



4449 Meandering Way  
Tallahassee, FL 32308  
Phone: 850.644.1543  
Fax: 855.230.7402

WELCOME!

Thank you for the opportunity for us to provide your healthcare with *FSU SeniorHealth*.

Attached is your registration packet; please complete this packet in its entirety. We ask that you call 850.644.1543, option 1 to schedule your appointment. If you have not selected the physician of your choice, we will schedule you with the first available appointment.

Please send your completed packet to us by fax to: 855-230-7402. You may also mail or hand-deliver your packet to: 4449 Meandering Way, Tallahassee, FL 32308 in the Lower Lobby of the Parry Center Building.

In addition to this registration packet, we ask that you bring the following to your appointment:

- **All medications and supplements/ name of your preferred pharmacy**
- **Insurance card(s)**
- **A photo ID**
- **Your email address (or your authorized representative email address)**

*So that our physicians can get to know you more quickly; we will ask to take a photo of you. \*This is a onetime request that will be directly uploaded to your patient medical record.*

We are located on the campus of Westminster Oaks at 4449 Meandering Way, Tallahassee, FL 32308 in the Lower Level within the Parry Center Building. Once on the campus, feel free to park at one of the '*FSU SeniorHealth*' parking spots or visitors parking. If you have any questions or need to reschedule your appointment, please call 850.644.1543, option 1.

We look forward to seeing you at your first visit! And don't forget to tell your friends and family about us!

Sincerely,

*Lynn Dorvil*

Lynn Dorvil, MHA  
Medical Practice Manager  
850.644.1543

*FSU SeniorHealth* is focused on helping patients live an active and healthy lifestyle.



## New Patient Questionnaire

(please complete all pages)

Full legal name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Name you wish to be called (if different): \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender:  Male  Female  Other \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street Address Apt. Number

City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Address Apt. Number

City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Preferred pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

Work phone # (if applicable): \_\_\_\_\_ Email address: \_\_\_\_\_

Contact preference (check all that apply):  home phone  cell phone  work phone  email  mail Race: \_\_\_\_\_  
 \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language preference: \_\_\_\_\_

Who is completing this form? \_\_\_\_\_

\*Relationship, if other than patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of primary doctor: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### A. PAST MEDICAL HISTORY

Which medical conditions do you have or have you had in the past? (check all that apply)

EYE & EAR PROBLEMS	HEART / VASCULAR PROBLEMS	LUNG PROBLEMS
<input type="radio"/> cataracts	<input type="radio"/> high blood pressure	<input type="radio"/> asthma
<input type="radio"/> glaucoma	<input type="radio"/> irregular heartbeats (arrhythmias)	<input type="radio"/> bronchitis
<input type="radio"/> macular degeneration	<input type="radio"/> heart failure	<input type="radio"/> emphysema
<input type="radio"/> hearing loss/hearing aid	<input type="radio"/> heart attack: year _____	<input type="radio"/> sleep apnea
<input type="radio"/> other, specify:	<input type="radio"/> hyperlipidemia	<input type="radio"/> other, specify:
	<input type="radio"/> other, specify:	

BONE/JOINT PROBLEMS	GLAND PROBLEMS	KIDNEY & URINARY TRACT PROBLEMS
<input type="radio"/> arthritis	<input type="radio"/> diabetes	<input type="radio"/> kidney disease
<input type="radio"/> osteoporosis	<input type="radio"/> overactive thyroid - high	<input type="radio"/> prostate disease
<input type="radio"/> fracture of hip, wrist or spine (circle)	<input type="radio"/> underactive thyroid - low	<input type="radio"/> bladder/kidney infections
<input type="radio"/> gout	<input type="radio"/> other, specify:	<input type="radio"/> urinary incontinence
<input type="radio"/> other, specify:		<input type="radio"/> other, specify:

<b>GASTROINTESTINAL PROBLEMS</b>	<b>NERVOUS SYSTEM PROBLEMS</b>	<b>OTHER HEALTH PROBLEMS</b> <i>(circle all that apply)</i>
<input type="radio"/> ulcers	<input type="radio"/> stroke	<input type="radio"/> allergies, specify:
<input type="radio"/> reflux / hiatal hernia	<input type="radio"/> dementia or Alzheimer's disease	<input type="radio"/> anemia
<input type="radio"/> diverticulosis	<input type="radio"/> Parkinson's disease	<input type="radio"/> hernia
<input type="radio"/> liver disease/cirrhosis	<input type="radio"/> epilepsy or seizures	<input type="radio"/> thrombosis (blood clots)
<input type="radio"/> hepatitis	<input type="radio"/> tremor	<input type="radio"/> depression
<input type="radio"/> polyps	<input type="radio"/> neuropathy	<input type="radio"/> sexual dysfunction
<input type="radio"/> gallbladder disease	<input type="radio"/> other, specify:	<input type="radio"/> cancer, specify:
<input type="radio"/> irritable bowel		
<input type="radio"/> other, specify:		
		<input type="radio"/> other, specify:

**Surgeries – inpatient and outpatient** *(use additional pages, if needed)*

<b>DATE</b>	<b>SURGERY</b>

**Other Hospitalizations** *(use additional pages, if needed)*

<b>DATE</b>	<b>REASON FOR HOSPITALIZATION</b>

**Do you have any drug or other allergies?**

*yes (specify below)*

*no*

<b>NAME OF DRUG</b>	<b>REACTION</b>

List all medicines that you currently use (Prescriptions, Non-Prescriptions, Natural Products)

Medications used regularly	What dose OR strength?	How do you use it? (How much OR how many tablets? How many times a day?)
Example: Tylenol	500 mg	1 pill 3 times a day

**B. SOCIAL HISTORY**

With whom do you live? (check one)	Which of the following best describes your residence? (check one)
<input type="radio"/> alone	<input type="radio"/> single-family house
<input type="radio"/> spouse or partner	<input type="radio"/> condo or apartment
<input type="radio"/> child or other family member	<input type="radio"/> live with other in their house, condo or apartment
<input type="radio"/> friend	<input type="radio"/> other, specify:
<input type="radio"/> other, specify:	<b>Are there stairs in your home?</b> <input type="radio"/> yes <input type="radio"/> no

Are you currently...(check one)	How many children do you have? _____
<input type="radio"/> married	<b>Are you in regular contact with your children?</b>
<input type="radio"/> divorced/separated (circle one)	<input type="radio"/> yes <input type="radio"/> no
<input type="radio"/> widowed	
<input type="radio"/> single (never married)	
<input type="radio"/> living with significant other	<b>Are you in regular contact with relatives?</b>
<input type="radio"/> other, specify:	<input type="radio"/> yes <input type="radio"/> no

How much school did you complete? (check one)	What has been your principal occupation?
<input type="radio"/> less than 6 <sup>th</sup> grade	_____
<input type="radio"/> less than high school	<b>Are you currently...(check one)</b>
<input type="radio"/> high school graduate	<input type="radio"/> retired, not working
<input type="radio"/> some college	<input type="radio"/> working part-time
<input type="radio"/> college - undergraduate	<input type="radio"/> working full-time
<input type="radio"/> college – graduate/doctorate	<input type="radio"/> unemployed (but not retired)

Do you employ someone to provide care or help in your home? <input type="radio"/> yes <input type="radio"/> no	Do you get help from a family member or friend in your home? <input type="radio"/> yes <input type="radio"/> no
If yes, how many hours a day and how many days a week is the person available for you? _____hours/day_____days/week	If yes, how many hours a day and how many days a week is the person available for you? _____hours/day_____days/week
Is this sufficient to meet your needs? <input type="radio"/> yes <input type="radio"/> no	Is this sufficient to meet your needs? <input type="radio"/> yes <input type="radio"/> no

Who would you call if you were sick and needed help? _____	Do you provide care for a family member? <input type="radio"/> yes <input type="radio"/> no
--	--

How often do you drink alcohol? (including beer, wine, other)	If you drink alcohol, has anyone ever been concerned about your drinking? <input type="radio"/> yes <input type="radio"/> no
<input type="radio"/> never	
<input type="radio"/> less than 1 time a week	
<input type="radio"/> 1 to 3 times a week	
<input type="radio"/> almost daily (4-6 times a week)	
<input type="radio"/> daily	

Have you <u>ever</u> used tobacco? <input type="radio"/> yes <input type="radio"/> no	
If yes, do you currently use tobacco? <input type="radio"/> yes <input type="radio"/> no	If you quit using tobacco...
How many years have you used tobacco? _____	How many years ago did you quit? _____
How much tobacco do you use daily? _____	For how many years did you use tobacco? _____

Have you <u>ever</u> used other drugs? <input type="radio"/> yes <input type="radio"/> no	
If yes, do you currently use other drugs? <input type="radio"/> yes <input type="radio"/> no	If you quit using other drugs...
How many years have you used other drugs? _____	How many years ago did you quit? _____
What other drugs are you using? _____	What other drugs have you used? _____

### C. DAILY FUNCTIONING

Do you require help with the following? If yes, who helps you?

TASK	NEED HELP	WHO HELPS YOU? (name and relationship)
feeding yourself	<input type="radio"/> yes <input type="radio"/> no	
getting from bed to chair	<input type="radio"/> yes <input type="radio"/> no	
getting to the toilet	<input type="radio"/> yes <input type="radio"/> no	
getting dressed	<input type="radio"/> yes <input type="radio"/> no	
bathing	<input type="radio"/> yes <input type="radio"/> no	
walking safely	<input type="radio"/> yes <input type="radio"/> no	
using the telephone	<input type="radio"/> yes <input type="radio"/> no	
taking medicines	<input type="radio"/> yes <input type="radio"/> no	
preparing meals	<input type="radio"/> yes <input type="radio"/> no	
managing money/financial affairs (checkbook)	<input type="radio"/> yes <input type="radio"/> no	
doing laundry	<input type="radio"/> yes <input type="radio"/> no	
doing house work	<input type="radio"/> yes <input type="radio"/> no	
shopping for groceries	<input type="radio"/> yes <input type="radio"/> no	
driving	<input type="radio"/> yes <input type="radio"/> no	
doing 'handyman' work	<input type="radio"/> yes <input type="radio"/> no	
climbing stairs	<input type="radio"/> yes <input type="radio"/> no	
getting to places beyond walking distance	<input type="radio"/> yes <input type="radio"/> no	

## D. FAMILY MEDICAL HISTORY

Have any members of your family had any of the following conditions?						
	Father	Mother	Brother/Sister (indicate which)	Brother/Sister (indicate which)	Brother/Sister (indicate which)	Brother/Sister (indicate which)
dementia or Alzheimers						
cancer, specify:						
heart disease or stroke						
diabetes						
depression						
other, specify:						

## E. REVIEW OF SYSTEMS

During the last three months, have you had any of the following symptoms or problems? (check all that apply)

<b>GENERAL</b>	<b>MUSCULOSKELETAL PROBLEMS</b>
<input type="radio"/> weight loss	<input type="radio"/> back or neck pain
<input type="radio"/> weight gain	<input type="radio"/> arm or leg pain
<input type="radio"/> fevers	<input type="radio"/> joint pain or stiffness
<input type="radio"/> chills	<input type="radio"/> foot problems
<input type="radio"/> fatigue	<b>SKIN AND BREAST PROBLEMS</b>
<b>EYES</b>	<input type="radio"/> rash
<input type="radio"/> trouble seeing	<input type="radio"/> sores
<input type="radio"/> eye pain	<input type="radio"/> dry skin
<input type="radio"/> dry eyes	<input type="radio"/> breast tenderness
<b>EAR, NOSE, MOUTH, THROAT</b>	<input type="radio"/> breast lump or discharge
<input type="radio"/> trouble hearing	<b>BRAIN AND NERVOUS SYSTEM PROBLEMS</b>
<input type="radio"/> ear pain or itching	<input type="radio"/> frequent headaches
<input type="radio"/> sinus problems / runny nose	<input type="radio"/> frequent dizzy spells
<input type="radio"/> nose bleeds	<input type="radio"/> passing out or fainting
<input type="radio"/> sore throat	<input type="radio"/> falls
<input type="radio"/> hoarseness	<input type="radio"/> leg or arm weakness
<input type="radio"/> teeth problems	<input type="radio"/> numbness or loss of feeling
<input type="radio"/> mouth sores	<input type="radio"/> tremor or shaking
<b>HEART PROBLEMS</b>	<b>MENTAL HEALTH</b>
<input type="radio"/> chest pain or tightness	<input type="radio"/> depression
<input type="radio"/> rapid or irregular heart beat	<input type="radio"/> anxiety
<input type="radio"/> swelling of feet	<input type="radio"/> problems with sleep
<b>LUNG PROBLEMS</b>	<input type="radio"/> problems with memory or difficulty thinking
<input type="radio"/> persistent cough	<b>ALLERGIC / IMMUNOLOGIC</b>
<input type="radio"/> coughing up blood	<input type="radio"/> hives
<input type="radio"/> difficulty breathing or shortness of breath	<input type="radio"/> seasonal allergies
<input type="radio"/> wheezing	<input type="radio"/> frequent infections
<b>GASTROINTESTINAL PROBLEMS</b>	<b>BLOOD / LYMPH</b>
<input type="radio"/> difficulty swallowing	<input type="radio"/> easy bruising
<input type="radio"/> frequent indigestion or stomach ache, heartburn	<input type="radio"/> bleeding
<input type="radio"/> frequent nausea or vomiting	<input type="radio"/> blood clots
<input type="radio"/> change in bowel habits	<input type="radio"/> swollen lymph nodes

<input type="radio"/> black bowel movement or bleeding from rectum	<b>ENDOCRINE</b>
<input type="radio"/> diarrhea	<input type="radio"/> excessive thirst
<input type="radio"/> constipation	<input type="radio"/> feel too hot or too cold
<b>GENITOURINARY PROBLEMS</b>	<input type="radio"/> problems with sexual function
<input type="radio"/> urination at night (how many times _____)	<input type="radio"/> Men: problems with erection
<input type="radio"/> frequent urination	<input type="radio"/> Men: problems with prostate
<input type="radio"/> painful urination	<input type="radio"/> Women: vaginal dryness
<input type="radio"/> loss of urine or getting wet	<input type="radio"/> Women: vaginal discharge or bleeding

**F. FALLS AND MOBILITY**

**Do you use a walking or mobility aid?**  yes  no

If YES, check all that apply:  cane  walker / rollator  wheelchair  other, specify \_\_\_\_\_

**Are you afraid of falling?**  yes  no

**Have you had a fall in the past year?**  yes *(Please continue to next question)*  
 no *(STOP – proceed to section G below)*

**Please tell us about your last two falls**

If you have had less than two falls, just tell us about the one you have had. To describe the circumstances of each fall, please tell us: *what you were doing when you fell, what you think caused the fall, whether you experienced light-headedness or palpitations, how you landed (front/back/side), if there was loss of consciousness, what treatment (if any) you received for the fall, and anything else you think is important.*

**Most Recent Fall**

Date *(as best you can recall)*: Month: \_\_\_\_\_ Year: \_\_\_\_\_

How did this fall happen *(briefly describe circumstances)*:

---



---

Did you need to see a doctor or other professional for treatment after this fall?  yes  no

If YES, describe the treatment you received:

---



---

**Prior Fall** \_\_\_\_\_ Check here if not applicable *(if you have had only one fall)*

Date *(as best you can recall)*: Month: \_\_\_\_\_ Year: \_\_\_\_\_

How did this fall happen *(briefly describe circumstances)*:

---



---

Did you need to see a doctor or other professional for treatment after this fall?  yes  no

If YES, describe the treatment you received:

---



---

**G. DRIVING**

Do you currently drive?  yes  no

If you do not drive, how do you get around town? (Check all that apply)

Family/Friend drives  Cab  Dial-a-Ride  Public Bus

Do you (or your friends / family) have concerns about your driving?  yes  no

Have you had (in the past year) any:  Accidents / Crashes  Tickets  Near Misses

Have you ever gotten lost driving?  yes  no

**H. HEALTH MAINTENANCE**

Have you ever had the Pneumovax vaccine (a shot to prevent pneumonia)?

yes  no If YES, in what year? \_\_\_\_\_

Have you ever had the Prevnar 13 vaccine (a shot to prevent pneumonia)?

yes  no If YES, in what year? \_\_\_\_\_

Have you ever had a Shingles vaccine? Zostavax  yes  no If YES, in what year? \_\_\_\_\_

Shingrix (2 shots)  yes  no If YES, in what year? \_\_\_\_\_

Have you ever had a tetanus shot?  yes  no

If YES, in what year did you have your last tetanus booster? \_\_\_\_\_

Did you get a flu shot during the most recent season (October-February)?  yes  no

Do you always wear a seatbelt when you drive or ride in a car?  yes  no

Do you currently participate in any regular activity to improve or maintain your physical fitness?

(either on your own or in a formal class)  yes  no

If YES, check all current activities

- |   |  |
|---|--|
| <input type="checkbox"/> walking                      | <input type="checkbox"/> swimming              |
| <input type="checkbox"/> aerobics or exercise classes | <input type="checkbox"/> dancing               |
| <input type="checkbox"/> bicycling or stationary bike | <input type="checkbox"/> jogging               |
| <input type="checkbox"/> tennis or pickle ball        | <input type="checkbox"/> golf or croquet       |
| <input type="checkbox"/> bowling or bocce             | <input type="checkbox"/> other, specify: _____ |

How many minutes a week do you exercise? \_\_\_\_\_

Have you had a hearing test within the last two years?  yes  no

Have you had an eye exam within the past year?  yes  no

Have you seen a dentist in the last year?  yes  no

Have you ever had an examination of your bowel with a scope?  yes  no

(Circle which one: sigmoidoscopy or colonoscopy)?

If YES, in what year did you have your most recent sigmoidoscopy or colonoscopy? \_\_\_\_\_

In the past 12 months, have you had a test for blood in your stool?  yes  no



**Men proceed to section I. Women proceed to section J.**

**I. QUESTIONS FOR MEN ONLY** *(After completing this section, proceed to section K)*

**Have you ever had a prostate exam (rectal exam)?**     yes     no

If YES, in what year did you have your last prostate exam? \_\_\_\_\_

**Have you ever had a blood test to look for cancer of the prostate (PSA)?**     yes     no

If YES, in what year did you have your last PSA? \_\_\_\_\_

**J. QUESTIONS FOR WOMEN ONLY**

**Do you perform breast self-exams (BSE) once a month?**     yes     no

**Have you ever had a mammogram?**     yes     no

If YES, have you had a mammogram within the last year?     yes     no

If YES, when was your last mammogram? month/year \_\_\_\_\_ / \_\_\_\_\_

**Have you had a hysterectomy (surgical removal of the uterus)?**     yes     no

If NO, have you ever had a Pap smear/pelvic examination?     yes     no

If YES, when was your last Pap smear? month/year \_\_\_\_\_ / \_\_\_\_\_

**K. PLANNING for FUTURE HEALTHCARE** *(please bring a copy of each document marked 'YES' below)*

Do you have a medical Durable Power of Attorney or Health Care Surrogate? Surrogate's name/relationship _____	<input type="radio"/> yes <input type="radio"/> no
Do you have a Living Will?	<input type="radio"/> yes <input type="radio"/> no
Do you have a 'Do Not Resuscitate Order Form' at your home or residence?	<input type="radio"/> yes <input type="radio"/> no

**Do you have any other health concerns that you would like your doctor to know about?**

---

---

---



Florida Medical Practice Plan™  
FSU Clinical Practices Financial Policies

MRN: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_ VISIT DATE: \_\_\_\_\_

---

1. Payment is expected at time of service. This includes co-pays, co-insurances and deductibles.
2. At check out, our staff will ask you for payment for any past due balances as well as your portion of the payment for today's service. Failure to meet your financial obligations could result in being discharged from the practice.
3. If you are unable to keep your appointment, it is important to notify us 24 hours prior to your appointment. This will allow us to free your appointment time for other patients. You may be charged a \$25 cancellation or no show fee if you fail to notify us.
4. Adult patients who do not show up for a scheduled appointment 3 times within a 12 month period and fail to notify us prior to the appointment, may be discharged as a patient. Patients under the age of 18 may be discharged for the same.
5. If you are scheduled for an elective non-covered procedure, an estimate of your portion of the payment will be given to you. Payment will be expected at least 10 days prior to this procedure. If you have any outstanding balance, we will also expect payment 10 days prior to the procedure. Failure to make the required payments will result in the service being rescheduled. When you receive your estimate, you will also receive a payment voucher to send back with your payment. Please remember to include the voucher along with your payment.
6. Some insurances require that your labs be performed in a different location other than your doctor's office. If you choose to have the test performed at your physician's office, you will be expected to pay the fee for this service. Your insurance cannot be billed in those instances.
7. Similarly, if your insurance does not authorize a procedure or test and you choose to have the procedure or test done anyway, you will need to pay for the service up front. Your insurance cannot be billed in those instances.

If you have any questions, please call our Patient Relations department at (850) 644-1543, and select option 4, Monday thru Friday, 8:30 AM to 4:30 PM.

Patient or Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



**Notice of Privacy Practices Acknowledgment**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name or Legal Guardian (print) Date

\_\_\_\_\_  
Signature

**Reassignment of Benefits**

I authorize the release of any medical or other information necessary to process my claims. I also request payment of all benefits including government benefits to the physician or supplier for services rendered under Florida Medical Practice Plan, Inc.

\_\_\_\_\_  
Patient Name or Legal Guardian (print) Date

\_\_\_\_\_  
Signature

**Authorization to Disclose Medical Information**

I authorize the release of any medical or other information necessary to provide care for myself to the individual(s) listed below.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

**Medical History Information**

I authorize *FSU SeniorHealth*™ to access all of my prior medical records in order to provide consultation(s).

\_\_\_\_\_  
Patient Name or Legal Guardian (print) Date

\_\_\_\_\_  
Signature



# Authorization for Release of Medical Records

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

From: \_\_\_\_\_  
(Health Care facility releasing information)

To: \_\_\_\_\_  
(Name of institution or individual receiving information)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip)

### Information to be disclosed:

From (Date) \_\_\_\_\_ To (Date) \_\_\_\_\_

<input type="radio"/> Discharge Summary	<input type="radio"/> EKG/EEG Reports	<input type="radio"/> Radiology Images
<input type="radio"/> History and Physical Examination	<input type="radio"/> Emergency Room Record	
<input type="radio"/> Operative Report	<input type="radio"/> Clinic Notes	
<input type="radio"/> Pathology Report	<input type="radio"/> Behavioral Health Information	
<input type="radio"/> Laboratory Results/	<input type="radio"/> Physical/ Occupational Therapy Notes	
<input type="radio"/> X-ray Reports	<input type="radio"/> Prenatal (Pregnancy) Records	
<input type="radio"/> Other (please specify) _____		

**Purpose of Release:**  Medical Care  Transferring Care  Personal Records  Attorney  
 Other \_\_\_\_\_

This Statement of Consent can be revoked at any time before disclosure of information, and expires on \_\_\_\_\_. If no expiration date or identifiable event is listed, then authorization expires 12 months after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Revoking the authorization will not have any effect on actions taken prior to revocation. I understand that the individual/ institution that receives the information described above, may not be covered by federal privacy regulations, and that the information may be disclosed publicly and no longer be protected by those regulations.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Signature of Parent, Guardian, or Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to patient)

Note:  
**Please fax all records to: (855) 230-7402**  
Or mail: *FSU SeniorHealth™*  
4449 Meandering Way  
Tallahassee, Florida 32308  
ATTN: FSU SeniorHealth