Sandra Cornine, APRN FNP-C

Okeechobee Family Practice, P.A.

1713 N Hwy 441 Suite D
Okeechobee, Fl. 34972

Phone (863) 467-8771
Fax (863) 467-2825

At Okeechobee Family Practice, P.A. our goal is to help everyone become the best they can be in mind, body, and spirit.

Medical:

- To aggressively control medical problems and prevent their complications
- To be up to date and use the most current medical information
- To maximize health and well being
- To be able to function at a high level in every area of life
- To reduce hospitalizations

Weight Loss

- Assistance to jump start weight loss to look and feel your best
- Assistance to maintain a healthy weight

Women's Health

- Annual cervical screenings
- Physical exams

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Helpful Tips to Optimize Your Time During You First Visit

1. Bring a copy of your medical records containing your treatment history for the past 12 months.

2. Bring an exact list of all medications that you are now taking, including the dose of and when take them. Include vitamins and supplements on this list as well.

3. Bring your insurance card(s) with you so our staff may photocopy the information for your chart. We will file your claim for you, but it is your responsibility to pay any co-pays and/or deductibles at the time of your visit.

4. It is always helpful to bring a loved one or close friend with you when coming in for your initial visit. There is an abundant amount of information that the provider will be reviewing and discussing with you, and two sets of ears are always better than one!

5. Feel free to bring a tape recorder into the exam room to record your visit with our practitioners. Many patients have commented on how helpful it was to be able to refer back to the recording when they couldn't remember exactly what was said after they had already returned home.

6. Bring a list of everything (regarding your health) you would like taken care of during your first visit and give that list to the provider at the beginning of your visit.

7. Check in with our receptionist at least 15-30 minutes prior to your scheduled appointment time and provide her with all your completed questionnaires. Our staff will then prepare your chart, verify your insurance information, and notify our medical assistants that you are ready for your visit.

8. Most importantly, be optimistic! The reason you have chosen to make this appointment is because you believe that our practitioners are able to help you like no one else has before.

NO SHOW/ LATE CANCELLATION FEES

March 7, 2024

Attn: All patients

This policy has been established to help serve everyone better.

While our practitioners always see patients the same day that they are ill, we operate on an appointment system to be as efficient as possible. "No-shows" and late cancellations cause problems that extend beyond financial impacts on our practice. We often have a two month wait list for new patients, some of whom are dangerously depressed. If we knew a patient wasn't going to keep their appointment, we could call someone on the waiting list in sooner. When an appointment is made, it takes an available time slot away from another patient. "No-shows" and late cancellations delay the delivery of health care to other patients, some of whom are quite ill.

A "no-show" is missing a scheduled appointment. A "late cancellation" is cancelling an appointment without calling 24 hours in advance of an office visit, and 48 hours in advance of any procedures.

A standard fee of $25.00 will be assessed for each "no-show" or late cancellation if less than 24-hour notice is given.

We understand that situations such as emergencies occasionally arise, and an appointment cannot be kept. These situations will be considered on a case-by-case basis.

Please understand that insurance companies consider the patient 100% responsible for these charges.

Sincerely,

Sandra Cornine, APRN FNP-C

Alisha Fowler, Office Manager

Sandra Cornine, APRN FNP-C

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Re: Prescription Refills

Within the last year, our prescription workload has increased significantly. This is due to an increase in complicated patients and new rules regarding refills. It has significantly affected our prescription turnaround time. Unfortunately, due to these circumstances we must enforce our prescription policy.

We ask that you give at least a 72-hour notice (3 business days) for prescription renewals. Minimizing mistakes is a high priority in our office and you must allow sufficient time for us to meet this objective. You may request your prescription by voicemail, email, written or pharmacy request but, please note that all requests require a 72-hour notice.

If your request is made after 3:00 p.m. Monday – Friday, the request will be treated as a next day request. If your request is made after 12:00 p.m. on Friday, the request will be treated as a Monday request. We do not work on prescriptions on Saturday or Sunday. If you call on the weekend or a day that we are closed, the request will not be considered until the next business day.

When leaving your request please remember to leave your full name, date of birth, medication name, directions, the quantity you need (30 day or 60 day), and if you want it mailed to you, or sent directly to your pharmacy. Stating "I need all my medications" is not adequate. You must be very clear about what medications you need; this prevents delays in renewing your prescriptions. If you need your scheduled prescriptions mailed to you, you must provide us with a self-addressed stamped envelope. If you need a "Do Not Fill" or DNF date changed, you must mention it in your request with a valid reason why. If you do not mention this in your request, you will have to wait an additional 72 hours for correction.

Our staff do not have time to call you when your prescription is completed. You may call 72 hours after leaving the refill message to see if the prescription is ready. If a prescription is escribed to your pharmacy, you will receive an automated message from our office.

The best way to get your prescription refills is to call when there are only 7-10 days left of your medication. Receiving prescriptions by mail can take longer, please keep in mind that the mail does not run on Sundays and takes at least two days to be processed by the post office. If

someone is picking up your prescriptions for you, you must inform our office ahead of time. We require identification for scheduled drug prescriptions.

If your prescriptions get stolen, you must contact the police and file a report. A replacement will not be considered without a complete report. Once the report is reviewed by our providers, a replacement prescription may be written. Please note that it is at our practitioners' discretion to provide you with a prescription replacement.

Please always bring a current medication list with you whenever you come into the office. List the medication name, dose, and how you take them. Include any vitamins and supplements. Carry a copy with you in case of emergency.

Thank you,

Sandra Cornine, APRN FNP-C

Alisha Fowler, Office Manager

Okeechobee Family Practice

Patient Registration Form

Patient Information

Social Security #	First Name		Middle Initial	Last Name	Suffix
Street Address	City		State	Zip Code	
Alternate Street Address	Alternate City		Alternate State	Alternate Zip Code	
Home Phone ( )	Mobile Phone ( )		Work Phone ( )	Email Address *(optional)*	
Birth Date	Age	Sex *(circle one)* M F	Race / Height	Marital Status / Spouse's Name	
Employer	Occupation		Employer Address	Employer Phone ( )	
Pharmacy Name	Pharmacy Phone ( )		City / State		
Drug Allergies *(please list)*:					

Billing Information *(Person responsible for payment if other than patient / Guarantor)*

Social Security #	First Name	Middle Initial	Last Name	Suffix
Address	City	State	Zip	Primary Phone ( )

Insurance Information

Please provide your insurance cards and I.D. to be photocopied

Primary Insurance Company	Subscriber's Name	Birth Date	Subscriber's Social Security #
Secondary Insurance Company	Subscriber's Name	Birth Date	Subscriber's Social Security #
Third Insurance Company	Subscriber's Name	Birth Date	Subscriber's Social Security #

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I consent to the following people to have access to my medical information:

Name	Relationship	Primary Phone
1.		( )
2.		( )
3.		( )
4		( )

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party that accepts assignment. Regulations pertaining to medical assignment of benefits apply. **If the patient is a minor / incompetent, please indicate your relationship to the patient.*

Signature _____ Date _____ Relationship to patient _____

**** Please complete the reverse side of this form ****

TURN OVER →

New Patient Consent to the Use and Disclosure Of Health Information
For Treatment, Payment, Or Healthcare Operations

I, _____, understand that as part of my health care, Okeechobee Family Practice, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice Of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Okeechobee Family Practice, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Okeechobee Family Practice, P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Okeechobee Family Practice, P.A. change their notice, they will send a copy of any revised notices to the address I've provided *(whether by U.S. mail or, if I agree, by email).*

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ACCEPT / DECLINE *(please circle one)* the terms of this consent.

_____ _____

Patient or guardian's signature Date

(Confidential record: Information contained here will not be released except when you have authorized us to do so.)

Marital Status S M D W SEP

Religion P C J A Other

Name _____ Age _____ Sex _____

Phone _____ Occupation _____ Business Phone _____

Birthdate _____ Birth Place _____ Date of last Physical Exam _____

Person to Notify _____ Relationship _____ Phone _____

MEDICATIONS: (Please list all current medications below.)

_____

_____

_____

_____

_____

_____

_____

Are you presently taking any of the following medications on a regular or frequent basis? If yes, please indicate with a check.

_____ aspirin, Advil, etc.
_____ Tylenol
_____ sleeping pills
_____ tranquilizers
_____ hormones
_____ laxatives
_____ stool softeners
_____ vitamins (if yes, which?)

_____ acne medication
_____ skin lotions or medicines
_____ allergy shots
_____ allergy or sinus pills
_____ weight reduction pills
_____ iron or "poor blood" pills
_____ birth control pills
_____ cold medication

DRUG ALLERGIES: List all drugs you are allergic to:

_____

_____

FAMILY HISTORY	Sex	If Living		If Deceased	
		Age	Health	Age at Death	Cause
Mother					
Father					
Brothers/Sisters* (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				

Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

Do you know of any blood relative who has or had (Circle and give relationship)

Stroke	Epilepsy	Heart Attack	Nervous Breakdown
Cancer	Suicide	Stomach Ulcers	
High Blood Pressure	Migraine	Kidney Disease	Rheumatic Heart
Tuberculosis	Asthma	Goiter	Insanity
Diabetes	Hay Fever	Arthritis	

PERSONAL HABITS: (Please circle yes or no. If yes please answer the subsequent question)

yes no Do you feel your physical activity and/or exercise is inadequate?
yes no Do you drink alcohol regularly? How much per day?_____ What kind?_____
yes no Do you smoke cigarettes? How many packs per day?_____ For how long?_____
yes no Have you ever quit smoking? When?_____ Did you start again?_____
yes no Do you drink coffee, cola or tea? How much each day?_____

yes no Have you ever been in an alcohol or substance abuse treatment program?
yes no Do you smoke a pipe or cigar, or chew tobacco? Which?_____ How often?_____
yes no Are you on a special diet? Please describe_____
yes no Do you feel your diet is inadequate nutritionally? Why?_____
yes no Do you overeat? Why?_____
yes no Do you eat too many snacks? Why?_____
yes no Do you eat your meals at odd hours (as opposed to on a regular schedule)?
yes no Do you eat an inadequate or skimpy breakfast?
yes no Do you feel you need help with dietary or nutritional education or counseling?
yes no Can you relax and fall asleep when you want to?
yes no Do you get enough sleep? How many hours do you need?_____
yes no Do you feel rested after sleep?
yes no Do you have trouble falling asleep? How often?_____
yes no Do you have trouble staying asleep? How often?_____ When do you awaken?_____
yes no Do you awaken too early? How early?_____
yes no Do you prefer driving without your seat belt protection?

Please write the names and year of any operations which you have had. (year first, then procedure)

year	*year*

Please write the names of any diseases you have had which required hospitalization:

year	*year*

Serious injuries or accidents

year	*year*

Serious illnesses not requiring hospitalization:

Name _____

Please circle yes or no

Have you noticed any of the following during the last year?

yes no Increased appetite?
yes no Decreased appetite?
yes no Weight gain?
yes no Weight loss?
yes no Nosebleeds?
yes no Easy bruisability?
yes no Feeling more afraid than usual?
yes no Nausea and/or vomiting (frequently)?
yes no Palpitations (heart racing)?
yes no Change in hair texture?
yes no Feeling more angry than before?
yes no Recent onset of cold intolerance?
yes no Recent onset of heat intolerance?
yes no Feeling depressed?
yes no Fatigue?
yes no Frequent itching?
yes no Decreased mental ability?
yes no Frequent rashes?

Do you have chest pain or tightness...

yes no When exerting yourself?
yes no When walking up a hill or stairs?
yes no After a heavy meal?
yes no When upset or excited?
yes no Awakening you from sleep?
yes no When sweeping or using a vacuum cleaner?
yes no Occurring only at rest?
yes no Radiating to neck or down the arm?
yes no That disappears when you rest?
yes no That worsens when you lie flat?
yes no With a thumping or racing heart?

Do you have shortness of breath...

yes no During your usual work or activities?
yes no Climbing a flight of stairs?
yes no Awakening you at night?
yes no Accompanied by wheezing?

Have you had a recent change in bowel habits...

yes no Crampy pain in abdomen?
yes no Alternating diarrhea & constipation?
yes no Pain during or after a bowel movement?
yes no Blood in stool?
yes no Ribbon-like or pencil-like stools?
yes no Black stools (like tar)?
yes no Excessively foul smelling stools?
yes no Do you use strong laxatives or enemas?
yes no Other changes?

Do you have stomach problems such as...

yes no Pain occurring 1-2 hours after eating?
yes no Pain after eating fried, greasy food?
yes no Pain awakening you at night?
yes no Discomfort relieved by antacids?
yes no Discomfort relieved by milk or eating?
yes no Pain while eating or immediately after?
yes no Recent onset of vomiting?
yes no Blood or dark brown material in vomitus?
yes no Difficult or painful swallowing?
yes no Recurrent heartburn or indigestion?

Have you had in the past 6 months...

yes no Burning with urination?
yes no Blood in urine?
yes no Dark colored urine?
yes no Trouble starting to urinate?
yes no Difficulty maintaining a strong, normal stream?
yes no Trouble holding your urine?
yes no Frequent urination at night?
yes no Previous kidney or bladder infection?
yes no Have you ever passed a kidney stone?

Over the past year have you had...

yes no Pain in calves when walking?
yes no Cramps in legs at night?
yes no Pain in big toe?
yes no Painful white fingertips when cold?
yes no Swelling in ankles?
yes no Phlebitis or inflamed leg veins?
yes no Varicose veins?
yes no Painful joints, especially in morning?

Over the past year have you had...

yes no Spells of dizziness?
yes no Spells of weakness in arm or leg?
yes no Ringing or roaring in ears?
yes no Fainting spells?
yes no Numbness or tingling in arms, legs or face?
yes no Double vision?
yes no Trouble with memory, coordination or speech?
yes no Temporary loss of vision in one eye?
yes no Twitching of parts of your body?
yes no Have you ever had a convulsion or seizure?

NAME: _____

To be answered by MEN & WOMEN

yes no Have you recently coughed up blood?
yes no Do you have a chronic cough?
yes no Do you sleep on more than one pillow?

yes no Do you cough up much sputum?
Describe sputum _____

yes no Have you ever been in counseling?
yes no Have you ever had suicidal thoughts?
yes no Have you ever attempted suicide?

yes no Have you ever been admitted to a mental or psychiatric hospital?
yes no Do you feel counseling can help people?

yes no Do you have frequent headaches?
yes no Are they throbbing?
yes no Do they cause vomiting?
yes no Do aspirin or Tylenol relieve them?
yes no Do you feel weak for days later?
yes no Mostly in back of head and neck?
yes no Do you have "warning" symptoms?

yes no Pain on one side of the head only?
yes no Do they cause visual trouble?
yes no Do they awaken you at night?
yes no Pain getting progressively worse?
yes no Feels like a tight band?
yes no Headache upon awakening?
yes no Did you get car sick frequently as a child?

To be answered by MEN only...

yes no Loss of sexual activity? How Long?_____
yes no Loss of sexual desire?
yes no Ever have a venereal disease?
yes no Discharge from penis?

yes no Prostate trouble?
yes no Inability to achieve/maintain erection?
yes no Have you ever had a hernia (rupture)?
yes no Lumps or bumps in scrotum (sack)?

To be answered by WOMEN only...

yes no Are you still having monthly periods?
yes no Do you have cramps, backache, and/or irritability with your periods?
yes no Do you have spotting between periods?
yes no Have you ever had an abnormal pap smear in the past?
yes no Have you ever had venereal disease?
yes no Have you ever taken birth control pills?
yes no Have you noticed any new breast lumps recently?
yes no Have you noticed a breast discharge recently?
yes no If post-menopausal, have you had any recent spotting?
yes no If post-menopausal, have you had any hot flashes recently?
yes no If post-menopausal, do you have problems with a dry and/or sore vagina?
yes no Do you have difficulty lubricating for sexual intercourse?
yes no Do you feel satisfied with your sexual enjoyment?
yes no Do you do a self-examination on your breasts every month?

How many children born alive? _____ How many miscarriages? _____
How many stillbirths? _____ How many abortions? _____
How many premature births? _____ How many cesarean operations? _____
Any complications with your pregnancy? yes no If yes, what were they? _____
Date of last pap smear? _____
Date of last menstrual period's onset? _____ Date of previous period's onset? _____
How long do your periods usually last? _____ How many days between periods usually? _____

Education level: Please circle highest education level

Some High School High School graduate Some College College graduate Masters Doctorate Technical School

Today's Visit: Why did you feel you needed to see a physician?

Records Release Authorization

I _____

(Name of Patient of Guardian)

Hereby request that my medical records be released from

_____

(Name of Facility or Doctor)

Fax: _____

Phone: _____

To: _____

Okeechobee Family Practice, P.A.

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**If records exceed more than 15 pages please send by mail.*

Please send the records indicated below:

- ☐ For the dates _____
- ☐ All records
- ☐ Labs/Diagnostics tests
- ☐ Radiology Reports
- ☐ Other _____

_____ _____

(Patient's Signature) *(Date of Request)*

_____ _____

(Date of Birth) *(Social Security Number)*

This authorization will expire at the end of 6 months from the date on which it was signed by the patient for whom the records are being requested