Today's Date: ____________________

Kristin Harmon, MD
2623 Centennial Blvd, Suite 204
Tallahassee, FL 32308

Patient Name: ________________________________ Date of Birth: _____________________

STAFF TO COMPLETE WT: __________ T: __________ HR: __________ BP: __________

PsO2: _________ BBG: __________ A1C: _________

Your Pain Level Today (circle one) 0 1 2 3 4 5 6 7 8 9 10

Chief Complaint: ____

____

Current Primary Care Physician: _______________________

Referring Physician if different: ____________________________

Current Pharmacy (Local): _____________________________

Current Pharmacy (Mail): _________________________

SYMPTOMS TODAY

◯ General Good Health
◯ Weight Gain
◯ Weight Loss
◯ Excessive Fatigue
◯ Excessive Thirst
◯ Blurred Vision
◯ Double Vision
◯ Shortness of Breath
◯ Cough
◯ Palpitations
◯ Irregular Heart Rate
◯ Chest Pain
◯ Ankle Swelling
◯ Sexual Problems
◯ Low Sex Drive

◯ Nausea
◯ Vomiting
◯ Constipation
◯ Diarrhea
◯ Blood in Stool
◯ Abdominal Pain/Cramping
◯ Hair Loss
◯ Abnormal Hair Growth
◯ Change in Nails
◯ Excessive Sweating
◯ Pain in Joints
◯ Back Pain
◯ Swelling in Joints
◯ Recent Fractures

◯ Weakness
◯ Numbness
◯ Burning
◯ Pins & Needles
◯ Tremor
◯ Headache
◯ Anxiety
◯ Depression
◯ Sleep Disturbances
◯ Frequent Urination
◯ Nighttime Urination
◯ How Often/Night
◯ Blood in Urine
◯ Poor Urine Control

FOR WOMEN ONLY: Are you still having periods? YES NO
If yes, are they regular? YES NO Length of cycle? _____ days
If no, age of menopause? _____
◯ Estrogen Therapy ◯ Discharge from Breast

Patient Name:________________________ Patient Date of Birth:___/___/_____

Personal History: (Check all that apply and briefly explain)

- Diabetes______________________________________
- Skin Problems: ________________________________
- High Blood Pressure: ____________________________
- Heart Disease: _________________________________
- Arthritis: _______________________________________
- Thyroid Disease: ________________________________
- Cancer:____
- Stomach Ulcers:_________________________________
- Kidney Disease: _________________________________
- Heartburn: _____________________________________
- Liver Disease: _________________________________
- Anemia: _______________________________________
- Neurologic Disease: _____________________________
- Blood Clots: ___________________________________
- Seizures: _____________________________________
- Other Medical Problems:

  ____
  ____
  ____

Medication History:

Drug Allergies and Reaction:

____
____
____

Current Medications with Dosage and Instructions:

____
____
____
____
____
____
____

Family History:

Type of Disorder:	**Family Relationship:**
- Diabetes: ___________________	____________________________
- Thyroid Disease: _______________	____________________________
- Heart Disease: ____________________	____________________________
- Hypertension: ____________________	____________________________
- Stroke: _________________________	_____________________________
- Cancer: ________________________	_____________________________
-Cholesterol/ Lipid Disorder: ______________	_____________________________
- Osteoporosis: ____________________	_____________________________
- Abnormal Calcium: ________________	_____________________________
- Kidney Stones: ___________________	_____________________________
- Pituitary or Adrenal Tumor: ______________	_____________________________
- Other: _______________________________	_____________________________

Mother Living:__ Yes ___ No Medical Problems: ______________________________
Father Living: __ Yes __ No Medical Problems: ______________________________

Patient Name:______________________ **Patient Date of Birth:** ___/___/______

Past Surgical History:

____

____

____

Smoking:

____ Yes ____No _____________Quit/ Date you stopped

______ Number of Cigarettes per day _______Smokeless Tobacco/ Vape

Alcohol:

___ Yes ___ No _______________Quit/ Date you stopped

______ Number of drinks per day ___________________Type of Alcohol

Substance Abuse:

___ Yes ___No Describe: ____

Marital Status:______________________________

Exercise:

___ Yes ___No _____Number of minutes per day, ____Days per week

Current Occupation:_________________________________

Number of servings of Caffeine a day: ________ **Type of Caffeine:**_____________

Describe your diet:____

Children:____

For Patients with Diabetes Only

- Duration of Diabetes:______________________________________
- Age of onset:_________
- Current Treatment Regimen:
    - Oral Agents:_____________________________________
    - Insulin:____
- Do you have a Glucose Meter or CGM: ___ Yes ___No Type: ___________________________
- How often do you check glucoses: ____
- Any complications with your diabetes (check all that apply):

___ Eye Problems ____ Angioplasty (Date:___________)

___ Kidney Problems ____ Foot Ulcer (Date:___________)

___ Nerve Damage ____ Bypass Surgery (Date:_________)

___ Heart Attack

- Date of Most Recent Stress Test: __________
- Date of Most Recent Eye Exam: ___________

2025 Centennial Blvd, Suite 204
Tallahassee, FL 32308
850-702-5007 p
850-219-1059 f

PATIENT COMMUNICATION INSTRUCTIONS

Date of Birth: ____________

Name: ____

Address: ____

COMMUNICATION METHODS:

1. Cell Home Work Email Text ____________________ Details No Details
2. Cell Home Work Email Text ____________________ Details No Details
3. Cell Home Work Email Text ____________________ Details No Details
4. Cell Home Work Email Text ____________________ Details No Details
5. Cell Home Work Email Text ____________________ Details No Details

**Email communication will require a Web Portal account

COMMUNICATION AUTHORIZATION:

Authorized (circle one) YES NO Name: ______________ Relation: ________

Authorized (circle one) YES NO Name: ______________ Relation: ________

Authorized (circle one) YES NO Name: ______________ Relation: ________

Authorized (circle one) YES NO Name: ______________ Relation: ________

Authorized (circle one) YES NO Name: ______________ Relation: ________

EMERGENCY CONTACT INFORMATION:

Name: ______________ Relationship: __________ Phone: __________

You may get a copy of our Notice of Privacy Practices at any time.

This authorization will expire on: ________
(if no date is specified, It will expire upon your completion of a new/replacement form)

______________________________ ____________
Signature of patient or legal guardian Date

APPOINTMENT CANCELLATIONS/NO SHOWS:

- We ask for 24 hour notice for appointment cancellations so that we may have an opportunity to schedule someone from our wait list.
- No Shows and Cancellations that occur less than 24 hours before your appointment time may incur a $45 fee. If your appointment is on Monday, this would require you to call us on Friday during business hours to cancel.
- If you have not been able to complete your pre-clinic testing (labs, radiology) the providers usually prefer for you to go ahead and come to your follow-up appointment anyway. Results can be shared via phone or portal after the appointment if needed.

LATE POLICY:

- We ask that patients arrive 15 minutes prior to their appointment time. Ideally, this allows for check in time, demographics verification and intake by the clinical staff so that each patient may start their appointment as close to their appointment time as possible.
- If you arrive more than 15 minutes past your appointment time we will make every effort to work you back into that day's schedule, but we may be forced to reschedule you to another date/time depending on patient load for that day.

PATIENT PORTAL:

- We recommend that all patients sign up for the patient portal at www.tallahasseeprimarycare.com
- This allows you to see your appointment schedule and test results (especially when performed at the TPCA facility) and allows for easier communication with staff via messaging.

REFILL REQUESTS:

- Please contact your pharmacy first for any refill requests.
- It may take up to 72 hours for your refill request to be processed, especially if it is a controlled medication.

MEDICATIONS:

- If actively followed in this clinic, you will need to have follow-up appointments & lab work on a regular basis. This timeframe is established by the provider based on your diagnosis, symptoms, and medications in order to help you in the safest, most effective way possible. Please understand that we may not be able to fill your medications if you have not been seen – This is for your safety.

MD/NP/PA:

- My practice uses a variety of professional healthcare providers in order to provide patients with the best and most timely care. Some of these providers include (but are not limited to): Endocrinologist (MD), advanced registered nurse practitioner (ARNP), physician's assistant (PA), certified diabetes educator (CDE), registered nurse (RN), licensed practical nurses (LPN), and certified medical assistants (CMA/RMA). While all of these individuals may be involved in your care, patient care is always overseen by a medical doctor. These individuals work together as a team to improve and provide comprehensive patient care. If you join this practice, your appointment may be with an ARNP or PA and not with the MD, but all care is collaborative even if you are not physically seeing the MD that day. If this type of practice does not work for you, then unfortunately we will be unable to meet your needs

Patient Signature: ____________________ **Today's Date:** __________

Patient Name (Print): ____________________ **Date of Birth:** __________

Kristin Harmon, MD – 2623 Centennial Blvd, Suite 204 - Tallahassee, FL 32308
850-702-5007 phone - 850-219-1059 fax

Tallahassee Primary Care Associates, P.A.
Corporate Policy

FINANCIAL POLICY

- Payment is always due PRIOR to service: We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will of course notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.
- Our Billing Services: We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our web site for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT TPCA IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY H.M.O. PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE H.M.O. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR H.M.O.
- Co-Pays, Deductibles, and Co-Insurances: Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contract with your insurer, and are your part of your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- Secondary Insurances: If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- Tertiary Insurance: If applicable, tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at the time of your appointment.
- Charges for failing to come to your appointment (generally termed "no-show fees"): The following fees will apply if you fail to present for an appointment:

  $25.00: - Office visits (or as determined by each office), Ambulatory Cardiovascular monitors.

  $50.00: - Ultrasound, CT, Travel Clinic (you must provide notice of cancellation to our Diagnostic Department scheduling personnel at least 24 hours prior to your scheduled appointment time).

  Variable: - Nuclear Medicine Studies (Patients failing to show for an appointment without providing at least 24 hours cancellation notice will be charged the cost of the Radioisotopes, which varies based upon market conditions. This cost has historically fluctuated in the $50-$250 range).

Tallahassee Primary Care Associates, P.A.
Corporate Policy

- Statements: We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question, if you believe there is a mistake on your statement, or if you have any concern about your statement transactions, we expect to hear from you in a timely manner (you may contact your physician's office, but for billing questions you may be referred to our billing department, which will most likely be our best resource for your inquiry). We reserve the right to avoid the cost of sending statements to patients who have a small balance outstanding (usually less than $5.00). For small balances, our Patient Registration/Reception staff in your physician's office will collect the balance at your next appointment.
- Financial Promissory Form: If you are truly unable to make payment in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Promissory Agreement. In this Agreement, you will have 14 calendar days to submit payment in full. If you do not make payment within 14 calendar days, we will add an **additional $25.00 administrative fee to the original copay, deductible, and/or coinsurance that is due.**
- Collections: If no payment is received within our 3rd statement cycle (approximately 90 days or more from your date of service), your account is considered delinquent and may be referred to an outside collection agency. *Referral to outside collections may damage your credit, so we strongly urge you to contact our Billing Department to work out payment arrangements so that we can avoid this step.* We will discharge patients who have balances that are referred to an outside collection agency.
- Payment Plans: Subject to the following specific rules, we permit payment plans for patients who may need additional time to pay their financial responsibility in full. Patients will adhere to our payment plan policy set forth below:
  - **We will not permit payment plans for individual patient balances of less than $100.00. The minimum balance for a payment plan is $100.00**
  - **If the balance is less than $350, you must pay the balance in full within 6 months.**
  - **Balances greater than $350 must be paid in full within 12 months.**
  - **We will expect you to make minimum payments of $50 per month.**
- **We want you to understand this document and our policies and procedures, and we do not want you to be confused.** If you have any questions or concerns about our Financial Policy, procedures or fees, your physician's office manager or our billing department can help. Please ask questions if necessary before signing below.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Patient Signature: ______________________________

Date: ______________

PATIENT INFORMATION (OFFICE USE ONLY)

Patient Name: ______________________________

D.O.B. ______________ MRN ______________