PLEASE PRINT - PATIENT INFORMATION

Last Name ________________________**First Name** ________________________ **Middle Name** ________________

Date of Birth ________________ **Age**________ **Social Security #** _____________________________________

Gender Identity (circle one) Female, Male, Female-to-Male Trans, Male-to-Female Trans, Non-Conforming, Other

Race____________ **Marital Status**_________ **Ethnicity** ______________ **Preferred Language** ______________

Email Address ____

Street Address____

City ______________________ **State** ______ **Zip** ____________ **Home/Cell Phone** _____________/_____________

Occupation ______________________ **Employer** _________________________ **Work Phone** ________________

Responsible Party / Parent / Guardian (Name/Relationship)____

Emergency Contact Name____________________________________ **Phone Number**_________________________

Primary Care Physician Name ________________________________ **Phone Number**_________________________

Referring Physician Name ___________________________________ **Phone Number**_________________________

Seasonal Address (if applicable) Street____

City ______________________ **State** ___________ **Zip** ____________ **Home Phone** _________________________

INSURANCE INFORMATION – PRIMARY

Insurance Company Name _____________________________________ **Phone Number**_______________________

Claims Address____

Policy # ________________________ **Group #** _____________________ **Subscriber** __________________________

Subscriber Social Security # ___________________________ **Subscriber Date of Birth**________________________

Subscriber Marital Status_____________________ **Relationship to Subscriber**_______________________________

INSURANCE INFORMATION – SECONDARY

Insurance Company Name _____________________________________ **Phone Number**_______________________

Claims Address____

Policy # ________________________ **Group #** _____________________ **Subscriber** __________________________

Subscriber Social Security # ___________________________ **Subscriber Date of Birth**________________________

Subscriber Marital Status_____________________ **Relationship to Subscriber**_______________________________

PHARMACY

Name ____

Address ____ **Phone**________________________________

TAMPA BAY SURGICAL GROUP

MEDICAL QUESTIONNAIRE

Patient Name: **Age/DOB:** **Date:**

Reason for Visit: (describe onset and treatments)

REVIEW OF SYSTEMS:

Constitutional	ENT	Eyes	Gastroenterology	Endocrinology
☐ Fever	☐ Nosebleeds	☐ Glaucoma	☐ Loss of Appetite	☐ Leg Swelling
☐ Recent Weight Gain	☐ Hoarseness	☐ Visual Disturbance	☐ Nausea	☐ Sleep problems
☐ Recent Weight Loss	☐ Ringing in the Ears	☐ Dry Eyes	☐ Heartburn	☐Temperature
☐ Night Sweats	☐ Allergies	☐ Double Vision	☐ Difficulty Swallowing	☐ Excessive Thirst
☐ Fatigue	☐ Snoring			
	☐ Ear Pain	**Respiratory**	**Neurology**	**Hematology**
Skin	☐ Ear Drainage	☐ Asthma	☐ Headaches	☐ Easy Bruising
☐ Skin Cancer	☐ Throat Pain	☐ Cough	☐ Stroke	☐ Bleeding Disorder
☐ Healing Problems	☐ Sinus Pressure	☐ Spitting Blood	☐ Paralysis	☐ Anemia
☐ Rash	☐ Post Nasal Drip		☐ Tingling	☐ Blood Clots in Legs
☐ Discoloration	☐Sinus Congestion	**Cardiology**	☐ Seizures	
	☐ Hearing Loss	☐ Chest pain	☐ Dizziness	
		☐ Irregular Heart	☐ Memory Loss	
		☐ Murmur		

MEDICAL HISTORY: Please indicate if you have/had history of following ☐ **See Attached List**

_____**Arthritis** _____**Emphysema** _____**High Cholesterol** _____**TIA**

_____**Asthma** _____**Hepatitis** _____**HIV** _____**Reflux (GERD)**

_____**Anxiety** _____**Stroke** _____**Treatment for Alcoholism**

_____**COPD** _____**Thyroid Disease** _____**Treatment for Substance Abuse**

_____**Diabetes** _____**High Blood Pressure*** **Additional:**_______________________

_____**Cancer:**______________________ ________________________________

____

Medication Allergies:

Other Allergies:

Vaccine, if age 64 or older: ☐ Pneumonia, List Date:_______________________________

☐ Influenza, List Date:_______________________________

Patient Name:_______________________________ Age_____DOB:_____________ Date:_____________

Family Medical Problem History:

Family Members:	**Mother**		**Father**		**Siblings**	
	Alive: ☐	Deceased: ☐	Alive: ☐	Deceased: ☐	Alive: ☐	Deceased: ☐
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Mental Illness						
Migraine						
Stroke						
Thyroid Disease						

Tobacco Use: cigarettes ☐cigars ☐pipe ☐ chewing tobacco

current every day smoker, how much? _________________
current some day smoker, how much? _________________
former smoker, quit in ___________Smoked for how long?________
never smoker

Do you use Recreational Drugs? ☐ No ☐ Yes, What?___________________

Alcohol Use: none moderate heavy formerly heavy

Caffeine Use: none ________ times daily

Marital Status: Single Married with _____ Children ☐ Divorced ☐ Widowed

Are you Retired? ☐ Yes ☐ No

Occupation: ____

Do you have a living will? yes no

Patient Name:_______________________________ **Age**_____**DOB:**_____________ **Date:**_____________

MEDICATION LIST: ☐ **See Attached List**
Please list ALL medications (Including Over-The-Counter Drugs) you are taking now; include dosage & frequency

Medication	Dosage	Frequency	Medication	Dosage	Frequency

SURGICAL/HOSPITALIZATION: ☐ **See Attached List**

Operation(s)	Year	Hospitalization(s)	Year

Screenings, if applicable: Mammogram within past 2 years, List date:
Colonoscopy within past 10 years, List date:_____________________________
Sigmoidoscopy within past 5 years, List date:_____________________________

Height:___________ **Weight:**___________

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you release a complete copy of my medical records to

Dr. ____

Address: _______________________________________

City: _________________________________, **FL** _____________

Phone: ____

Fax: ____

Name of Patient: ____

Address of Patient: ____

Date of Birth: ____

Signature of Patient or Representative: ____

Date: ________________________________

Print Name, if not Patient: ____

Records Requested From:

Name of Physician: ____

Address: ____

Phone: ____

Fax: ____

PERMISSION FOR VERBAL COMMUNICATIONS

____ ____

(Print name of patient) (Birth date)

____ ____

(Street address) (City, state, zip code)

____

(Phone number)

I permit Tampa Bay Surgical Group, its' physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care).

Name Phone Number Relationship

1. ____________________________ _________________________ ___________________________

2. ____________________________ _________________________ ___________________________

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from ______________________ (date) to ____________________ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office.

Patient's Signature: ____ Date: _____________________________

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ____

Relationship to Patient: ___________ ____

INSTRUCTIONS: Please print, sign and return to your surgeon's office.

Financial Policy and Assignment of Benefits

Patient Name: ____

Thank you for choosing Dr. ___________ as your health care provider. We are committed to providing you the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our Patient Information Form prior to seeing the physician. Payments for service are due at the time services are rendered. We accept cash, check, Visa, Discover and MasterCard. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility -- whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or limit your coverage by design.
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the end of treatment.
4. If you have a high deductible health plan, we may collect your deductible before your surgical procedure is performed.
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.
6. If your insurance company does not pay in full within 60 days, we require you to pay the balance by cash, check, Visa, Discover or MasterCard.
7. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney's fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you in the management of your account.

Lifetime Authorization

I hereby assign all medical and surgical benefits allowable and otherwise payable under my current insurance policy for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to Tampa Bay Surgical Group/Dr. Brown. I understand that I am responsible for any amount not covered by insurance, including applicable co-payments, deductibles, non-covered services, and unauthorized services, and agree to pay in a current manner.

I understand that Tampa Bay Surgical Group/Dr. Brown does accept assignment for Medicare and payments will be directed to Tampa Bay Surgical Group.

Should my account be referred for collection procedures, I also agree to pay reasonable attorney's fees and collection expenses.

I certify that I have read and understand the above, and as the patient, guarantor, or patient's responsible party, agree to and accept these terms.

Signature of Patient/Responsible Party   Date

Print Name/Relationship

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES (“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.

How We May Use and Disclose Health Information About You

1. We may use and disclose health information about you to:

a. Provide you with medical treatment or services (such as sharing information with a consulting physician who has been asked to examine your health information). We also may share health information about you with people who may be involved with your medical care. These people include family members (unless you object), home health agencies, nursing homes, or others we use to help provide services that are part of your ongoing care;

b. Bill and collect payment from you, an insurance company or a third party. For example, we may need to give a health plan information about a procedure performed on you so that they will pay us, or reimburse you, for the cost of the procedure. We also may share health information with our business associates who assist us with billing and collection. Our business associates include billing companies, claims processing and precertification companies, collection agencies, clearinghouses and others that process our health care claims.

c. Assist us with our healthcare operations. For example, we may use health information about you to review our treatment and services and/or to evaluate the performance of our staff. We may also share health information with our business associates that assist us with health care operations and perform other technical and administrative activities on our behalf. This may include e-prescribing gateways, patient safety organizations, health information exchanges, personal health records vendors, and others.

2. We may contact you to remind you that you have an appointment, to follow up on health care services that were provided to you, to tell you about treatment alternatives or to tell you about other health related benefits and services that may be of interest to you.

3. We may share health information about you with family members or friends whom you indicate are involved in your medical care. In certain disasters and related emergency situations, we share health information about you with disaster relief organizations (such as the Red Cross, etc.) so that your family can be notified about your condition, status and location.

4. In certain situations, we may use and share health information about you for research purposes. However, all research projects are subject to a special review and approval process designed, among other things, to ensure the privacy of your health information. We may disclose health information about you to people preparing to conduct research (for example, to help them look for patients with specific medical needs).

5. We may use or disclose health information about you without your permission only as allowed by law. Examples of situations where we may be required to release health information about you include: emergencies, public health, health or safety threats, reporting abuse or neglect, health over sight and audit activities, national security, coroners, medical examiners, funeral directors, organ/tissue donation, and workers’ compensation. We also may be required by law to provide health information about you in response to requests from law enforcement officials in limited circumstances, correctional institutions, or as part of legal proceedings in response to valid judicial or administrative orders and/or other valid legal authority.

Other Uses of Health Information

Uses or disclosures of your health information that are not covered by this Notice or the law will be made only with your written permission. (This includes those used for marketing purposes other than materials sent to you about health care services or other treatment options). In further support of your right to privacy, we cannot accept your blanket authorization to disclose health information for treatment you have not yet received. If you permit us to use or share health information about you, you may take back that permission, in writing, at any time. If you take back your permission, we will no longer use or share the health information you specified for the reasons you noted in writing. You understand that when you take back your permission we are unable to retrieve any information we may have already shared with your permission. We also are required to maintain original records of the care that we provide to you.

Your Rights Regarding Health Information About You

1. You have the right to see and receive a copy of health information about you. To do so, you must submit your request in writing. If you request a copy, it must be requested in advance and we may charge a fee for the cost of copies, postage and/or other supplies. In certain situations, we may

deny your request. If we deny your request, we will tell you, in writing, why your request was denied and explain to you your right to have the denial reviewed.

2. You have the right to receive a clinical summary of your office visit. To do so, simply request this at the time of your visit. We will try to make this available to you within three business days.

3. You have the right to receive an electronic copy of your health information. If you request an electronic copy, it must be requested in advance and we may charge a fee for the cost of providing you a CD, USB drive, postage and/or other supplies. We may also provide you with access to a Universal Health Record, which allows you to create, maintain and share your health record electronically.

4. If you feel that our record of your health information is incorrect or incomplete, you have the right to request to amend the information. You may do this by sending your request in writing, including your reason for the request. We may deny your request if the information was not created by us, is not part of the health information maintained by us, or if it is determined that the health information is correct. You may appeal our decision by sending a written request to us.

5. You have the right to request a list of all of our disclosures of your health information, except for information disclosed for treatment, payment or health care operations, or for those disclosures you specifically authorized and for certain other activities. To request this list, you must send your request in writing. Your request must tell us a specific time period (beginning after April 14, 2003) of not more than six years. The first disclosure list you request in any 12-month period is free. We may charge a fee for additional lists.

6. You have the right to ask that we limit how we use and disclose health information about you. You may do so by submitting a request in writing, telling us how and what information to limit. We will consider your request but we are not legally required to accept it. We also are not required to agree to your request. If we do agree, we will follow your request unless the information is needed to provide you with emergency treatment.

7. If you pay all of your bill out-of-pocket, you may request that we do not share treatment information with your health plan.

8. You have the right to ask us to send information to you at a different address (for example, sending information to your work address instead of your home address) or in a different way (for example, in an unmarked envelope instead of our regular mailing envelope), or to a third party. You may do so by sending a request in writing, and identifying where to send the information. We have the right to decide whether the request is reasonable. We do not have to comply with an unreasonable request.

9. You have the right to be notified of any breaches to your information.

10. We may share decedent information about you with family members and others involved in your care.

11. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Complaints

If you feel that your privacy rights have been violated, you may file a complaint by calling our office manager at ___________________or with Tampa Bay Surgical Group's Administrative Office at 2901 W. Busch Blvd., Ste. 707, Tampa, FL 33618. You also may file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Changes to this Notice

We reserve the right to change this Notice and our privacy policies at any time. Before we make an important change to our policies, we will promptly revise this Notice and post a new Notice. Any changes will apply to the health information we have on file and health information we create or receive after the effective date of the new Notice. You may request a copy of the current Notice from our office. The effective date of this Notice is: April 1, 2013.

Patient Name (Print):____ Date of Birth:_________________________

Signature of Patient/Legal Representative:_______________________________________ Today's Date:______________

If Legal Representative, List Relationship to Patient:____