



## **Directions to the Office**

### **If you are traveling North on I-95:**

Exit Butler Boulevard as you come off the exit ramp, stay in the right lane and proceed straight toward the light, which is Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Pkwy West, turn right. Once on Gate Pkwy West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

### **If you are traveling South on I-95:**

Take the Butler Exit turn left off the ramp on to Butler and immediately get into the right lane and take the first exit, which is the Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Pkwy West, turn right. Once on Gate Pkwy West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

### **If you are traveling West on JTB (from the beach):**

Take Southside North, get in the left lane and turn left at Gate Pkwy West, go about a mile and a half, you will see the medical complex (Gate Parkway West Professional Center) on the right. Our office building is to the left next to Gulani Vision Institute.



## PATIENT REGISTRATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Welcome to Quinn, MD! We are privileged to have the opportunity to include you as one of our patients and will make every endeavor to ensure that your visits with us are enjoyable. Please take a few moments to answer the following questions so we can be of better service to you now and in the future. Keep in mind, your comments about our services and staff are welcome at anytime during or after your visit.

### How did you hear about Quinn, MD?

\_\_\_ Brochure      \_\_\_ Folio      \_\_\_ Times Union      \_\_\_ TV  
\_\_\_ Internet      \_\_\_ Yellow Pages      Other \_\_\_\_\_

### What information did you receive about the treatment you are seeking before this visit?

How can we improve our communication with you? \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, St., Zip \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Email Address \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: S M D W  
Spouse: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Who should we contact in case of an emergency? \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone Number \_\_\_\_\_

## INSURANCE/FINANCIAL INFORMATION

Primary Insurance Company: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Is this Policy a: HMO PPO PPC POS  
Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Is this Policy a: HMO PPO PPC POS  
Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
Credit Card you wish to use at this office: VISA MASTERCARD AMERICAN EXPRESS DISCOVER  
Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### Person Responsible for this account:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Employer: \_\_\_\_\_  
Who REFERRED you to our office?  
Name: \_\_\_\_\_ Address: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_

MR#: \_\_\_\_\_

Please answer all the questions and fill in the blanks when indicated. All answers to the questions will be for chart use office records only and will be considered confidential.

1. Are you in good health? .....  Y  N
2. My last physical examination was \_\_\_\_\_.
3. Are you under the care of a physician? .....  Y  N  
If so, what is the condition being treated? \_\_\_\_\_.
4. The name and address of my physician is: \_\_\_\_\_  
\_\_\_\_\_
5. Have you had any serious illnesses or operations? .....  Y  N  
If so, please list \_\_\_\_\_  
\_\_\_\_\_
6. Have you ever had any prior cosmetic procedures (Botox, fillers, etc), breast augmentation/reduction, liposuction, tummy tuck, or other cosmetic surgery? ...  Y  N  
If so, please list \_\_\_\_\_  
\_\_\_\_\_
7. Have you been hospitalized or had a serious illness within the last five (5) years?  Y  N
8. Do you drink alcoholic beverages?  NEVER  SOCIALLY  SOMETIMES  ALWAYS
9. Do you have, or have you had, any of the following diseases or problems?
  - Rheumatic fever or rheumatic heart disease .....  Y  N
  - Congenital heart lesions .....  Y  N
  - Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .....  Y  N
  - Allergies .....  Y  N  
If so, please list \_\_\_\_\_
  - Asthma or hay fever .....  Y  N
  - Hives, skin rash, or fever blister .....  Y  N
  - History of lightheadedness or fainting .....  Y  N
  - History of seizures, neurological or psychiatric problems .....  Y  N
  - History of excessive bleeding or scarring .....  Y  N
  - Diabetes .....  Y  N
  - Hepatitis or other liver disease .....  Y  N
  - Arthritis .....  Y  N
  - Inflammatory rheumatism (painful swollen joints) .....  Y  N
  - Stomach ulcers .....  Y  N
  - Kidney trouble .....  Y  N
  
  - Tuberculosis .....  Y  N
  - Do you have a persistent cough or cough up blood at any time? .....  Y  N
  - Low blood pressure .....  Y  N
  - Venereal disease .....  Y  N



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- Chronic viral infection.....  Y  N
- Personal or family history of blood clots in legs or lungs, or leg swelling?.....  Y  N
- Other \_\_\_\_\_

10. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? .....  Y  N
- Do you bruise easily?.....  Y  N
  - Have you ever required a blood transfusion for a medical condition?.....  Y  N
  - If so, please explain the circumstances
- 
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11. Family history of severe reactions to anesthesia or malignant hyperthermia .....  Y  N

12. Do you have any blood disorders such as anemia, etc. ....  Y  N

13. Have you had surgery or X-ray treatment for tumors, growth or other condition for your mouth or lips?  Y  N

14. Are you taking any drug or medication, prescription, or non-prescription?.....  Y  N  
If so, please list \_\_\_\_\_

15. Are you taking any of the following?
- Antibiotics .....  Y  N
  - Anticoagulants (blood thinners).....  Y  N
  - Non-prescription medications such as vitamins, herbal remedies, weight loss  Y  N
  - Medicine for high blood pressure .....  Y  N
  - Cortisone (steroids).....  Y  N
  - Tranquilizers .....  Y  N
  - Aspirin .....  Y  N
  - Insulin, tolbutamide (Orinase) or similar drugs.....  Y  N
  - Digitalis, drugs for heart trouble .....  Y  N
  - Nitroglycerin .....  Y  N
  - Other \_\_\_\_\_

16. Are you allergic or have you reacted adversely in any way to the following?
- Local anesthesia .....  Y  N
  - Penicillin or other antibiotics .....  Y  N
  - Sulfa drugs.....  Y  N
  - Barbiturates, sedatives or sleeping pills .....  Y  N
  - Aspirin .....  Y  N
  - Iodine .....  Y  N
  - Other \_\_\_\_\_
- 

17. Do you have any disease, condition or problem NOT listed that you think the doctor and office should be aware of or know about?.....  Y  N



If so, please explain: \_\_\_\_\_

18. Are you pregnant? .....  Y  N

**I, MYSELF, HAVE FILLED OUT THIS HEALTH QUESTIONNAIRE COMPLETELY AND I HAVE NOTIFIED THE OFFICE OF ALL MY MEDICAL PROBLEMS.**

Patient's Signature \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date:

Patient Policies: Appointment, Records, Disputes and Informed Consent to Treatment

APPOINTMENTS



All appointment cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice, or simply not showing will result in a \$25 office visit assessment. Call 904-296-0900 to cancel. Email notification is not an accepted form of cancellation.

## QUINN, MD SIGNATURE SERVICES

Signature Services are the Fraxel laser, Varicose Vein treatments, Vein Removal procedures, and Laser Hair removal treatment greater than an hour. All Signature Service cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice will result in a \$100 Signature Service assessment. Call 904-296-0900 to cancel.

## MEDICAL RECORDS POLICIES

For a copy of your medical records, please allow us 10 business days notice. There will be a charge of \$1.00 per page for the first 25 pages and \$0.25 for every page after. You will need a signed medical records release form to proceed.

Payment is due the day of the service unless previous arrangements have been made. Our office often distributes coupons to patients. Only one coupon can be redeemed per visit and it can not be combined with another pre-arranged discount. Our office is proud to offer financing through CareCredit and CapitolOne. These are no interest payment plans for 12 months. Please see representative for information.

## DISPUTES AND INFORMED CONSENT TO TREATMENT

In the event of any dispute between me and Quinn, MD, and/or any other person associated with Quinn, MD, I agree to submit a written claim of such dispute to Quinn, MD within on (1) year of this date. I acknowledge and agree that failure to timely make such a claim shall constitute a waiver of any and all rights and remedies related thereto.

Any claim made in accordance with the paragraph above, including, without limitation, claims for Professional Liability, Personal Injury, Contract, Warranty or other breach of duty, or the coverage of this arbitration provision, shall be settled by arbitration pursuant to the Florida Arbitration Code. By agreeing to arbitrate, I am waiving my right to a jury trial. Any such arbitration shall be conducted in Jacksonville, Florida. The arbitration of such issues, including determination of the amount of any damages suffered, shall be to the exclusion of any resolution in a court of law. The decision of the arbitrators shall be final and binding upon me, my heirs, executors, administrators, successors and/or assigns.

In the event any action is initiated for any breach, fault, or default of any of the terms, conditions, or provisions of the Agreement, then the party in whose favor judgment shall be entered shall be entitled to have and recover from the other party all costs and expenses, including attorneys' fees.



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All terms and conditions embodied in the Informed Consent to Treatment are to be interpreted and construed according to the laws of the State of Florida; any litigation would be filed in a Florida State Court.

If any part of this Informed Consent to Treatment is deemed to be unenforceable for any reason whatsoever, the remaining portions shall remain in full force and effect. Nothing herein shall be construed to constitute a waiver of, or any other limitation upon, any of the legal and/or equitable rights of Quinn, MD, all of which are hereby expressly reserved.

I understand that consent to arbitration is not a prerequisite to treatment at this clinic, and is voluntarily given by me. I understand there are other clinics where my needs can be addressed, but have chosen Quinn, MD even with all these conditions I have agreed to, and promises I have made,

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**NOTICE OF PRIVACY PRACTICES**

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

8075 Gate Pkwy West Suite 101 Jacksonville, FL 32216  
(904) 296-0900



State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Linda Quinn. Information on contacting us can be found at the end of this Notice.

### **TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. Furthermore, we will provide you with a treatment estimate describing or recommending treatment alternatives.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. We reserve the right to discuss your payment options with the individual financially responsible for your treatment.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. In addition, this may require speaking with your primary care physician, obtaining information from hospitals and/or labs directly relating to your treatment. Your information may also be disclosed to laboratories for the purpose of ordering blood tests.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

### **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1.00 for each page and the staff time including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be



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released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing or request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Dispensed Medications:** You have a right to medication counseling by a provider in this office regarding any prescribed or dispensed medications.

**HOW TO CONTACT US**

Practice Name: Dr. Quinn MD      Privacy Officer: Dr. Linda Quinn      Telephone: (904) 296-0900

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Notice to Patient:**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Privacy Practices.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office Use Only**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.                       Due to an emergency situation it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.       Other (please provide specific details) \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

8075 Gate Pkwy West, Suite 101 Jacksonville, FL 32216

Phone 904-296-0900 Fax 904-296-7597