veriMED Health Group
Riverview
9366 Balm Riverview Rd. Riverview, Fl. 33569
Office (813) 672-3200 Fax (813) 672-3202

Please Print

Today's Date _____ Prior Physician _____

Whom may we thank for referring you to us? _____ Phone: _____

Patient's Name _____ DOB _____ Age _____

Mailing Address _____ Sex:____ Male____ Female

_____ Social Security # _____

Home Ph. _____ Work Ph. _____

Pharmacy Name/City:_____/_____ Pharmacy telephone #:_____

Race:_____ Ethnic:_____ Language:_____ Dominant Hand:_____

Has any member of your immediate family been treated by us before? _____

Who is financially responsible for this bill? _____ Employer: _____

Employer Address: _____ Ph. _____ Occupation: _____

Driver's License #/State _____/_____ DOB _____ SS# _____

Insurance Company: _____ Policy # :_____

Group#:_____ Insurance Claims Address_____

Secondary Insurance _____ Policy # _____

Group#_____ Insurance Claims Address _____

Marital Status _____ Spouse DOB: _____ Spouse SS# _____

Spouse Name _____ Employer _____ Ph. _____

Insurance Company _____ Policy # _____

Group # _____ Insurance Claims Address _____

Nearest relative not living with you: _____ Ph. _____

Address _____

May we contact the above person in case of emergency:_____ Yes _____ No

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the best medical care possible. This for will be reviewed with you during your visit.

General

Name:	DOB:	SS#
Date of your last complete physical exam?	Date of your last chest X-ray?	
Date of your last cholesterol screening?	Date of your last dental exam?	
Date of your last eye exam?	Date of your last colonoscopy?	
Women	**Men**	
Date of last mammogram?	Date of last PSA?	
Date of last pap smear?	Date of last rectal/prostate exam?	

Immunizations:		Pneumonia	
Measles – Mumps- Rubella (MMR)	Date:	Hepatitis B	Date:
Tetanus and diphtheria toxoids (Td)	Date:	Influenza	Date:

Past Medical History: (check those that apply)

	AIDS or HIV+		Chicken Pox		Measles		Rheumatic Fever
	Blood or Plasma Transfusions		Epilepsy		Mumps		Scarlet Fever
	Cancer		Infectious Mononucleosis		Polio		Whooping Cough

Hospital/ Surgical History:

Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

Allergies: Please list any drug, food, contact, or environmental substances to which you have had an allergic or bad reaction.

Medications:

Please list any prescription medications, over the counter medications, vitamins, herbs, or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1)	4)	7)
2)	5)	8)
3)	6)	9)

Social History:

Occupation:				Marital Status:					
Do you exercise Regularly?	YES	NO	What type?			How often?			
Do you smoke?	YES	NO	I currently smoke packs per day.			I have smoked for years.			
I formerly smoked but stopped in: (list yr)			Do you wear seat belts?	YES	NO	Do you drink alcohol? How often/how much?	YES	NO	
Do you use other forms of tobacco? How often/how much?	YES	NO	Do you use illicit drugs? How often/how much?	YES	NO				
Do you have any risk factors for HIV infection?	YES	NO	Have you ever been exposed to anyone w/ tuberculosis?				YES	NO	
Have you had excessive exposure to the sun because or your work or recreation?							YES	NO	
Are you currently experiencing unusual stress?	YES	NO	Explain:						
Are there any environmental risks involved in your job or home environment?	YES	NO	Explain:						

Family History:	Relationship		Relationship		Relationship
Anemia		Epilepsy		High cholesterol	
Asthma		Glaucoma		Kidney disease	
Obesity		Leukemia		Thyroid disease	
Cancer		Depression		High blood pressure	
Diabetes		Heart disease		Alcohol problems	
Stroke		Lung disease		Bleeding Tendency	

Present Age or Age of Death:	Mother:	Father:
Sibling #1	Sibling #2	Sibling # 3

Women Only: Menstrual Period Onset: Regular? YES NO Date last period began:

Age at menopause:	Difficulty w/ periods? YES NO	Specify:			
Pregnancies/No. of children:	Born alive:	Cesarean:	Premature:	Stillborn:	Miscarriages:
Describe complications:					

Do you have any pending medical procedures? _____

If any pending medical procedures, please explain: _____

_____

General Questions

Weight loss
Weight gain
Change in Sleep patterns
Change in activity capacity

Neurological and Psychiatric

Anxiety
Headaches
Depression
Meningitis
Paralysis
Seizure
Stroke
Tingling
Tremors
Memory Loss
Fainting spells, dizziness
Head injuries
Blackouts or near blackouts
Change in sensation anywhere on your body
Localized weakness or numbness

Ears, Eyes, Nose & Throat

Hay fever
Glaucoma
Polyps
Allergy
Cataracts
Goiter
Hoarseness
Double vision
Gum problems
Eye problems
Ear infections
Glasses/contacts
Ear discharge/pain
Frequent nosebleeds
Ringing in your ears
Sinus infections
Swollen glands

Cardiovascular

Angina
Leg cramps
Ankle swelling
Awakening at night short or breath & getting out of bed
Cardiac catherization
Cold hand or feet
Congenital heart defects
Dizziness when standing up quickly
Heart attacks
Heart failure
High or low blood pressure
Irregular heart rate
Purple fingers or lips
Leg pain that resolves w/ rest
Heart palpitations
Varicose veins
Chest pain
Murmurs

Respiratory

Pleurisy
Asthma
Breathlessness when lying flat
Prolonged cough
Coughing up blood
Emphysema
Shortness of breath
Tuberculosis
Pneumonia
Frequent infections(bronchitis)
Wheezing

Skin

Abscess
Acne
Boils
Hives
Lumps
Jaundice
Athletes foot
Excessive body odor
Excessive sweating
Fungal infections
Nail problems
Moles – irregular
Moles – change/new
Dandruff
Oily skin
Rashes
Dry skin
Psoriasis

Kidney & Urinary Tracts

Blood in urine
Brown in urine
Dribbling after urination
Painful urination
Excessive thirst
Involuntary urination/incontinence
Urinating frequently (day)
Urinating frequently (night)
Urine hesitancy
Weak flow
Frequent bladder infections
Kidney disease
Kidney stone

Endocrine

Diabetes
Abnormal body hair
Changes in skin texture
Cold intolerance
Heat intolerance
History of “borderline” diabetes
Increased loss of hair
Rheumatism
Thyroid disease
Sickle cell

Male & female

Painful sexual intercourse
Loss of sexual interest
Unprotected sex
Groin itching
Sexually transmitted diseases

Males only

Hernia
Bloody ejaculation
Inability to complete intercourse
Lump on testicle
Penile discharge
Premature ejaculation
Problems maintaining or keeping an erection
Prostate disease
Sores on penis or warts
Testicular pain
Testicular swelling
Sterility

Musculoskeletal

Anemia
Back pain
Gout
Neck pain
Abnormal blood counts
Blood clots in legs/lungs
Bone marrow biopsy
Easy bleeding
Easy bruising
Joint swelling
Morning stiffness
Muscle aches
Arthritis
Bursitis
Joint aches
Tendonitis

Gastrointestinal

Diarrhea
Reflux
Ulcers
Hepatitis
Abdominal pain
Anal fissures
Black tarry stools
Vomiting blood
Constipation
Nausea
Problems swallowing
Hiatal hernia
Intestinal obstruction
Liver disease
Hemorrhoids
Red blood after bowel movements
Gallstones
Vomiting
Heartburn
Indigestion

Females Only

D+C
Hernia
Abn. bleeding between cycles
Abnormal pap smear
Bleeding after intercourse
Complication w/ pregnancy
PMS
Endometriosis
Heavy bleeding during cycles
Discharge from breast
Ovarian cysts
Pelvic inflammatory disease
Postmenopausal symptoms
Vaginal discharge
Vaginal dryness
Vaginal warts
Hot flashes
Fibroids

Provider Notes _____

_____

_____

_____

_____

Provider Signature **Date**

PLEASE CIRCLE EACH CURRENT SYMPTOM YOU HAVE

Financial Policy

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and understating of our payment policy.

Payments for Service is Due at Time Services are Rendered: We accept cash, credit card, and personal checks. Returned checks less than $50.00 is subject to a service charge (per Florida statute 832.08) of $25.00. Checks between $50.00 and $300.00 have a fee of $30.00. For check greater than $300.00, the fee is $40.00. You may also lose your privilege to write checks in our office.

Cancelled Appointments: Please provide at least 24 hours notification if an appointment must be cancelled. Patients who do not cancel appointments may be charged a fee and discharged from the practice after the third no-show.

Contracted Coverage: Co-payment and Deductible must be paid at the time of service. Because we are under contract with specific insurance companies, we will file your insurance claim directly.

Medicare: You are responsible for your annual $147.00 deductible and 20% of the allowable charges due at the time of service, unless you have supplementary insurance.
Please bring your Medicare Explanation of Benefits (EOB) showing that you have met your deductible.

HMO/MCO: If you are required to select a PCP by your insurance carrier, then you must change your PCP prior to scheduling an appointment with our office. If this is not done and your insurance carrier declines payment you will be responsible for the office visit in full based on our fee schedule.

Financial Agreement: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company.

All charges are your responsibility from the date services are rendered.
Any balance on your account after 90 days, including those that insurance has not paid, may result in a collection action. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, **please contact our billing staff promptly for assistance in the management of your account.** We are willing to work with you on setting up a payment plan.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above referenced information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above financial policy.

Signature_____**Date**_____

Welcomes You!

We realize that time is as important to you as it is to us. We adhere to our appointment schedule as closely as possible. However, due to the unpredictable nature of medical care, unexpected delays may occur. We trust that you will understand.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS
I hereby authorize the release of any medical information required in the course of my treatment necessary to process insurance claims. I also, authorize payment of medical benefits to *veriMED Health Group Riverview* for medical services rendered in the course of my treatment. I understand that I am personally responsible for payment in full for all expenses incurred for services rendered.

PATIENT SIGNATURE: _____ (guardian if patient is a minor)

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with: ( ) Spouse ( ) Children ( ) Other

Name(s):_____

Please list the family members or significant others, if any, whom me may inform about your medical condition.
ONLY IF AN EMERGENCY:

Name: _____ Phone Number:_____
Name: _____ Phone Number:_____

Please print the address of where you would like your billing statement and/or correspondence from our office to be sent if other than your home.

_____

_____

_____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked, "**CONFIDENTIAL"**
( ) YES ( ) NO
I authorize the pick-up of my medical records/prescriptions/test results by:
( ) Spouse ( ) Children ( ) Other

Name(s):_____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health information if other than your home phone number:_____

I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE
Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?
( ) YES ( ) NO
This authorization is only valid for the person(s) I have listed above.
PATIENT SIGNATURE: _____ DATE:_____
(Guardian, if patient is a minor)

WITNESS SIGNATURE: _____ DATE:_____
(Staff employee/office manager)

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

□ I have made such declaration.
□ I have NOT made such a declaration.

Health Care Surrogate

□ I have designated a Health Care Surrogate.
□ I have NOT designated a Health Care Surrogate.

Durable Power of Attorney

□ I have appointed a Durable Power of Attorney for Health Care decisions.
□ I have NOT appointed a Durable Power of Attorney for Health Care decisions.

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

_____ _____-- --_____
Please Print Full Name Social Security Number

_____ _____
Signature Date

Relationship of Patient Representative (If applicable) : _____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

_____ _____
Signature of Patient or Patient Rep. Date Signature of Patient or Patient Rep. Date

_____ _____
Signature of Patient of Patient Rep. Date Signature of Patient of Patient Rep. Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Rep: _____ Date: __________

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your healthcare provider or health care facility recognize your rights while you are receiving medical care and respect that health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy or full text of this law from your health care provider or facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to who what support services are available, including whether an interpreter is available if he or she doesn't speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources to his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of reasonable clear and understandable, itemized bill, and upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation or his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or facility in which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information and present complaints, past illnesses, hospitalizations, medications, and other matter relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or facility.

A patient is responsible for his or her actions if he or she refuses treatment or foes not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

PATIENT SIGNATURE:_____ **DATE:**_____

veriMED Health Group
Riverview

AUTHORIZATION FOR USE OR DISCLOSURE OF INFO

I, _____, herby authorize

_____
(Name of Physician or Group Practice requesting medical information from)

_____ To disclose the following protected health information outlined below to:
veriMED Health Group Riverview • 9366 Balm Riverview Road • Riverview, Florida 33569
Phone • (813) 672-3200 • Fax (813) 672-3202
Description of records requested: _____
_____
IF MORE THAN TEN PAGES PLEASE MAIL

This protected health information is being used or disclosed for the following purposes: _____
_____

This authorization shall be in force and effect for one year from _____
Date
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **veriMED Health Group Riverview** • 9366 Balm Riverview Road • Riverview, Florida 33569 • Phone • (813) 672-3200 • Fax (813) 672-3202

I understand that a revocation is not effective to the extent that _____
Provider requesting records from
has relied on the use of disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

veriMED Health Group Riverview, will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provider authorization for the requested use or disclosure. I understand that I have the right to:
• Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

The use or disclosure requested under this authorization will result in direct or indirect remuneration to **veriMED Health Group Riverview**, from a third party. (If applicable)

_____ DOB: _____
Signature of Patient or Personal Representative

_____ Date: _____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority