CLEOPATRA GORDON-PUSEY, MD

700 North Hiatus Rd Suite #213, Pembroke Pines FL 33026
222 S. Flamingo Rd. Pembroke Pines, FL 33027
Phone: 954-392-9026 Fax: 954-357-2353

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. The Notice of Privacy Practice is posted on the wall in the patient waiting room.

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Parent, Guardian of Patient's legal representative:

_____

Signature:

Date

_____

FLORIDA
Advance Directive
Planning for Important Health Care Decisions

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
3. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Florida Advance Directive

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part One, Part Two, or both, depending on your advance planning needs. You must complete Part Three.

Part One. The **Florida Designation of Health Care Surrogate** lets you name a competent adult to make decisions about your medical care, including decisions about life-prolonging procedures, if you can no longer speak for yourself. The designation of health care surrogate is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your health care surrogate's powers go into effect when your doctor determines that you are physically or mentally unable to communicate a willful and knowing health care decision.

Part Two. The **Florida Living Will** lets you state your wishes about health care in the event that you are in a persistent vegetative state, have an end-stage condition or develop a terminal condition. Your living will goes into effect when your physician determines that you have one of these conditions and can no longer make your own health care decisions.

Your living will also allows you to express your organ donation wishes.

Part Three contains the signature and witness provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs. However, unless your Designation of Health Care Surrogate expressly states otherwise, your health care surrogate presumptively may make health care decisions regarding mental health treatment.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Completing Your Florida Advance Directive

Whom should I appoint as my surrogate?
Your surrogate is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your surrogate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your surrogate should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate surrogate. The alternate will step in if the first person you name as a surrogate is unable, unwilling, or unavailable to act for you.

How do I make my Florida Advance Directive legal?
The law requires that you sign your Advance Directive in the presence of two adult witnesses, who must also sign the document. If you are physically unable to sign, you may have someone sign for you in your presence and at your direction and in the presence of your two witnesses.

Your surrogate and alternate surrogate cannot act as witnesses to this document. At least one of your witnesses must not be your spouse or a blood relative.

Note: You do not need to notarize your Florida Advance Directive.

Should I add personal instructions to my Florida Advance Directive?
One of the strongest reasons for naming a surrogate is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your surrogate carry out your wishes, but be careful that you do not unintentionally restrict your surrogate's power to act in your best interest. In any event, be sure to talk with your surrogate about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?
You can always revoke your Florida Advance Directive. State law permits you to revoke your document in the following ways:

1. through a signed and dated writing showing your intent to revoke;
2. by physically destroying the original, or having someone destroy it for you in your presence at your direction;
3. by orally expressing your intent to revoke; or
4. by executing a new Advance Directive that supersedes the older document.

You should notify your health care provider and surrogate(s) to ensure that your revocation is effective.

If you name your spouse as your surrogate and you are divorced or your marriage is subsequently annulled, your spouse's powers as surrogate will be automatically revoked. If you would like your spouse's powers to continue in the event of a divorce or annulment, you can state this in the "Additional Instructions" section on page 2 of the form by adding an instruction such as, "The authority of my surrogate shall not be revoked by divorce or annulment of our marriage."

What other facts should I know?

If you would like to give your surrogate the authority to refuse life-prolonging treatment for you in the event that you become terminally ill and incompetent while you are pregnant, you must add an instruction such as, "My surrogate has the authority to order the withholding or withdrawal of life-prolonging treatment, even if I am pregnant," under the "Additional Instructions" section on page 2 of the form.

Also, unless you expressly state otherwise under the "Additional Instructions" section, your health care surrogate, if you appoint one, does not have authority to authorize abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments, or voluntary admission to a mental health facility.

Part One. Designation of Health Care Surrogate

First Name _____ **Middle Name / MI** _____ **Last Name** _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name of Surrogate _____ **Phone Number** _____

Address of Surrogate _____ **City/State/Zip** _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name of Alternate Surrogate _____ **Phone Number** _____

Address of Alternate Surrogate _____ **City/State/Zip** _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

Additional instructions (optional)

_____

Part Two. Declaration

Today's Date

_____

I, the patient, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that

If at any time I am incapacitated and

Select any that apply

- ☐ I have a terminal condition, or
- ☐ I have an end-stage condition, or
- ☐ I am in a persistent vegetative state

Initial

_____

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (select one choice below):

- ○ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;
- ○ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education (listed below)
- ○ my body for anatomical study if needed. Limitations or special wishes, if any listed below
- ○ I have already arranged to donate

I give only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education

_____

Limitations or special wishes I put on my body for anatomical study if needed

_____

Initials

_____

If I have already arranged to donate selected

- ○ I donate any needed organs, tissues, or eyes,
- ○ I donate the following specified organs, tissues, or eyes

Specified organs, tissues, or eyes

_____

Name of Donee **Phone Number**

_____ _____

Donee Address **City/State/Zip**

Part Three. Execution

I, the patient, understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Dated

Signed

Witness 1:

Signed

Address of Witness 1 **City/State/Zip**

Witness 2:

Signed

Address of Witness 2 **City/State/Zip**

(Optional) I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name **Address** **City/State/Zip**

Name **Address** **City/State/Zip**

You Have Filled Out Your Health Care Directive, Now What?

1. Your Florida Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your surrogate and alternate surrogate, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your surrogate(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Florida document.
7. Be aware that your Florida document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Quality of Life Questionnaire

First Name _____ **Middle Name / MI** _____ **Last Name** _____ **Date of Birth** _____

1. Have you ever been diagnosed with Allergies?

Yes No

2. Are you currently taking or have taken within the last year any over-the-counter medication or have prescribed prescription strength medications for allergies, hay fever, or nasal congestions?

Yes No

If yes, please list all that apply

_____

3. Have you ever been diagnosed with asthma?

Yes No

4. Is your doctor currently treating your asthma with medications?

Yes No

If yes, please list all that apply

_____

5. Please check any/all of the following symptoms that you experience more than three times in a month or for more than three consecutive months. Please note that in the case of seasonal allergies, you may not be experiencing these now, but may experience them regylarly during a different season of the year. Please select all that apply:

- Stuffy Nose
- Runny Nose
- Nasal Congestion
- Itchy Eyes
- Watery Eyes
- Itchy Throat
- Sore Throat
- Cough
- Past Nasal Drip
- Headaches
- Trouble Sleeping
- Fatigue

FINANCIAL AGREEMENT

CLEOPATRA GORDON-PUSEY, MD

Life is Beautiful
700 North Hiatus Rd Suite # 213, Pembroke Pines FL 33026

222 S. Flamingo Rd. Pembroke Pines, FL 33027
Telephone: (954) 392-9026, (954) 392 9025
Fax: (954) 357-2353
lifeisbeautifulmd@gmail.com

First Name _____ **Middle Name / MI** _____ **Last Name** _____

I, the above named person, acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents, guardians or person representatives are responsible for all fees and services rendered for treatment of minor/child. I accept full financial responsibility for all charges for services or items provided to me, to minor/child, or to the patient for whom, I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Guardian or Personal Representative:

Date:

_____

Name of Patient, Guardian or Personal Representative:

_____

Date:

_____

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Health Care Advance Directives

The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A- 4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

• A Living Will

• A Health Care Surrogate Designation

• An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

• If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.

• Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.

• Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.

• Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

• If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

• As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

• If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies
people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

• If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

• If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.

• Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity
www.AgingWithDignity.org
(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)
www.aarp.org (Type "advance directives" in the website's search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthFinder.gov
(888) 419-3456

700 North Hiatus Rd Suite # 213
Pembroke Pines, FL 33026

222 S. Flamingo Rd.
Pembroke Pines, FL 33027

Date: _____

HEALTH HISTORY QUESTIONNAIRE

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

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Gender: _____ **DOB:** _____ **Marital Status:** _____

Previous or referring doctor: _____ **Date of last physical exam:** _____

PERSONAL HEALTH HISTORY

Child Illness (check all that apply):

- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Chickenpox
- ☐ Rheumatic Fever
- ☐ Polio

Please list Dates for Immunizations you have received.

Tetanus: _____ **Hepatitis:** _____ **Influenza:** _____

Pneumonia: _____ **Chickenpox:** _____ **MMR (Measles, Mumps, Rbuella)** _____

List any medical problems that other doctors have diagnosed.

_____

Surgeries

Year: _____ **Reason:** _____ **Hospital:** _____

Year: _____ **Reason:** _____ **Hospital:** _____

Year: _____ **Reason:** _____ **Hospital:** _____

Year: **Reason:** **Hospital:**

Year: **Reason:** **Hospital:**

Other hospitalizations

Year: **Reason:** **Hospital:**

Year: **Reason:** **Hospital:**

Year: **Reason:** **Hospital:**

Year: **Reason:** **Hospital:**

Year: **Reason:** **Hospital:**

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 of Drug: **Strength:** **Frequency Taken:**

Name of Drug: **Strength:** **Frequency Taken:**

Name of Drug: **Strength:** **Frequency Taken:**

Name of Drug: **Strength:** **Frequency Taken:**

Name of Drug: **Strength:** **Frequency Taken:**

Allergies to medications

Name the Drug: **Reaction you had:** **Name the Drug:** **Reaction you had:**

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

Frequency:

- [ ] 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:

- ( ) High
- ( ) Medium
- ( ) Low

Rate fat intake:

- ( ) High
- ( ) Medium
- ( ) Low

Caffeine:

- [ ] None
- [ ] Coffee
- [ ] Tea
- [ ] Cola

Number of Cups per day:

_____

Alcohol

Do you drink alcohol?

- ( ) Yes
- ( ) No

If Yes, what kind?

_____

How many drinks per week?

_____

Are you concerned about the amount you drink?

- ( ) Yes
- ( ) No

Have you considered stopping?

- ( ) Yes
- ( ) No

Have you ever experienced blackouts?

- ( ) Yes
- ( ) No

Are you prone to “binge” drinking?

- ( ) Yes
- ( ) No

Do you drive after drinking?

- ( ) Yes
- ( ) No

Tobacco

Patient Smoking Status

_____

Type:

- [ ] Cigarettes
- [ ] Chew
- [ ] Pipe
- [ ] Cigar

Patient Smoking Frequency

_____

Number of years or Year quit:

_____

Drugs

Do you currently use recreational or street drugs?

- ( ) Yes
- ( ) No

Have you ever given yourself street drugs with a needle?

- ( ) Yes
- ( ) No

Sex

Are you sexually active?

- Yes
- No

If yes, are you trying for a pregnancy?

- Yes
- No

If not trying for a pregnancy list contraceptive or barrier method used:

_____

Any discomfort with intercourse?

- Yes
- No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?

- Yes
- No

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

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?

- Yes
- No

FAMILY HEALTH HISTORY

Father:

Mother:

Brother(s):

Sister(s):

Children - Boys:

Children - Girls:

Grandmother (Maternal):

Grandfather (Maternal):

Grandmother (Paternal):

Grandfather (Paternal):

MENTAL HEALTH

Is stress a major problem for you?
Yes No

Do you feel depressed?
Yes No

Do you panic when stressed?
Yes No

Do you have problems with eating or your appetite?
Yes No

Do you cry frequently?
Yes No

Have you ever attempted suicide?
Yes No

Have you ever seriously thought about hurting yourself?
Yes No

Do you have trouble sleeping?
Yes No

Have you ever been to a counselor?
Yes No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

# of days between periods (average):

Heavy periods, irregularity, spotting, pain, or discharge?
Yes No

Number of pregnancies:

Number of live births:

Are you pregnant or breast feeding?
Yes No

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

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?
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

Is there 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
- Head/Neck
- Back
- Ears
- Intestinal
- Nose
- bladder
- Throat
- Bowel
- Lungs
- Circulation

Recent changes in:

- Weight
- Energy level
- Ability to sleep

Other pain/discomfort:

_____

CLEOPATRA GORDON-PUSEY, M.D.

700 North Hiatus Rd Suite # 213
Pembroke Pines, FL 33026
222 S. Flamingo Rd.
Pembroke Pines, FL 33027
Phone: (954)-392-9026 Fax: (954)-357-2353
E-mail: lifeisbeautifulmd@gmail.com

Medication Form

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Date of Birth _____ **Diagnosis:** _____ **Allergy:** _____

MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES

Date _____

Dr. Cleopatra Gordon-Pusey

700 North Hiatus Rd Suite # 213

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Pembroke Pines, FL 33027

(954) 392 9026

ATTENTION!

TO OUR PATIENTS:

PLEASE NOTE THAT CO-PAYMENTS

AND PLAN DEDUCTIBLES

ARE DUE AT THE TIME SERVICES ARE RENDERED.

THANK YOU.

Note: $25.00 missed appt fee

DATE

_____

SIGNATURE

700 North Hiatus Rd Suite # 213
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Pembroke Pines, FL 33027

Notice Of Privacy Practices

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

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we Issue this offrcial Notice of our privacy practices. You have the right to the confidentiality of your medical information. and this practice IS required by taw to maintain the privacy of that protected health information. This practice is required to abide by tho terms of the Notice of Privacy Practices currently In effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Privacy Officer: Dr. Gordon-Pusey

Effective Date: March 2012

Who Will Follow This Notice

Any health care professional authorized to enter information Into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment Is Involved, only the rninirnum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe drfferent ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure 10 a category is listed.

For Treatment. We may use medical information about you to provide you With medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe lor the treatment process.

For Payment. Wo may use and disclose medical Information about you so that tho treatment and services you receive from us may bo billed and payment may be collected from you, an Insurance company or a third party. Example: We may need to send your protected health Information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may uso medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by milhary command authorities lor their medical records
- To workers' compensation or Similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification ol a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be ol interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, \ve will thereafter no longer use or disclose medical information about you tor the reasons covered by your written authorization. You understand that we are unable to take back any disclosures wo have already made with your permission, and that we are required to retain our records of tho care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have boon violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of tho Department of Health and Human Services. All complaints must be submitted in writing. You wilt not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request. you must tell us what information you want to limit and where rn your records this information is contained.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests, but reserve tho right to charge you a cost·based fee for any non·customary expenses involved. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy. You have the right to Inspect and copy medical Information that may be used to make doosions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use In a civil, criminal, or administrative action or proceedrng, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to change a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to tho Privacy Officer at this practice. In addition, you must provide a reason that supports your request. Wo may deny your request lor an amendment lilt is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice. is not part of the Information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If wo deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non·Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list. you must submit your request in writing to tho Privacy Officer at this practice. Your request must state the time period lor which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14,2003. Your request should Indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12·month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice elcclronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice

Changes To This Notice: We reserve tho right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive In the future. We will post the current Notice, with tho effective date in tho upper right corner.

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Patient Demographics

Date:

Last Name	First Name	Middle Name / MI	Name Suffix

Date of Birth	Social Security Number	Professional Title

Allergies:

Home Phone	Cell Phone	Work Phone

Patient Fax	Email

Patient Address Line 1	Patient Address Line 2

City	State	Zip

Referred by:	Race	Ethnicity	Religion:

Marital Status	Education:	Language

EMERGENCY CONTACT/NEXT OF KIN:

Emergency Contact Name	Emergency Contact Address Line 1	Emergency Contact Address Line 2

Emergency Contact City	Emergency Contact State	Emergency Contact Zip

Emergency Contact Home Phone	Emergency Contact Cell Phone

Patient Health Questionnaire (PHQ-9)

Important Notice: The information gathered on this questionnaire will remain confidential.

First Name _____ **Last Name** _____ **Date of Birth** _____

Visit Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

2. Feeling down, depressed, or hopeless

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

4. Feeling tired or having little energy

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

5. Poor appetite or overeating

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

For Office Coding:

Total Score of 1's	+ Total Score of 2's	+ Total Score of 3's	= Total Overall Score

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If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Patient Stress Questionnaire*

Date

_____

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Date of Birth

_____

Over the last two weeks, how often have you been bothered by any of the following problems?

(Please select your answer & check the boxes that apply to you)

1. Little interest or pleasure in doing things

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

2. Feeling down, depressed, or hopeless

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

3.

- Trouble falling or staying asleep, or
- Sleeping to much

–

0 - Not at all 1 - Several days
2 - More than half the days
3 - Nearly Every day

4. Feeling tired or having little energy

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

5.

- Poor appetite or
- overeating

–

0 - Not at all 1 - Several days
2 - More than half the days
3 - Nearly Every day

6. Feeling bad about yourself or tha tyou are a failure or have let yourself or your family down

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

8.

- Moving or speaking so slowly that other people could have noticed, or
- the opposite - being so fidgety or restless that you've been moving around a lot more than usual

–

0 - Not at all 1 - Several days
2 - More than half the days
3 - Nearly Every day

9.

- Thoughts that you would be better off dead, or
- hurting yourself in some way

–

0 - Not at all 1 - Several days
2 - More than half the days
3 - Nearly Every day

Total Score

_____

1. Feeling nervous, anxious or on edge

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

2. Not being able to stop or control worrying

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

3. Worrying too much about different things

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

4. Trouble relaxing

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

5. Being so restless that it is hard to sit still

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

6. Becoming easily annoyed or irritable

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

7. Feeling afraid as if something awful might happen

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

Total Score

_____

Are you currently in any physical pain?

No Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. have had nightmares about it or thought about it when you did not want to?

No Yes

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

No Yes

3. Were constantly on guard, watchful, or easily startled?

No Yes

4 . Felt numb or detached from others. activities, or your surroundings?

No Yes

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

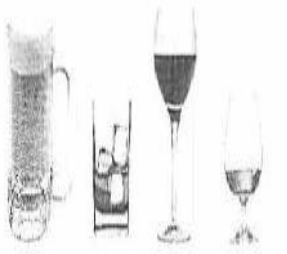
Standard serving of one drink:

12 ounces of beer or wine cooler

1.5 ounces of 80 proof liquor

5 ounces of wine

4 ounces of brandy, liqueur or aperitif



How often do you have one drink containing alcohol?

0 - Never 1 - Monthly or less 2 - 2-4 times a month 3 - 2-3 times a week 4 - 4+ times per week

How many drinks containing alcohol do you have on a typical day when you are drinking?

0 - 1 or 2 1 - 3 or 4 2 - 5 or 6 3 - 7 to 9 4 - 10 or more

How often do you have four or more drinks on one occasion?

0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

How often during the **last year** have you...

... found that you were not able to stop drinking once you had started?

0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... failed to do what was normally expected from you because of drinking?

0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... needed a first drink in the morning to get yourself going after heavy drinking?

0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... had a feeling of guilt or remorse after drinking?

0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... been unable to remember what happened the night before because you had been drinking?

0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

Have you or someone else been injured as a result of your drinking?

0 - No 1 - Yes, but not in the last year 3 - Yes, during the last year

Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

0 - No 1 - Yes, but not in the last year 3 - Yes, during the last year

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Cleopatra Gordon-Pusey, M.D., P.A.

REGISTRATION FORM

Today's Date:

PCP:

Patient Information

Last Name

First Name

Middle Name / MI

Name Suffix

Marital Status

Is this your legal name?

- Yes
- No

If not, what is your legal name?

(Former Name)

Date of Birth

Age:

Sex

Patient Address Line 1

Patient Address Line 2

City

State

Zip

P.O. Box:

City

State

Zip

Social Security Number

Home Phone

Professional Title

Employer Name

Employer Phone

Chose clinic because/referred to clinic by (Please check one box):

- Dr.
- Insurance Plan
- Hospital
- Family
- Friend
- Close to Home/Work
- Yellow Pages
- Other

Other:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:

Birth Date:

Home Phone:

Is this person a patient here?

- Yes
- No

Address (If different):

Address (If different) Cont.

Occupation:

Employer:

Employer Address:

Employer Phone:

Is this patient covered by insurance?

- Yes
- No

Primary Insurance Name

Subscriber Name:

Subscribers SSN#:

Birth Date:

Primary Group No.

Primary Subscriber ID

Co-Pay:

Primary Relationship to Insured

IN CASE OF EMERGENCY

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Work Phone

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 this practice or insurance company to release any information required to process my claims.

Signature:

Date: