. To achieve this goal we request all patients adhere to the following administrative policies. Your cooperation is greatly appreciated. Non-compliance with the practice policies may result in fees as stated below.

Fee Policies

1. If you cannot keep an appointment, you are responsible for notifying the office a minimum of 24 hours in advance. **Fee for missed appointment without notifying office.** _____**$60.00**
2. We accept cash, check, credit, and debit cards. **Returned check fee** _____ **$35.00**
3. Unaddressed overdue bills of 120+ days will be sent to collections. **Collection Fee** _____ **$50.00**
4. FORMS— Completion of health forms requiring a physician signature **Form Fee** _____ **$10.00**

Medication Refills

- **Please request your medication refills at the time of your appointments. This provides patients with the most timely refill services.**
- Allow **48 hours/2 business days** to process refill requests made by phone.
- **Please Note—** medications prescribed elsewhere (i.e. : specialist) must be refilled by original ordering physician unless previously approved by your provider.

Insurance Referrals

- **48 hours/2 business days** is requested for non-urgent referrals.

Test Results

- **Results of tests ordered by other physicians (i.e. : specialist) are not available though our office.**
- Lab testing can take 2-30 days to process depending on tests ordered. You will be contacted regarding results within **48 hours/2 business days after receipt of all test results.**

I, _____ have read, understand, and agree to the above office policies.

_____ _____

Signature of Patient/Legal Guardian **Date**

_____ _____

Name of Legal Guardian/Legal Representative **Relationship to Patient**

NEW PATIENT INTAKE FORM

Patient Name : _____ **Date of Birth** : _____

WELLNESS SCREENING HISTORY :	DATE	RESULT	ADDRESS
Wellness/Routine Physical Exam			
Routine Blood Work			
Mammogram			
DEXA (Bone Density) Scan			
Pap Smear			
PSA			
Hepatitis C Screening			
Colonoscopy			

ADULT VACCINATION/IMMUNIAZTION HISTORY (IF AVAILABLE PLEASE ATTACH CHILDHOOD IMMUNZATIONS SEPARATELY)

	DATE		DATE
TETANUS		ZOSTER	
TDAP		SHINGLES	
PREVNAR 13		PNEUMOVAX 23	

HEALTH HISTORY—HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

General / Constitutional :

Good Health	☐ Yes	☐ No
Recent Weight Change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

Eyes and Vision :

Eye Disease / Injury	☐ Yes	☐ No
Glasses / Contact Lenses	☐ Yes	☐ No
Blurred/Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Ears, Nose, & Throat :

Hearing Loss	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Earaches	☐ Yes	☐ No
Sinus Issues	☐ Yes	☐ No
Nose Bleeds	☐ Yes	☐ No
Mouth Sores	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Bad Breath/Taste	☐ Yes	☐ No
Sore Throat/Voice Change	☐ Yes	☐ No
Swollen Glands in Neck	☐ Yes	☐ No

Psychiatric :

Memory Loss/Confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Sleep Issues	☐ Yes	☐ No

Cardiovascular :

Heart Trouble	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No
Sudden Heartbeat Changes	☐ Yes	☐ No
Swelling of feet/ankles/hands	☐ Yes	☐ No

Gastrointestinal :

Loss of Appetite	☐ Yes	☐ No
Change in Bowel Movements	☐ Yes	☐ No
Nausea/ Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in Stool	☐ Yes	☐ No
Stomach Pain	☐ Yes	☐ No

Musculoskeletal :

Joint Pain/Stiffness	☐ Yes	☐ No
Joint Swelling	☐ Yes	☐ No
Weakness of muscles/joints	☐ Yes	☐ No
Muscle pain/Cramps	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Cold Extremities	☐ Yes	☐ No
Difficulty Walking	☐ Yes	☐ No

Respiratory :

Frequent Coughing	☐ Yes	☐ No
Spitting up Blood	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Asthma/Wheezing	☐ Yes	☐ No

Genitourinary :

Frequent Urination	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
Strain with Urination	☐ Yes	☐ No
Incontinence/Dribbling	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Sexual Difficulty	☐ Yes	☐ No
Painful Periods	☐ Yes	☐ No
Irregular Periods	☐ Yes	☐ No
Vaginal Discharge	☐ Yes	☐ No

Endocrine:

Thyroid Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Excessive Thirst/Urination	☐ Yes	☐ No
Heat/Cold Intolerance	☐ Yes	☐ No
Dry Skin	☐ Yes	☐ No
Change in Hat/Glove Size	☐ Yes	☐ No

Hematologic/Lymphatic:

Slow Healing	☐ Yes	☐ No
Easy Bruising/Bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Transfusion	☐ Yes	☐ No
Swollen Glands	☐ Yes	☐ No

Neurological :

Headaches	☐ Yes	☐ No
Dizzy or Lightheaded	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Numbness or Tingling Sensations	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No

Skin & Breasts:

Rashes/Itching	☐ Yes	☐ No
Change in Skin Color	☐ Yes	☐ No
Change in Hair / Nails	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Breast Pain	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No
Breast Discharge		

NEW PATIENT INTAKE FORM

Patient Name : _____ **Date of Birth** : _____

CURRENT MEDICATIONS WITH DOSAGES - □ None □ Attached **Reconciled** □

ALLERGIES - □ No Known Drug Allergies Latex □ Yes □ No **Reconciled** □

FAMILY HISTORY- **Reconciled** □

RELATION	CURRENT AGE	AGE AT DEATH	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	CANCER	DIABETES	GLAUCOMA	ASTHMA	BLEEDING DISORDER	SEIZURES
FATHER			□	□	□	□	□	□	□	□	□
MOTHER			□	□	□	□	□	□	□	□	□
SIBLING(S)			□	□	□	□	□	□	□	□	□

Other Family History : _____

_____

SOCIAL HISTORY **Reconciled** □

TOBACCO USE : □ YES □ NO *Quit* : ___ Type _____ : _____/DAY NUMBER OF YEARS: _____ **ALCOHOL USE** : □ YES □ NO *Quit* : ___ Type _____ : _____/DAY NUMBER OF YEARS: _____	**EXERCISE** : □ YES □ NO TYPE OF EXERCISE : _____ _____ HOW OFTEN : _____ _____	**CAFFEINE** : □ YES □ NO *Quit* :___ Type _____ : _____/DAY NUMBER OF YEARS: _____

SURGICAL HISTORY □ None □ Details Attached **Reconciled** □

Procedure :	Date :	Procedure :	Date :

VITALS

Height :	Temp :	Right BP :	Pulse :
Weight :	Pulse Ox :	Left BP :	Pulse :

COMPTON CARE

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Consent to Release Information

May we release **test results** or **appointment information** to anyone other than you, (i.e., spouse, child)?

_____
Initials

Yes _____ No _____ If YES, please list first and last name and relationship to you:

Name	Relationship
_____	_____
_____	_____
_____	_____

Consent to View Prescription History

_____
Initials

I give permission for my medical provider to view all prescriptions filled at other pharmacies using my current prescription insurance plan.

_____ _____ _____
Printed Name of Patient | Patient Date of Birth | Relationship to Patient

Signature of Patient/Guardian or Power of Attorney

_____
Date

Consent to Communicate

_____
Initials

I give permission for my medical provider to communicate with other physicians in regards to my care.

_____ _____ _____
Printed Name of Patient | Patient Date of Birth | Relationship to Patient

Signature of Patient/Guardian or Power of Attorney

_____
Date

Valid until written request to revoke is submitted to office by patient