

verMED Health Group

South Tampa

Our Physician is always available through our answering service.

Please call (813) 871-2959.

Answering Service is available 24-hours

OFFICE HOURS

Monday-Friday 8:00 am – 5:00 pm

Lunch Daily 12:00 pm-1:00 pm

APPOINTMENTS PREFERRED

*****All non-emergent walk-ins will be seen after scheduled patients*****

EMERGENCIES: Prior authorization must be obtained for all emergencies.

In the event of a ***LIFE THREATENING EMERGENCY CALL 911*** for the emergency transportation to the nearest emergency facility.

HOSPITALS: **Memorial Hospital of Tampa**

2901 W Swann Ave
Tampa, FL 33609
Phone: (813) 873-6400

St. Joseph's Hospital

3001 W Dr. Martin Luther King Jr Blvd
Tampa, FL 33607
Phone: (813) 870-4000

PRESCRIPTIONS: For your convenience you may fill your prescriptions at any local Pharmacy. ***Please give 48 hours notice to have your prescription refilled. After hours, your prescription cannot be filled because your medical records are not accessible.***

REFERRALS: Prior authorization must be given by verMED Health Group South Tampa before an initial appointment to a specialist may be scheduled. Continued authorization must be received for any follow-up appointments which may be necessary.

*****PLEASE ALLOW 7-10 BUSINESS DAYS FOR YOUR INSURANCE TO AUTHORIZE ANY REFERRALS*****

verMED Health Group

South Tampa

2919 Swann Avenue • Suite 400A • Tampa Florida 33609

(813) 871-2959 Telephone (813) 877-8891 Fax

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

Past Medical History: (check those that apply)

<input type="checkbox"/> AIDS or HIV+	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood or Plasma Transfusions	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Infectious Mononucleosis	<input type="checkbox"/> Polio	<input type="checkbox"/> 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?	YES	NO	
Do you use other forms of tobacco?	YES	NO	How often/how much?	Do you use illicit drugs?	YES	NO	How often/how much?			
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 of 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	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 # 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: _____

<p>General Questions</p> <p>Weight loss Weight gain Change in Sleep patterns Change in activity capacity</p> <p>Neurological and Psychiatric</p> <p>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</p> <p>Ears, Eyes, Nose & Throat</p> <p>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</p>	<p>Cardiovascular</p> <p>Angina Leg cramps Ankle swelling Awakening at night short or breath & getting out of bed Cardiac catheterization 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</p> <p>Respiratory</p> <p>Pleurisy Asthma Breathlessness when lying flat Prolonged cough Coughing up blood Emphysema Shortness of breath Tuberculosis Pneumonia Frequent infections(bronchitis) Wheezing</p> <p>Skin</p> <p>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</p> <p>Dry skin Psoriasis</p>	<p>Kidney & Urinary Tracts</p> <p>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</p> <p>Endocrine</p> <p>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</p> <p>Male & female</p> <p>Painful sexual intercourse Loss of sexual interest Unprotected sex Groin itching Sexually transmitted diseases</p> <p>Males only</p> <p>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</p>	<p>Musculoskeletal</p> <p>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</p> <p>Gastrointestinal</p> <p>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</p> <p>Females Only</p> <p>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</p>
<p>Provider Notes _____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
<p>Provider Signature _____</p>		<p>Date _____</p>	

PLEASE CIRCLE EACH CURRENT SYMPTOM YOU HAVE

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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 know 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 of 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 does 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: _____

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South Tampa

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** _____

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 or Patient Rep.

Date

Signature of Patient or 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: _____

verMED Health Group South Tampa

AUTHORIZATION FOR USE OR DISCLOSURE OF INFO

I, _____, hereby authorize

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

_____ To disclose the following protected health information outlined below to:

verMED Health Group South Tampa • 2919 Swann Ave • Suite 400A • Tampa, Florida 33609
Phone • (813) 871-2959 • Fax (813) 877-8891

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 **verMED Health Group South Tampa**•2919 Swann Ave•Suite 400A•Tampa, Florida 33609

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.

verMED Health Group South Tampa, 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 **verMED Health Group South Tampa**, from a third party. (If applicable)

Signature of Patient or Personal Representative

DOB: _____

Print Name of Patient or Personal Representative

Date: _____

Description of Personal Representative's Authority

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South Tampa

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 verMED Health Group South Tampa 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)

AUTHORIZATION FOR OTHER USES OF
PROTECTED HEALTH INFORMATION [PHI]

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1009 [HIPPA]

Specific description of the information to be used or disclosed, including the specific purpose:

Individuals who may use or disclose this information:

Expiration date of this authorization: _____

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize veriMed Health Group South Tampa to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization, in writing, signed by you at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of veriMED health Group South Tampa.

This authorization was signed by: _____

In front of: _____

Witness: _____
Name Date

By: _____
Patient or Representative

Relationship to patient [if other than patient]: _____

Date: ____/____/____