WILLIAM J. FLYNN, M.D.P.A.
2211 HARRISON AVE
PANAMA CITY, FL 32405
TEL: (850) 763-2555
FAX: (850) 763-9374

WE DO NOT BILL SECONDARY INSURANCE

REGISTRATION INFORMATION

(PLEASE PRINT)

DATE: _____ HOME PHONE: _____

PATIENT: _____
LAST NAME FIRST NAME MIDDLE INITIAL

RESPONSIBLE PARTY (IF A MINOR): _____

STREET ADDDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

SEX: M ___ F___ BIRTHDATE _____ AGE ____ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED____

PATIENT EMPLOYED BY: _____

BUSINESS ADDRESS: _____

OCCUPATION: _____ BUSINESS PHONE: _____

PURPOSE OF VISIT: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT: _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____

SPOUSE'S SOCIAL SECURITY # _____ SPOUSE'S DATE OF BIRTH _____

DO YOU HAVE MEDICAL INSURANCE? NO _____ YES _____

NAME OF PRIMARY INSURANCE _____

POLICY NUMBER _____ GROUP # _____

NAME OF SECONDARY INSURANCE _____

POLICY NUMBER _____ GROUP # _____

ALLERGIES: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ PHONE: _____

YOUR DRUG STORE NAME: _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

ASSIGNMENT OF INSURANCE BENEFITS

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS SUBMITTED FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I _____ HEREBY AUTHORIZE _____
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

TO PAY AND HEREBY ASSIGN DIRECTLY TO WILLIAM J. FLYNN, M.D. ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED ON THE ATTACHED FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I FURTHER ACKNOWLEDGE THAT ANY INSURANCE BENEFITS, WHEN RECEIVED BY AND PAID TO DR. WILLIAM J. FLYNN,M.D. WILL BE CREDITED TO MY ACCOUNT, IN ACCORDANCE WITH THE ABOVE ASSIGNMENT.

_____ _____
(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)

WILLIAM J. FLYNN, M.D., P.A.
2211 Harrison Avenue
Panama City, FL 32405-4549

PATIENT AGREEMENT / NARCOTICS AND OTHER MEDICATIONS

Please read and initial each paragraph to signify your acceptance and understanding of this agreement.

_____ I understand and agree that prescriptions for narcotics are only issued during normal operational hours of this office, 8-5 Monday - Friday, and 8-12 noon on Thursday. The office is closed for lunch from 12 - 1:00 Monday - Friday, excluding holidays and other posted closures.

_____ I understand that written prescriptions for refills can be provided during my office visits and that telephone requests for refills must be made 24 hours (week/work days) in advance of my last remaining dose.

_____ I understand that written prescriptions requested by phone will be available 24 hours after request is made, and I will not be notified from this office when a prescription has been called to a pharmacy. It is the patient's responsibility to contact the pharmacy.

_____ I understand that the physician on call DOES NOT refill pain medications.

_____ I understand that lost, destroyed, or altered written prescriptions will not be replaced.

_____ Without deception or exception, I agree NOT to obtain duplicate prescriptions of medications prescribed by this office from another physician or healthcare provider while under the care of this office.

By signing this document, I agree to abide with all the information presented in this agreement. I understand that failure to do so may result in termination of all prescriptions and/or transfer of care to a different provider of my choice.

Patient or Legal Guardian _____ Date _____

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

Your have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician ament your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provide in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature:_____Date_____

I hereby give Dr. Flynn's office permission to release medical information regarding myself to the following person(s):

_____

_____

_____

PATIENT INFORMATION SHEET

Name:_____ Gender:____DOB:_____Date:_____

Allergies:_____

LIST ALL MEDICATIONS YOU TAKE, INCLUDING OVER-THE-COUNTER &VITAMINS

INCLUDE SPECIFIC DOSES & WHEN TAKEN. IF YOU DON'T KNOW CALL YOUR PHARMACY.

_____

_____

_____

_____

_____

_____

_____

_____

PERSONAL MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ADHD
ALCOHOLISM
ALLERGIES
ANEMIA
ANXIETY
IRREGULAR HEART BEAT
ARTHRITIS
GLAUCOMA
OSTEOPENIA/OSTEOPOROSIS
HEART DISEASE
HIATAL HERNIA
COPD/EMPHYSEMA
DEMENTIA
DEPRESSION
DIABETES: 1 OR 2
DIVERTICULITIS
ACID REFLUX
NEUROPATHY
HEART ATTACK
CANCER_____
HIGH CHOLESTROL
HIV
HEPATITIS
IRRITABLE BOWEL SYN.
LUPUS
BLOOD CLOT
MACULAR DEGENRATION
BLADDER PROBLEMS
ULCERATIVE COLITIS
PARKINSON'S DISEASE
PERIPHERAL VASCULAR
RHEUMATOID ARTHRITIS
SEIZURE DISORDER
SLEEP APNEA
STROKE
THYROID DISORDER
LIVER DISEASE
ASTHMA
HEART ATTACK
BIPOLAR
BLEEDING PROBLEMS
HIGH BLOOD PRESSURE

PEPTIC ULCER HEADACHES KIDNEY STONES PSORIASIS

CROHN'S DISEASE KIDNEY DISEASE PULMONARY EMBOLISM

OTHER MEDICAL PROBLEMS_____

SURGICAL HISTORY & DATE_____

_____

SMOKING/TOBACCO USE:_____CURRENT_____PAST____NEVER____TYPE_____AMT__YRS

ALCOHOL:_____CURRENT_____PAST_____NEVER_____DRINKS PER WEEK

RECREATIONAL DRUG USE:_____CURRENT_____PAST_____NEVER_____TYPE

FAMILY HISTORY:

FATHER: LIVING AGE_____ DECEASED AGE_____

ALCOHOLISM BIPOLAR DEPRESSION HIGH CHOLESTROL OSTEOPOROSIS ANEMIA CANCER____

DIABETES 1 OR 2 HIGH BLOOD PRESSURE STROKE ASTHMA COPD BLOOD CLOT KIDNEY DISEASE

THYROID DISORDER ARTHRITIS DEMENTIA HEART DISEASE MIGRAINES OTHER_____

MOTHER: LIVING AGE_____ DECEASED AGE_____

ALCOHOLISM BIPOLAR DEPRESSION HIGH CHOLESTROL OSTEOPOROSIS ANEMIA CANCER____

DIABETES 1 OR 2 HIGH BLOOD PRESSURE STROKE ASTHMA COPD BLOOD CLOT KIDNEY DISEASE

THYROID DISORDER ARTHRITIS DEMENTIA HEART DISEASE MIGRAINES OTHER_____

SIBLINGS:_____

_____

LIST ON MEDICAL PROVIDERS YOU SEE ON A REGULAR BASIS & WHY :

_____

_____

PATIENT SIGNATURE:_____DATE_____