Welcome to Total Wellness Direct Primary Care (DPC)

Dr. Jepma is privileged you selected him as your physician.
To ensure successful collaboration in your health care needs please complete our new patient registration paperwork.

- **Patient Registration - click to view**
- **Member Agreement - click to view**
- **Authorization for Auto-Payment - click to view**
- **Medicare Opt-out Agreement (as applicable) - click to view**
- **Medical Records Release Authorization (as applicable) - click to view**

To complete the forms by hand click the icon and follow the prompts to print all forms (the default print setting skips printing this page)

Click to Print

To complete the paperwork on-line, enter patient information below (used to auto populate patient fields in the forms) and proceed to the next page.

Patients Full Name

Patients Date of Birth

Patient Address

City

State

Zip Code

Person to call in the event of an emergency

Emergency Contact Name

Contact Number

click to select

Relationship to Patient

Click here to proceed to the Patient Registration form

Tips: Use the tab key to navigate fields or simply click in a field and begin typing. Auto-populated text can be typed over and/or deleted as needed.

Patient Registration

General Information

Full Name _____ Birthday _____

How would you like to be addressed (Mr./Mrs., nickname, etc.)? _____

Preferred pronoun: ☐ She / Her ☐ He / Him ☐ They / Them

Height _____ feet _____ Inches Usual Weight _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Is it okay to leave a detailed message on this number? ☐ Yes ☐ No

Email _____

Introduction

How did you learn about our office (did anyone refer you, if yes please provide name)?

What are your goals for your first visit?

How would you describe your health?

What are your health goals?

What is your most concerning health problem?

What measures have you taken so far to address it (treatments, medications, specialists seen)?

Emergency Contact Information

	Name	***Phone Number***	***Relationship***
Primary			click to select
Secondary			click to select

Background

Where were you born? _____ Where did you grow up? _____

What is your family race/ethnicity background? _____ Your first language? _____

What type of work have you done or do you do? _____

Hospital & Pharmacy Preference

Hospital Name _____ Pharmacy Name _____

Location _____ Phone _____ Fax _____

Patient Name: _____ Signature: _____ Date: _____

Total Wellness Health Care | totalwellnesshc@gmail.com

139 Executive Circle, Suite 104 Daytona Beach, FL 32114 | P/T: 386-232-5505 | Fax: 386-223-4932

Click to Save

Patient Registration

Health History

Thank you for taking the time to complete this Health History section of your patient registration. Any information you share with me will be held in the strictest of confidence. It is important to be as thorough as possible, as this will aid me in caring for you.

Patient Medical *(check all that currently apply or have had previously)*

- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bowel irregularity
- ☐ Cancer
- ☐ Childhood hyperactivity
- ☐ COPD
- ☐ Depression
- ☐ Diabetes-Type 1
- ☐ Diabetes-Type 2
- ☐ Dizziness/fainting
- ☐ Eczema
- ☐ Endocrine problems
- ☐ Epilepsy / Seizures
- ☐ Eye infections/disorders
- ☐ Frequent colds
- ☐ Gallbladder disease
- ☐ German Measles
- ☐ Glaucoma
- ☐ Heart Trouble/chest pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ Kidney/bladder problems
- ☐ Lactose intolerance
- ☐ Liver disease/Jaundice
- ☐ Lung Disease
- ☐ Malaria
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Night sweats
- ☐ Pancreatitis
- ☐ Paralysis/Numbness
- ☐ Persistent Cough
- ☐ Pneumonia/Bronchitis
- ☐ Polio
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexual/menstrual probs
- ☐ Shortness of Breath
- ☐ Sinus trouble
- ☐ Skin Disease
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ TB/Tuberculosis
- ☐ Thyroid Problems
- ☐ Tumor
- ☐ Urinary Problems
- ☐ Venereal disease
- ☐ Weight gain
- ☐ Weight loss
- ☐ Injuries to: _____
- ☐ Other: _____

Surgeries

Type	Year
☐ C-section	
☐ Gallbladder	
☐ Hysterectomy	
☐ uterus only	
☐ uterus & cervix	
Why:	
☐ Ulcer	
☐ Tonsils	
☐ Prostate	
☐ Cataracts	

Tests / Exams

Type	Year
☐ Eye Exam	
☐ Dental Exam	
☐ Hearing Test	
☐ EKG	
☐ Colonoscopy	
☐ Sleep Study	
☐ Stress Test	
☐ Bone Density	
☐ Pulmonary	
☐ Mammogram (female only)	
☐ Pap Smear female only)	
☐ Prostate Exam (male only	

Vaccines

Type	Year
☐ Tetanus	
☐ Flu	
☐ Pneumonia	
☐ Hepatitis B	
☐ Shingles	
☐ List any other	

Allergies

Type	Details
☐ Aspirin	
☐ Codeine	
☐ Penicillin	
☐ Sulfa	
☐ Erythromycin	
☐ Iodine	
☐ Seafood	
☐ Dye	
☐ List any other	

Patient Name: _____ Signature: _____ Date: _____

Patient Registration

Hospitalization (Please provide details, other than surgery listed above, you stayed overnight in the hospital)

Overnight Stay	Approx. Date	Reason	Hospital

Medications *(Please list all prescription and nonprescription (over the counter) medications, as well as any nutritional supplements. Okay to include on a separate sheet of paper if you have a pre-printed list.)*

Name	Dose	Frequency (daily, twice daily, etc.)	Purpose?
		click to select	
		click to select	
		click to select	
		click to select	
		click to select	

Family Medical *(check all that currently apply or have previously applied to patient's biological Father, Mother, Sibling or other immediate relation)*

Condition	Relation	Condition	Relation	Condition	Relation
☐ Abdominal Pain	click to select	☐ Heart Trouble/chest pain	click to select	☐ Persistent Cough	click to select
☐ Anemia	click to select	☐ Heart Attack	click to select	☐ Pneumonia/Bronchitis	click to select
☐ Anxiety	click to select	☐ Heart Disease	click to select	☐ Polio	click to select
☐ Arthritis	click to select	☐ Heart Failure	click to select	☐ Prostate Problems	click to select
☐ Asthma	click to select	☐ Hemorrhoids	click to select	☐ Rheumatic Fever	click to select
☐ Bowel irregularity	click to select	☐ Hepatitis	click to select	☐ Scarlet Fever	click to select
☐ Cancer	click to select	☐ Hernia	click to select	☐ Sexual/menstrual probs	click to select
☐ Childhood hyperactivity	click to select	☐ High Blood Pressure	click to select	☐ Shortness of Breath	click to select
☐ COPD	click to select	☐ High Cholesterol	click to select	☐ Sinus trouble	click to select
☐ Depression	click to select	☐ Hives	click to select	☐ Skin Disease	click to select
☐ Diabetes-Type 1	click to select	☐ Kidney/bladder problems	click to select	☐ Stomach ulcer	click to select
☐ Diabetes-Type 2	click to select	☐ Lactose intolerance	click to select	☐ Stroke	click to select
☐ Dizziness/fainting	click to select	☐ Liver disease/Jaundice	click to select	☐ Swelling of ankles	click to select
☐ Eczema	click to select	☐ Lung Disease	click to select	☐ TB/Tuberculosis	click to select
☐ Endocrine problems	click to select	☐ Malaria	click to select	☐ Thyroid Problems	click to select
☐ Epilepsy / Seizures	click to select	☐ Migraines	click to select	☐ Tumor	click to select
☐ Eye infections / disorde	click to select	☐ Mononucleosis	click to select	☐ Urinary Problems	click to select
☐ Frequent colds	click to select	☐ Mumps	click to select	☐ Venereal disease	click to select
☐ Gallbladder disease	click to select	☐ Night sweats	click to select	☐ Weight gain	click to select
☐ German Measles	click to select	☐ Pancreatitis	click to select	☐ Weight loss	click to select
☐ Glaucoma	click to select	☐ Paralysis/Numbness	click to select	☐ Other	click to select

Patient Name: _____ Signature: _____ Date: _____

Patient Registration

Social History

☐ **Tobacco**	Packs per day:	How many years?:	When did you quit?
☐ **Smokeless**	Uses per day:	How many years?:	When did you quit?
☐ **Alcohol**	Drinks per week:	Treatment?:	When did you quit?
☐ **Drugs**	Type:	Treatment?:	
☐ **Medical Marijuana**	Reason:	How Long?	
☐ **Exercise**	Type:	Minutes per day:	Days per week:

Occupation ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Psychiatric History

What are your stressors?

What do you do to relieve stress?

Do you feel depressed or anxious?

Please describe any formal diagnoses of any psychiatric condition, or care of a psychiatrist in a clinic/hospital:

Sexual History

Do you have any question or concern about your gender identity? ☐ Yes ☐ No

In your intimate relationships, do you favor partners who are male, female, or those who might identify otherwise?

Do you have any questions about your sexual health? ☐ Yes ☐ No

Do you think you are at risk for HIV or other sexually transmitted diseases? ☐ Yes ☐ No

Dietary History

What kinds of foods do you usually eat for breakfast, lunch, or dinner?

Can you eat all consistency of foods? ☐ Yes ☐ No, if no why not?

Are there any specific foods you avoid, and if so, why?

Exposure History (Examples: Lead-based paint, water-damaged building with mold, living in an area exposed to pesticides or radiation, working in a place with chemicals, animals, or radiation)

Have you ever been exposed to chemicals, irritants, or pollutants in the past (if yes please describe)?

Patient Name: _____ Signature: _____ Date: _____

Patient Registration

Safety Concerns

	Yes	No
Do you feel safe in your home (if no, explain)?	☐	☐
Is there anyone in your life now who says abusive things or who has physically harmed you (if yes, explain)?	☐	☐
Is there anyone in your past who says abusive things or who has physically harmed you (if yes, explain)?	☐	☐
Is there anyone using your money without your permission (if yes, please explain)?	☐	☐
Do you have problems with walking or falls (if yes, please explain)?	☐	☐
Do you or anyone in your life have concerns about your driving safely (if yes, please explain)?	☐	☐

Functional History (Please check all items that apply)

Do you need help with:

☐ transferring from a bed to a chair, walking, or travelling by car

☐ buying food, making meals, or feeding yourself

☐ upper or lower body dressing or bathing

☐ managing your medications or finances

Do you have any problems with bowel or bladder continence (if yes please explain)? ☐ Yes ☐ No

Please explain the use of any medical equipment at home (CPAP machine, oxygen, walker, etc.) ☐ Yes ☐ No

Advance Directives

Please provide the name and contact number for the following:	***Name***	***Number***
Person to call in the event of an emergency		
Person you would want to make decisions for you if you are unable to speak for yourself		

Do you have an advance directive? (*If so, please bring a copy for your electronic medical record. This can be submitted electronically by email or by paper for scanning into your record.)* ☐ Yes ☐ No

Patient Name: _____ Signature: _____ Date: _____

Patient Registration

Care Providers (Please provide details below for any medical/healthcare professionals involved in your care, including doctors, dentists, eye doctors, massage therapists, chiropractors, specialists, etc.)

Type	Name	Phone
Cardiologist (Heart)		
Dermatologist (Skin)		
Endocrinologist (Hormone)		
Gastroenterologist (Stomach)		
Pulmonologist (Lung)		
Nephrologist (Kidney)		
Neurologist (Nervous Sys.)		
OB/GYN (Women's Health)		
Oncologist / Hematologist (Cancer)		
Ophthalmologist (Eye)		
Orthodontist (Dentist)		
Orthopedic (Bone/Muscle)		
Otolaryngologist (Ear/Nose/Throat)		
Pain Management		
Physical Therapy		
Psychiatrist or Counselor		
Rheumatologist (Autoimmune)		
Social/Case Worker		
Urologist (Kidney/Bladder)		
Other		

Patient Name: _____ Signature: _____ Date: _____

Patient Registration

Release of Health Information

I authorize Total Wellness DPC to disclose protected health information (medical records) as follows:

Name to disclose information to	**Information** that may be disclosed	**Duration** of disclosure

1. The information will be used on my behalf for the following purpose(s): Continuity of Medical Care
2. This authorization is limited to the following time period: All
3. This authorization is limited to the following treatment: Medical Care
4. This authorization shall expire on the following date or event: Upon discharge

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Total Wellness DPC where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Patient Name: _____ Signature: _____ Date: _____

Patient or Legal Guardian

Patient Registration

Total Wellness DPC Notice of Privacy Practices

Total Wellness DPC Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the Total Wellness DPC Administrator.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Total Wellness DPC Notice of Privacy Practices.

Patient/Legal Representative Signature	Date	Time

Print Name of Patient	Patient Date of Birth

Click to Print

Patient Registration

Medications *(Please list all prescription and nonprescription (over the counter) medications, as well as any nutritional supplements. Okay to include on a separate sheet of paper if you have a pre-printed list.)*

Name	Dose	Frequency *(daily, twice daily, etc.)*	Purpose?
		click to select	
		click to select	
		click to select	
		click to select	
		click to select	
		click to select	
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Patient Name: _____ Signature: _____ Date: _____

Total Wellness Health Care | totalwellnesshc@gmail.com
139 Executive Circle, Suite 104 Daytona Beach, FL 32114 | P/T: 386-232-5505 | Fax: 386-223-4932

Click to Save

Click to Print

Member Agreement

Terms:

- I acknowledge and understand that I am voluntarily becoming a **Total Wellness Direct Primary Care, LLC** ("**Total Wellness DPC**") member for primary care services on behalf of myself or individuals for whom I am a parent or legal guardian. I understand that this agreement is non-transferable.
- I have received and reviewed the provider services as listed in the Member Services section of this agreement, which describes the types of services provided. I have had the opportunity to ask questions and receive answers about its content.
- I acknowledge and understand that the monthly membership fee is paid in consideration for the services outlined in the Member Services section of this agreement. I understand that if my care requires services or supplies that are not included in my membership, the fees for these services or supplies will be discussed with me in advance and I will be responsible to pay these fees in full at the time of service.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance. It only provides for primary care health care services as specifically described in the Member Services section of this agreement. I recognize that I am encouraged to obtain conventional private individual, catastrophic, or comprehensive health insurance.
- I acknowledge and understand that the monthly fee paid to Total Wellness DPC does not cover the cost of prescription drugs, hospitalization costs, major surgery, dialysis, high level radiology (CT, MRI), rehabilitation services, or procedures requiring general anesthesia, or similar advanced procedures, services or supplies and that I am responsible for any charges incurred for those services performed outside of Total Wellness DPC.
- I acknowledge and understand that Total Wellness DPC will not bill an insurance carrier, Medicare or Medicaid for any services provided.
- I acknowledge and understand that if I am enrolled in Medicare, I will receive a copy of the "Medicare Opt-Out Agreement" for review and signature before my first appointment.
- I acknowledge and understand that to become a Total Wellness DPC member, I must submit my first month's membership fee with my enrollment fee and forms, which shall include my authorization for automatic monthly payment of my monthly membership fee.

Patient Name:_____ Signature:_____ Date:_____

Member Agreement

- I acknowledge and understand that my monthly membership fee will be automatically transferred from my selected choice of payment each month on the same day of the month that my membership was accepted by Total Wellness DPC. This day of the month is considered to be the beginning of that month's services. In the event payment is not received, Total Wellness DPC will notify me through my given contact information and will charge a $25 late fee.
- I acknowledge and understand that Total Wellness DPC may add or discontinue services included in the fee or increase my fee schedule at any time (but no more than once annually) and that I will be given at least sixty (60) days' notice of fee schedule changes.
- I acknowledge and understand that Total Wellness DPC may cancel this Member Agreement for cause due to nonpayment of fees or for unruly, threatening, or inappropriate behavior by providing me written notice. Any pre-paid monthly fees will not be refunded. Total Wellness DPC will not cancel this Member Agreement solely on the basis of health status.
- I acknowledge and understand that I am free to cancel this Member Agreement at any time by providing written notice to Total Wellness Direct Primary Care, 139 Executive Circle, Suite 104, Daytona Beach, FL 32114. Monthly fees will continue to accrue until the written cancellation is received. Any pre-paid care fees will not be refunded.
- I acknowledge and understand that if I cancel this Member Agreement, I must submit a registration fee of $250 along with the other requirements for re-enrollment. Total Wellness DPC makes no representations that I will be able to re-enroll at some future date.

Rights and Responsibilities:

- I agree to disclose all information relating to my health condition and to actively collaborate with my health care provider to understand my treatment options and develop the best course of action.
- I understand that my enrollment in Total Wellness DPC is a commitment to my ongoing health and wellness. I agree to commit to those plans for my medical care, which have been agreed upon by my provider and me.
- I understand that I will be forthright with regard to my prescription medication and my use of them.
- I understand that it is my responsibility to inform Total Wellness DPC of any changes to my credit/debit card or bank account information.

Patient Name:_____ Signature:_____ Date:_____

Member Agreement

- I understand that it is my responsibility to ensure that Total Wellness DPC has correct contact information (e.g. mailing address, phone) for my account.
- I agree to arrive on time for my appointment. If I do not arrive on time, my provider may not be able to spend as much time with me as I may need. In addition, I agree to call Total Wellness DPC at least 24 hours before an appointment if I need to cancel so that other patients can use my visit time.
- I understand that I have the right to receive accurate and easily understood information about Total Wellness DPC health care services, health care professionals, and health care facilities.
- I understand that I have the right to speak in confidence with my Total Wellness DPC provider and to have my health care information protected. I understand that Total Wellness DPC will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider amend my record if I feel it is inaccurate or incomplete by contacting my Total Wellness DPC provider.
- I understand that the monthly fee is intended to cover Total Wellness DPC provider's availability to provide services as well as the individual services provided and that the monthly fee is due for months under the Member Agreement even if I do not communicate with Total Wellness DPC providers or see them during a particular month.
- I understand that I am responsible for all bills associated with services provided outside the direct agreement for primary care services, whether provided by Total Wellness DPC or another organization or individual.
- In the event I wish to cancel my membership, I understand that I must notify Total Wellness DPC in writing of my intent to cancel. If my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I understand that if I am dissatisfied for any reason, I may contact the Total Wellness DPC Administrator to address any complaints. I agree to first bring issues to the attention of Total Wellness DPC.

Patient Name:_____ Signature:_____ Date:_____

Click to Print

Member Agreement

- By my signature below, I agree to become a Total Wellness Direct Primary Care member and I agree to the terms outlined in this Member Agreement. Parents or guardians of members under age 18 may sign on their behalf as their representative. A separate registration must be completed for each patient in a family. This Member Agreement will become effective when fully signed by the prospective Member and accepted by Total Wellness Direct Primary Care LLC.

Signature:_____ Date: _____

Member Name:_____

Signature by: ☐ Member ☐ Parent ☐ Legal Guardian

Member Services:

- Health Exams and Health Risk Assessment
- Office Visits including Essential/Basic Primary Care Services
- Well Child Checks
- Convenient Appointment Scheduling
- Personal connection via text, email, or telephone
- Video Appointments when appropriate
- Yearly Lab Screening and additional Discounted Laboratory Services
- Minor Office Procedures
- EKG (when available)
- Pulmonary Function Testing (when available)
- Discounted Access to Age Management Center

Dr. Jepma is **honored** to be your physician, and looks forward to partnering with you in your health care needs.

Thank you!

Click to Print

Medicare Opt-Out Agreement

This agreement is between John W. Jepma D.O. whose principal place of business is at 139 Executive Circle, Suite 104, Daytona Beach, FL 32114, and

Beneficiary: _____

who resides at: _____

_____

_____

Medicare ID #: _____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

Medicare Opt-Out Agreement

Initial

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:

Date: _____

By: _____
Beneficiary or his/her legal representative

and: _____
John W. Jepma D.O.
Total Wellness Direct Primary Care LLC
139 Executive Circle, Suite 104
Daytona Beach, FL 32114
Phone: 386-232-5505
Fax: 386-223-4932

Click to Print

Medical Records Authorization

I hereby authorize the release of my individually identifiable health information as outlined below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory and imaging reports, medical history, treatment, and any other such related information.

I hereby authorize the release of my medical information detailed on this form as follows:

☐ **From** my current provider **to Total Wellness DPC (medical facility)**

OR

Dr. John W. Jepma, D.O.
139 Executive Circle, Suite 104
Daytona Beach, FL 32114
Fax: 386-223-4932

☐ **From** Total Wellness DPC (medical facility) **to**:

Provider Name: _____

Phone # _____ Fax # _____

_____ _____ _____
Patient Name (please print) Date of Birth Social Security Number

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Phone Number

Information to be released:

☐ Complete records from _____ to _____, including lab and imaging reports

☐ All vaccinations ☐ All preventive measures (colonoscopies, mammograms, paps, etc.)

☐ Other _____

_____ _____ _____
Patients Name (printed) Signature Date

Relationship to Patient

☐ Self ☐ Other _____

Relationship to patient: (legal authority if minor, attach supporting documentation)