______________________________ ______________
Form Completed by Date

Section 1:
PATIENT INFORMATION

Last Name:_______________________________ First Name:__________________ MI: __________

DOB:_______________________ SSN:_____________________ ◯Male ◯ Female

Physical Address: ____

Apt or Room #: _______________ Facility Name (if applicable): _________________________________

City: ◯ Pensacola ◯Cantonment ◯Milton ◯Pace ◯Gulf Breeze ◯Navarre ◯FT Walton Beach

◯Crestview ◯DeFuniak Springs ◯Other: ____

State: _X_ FL **Zip Code:** _____________

Mailing Address (If residing in a facility OR mailing address is different than physical address):

Street: ____

City: _________________________ State: _________________________ Zip Code: __________

Primary Phone: ____ ◯ Cell ◯ Home

Secondary Phone: ____ ◯ Cell ◯ Home

Email: ____

Would you want to receive emails or text messages from Beacon Medical?

◯ Email ◯ Text ◯ Both Email and Text ◯ Do not contact by email or text

Is WiFi access available in your home or facility? ◯Yes ◯No

Race: ◯ Caucasian/White ◯ African American/Black ◯ Asian ◯ Unknown/Declined to Answer

Ethnicity: ◯ Hispanic/Latino ◯ Not Hispanic/Latino ◯ Unknown/Declined to Answer

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(If Applicable)

Caregiver Name: ____

Relationship: ________________________________

Address: ____

City: ____________________ State: ______ Zip: ______________

Primary Phone: ____ ◯ Cell ◯ Home

Secondary Phone: ____ ◯ Cell ◯ Home

Email: ____

Section 2:

PHOTO DOCUMENTATION

I hereby grant authorization for Beacon Medical, LLC to make a copy of my photo identification to be included in my confidential record as well as to take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

Patient Initials: _______

Section 3:

ADVANCE DIRECTIVES

Do you have any of the following documents?

◯ Living Will ◯ POLST – Provider Orders for Life Sustaining Treatment

◯ DNR - Do Not Resuscitate ◯ Healthcare Surrogate

◯ Healthcare Power of Attorney ◯ Five Wishes

◯ Advanced Directive ◯ Other ____

At Beacon Medical, we want to be able to honor your wishes should the need arise; therefore, we ask that you please provide us with copies of the above documents so that we can add them to your patient file.

Patient Initials: _______

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Section 4:

INSURANCE: Please list the insurance company and policy number for any medical insurance policies you have. This information can be found on your insurance card. Common insurance carriers include Medicare, Humana, Tricare, WellCare, United Healthcare, and Blue Cross Blue Shield. Please note that Beacon Medical does not accept HMO policies at this time.

PRIMARY Insurance: ____

Policy Number: ___________________________________

Policy Holder Name and DOB (if not the patient): ____

SECONDARY Insurance: __ ___________ _ _____________________ __

Policy Number: ___________________________________

Policy Holder Name and DOB (if not the patient): ____

RESPONSIBLE PARTY/NEXT OF KIN

(person/party who is authorized to receive verbal and/or written medical and financial correspondence)

Relationship to Patient: ○ Spouse ○ Son/Daughter ○ Other: ____________________

Last Name: __________________________ First Name: ____________________ MI: ________

Mailing Address: ____

City: ___________________ State: ______ Zip: _____________

Primary Phone: ____ ○ Cell ○ Home

Email: ____

Section 5:

CONSENT TO TREATMENT

I hereby grant authorization and consent for medical treatment and/or procedures for myself or for the patient for whom I am the legally authorized representative. I understand that no guarantee or assurance has been made regarding results that may be achieved through any treatment I or the patient I represent may receive.

Patient Initials: _______

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Section 6:

HIPAA CONSENT AND CONTACTS

I authorize Beacon Medical to disclose and discuss my healthcare information and needs with those I designate. I further authorize the release of my billing information, and give the individuals listed below the ability to pick up prescriptions on my behalf. I understand that a photo ID is required for prescription pickup. I understand that an address is requested for at least one authorized individual to allow Beacon Medical to communicate in writing with someone I have authorized should I become unable to relay my wants and needs myself.

I understand I can designate the individuals below as my emergency contact and/or medical point of contact (POC). If designated as an emergency contact, I authorize Beacon Medical to contact that individual in an emergency. If designated as a POC, I understand that Beacon Medical may reach out to that individual if they are unable to get in contact with me or if I become unable to communicate my medical needs and wishes effectively.

I understand that without authorization, no information may be shared. I authorize Beacon Medical, LLC to disclose my personal health information to the following people:

Name: ________________________________ ○ POA ○ Emergency Contact ○ Medical POC ○ Next of Kin

Relationship: _______________________________ Phone: _________________________________

Mailing Address: ____

Email Address: ____

Name: ________________________________ ○ POA ○ Emergency Contact ○ Medical POC ○ Next of Kin

Relationship: _______________________________ Phone: _________________________________

Mailing Address: ____

Email Address: ____

Name: ________________________________ ○ POA ○ Emergency Contact ○ Medical POC ○ Next of Kin

Relationship: _______________________________ Phone: _________________________________

Mailing Address: ____

Email Address: ____

Section 7:

PHARMACY INFORMATION

Pharmacy Name: ____ ○ **LOCAL /** ○ **MAIL ORDER**

Address: ____Phone: ____

Prescription Insurance Information (if applicable)

Plan Name: ____ ID# ____

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Section 8:

AVAILABLE MEDICARE SERVICES

(A) Chronic Care Management (CCM)

As a Beacon Medical, LLC patient, you may benefit from a Medicare sponsored care management program offered by our office. Chronic Care Management (CCM) services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months, and which place you at significant risk of further decline. Our goals are to keep you as healthy as possible while providing you with the best care and keeping you out of the hospital.

CCM services help you manage ongoing health conditions, both by making appointments for your provider to see you at your residence as well as calls in between visits from our dedicated office staff.

CCM benefits also include:

- ✓ 24-hours-a-day, 7-days-a-week access to a health care provider to address acute chronic care needs
- ✓ A systematic assessment of your health care needs
- ✓ A process to assure that you receive preventative care services in a timely manner
- ✓ Medication reviews and oversight
- ✓ A plan of care covering your health issues
- ✓ Management of care transitions among health care providers and settings

By consenting to CCM services, you agree to allow Beacon Medical, LLC (referred to as "Provider"), to bill Medicare for these services during any month that we provide at least 20 minutes of chronic care management services to you.

You are aware that only one provider or hospital can provide and bill for chronic care management services for you during a calendar month. Please let us know if you receive these services from any other provider during any month.

You agree to allow the Provider to share your care information electronically with other providers who are delivering care to you.

You understand that standard coinsurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month, even if there is not a face-to-face meeting with your provider. If you have secondary or supplementary insurance, this cost may be covered for you.

As part of receiving chronic care management services, you may request to receive a copy of your care plan.

You have the right to stop chronic care management services at any time (effective at the end of a calendar month). You may revoke this agreement verbally by calling 850-290-8410, or in writing addressed to:

Beacon Medical, 45 Industrial Blvd - Suite C, Pensacola, FL 32503

By signing this section, you consent to Beacon Medical providing chronic care management services (referred to as "CCM Services") to you as described above.

Patient Signature____

(B) Remote Patient Monitoring (RPM)

Beacon Medical, LLC provides Remote Patient Monitoring (RPM) to eligible patients who are interested in this service. Remote Patient Monitoring (RPM) is the use of connected electronic tools to record and securely transmit collected health data to your healthcare team. Patient specific data that maybe collected includes blood pressure, weight, heart rate, pulse oximetry, or blood glucose. RPM provides instantaneous and daily data to Beacon Medical, LLC for optimization of your healthcare. If you are interested in participating in RPM, or if your provider thinks you may benefit from the program, a separate consent form will be made available for you to sign.

I acknowledge that I have received information regarding the RPM program. I understand that participation in the RPM program is optional and available to me should my provider and I decide it would be beneficial. Should I decide to participate, a separate consent will be collected.

Patient Initials: ________

Section 9:

PATIENT–PROVIDER AGREEMENT FOR CONTROLLED SUBSTANCE USE

This agreement is between person listed in section 1 of this document (the Patient) and Karen Jackson, APRN

& Beacon Medical, LLC (The Prescriber) concerning the use of opioid analgesics (narcotic painkillers) for the treatment of chronic pain. Please initial next to each statement, indicating you agree with the conditions of the controlled substance agreement, even if the agreement does not currently apply to you.

We work closely with the DEA Strike Force to prevent prescription drug abuse.

______ I understand that the medication will probably not eliminate my pain but is expected to reduce it enough that I may become more functional and improve my quality of life.

______ I understand that opioid analgesics are strong medications for pain relief, and I have been informed of the risks and possible side effects involved with taking them.

______ I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweating, chills) that may occur within 24-48 hours of the last dose.

______ I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life threatening for a baby.

______ Overdose on this mediation may cause death by stopping my breathing. This can be reversed by emergency medical personnel if they know I have taken narcotic painkillers.

______ I understand it is my responsibility to inform the provider of all side effects I have from this medication.

______ If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

______I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescriber. Running out early, needing early refills, escalating doses without permission, and losing

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prescriptions may be signs of misuse of the medication and may be reasons for the Nurse Practitioner to discontinue prescribing to me.

_____ I agree that the opioids be prescribed by only **one prescriber**, and I agree to fill my prescriptions at only **one pharmacy**. I agree not to take any pain medication or mind-altering medications prescribed by any other physician or provider without first discussing it with the above prescriber. I give permission for the above prescriber to verify that I am not seeing other prescribers for opioid medication or going to any other pharmacies.

NOTE: Filling any opioid prescribed by another Physician, Hospital, Emergency Room, Clinic etc. other than Beacon Medical, LLC can void Section 5 of this agreement. This will prevent Beacon Medical, LLC and its providers from prescribing all opioid based pharmaceuticals and will force the patient to seek pain management medications from another source.

PLEASE CONTACT BEACON MEDICAL, LLC BEFORE filling any opioid prescriptions prescribed by sources other than Beacon Medical, LLC.

_____ I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

_____ I agree not to sell, lend or in any way give my medication to any other person.

_____ I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic mediation. I agree to submit a urine specimen at any time that my prescriber requests and give permission for it to be tested for alcohol or drugs.

_____ I agree that I will attend all required follow up visits with the prescriber to monitor this medication and I understand that failure to do so will result in a discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my prescriber.

_____ I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high or be unable to control my use of it. People with a history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued, and I will be referred to a drug treatment program for help with the problem.

_____ I agree to participate in random toxicology screening through urine testing should I at any point be prescribed opioid pain medication by the prescriber.

While emergencies do happen, it is in the best interest of all involved to have controlled substances prescribed by only one practitioner whenever feasible. If you have recently been discharged from the hospital, rehab, or another facility that temporarily took over your care, please contact us as soon as possible so we can work to ensure there are no lapses in your care or medication schedule.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I understand the Nurse Practitioner and Beacon Medical may discontinue this form of treatment.

Patient Signature: ____

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Section 10:

FINANCIAL AGREEMENTS AND AUTHORIZATIONS

(A) AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS and RELEASE OF MEDICAL INFORMATION

I hereby authorize the offices of Beacon Medical, LLC to release any medical information that is required or requested to my insurance company and permit payment to Beacon Medical, LLC from my insurance company for any benefits due for services rendered.

I authorize the release of any medical records and/or other information required by my insurance company or its designated review agents working on my behalf, including, if applicable, my employer, employer's workman's compensation insurance company, the Social Security Administration and/or the Centers for Medicare & Medicaid Services, needed to process claims, authorizations, and referrals.

(B) SELF-PAY POLICY

To make our services accessible to patients lacking health care coverage, Beacon Medical offers a self-pay option which provides services to uninsured individuals at a reduced price. We will identify patients without insurance coverage and consistently apply a method of billing, discounting, and collecting from our uninsured patients. Patients without insurance coverage are not required to apply for the self-pay discount to obtain treatment.

The following information applies for self-pay patients:

- Self-pay pricing excludes all third-party services (DME, Labs, X-ray, etc) as well as additional Beacon Medical, LLC services such as Advanced Care Planning, which are billed separately.
- Self-pay patients will be required to have a valid credit card on file with Beacon Medical, LLC as well as a signed credit card authorization form.
- The card on file will be charged the day after the appointment date and only if the visit was completed.

For self-pay patients, new patient appointments will be charged $250.00, and subsequent established patient visits will be charged $200.00.

(C) NO SHOW POLICY

Beacon Medical, LLC reserves the right to enforce a no-show policy and applicable fees in situations where the patient shows a pattern or history of confirming appointments with our providers and then being unavailable for said appointment. We ask that if you have conflicts with your schedule, you inform our office during your appointment confirmation call so we can make the necessary accommodations. If you are unable to inform us during the confirmation call, we request that you contact our office as soon as you are aware a conflict exists so we can get your appointment rescheduled. Enforcement of the no-show policy will be reviewed and enforced on a case-by-case basis. Each appointment labelled a no-show will result in a fee of $25. Exceptions will be made for emergency situations.

I acknowledge that I am aware of, and agree to adhere to, Beacon Medical's Self-Pay and No-Show policies, should either of these policies ever be applicable to me or my situation.

Patient Initials : ________

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(D) FINANCIAL AGREEMENT

By signing the Financial Agreement, I agree to and understand the following:

- ✓ I agree that any balances that arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reasons will be my responsibility. I agree to pay all charges within 30 days of receipt of Beacon Medical, LLC's statement. I understand Beacon Medical, LLC reserves the right to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify credit bureaus of my delinquencies.
- ✓ I understand that I may be billed separately for services rendered by other professionals outside of Beacon Medical, LLC providers and staff, such as laboratory, durable medical and prescription services.
- ✓ I agree that if for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fee(s) for service(s).
- ✓ I agree that if I do not have insurance, myself and/or my representative will pay according to Beacon Medical, LLC's Self Pay Policy, which was provided to me or my designated representative in the consent packet.
- ✓ I agree to Beacon Medical, LLC's No-Show Policy, which was provided to me or my designated representative in the consent packet during an appointment, through verbal communication between Beacon Medical, LLC office staff or through any means of electronic or mailed correspondence. I agree to pay any applicable fees associated with cancelled and/or missed appointments per the No Show Policy.
- ✓ I understand that there may be insurance requirements that require the staff at Beacon Medical, LLC to request an authorization from my insurance carrier. I understand that if an authorization is required and requested but is subsequently denied by my insurance carrier, I will be responsible for the payment of all charges should I agree to proceed with un-authorized services.
- ✓ I agree that myself or my designated representative will assist Beacon Medical, LLC concerning questions, disputes concerning insurance coverage, and/or payment for services rendered.
- ✓ I agree to inform Beacon Medical, LLC immediately of any change in insurance coverage, benefits and/or change of personal information.
- ✓ I permit a copy of this authorization and signature to be used in place of this original on all insurance claim and submissions, whether manual, electronic or telephonic.

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(E) Certification

I certify that the information I provided prior to receiving care is true and complete. I understand and agree that the terms herein are reaffirmed each time services are rendered.

PATIENT SIGNATURE____

Section 11:
CONSENT FORM ACKNOWLEDGEMENT

By signing this document, I understand and agree with all sections initialed or signed (Section 1-10). I understand I have the right to retain a copy of my signed consent form. I acknowledge that I have been given the opportunity to ask questions while reviewing this document, be it in person with a provider or over the phone with Beacon Medical, LLC staff. I understand that should questions arise in the future, I can contact Beacon Medical, LLC via phone at 850-290-8410, via email at teambeacon@beaconmednp.com, or in writing addressed to:

Beacon Medical, 5113 North Davis Hwy - Suite 1, Pensacola, FL 32503

I certify that the information provided is current and accurate to the best of my knowledge.

____ _____________________

Signature of Patient or Legal Guardian Date

A copy of Power of Attorney documents must be obtained and included with this admission document if POA is signing on behalf of the patient.

Medical Record Release Form

Patient Name: ________________________________ **DOB: ___________________**

I request and authorize the entity listed below to release medical information to Beacon Medical, LLC.

Name: ____Telephone: _______________________

Address: ____ Fax: ____________________

City: ____ State: _____________ Zip: ________

The Medical Information Requested Is Checked Below:

- ○ All Records
- ○ Radiology Films (X-Ray, Mammography, Ultrasound, CT, MRI, etc.)
- ○ Lab Results
- ○ Immunization & Physical Examinations
- ○ Discharge Summary
- ○ History and Physical
- ○ Consultation
- ○ Specific Records from _____________ to _______________

Please forward medical records to the following:

Beacon Medical, LLC
45 Industrial Blvd Suite C
Pensacola, FL 32503
P: 850-290-8410 opt 2
F: 866-574-6391
teambeacon@beaconmednp.com

____ ________________

Signature of Patient or Legal Guardian Date

I understand that these records are protected under Federal and State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol for substance abused, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admission. I understand that I have the right to revoke this consent at any time in writing.

Notice of Privacy Practices

This notice describes how medication information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

Section 1: Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

- ✓ Get an electric or paper copy of your medical record: You can ask to see or get an electric or paper copy of your medical record and other health information we have about you. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a cost-based fee for printing and mailing these documents.
- ✓ Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
- ✓ Request confidential communications: You can ask us to contact you in a specific way or to send mail to a different address. We will say "yes" to all reasonable requests.
- ✓ Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for purpose of payment or our interactions with your health insurer. We will say "yes" unless a law requires us to share that information.
- ✓ Get a list of who we have shared information with: You can ask for a list, or accounting, of the times we've shared your health information, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures, such as those you asked us to make. We will provide one accounting a year for free but will charge a cost-based fee if you ask for another one within 12 months.
- ✓ Get a copy of this notice: you can ask for a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- ✓ Choose someone to act for you: if you have given someone medical power of attorney or someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure any such person has that authority and can act for you before we take any action.
- ✓ File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights and we will not retaliate against you if you file a complaint.
- ✓ **You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington DC, 20201, visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by calling 1-877-696-6775.**

Please note that our practice follows Florida statutes 395.3025 and 395.301, as well as rule 64B8-10.003 when determining charges for records requested by patients or governmental agencies.

Section 2: Your Choices

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For certain health information, you can tell us your choices about what we share. If you have a preference for how we share your information in the situations below, please tell us and we will follow your instructions.

- ✓ In these cases, you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory.

If you are not able to tell us your preferences, for example if you are unconscious, we may proceed to share information if we believe it is in your best interest. We may also share your information if it is needed to lessen a serious or imminent threat to health or safety.

- ✓ We will NEVER share your information unless you give us written permission in these cases:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
- ✓ We may contact you for fundraising efforts, but you can tell us not to contact you again for this purpose.

Section 3: Our Uses and Disclosures

How do we typically use or share your health information?

- ✓ To treat you: we can use your health information and share it with other professionals who are treating you. For example, sending test results to a specialist who has requested them to aid in treatment
- ✓ Run our organization: we can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information to manage your treatment and services.
- ✓ Bill for your services: we can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about your to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We have to meet many conditions in the law before we can share your information for these purposes, but there are situations where we are allowed or required to share your information-usually in ways that contribute to public good, such as public health or research.

- ✓ Help with public health and safety issues, such as preventing disease, helping with recalls, reporting adverse reactions to medications, reporting suspected abuse or neglect, and preventing or reducing a serious threat to anyone's health and safety
- ✓ Contribute to or participate in health research.
- ✓ Comply with the law: we will share information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see we are complying with the federal privacy law.
- ✓ Respond to organ and tissue donation requests: we can share information about you with organ procurement organizations.
- ✓ Work with a medical examiner or funeral director: we can share health information with a coroner, medical examiner, or funeral director when an individual passes.

- ✓ Address law enforcement, worker's compensation, and other government requests: we can use or share your health information for worker's compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services
- ✓ Respond to lawsuits and legal actions: we can share health information about you in response to a court or administrative order, or in response to a subpoena.

Section 4: Our Responsibilities

- ✓ We are required by law to maintain the privacy and security of your protected health information.
- ✓ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ✓ We must follow the duties and privacy practices described in this notice and give you a copy of it
- ✓ We will not use or share your information other than as described unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by informing us in writing.

For more information, please visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Section 5: Changes to the Terms of this Notice

We can change the terms of this notice at any time, and the changes will apply to all the information we have about you. The new notice will be available upon request.

Notice of Privacy Practices effective date: 03/09/2023

Last updated: 03/09/2023

For questions, comments, and concerns, please contact our office compliance officer via phone at (850) 290-8410, via email at teambeacon@beaconmednp.com attn: Compliance Officer, or by mail at: Beacon Medical, LLC, c/o Compliance Officer, 45 Industrial Blvd, Suite C, Pensacola, FL, 32503