zumedic
personalized mobile healthcare

To schedule an appointment: **239-789-2300**

REGISTRATION FORM

Today's Date:			**Reason for first visit:**		
PATIENT INFORMATION					
Patient's last name:	**First:**	**Middle**	**Marital status:**		
Is this your legal name? ○ Yes ○ No	**If not, what is your legal name?**	**Former name:**	**Birth date:**	**Age:**	**Sex:** ○ M ○ F
Address:					
Social Security no.:	**Home phone no.:**		**Cell phone no.:**		
Occupation:	**Employer:**		**Employer phone no.:**		
Chose clinic because/referred to clinic by (Please choose one option): ○ **Acquaintance** ○ **Physician: (name)**					
Other family members seen here:					
INSURANCE INFORMATION					
(Please give a copy of your insurance card.)					
Person responsible for bill:	**Birth date:**	**Address (if different):**	**Home phone no.:**		
Is this person a patient here? ○ Yes ○ No		**Is this patient covered by insurance?** ○ Yes ○ No			
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:**		
Name of primary insurance:		**| Other:**			
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment: $**

Patient's relationship to subscriber:	**| Other:**		
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber:	**| Other:**		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:**	**Cell phone no.:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Zumedic, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

Original Date: 4/4/2018
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio		
Immunizations, preventives and dates:	☐ Tetanus	☐ Pneumonia
	☐ Abdominal ultrasound	☐ Colonoscopy
	☐ Influenza	☐ Shingles

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	□ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	

	☐ # of years	☐ Or year quit		
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?		☐ Yes	☐ No
	Would you like information on the preparation of these?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

WOMEN ONLY

Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

INFORMED CONSENT TO TREAT

REQUEST FOR GENERAL TREATMENT

This consent applies to Zumedic, LLC ("Zumedic"), its agents, associates, and providers. I hereby request and authorize Zumedic, its employees, associates and agents and their employed or contracted physicians, physician assistants, nurse practitioners or other licensed health care professionals to provide my general treatment and care. I understand that my care and treatment may be provided via telemedicine services utilizing Zumedic's proprietary systems, methods, and protocols to access, diagnose, consult, treat and educate myself and those I am authorized to represent. I also understand that my care and treatment may be provided in my home or at another location mutually agreed upon between me and the Zumedic provider treating me. In the event of an emergency or extraordinary circumstances, I should dial 911 or go to the nearest Emergency Room. No other substantial or invasive procedure will be performed on me without providing me an opportunity to give informed consent for that procedure. Prescription medicines ordered utilizing Zumedic's app-based services will only be issued when indicated and approved by a Zumedic provider and as permitted by the laws of the State of Florida.

I may revoke this consent at any time, except to the extent that Zumedic has already taken action in reliance on it. I agree that I have read this form or it has been read to me carefully and agree that everything in this agreement applies to current and future health care services provided by Zumedic. I am satisfied with this consent form and understand its contents. My questions have been answered to my satisfaction.

X_____

Patient or Guardian Signature

PATIENT RIGHTS

You have the right, as a patient, to be informed about your condition and the recommended treatment, procedure, or prescription to be used so that you may make the decision whether or not to receive the treatment, procedure, or prescription after knowing the risks and hazards involved. This disclosure is simply an effort to make you better informed so that you may give or withhold your consent to the treatment, procedure, or prescription.

GENERAL SERVICES

I understand that the purpose of the visit is to assess and treat my medical condition(s) and that Zumedic will make every attempt to accurately assess, diagnose and treat the condition(s) for which I or those I am authorized to represent present to Zumedic.

I understand that once a Zumedic provider decides on any prescription medicines or other treatment, procedure, service or product, if any, it is my responsibility to read and understand the risks and the potential side-effect profile and the adverse drug interactions of the medications and any other medications I may be taking concurrently, or consult with my primary care or specialty physician and pharmacist regarding the same, and ultimately to determine if I accept the risks.

I understand that all health care treatments can have potential adverse side effects and I accept responsibility for such potential adverse outcomes. If adverse effects are noted, I understand that it is my responsibility to stop any prescription medicines or other treatment, procedure, service or product prescribed or recommended by Zumedic, and to report any adverse side-effects to Zumedic, my primary care or specialty physician, if any, or go to the nearest Emergency Room if I have any reason to suspect that I have a medical emergency.

I acknowledge that the Zumedic providers shall exercise reasonable medical judgment in delivery of the services provided, if any, but the condition for which I or those I am authorized to represent may seek a diagnosis, consultation or treatment may worsen after the service is provided, and both I and those I am authorized to represent are subject to the risks, including that the condition may worsen. I agree that I will not be entitled to a refund or recompense of my membership fees from Zumedic for any reason, including poor outcomes.

I will inform Zumedic of any condition that would limit my ability to receive the services provided or that would be relevant to the services themselves. In particular, I understand that if I am planning to become pregnant, am

currently pregnant, become pregnant, or am breastfeeding, that I will (A) advise Zumedic of this fact, and (B) ask my OB/GYN or pediatrician if the treatments recommended by Zumedic are acceptable during this period of time.

I understand that I have a responsibility to communicate and provide Zumedic with detailed, accurate and complete information concerning medical, medication and other history, allergies to medications and procedures, physical, mental and other relevant symptoms and conditions, and any other information or records requested or pertinent to the diagnosis and treatment of myself or those I am authorized to represent. I understand that, as with any service, to the extent that information is not provided or, if provided, is not detailed, accurate and complete, the services provided by Zumedic may be materially affected. I assume all risks, and assume full responsibility and waive all claims against Zumedic for personal injury, death or damages of any kind and agree to the extent permitted by applicable law to defend, indemnify and hold harmless Zumedic from and against any and all claims of any nature including all costs, expenses and attorneys' fees, which in any manner result from the failure to provide pertinent information and/or the failure to provide accurate and/or complete information as required.

TELEMEDICINE

"Telemedicine" means the use of electronic information and communication technologies as a mode of delivering health care services and public health to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telemedicine facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

The telemedicine/telepharmacy consult is done through a two-way video link-up whereby the physician or other health provider at Zumedic can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite health care providers. Zumedic and affiliated telemedicine/telepharmacy consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

- **I understand that I have the option to withhold or withdraw my consent to receive services utilizing telemedicine at any time, without affecting my right to future care or treatment. I may revoke my consent in writing at any time by sending a notice of revocation of consent to Zumedic at 16010 Old 41 Road, Suite 102, Naples, Florida 34110. As long as this consent is in force (has not been revoked), Zumedic may provide health care services to me utilizing telemedicine without the need for me to sign another consent form.**
- **I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, my insurance carrier will have access to my medical records for quality review/audit.**
- **I understand that I can ask questions and seek clarification of the procedures and telemedicine technology.**
- **I understand that the telemedicine examination and/or videoconference can be stopped at any time.**
- **I understand that there are potential risks with the use of telemedicine technology, such as, but not limited to: (A) interruption of the audio/video link; (B) disconnection of the audio/video link; (C) a picture that is not clear enough to meet the needs of the consultation; or (D) electronic tampering.**
- **I understand that my telemedicine consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.**
- **I hereby consent to Zumedic providing health care services to me utilizing telemedicine.**

X_____

Patient or Guardian Initials

RISKS AND REPRESENTATIONS

I acknowledge that I have read or have had read to me and fully understand the information contained herein, including any attachment, and all blanks were filled in prior to my signing. The authorization for and consent to medical treatment is and shall remain valid until revoked. Furthermore, I certify that all my questions and concerns regarding the nature of my condition, the treatment, its attendant risks and hazards, benefits, and alternatives have been explained to my satisfaction.

- **I understand that I may consult or could have consulted with another physician or other health care provider about this treatment.**
- **I understand that I have the right to refuse any treatment or prescription recommended at any time prior to its performance.**
- **I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees, expressed or implied, have been made to me concerning the results of this procedure.**
- **I acknowledge that the nature of my treatment and any necessary procedures or prescriptions, the risks and hazards and benefits of my treatment, and reasonable alternatives to my treatment, including, if appropriate, doing nothing, have been fully explained to me.**

AUTHORIZATION TO RELEASE INFORMATION

I authorize Zumedic to disclose all or part of my medical information to (A) any person or facility that is currently involved in my care, such as physicians and nurses, and any facility that may be involved in the continuum of my care, such as a nursing home, home health agency, or durable medical equipment provider; (B) my employer if my injury is work-related; (C) Zumedic's legal counsel in any matter to which such information is relevant and necessary; (D) persons, committees, or entities performing audits or analyzing patient medical information for quality of care, peer review, financial or compliance purposes; (E) researchers for medical research purposes; (F) family members or certain friends directly involved in my care; (G) my personal representative, such as a durable power of attorney for health care or administrator; (H) clergy; (I) companies that provide services to Zumedic and, in doing so, will have access to patient health information; (J) an attorney or law enforcement personnel pursuant to a subpoena; and (K) non-medical personnel at Zumedic ensuring the quality of telemedicine and app-based services. At any time, I may change my mind about agreeing to any part of this release of information and may opt out by giving notice to Zumedic in writing.

X_____
Patient or Guardian Initials

PRESCRIPTION HISTORY CONSENT

I authorize Zumedic to obtain my prescription history from an external source.

X_____
Patient or Guardian Initials

MEDICAL RECORD HISTORY CONSENT

I authorize Zumedic to obtain my past medical records from an external source.

X_____
Patient or Guardian Initials

PRIVACY

I understand that federal and state laws concerning confidentiality of personal health information apply to services delivered and information acquired via telemedicine, including patient access and amendments to medical records. I understand that in rare circumstances, security safeguards and protocols could fail causing a breach of patient privacy. Under my membership plan, my personal health information may be shared with third parties to effectively provide the services under my plan. I acknowledge that I have received, read, and fully understand the following:

I acknowledge that I have received a copy of the "Privacy Policies."	**☐Yes**	**☐No**
I acknowledge that I have received a copy of the "Terms and Conditions of Use."	**☐Yes**	**☐No**
I acknowledge that I have received a copy of the "Platform Use and Software License Agreement."	**☐Yes**	**☐No**

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE WRITTEN INFORMATION PROVIDED ABOVE AND CAN REVOKE MY CONSENT IN WRITING TO ZUMEDIC AT ANY TIME. I AGREE THAT THE INFORMATION PROVIDED ABOVE ADEQUATELY EXPLAINS THE SERVICES, ALONG WITH THE RISKS AND BENEFITS OF SAID SERVICES. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THIS INFORMATION–IF I HAD ANY QUESTIONS, ALL OF MY QUESTIONS HAVE BEEN ANSWERED IN FULL BY ZUMEDIC. BY SIGNING THIS FORM, I ACKNOWLEDGE AND AGREE TO ALL OF THE ABOVE, AND CERTIFY THAT I HAVE NO QUESTIONS AND/OR HAVE HAD MY QUESTIONS ANSWERED IN FULL. BY SIGNING THIS CONSENT FORM, I AM AGREEING TO CONDUCT TRANSACTIONS ELECTRONICALLY AND INTEND FOR MY SIGNATURE TO BE A BINDING SIGNATURE/CONTRACTUAL OBLIGATION ON MYSELF AND THOSE I AM AUTHORIZED TO REPRESENT.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

Signature: _____

Relationship to Patient: _____

Date:_____ **Time:**_____ **A.M./P.M.**

Provider Signature:_____

Witness Signature:_____

An employee of Zumedic may witness your consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Zumedic.

Grievance Process: Should you experience dissatisfaction with your care or services provided by Zumedic, you may call (844) 342-4325 or visit http://www.zumedic.com to report your concerns. You will be contacted and follow-up on your concerns will occur.