



C.W. Randolph, Jr., M.D. • Phillip Bruner, M.D.
Patricia A. Landry, M.S.N., A.R.N.P • Nicole Aldrich, M.S.N., A.R.N.P

Welcome and thank you for choosing our medical practice. We want to do everything we can to address your health care needs and make your first visit comfortable and convenient.

The following paperwork is necessary for us to get an accurate assessment of your health concerns. In this packet you will find the following forms:

- General Patient Information
- Health History
- Medication List
- Hormone Imbalance Questionnaire (required for Hormone Consultations)
- Policies and Authorizations
- Notice of Privacy Policies

Please fill out all forms completely. **For your appointment, please bring** your 1) new patient paperwork (filled out), 2) insurance card, 3) driver's license and 4) any referrals needed. We ask that you **arrive 10 minutes early** to process your paperwork and health insurance.

Please do not wear perfume as many of our staff and other patients are allergic.

Please contact our office at (904) 249-3743 if you have any questions. Thank you and we look forward to seeing you soon!!

Your appointment is with:

- C.W. Randolph, Jr., M.D.
- Phillip Bruner, M.D.
- Patricia Landry, M.S.N., A.R.N.P
- Nicole Aldrich, M.S.N., A.R.N.P

Your appointment is for a:

- Well Woman Exam (includes a pelvic exam, breast exam, and possible Pap smear)
- Hormone Consultation

Date: _____

Time: _____

Phone: 904.249.3743 • Fax: 904.249.2047
1891 Beach Blvd. • Suite 200 • Jacksonville Beach, Florida 32250
AGELESSANDWELLNESS.COM

FEMALE HEALTH HISTORY FORM
(Please Print Clearly)

Date: _____

Name: _____

DOB: _____

Reason for today's visit: _____

Gynecological History

Age of menstrual period onset _____

Date of last period _____

How long did it last? _____

Are your periods generally regular? No Yes

Do you bleed between periods? No Yes

Do you or did you ever have PMS? No Yes

Method of birth control used _____

Do you bleed after intercourse? No Yes

Date of last pap smear _____

Were the results normal? No Yes

Have you ever had an abnormal pap? No Yes

If yes, what follow-up was needed? _____

When was your last mammogram? _____

Were the results normal? No Yes

If no, what follow-up was needed? _____

Do you desire STD testing? No Yes

Do you have sexual concerns? No Yes

Do you have any problems with leaking urine or have
incontinence concerns? No Yes

Pregnancies

How many pregnancies have you had? _____

How many miscarriages? _____

How many children were born alive? _____

How many abortions? _____

How many tubal pregnancies? _____

Any complications with pregnancy? No Yes

Explain _____

Menopause

At what age did your periods stop? _____

Have you had a hysterectomy? No Yes

If yes, when? _____

Do you have your ovaries? No Yes

Allergies (check all that apply)

__Aspirin __Betadine

__Codeine __Latex

__Novocain __Sulfa

__Shellfish

__Other _____

Weight

Usual: _____ Recent Gain: _____ Recent Loss: _____

Personal Medical History (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Glaucoma/Eye Disease | <input type="checkbox"/> Nervous / Mental Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Headaches | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Redness/Pain in Leg |
| <input type="checkbox"/> Cancer / type: _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> FMS/CFS | <input type="checkbox"/> Mood Changes | _____ |

Medical Tests (check all that apply)

- | | |
|--------------------------------------|---------------|
| <input type="checkbox"/> Mammography | (Date: _____) |
| <input type="checkbox"/> PAP Smear | (Date: _____) |
| <input type="checkbox"/> DEXA | (Date: _____) |
| <input type="checkbox"/> Colonoscopy | (Date: _____) |
| <input type="checkbox"/> Cholesterol | (Date: _____) |

Surgical History (check all that apply)

- | | | | |
|--|---------------|---|---------------|
| <input type="checkbox"/> Appendix Operation | (Date: _____) | <input type="checkbox"/> Laparoscopy | (Date: _____) |
| <input type="checkbox"/> Breast Biopsy | (Date: _____) | <input type="checkbox"/> Plastic Surgery | (Date: _____) |
| <input type="checkbox"/> Bladder Surgery | (Date: _____) | <input type="checkbox"/> Removal of Tube or Ovary | (Date: _____) |
| <input type="checkbox"/> C-Section | (Date: _____) | <input type="checkbox"/> Thyroid Operation | (Date: _____) |
| <input type="checkbox"/> D&C | (Date: _____) | <input type="checkbox"/> Tonsillectomy | (Date: _____) |
| <input type="checkbox"/> Endometrial Ablation | (Date: _____) | <input type="checkbox"/> Tubal Ligation | (Date: _____) |
| <input type="checkbox"/> Gallbladder Operation | (Date: _____) | <input type="checkbox"/> Varicose Vein Operation | (Date: _____) |
| <input type="checkbox"/> Hemorrhoid Operation | (Date: _____) | <input type="checkbox"/> Other _____ | _____ |
| <input type="checkbox"/> Hernia Operation | (Date: _____) | | |
| <input type="checkbox"/> Hysterectomy | (Date: _____) | | |

X-Rays (check all that apply)

- Chest
- Lower GI
- Skull
- Stomach/Esophagus
- Gallbladder
- Colon
- Upper GI
- Kidneys

Social History (check all that apply)

- Do you drink caffeinated products? No Yes How many drinks per day/month? _____
- Are you a smoker? No Yes Packs per day? _____ Years smoked? _____
- Do you drink alcohol? No Yes How many drinks per day/month? _____
- Do you exercise? No Yes How many times per week? _____ What type? _____
- Do you use drugs? No Yes

Family History (check all that apply)

Does anyone in your immediate family – mother, father, siblings – have the following conditions(s):

<u>Condition</u>	<u>Whom</u>
<input type="checkbox"/> Breast Cancer	_____
<input type="checkbox"/> Bleeding Disorders	_____
<input type="checkbox"/> Cancer, other type	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Fibrocystic Breast	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Thyroid Disorder	_____
<input type="checkbox"/> Other	_____ Explain _____
<input type="checkbox"/> Other	_____ Explain _____

Are there any other pertinent medical history concerns we should be aware of?

Name of any physicians familiar with your medical history:

Patient Signature

Date

Provider Initials

FEMALE HORMONE IMBALANCE QUESTIONNAIRE

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experience.

Symptoms of Hormone Imbalance	Extremely Mild 1					Extremely Severe 10				
Fatigue	1	2	3	4	5	6	7	8	9	10
Food Cravings	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Dry Hair	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Fibrocystic Breasts	1	2	3	4	5	6	7	8	9	10
Heart Palpitations	1	2	3	4	5	6	7	8	9	10
Bloating	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Frequent UTI or Incontinence	1	2	3	4	5	6	7	8	9	10
Painful Intercourse	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Arthritis/Joint Pain	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Foggy Brain/Fuzzy Thinking	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Inability to concentrate	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
PMS	1	2	3	4	5	6	7	8	9	10
Poor Sleep	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10

Dr. Randolph's Ageless & Wellness Medical Center
C.W. Randolph, Jr., M.D. • Phillip Bruner, M.D.
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POLICIES AND AUTHORIZATIONS
(Please Initial and Sign)

Name: _____ DOB: _____

Appointment 'No Show' and Cancellation Policy

_____ A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a 'no show.' A \$25.00 'no show' and cancellation fee will be issued for any appointment that is missed by the patient or not cancelled 24-hours prior to the appointment. Patients will receive an invoice in the mail.

Late Appointment Policy

_____ We recognize that unforeseen events may delay your arrival, however, please note that you are considered late if you arrive **10 minutes past** your scheduled appointment. If you should arrive late for your scheduled appointment, it is to the provider's discretion whether you are worked back into the schedule (prioritize among those patients who arrived on time) or rescheduled.

Patient Responsibility

_____ I understand it is my responsibility to provide a copy of my current insurance card and obtain all necessary authorizations. Should I not provide the required information, I will be personally financially responsible for the total charge of rendered services by C. W. Randolph Jr. M.D., P.A.

_____ I understand that I am responsible for charges not covered or reimbursed by my insurance carrier. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

Notice of Privacy Policies

_____ I acknowledge receipt of the Notice of Privacy Policies of C.W. Randolph, Jr. M.D, P.A. This Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice. If you have any questions about our Notice of Privacy Policies please contact our Office Administrator.

Authorization to Release Medical Information

_____ I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information as it relates to my care.

Individual's Name (Please Print)

Relationship to Patient

_____ I authorize C.W. Randolph, Jr. M.D., P.A to

- | | |
|---|--|
| 1. Leave medical information on my answering machine at home? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Leave medical information on my cell phone? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Leave a message at my place of employment? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Signature of Patient or Legal Guardian

Date

NOTICE OF PRIVACY POLICIES FOR

C.W. RANDOLPH, JR., M.D., P.A.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Introduction

At C.W. Randolph, Jr., M.D., P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It 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.

Understanding Your Health Record/Information

Each time you visit C.W. Randolph, Jr., M.D., 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, 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 C.W. Randolph, Jr., M.D., P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.526.
- 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.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

C.W. Randolph, Jr., M.D., P.A. is required to:

- Maintain the privacy of your health information,

- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
 - Abide by the terms of the Notice currently in effect,
 - Notify you if we are unable to agree to a requested restriction, and
 - Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, such revised Notices will be made available to you.

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.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Practice at (904) 249-3743

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.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of

treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

We will use your health information for regular health 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.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we 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 will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal

representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. We may mail to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany the patient into the exam room, it is considered implied consent that a disclosure of the patient medical data is acceptable.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer.

Marketing: We may contact you to provide appointment reminders or 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: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or

disability. State law requires the reporting of certain types of cancer to the Florida Cancer Data System. Under HIPAA, covered entities may disclose protected health information to these registries without the individual informed consent of each patient pursuant to the "public health" exception to HIPAA general disclosure rule. A log of these releases will be maintained.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

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.