PATIENT INFORMATION

Patient Name: (Last) _____ (First) _____ (MI) _____

Patient address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Date of Birth: _____ Sex: M F Social Security #: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian ☐ Black of African American ☐ Hispanic ☐ White ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Do you require a translator? ☐ Yes ☐ No

EMPLOYER INFORMATION

Employer: _____ Job Title: _____

Employer Address: _____

Work Phone: _____ ext: _____

EMERGENCY CONTACT

In case of a medical emergency please notify:
Name: _____ Contact Number: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Subscriber/Policy #: _____ Group #_____

Subscriber Name: (Last) _____ (First) _____

Welcome to our office:

My staff and I would like to welcome you to our office. We work as a team with the goal of providing thorough medical care. We are always working to improve our care and service in any way possible. An internal medicine practice encompasses quality care and covers a vast range of medical problems. This allows for continuity of care for you as a patient, I will work with you to ensure you receive the best quality care you need.

Insurances

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Dr. Ananda Som, MD, Medical Center on the Gulf, LLC. I acknowledge that I am financially responsible for the payment whether or not covered by my insurance. This authorization shall continue until such time as I revoke it in writing.
_____(initials)

Appointments

Please make appointments so my staff can schedule the time needed for your concerns. If cancelling an appointment, please allow 24 hours notice. Cancelling without appropriate notice would cause other patient to be denied an appointment when they might otherwise be seen. Your cooperation and consideration in these matters would be appreciated. Please bring ALL medications you are currently taking and pertinent medical history information to each appointment. This will greatly aid in accurate evaluation of your problem and may save unnecessary delays in your treatment.
_____ (initials)

Telephone Calls

Our office telephones are very busy and you will occasionally be asked to hold for a brief period. Please be patient with this. I receive many calls during the day and it is unfair to the patients who have scheduled appointments to continually interrupt me for telephone calls. Therefore, the receptionist will usually take a message and your call will be returned at the end of the day. Please inform the receptionist if your problem is urgent and they will let me know.
_____ (initials)

Prescriptions

If you wish a refill of a prescription that you are already taking, you should call the pharmacy and the pharmacist will call or fax our office for an OK to refill at least 48 hours before you completely run out. You cannot have medications refills for a condition not currently being treated. Narcotics and antibiotics are not refillable prescriptions and require an office visit to be made 48 hours in advance. Request for Prescription refills will be responded to only during office hours.
_____ (initials)

Financial Policy

If you have a health plan we will bill them directly. Deductibles will be billed when they become due or when your insurance notified us. Co-payments are due at the time of service is rendered. We do not carry balances for patients. We accept cash, most checks, and credit cards. There will be a $30 fee charged for all checks returned with non-sufficient funds.

_____ (initials)

Emergencies

If you have an emergency situation during office hours please call first so you can receive a prompt treatment as possible and all the staff to adjust the days schedule. Call 911 for a serious emergency. If you choose to call the office after regular office hours you will reach the answering service which directs your call according to my instructions. The practice has 24 hours physician coverage. Please do not call the answering service to request refills on your prescriptions.

_____ (initials)

I have read, initialed, and understood the above policies

X_____ _____

Patient signature Date

MEDICAL RECORDS RELEASE FORM

Patient: _____ DOB: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

I AUTHORIZE RECORDS RELEASE FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Type of Extent of Information (circle all that apply)

- Imaging studies within the last ONE year (DEXA, Mammogram, CXR, CT, MRI, ext.)
- Lab and/or pathology results from the last 12 months
- Last 3 office visit notes, last physical, immunization records
- Hospital discharge summaries from last 12 months

I hereby authorize and request that you release my medical records to Dr. Ananda Som, MD as specified above. I understand that my records may contain information regards drug, alcohol and communicable disease which are protected by Federal Law (42CRF Part 2) and cannot be disclosed without written consent, unless otherwise provided in the federal regulations. I also understand that I may revoke this consent in writing any time. My signature also means that I have read this form and/or have had it read to me, and explained in a language that I can understand. I also understand that there is a potential for my records to be disclosed by the recipient.

This authorization expires one year from the date it is signed.

_____ _____

Signature of Patient Date

PREVIOUS PHYSICIANS

Please fill in previous doctor's information so we may obtain your prior records including specialists.

Previous Primary Care Physician: _____ Phone #: _____

Previous Cardiologist: _____ Phone #: _____

Previous Gastroenterologist: _____ Phone #: _____

Previous Endocrinologist: _____ Phone #: _____

Other Physician: _____ Phone #: _____

Other Physician: _____ Phone #: _____

Other Physician: _____ Phone #: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPAA)

"This notice describes how medical information about you may be used and disclosed and how you may get access to this information." Please review it carefully!

We safeguard information about your health and person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance, and other non-office personnel have no access to the chart area. Services technicians may have access to the computer, but only for services of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurances and for healthcare options. Outside our office, we restrict the disclosure to those people, entities and agencies for which you authorize disclosure such as other healthcare providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect, domestic violence, problems with products reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster relief

We will not use of disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorizations you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your records. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosure made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosure noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be give with all new patient packets.

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of the Medical Center on the Gulf health care operations. This also describes my rights and the duties of Medical Center on the Gulf with respect in protected health information. Medical Center on the Gulf reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy of the revised Notice of Privacy Practices by calling the office at 727-738-0220 and requesting a copy to be sent to me via mail or electronically providing I have an email consent on file.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

PATIENT EMAIL COMMUNICATION CONSENT

Medical Center on the Gulf, LLC is dedicated to keeping your medical record information confidential. Despite our best efforts and due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you should take into consideration that your email communication is not always confidential. In addition, you should be aware that, although your intended email is addressed to your physician, his/her staff and/or colleagues would have access to this information as well.

I understand that this office will not be responsible for information loss, delay, or breaches in confidentially that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below I agree Medical Center on the Gulf, LLC may send medical related correspondence to me via email and that they may respond to my email communication at the following email address (es):

_____ or _____

☐ Yes ☐ No I would like to participate in the patient portal access program allowing me to have access to my medical information and communicate with the office via the web. Please activate my account with the above email address. I understand that a link to register will be sent to me via email.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by **Dr. Ananda Som, MD** deemed advisable and necessary in the diagnosis and treatment of any condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any past/current medical records that are needed for my treatment from any prior healthcare providers.

_____ _____

Signature of Patient Date

AUTHORIZATION AND ASSISGNMENT

I request that the payment of authorized medical insurance benefits be made either to me or on my behalf for any services furnished by **Medical Center on the Gulf, LLC**. I authorize any holder of medical information about me to release to insurance carriers and its agents to any information needed to determine these benefits or benefits related to services.

I hereby authorize **Medical Center on the Gulf, LLC** to furnish information to medical insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier to make payment directly to **Medical Center on the Gulf, LLC** for medical/diagnostic/surgical benefits payable for the services rendered.

I understand that any unpaid balance not covered by this policy will be payable to me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that my insurance carrier do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to **Medical Center on the Gulf, LLC** for services rendered. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

_____ _____

Signature of Patient Date

VOICE MESSAGES

☐ Yes ☐ No Messages may be left on my answering machine/voicemail regarding my health and appointments made.

_____ _____

Signature of Patient Date

DESIGNATED RELATIVE

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

☐ Spouse ☐ Children ☐ Other: _____

Please list the family members or significant others, if any, whom we may inform about your medical condition, and/or in case of an emergency

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #:_____

MEDICAL HISTORY

Last Name: _____
First Name: _____

Do you have a present or past history of:
(Check all that apply)

Head/ Neurological
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Concussion/ Head Injury
- ☐ Dizziness/ Fainting
- ☐ Insomnia/ Sleep Issues
- ☐ Neuromuscular Disorder
- ☐ Weakness/ Paralysis
- ☐ ADD/ ADHD
- ☐ Seizures/ Epilepsy
- ☐ Other: _____

Eyes
- ☐ Eye Injury/ Disease
- ☐ Other: _____

Ear, Nose, & Throat
- ☐ Seasonal Allergies
- ☐ Hearing Loss/ Deafness
- ☐ Frequent Ear Infections
- ☐ Repeated Nosebleeds
- ☐ Sinus Infections
- ☐ Frequent Sore Throats
- ☐ Tonsils/ Adenoids Surgery
- ☐ Other: _____

Lungs
- ☐ Asthma
- ☐ Exercise-Induced Asthma
- ☐ Chronic Cough
- ☐ Bronchitis or Pneumonia
- ☐ Other: _____

Infections
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Mononucleosis
- ☐ Positive TB Skin Test
- ☐ Meningitis
- ☐ Other: _____

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ History of Palpitations
- ☐ Chest Pain
- ☐ Other: _____

Gastrointestinal
- ☐ Constipation
- ☐ Stomach Problems/ Ulcers
- ☐ Requires Special Diet
- ☐ Hepatitis
- ☐ Gallbladder Bowel Prob.
- ☐ Hernia
- ☐ Other: _____

Endocrine
- ☐ Diabetes
- ☐ Sudden Weight Change
- ☐ Thyroid Problems/Disease
- ☐ Other: _____

Genitourinary
- ☐ Urinary Tract Infection
- ☐ Kidney Stone or Disease
- ☐ STD's or STI'S
- ☐ Other: _____

Musculoskeletal
- ☐ Arthritis
- ☐ Fracture or Dislocations
- ☐ Back/ Disc Problems
- ☐ Scoliosis
- ☐ Other: _____

Women's Health
- ☐ Ovarian Cysts
- ☐ Pelvic Infection (PID)
- ☐ Pregnancy
- ☐ Recurrent Vaginal Infections
- ☐ Menstrual Irregularity
- ☐ Severe Cramps
- ☐ Abnormal Pap Smear
- ☐ Breast Problems
- ☐ Other:_____

Blood Disorder
- ☐ Anemia/ Low Iron
- ☐ Sickle Cell Trait/ Disease
- ☐ Clotting Disorder
- ☐ Other: _____

Mental Health
- ☐ ADHD/ ADD
- ☐ Alcohol or Drug Abuse
- ☐ Anorexia and/or Bulimia
- ☐ Anxiety/ Pain Disorder
- ☐ Depression
- ☐ Learning Disability
- ☐ Suicide Attempt
- ☐ Other: _____

☐ **No known medical problems**

SURGICAL/ HOSPITALIZATIONS HISTORY

Surgery	Date

ALLERGY HISTORY include drug and non-drug allergies

Allergy	Reaction

CURRENT MEDICATIONS

Medication	Strength/ Dose	Frequency

FAMILY HISTORY Please indicate member of family: mother, father, sister, brother, grandparents, etc.

Type of Illness	**Family Member**	**Alive/Deceased**	**Family Member**	**Alive/ Deceased**
Heart Disease				
High Blood Pressure				
Stroke				
Diabetes or Sugar Problems				
Cancer (list type)				
Bleeding Problems				
Kidney Problems				
Hearing Loss				
Dizziness				
Cholesterol Problems				
Other				

SOCIAL HISTORY

Do you have children? ☐ Yes ☐ No If yes, how many _____

Female Only: Are you pregnant now? ☐ Yes ☐ No

Do you smoke of chew tobacco? ☐ Yes ☐ No

If YES, how many pack(s) ____ ☐ Day ☐ Week

If NO, have you ever smoked or chewed tobacco?

☐ Yes, I quit _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago

Do you consume alcohol? ☐ Yes ☐ No

If YES, how often? ☐ Frequently ☐ Socially ☐ Occasionally

If YES, what type of alcohol? ☐ Beer ☐ Wine ☐ Liquor

OTHER NOTES

When was your last physical exam? _____

Females Only:

When was your last menstrual cycle? _____

When was your last pap smear? _____ ☐ Normal ☐ Abnormal

Any other medical history or concerns you would like to bring up to the doctor today?

_____

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PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several Day	More than half the days	Nearly Every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling, down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired of having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper, or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Electronic Medical Records

Consent to share my health information with the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (**BayCare eHX**) is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance, and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals, and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate that operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this consent form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent to deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the "**I GIVE CONSENT**" box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the "**I DENY CONSENT**" box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information above before making your decision.

Your consent choices: You can fill out this form now or in the future. You have two choices:

☐ **YES , I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this consent form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in the consent form.**

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date

NO SHOW/ CANCELLED APPOINTMENTS

A **$25.00 FEE** will be charged for all no show appointments and appointments that are cancelled without giving a 24 hours notice.

Insurance will not cover this fee. Patients will be personally responsbile for the full **$25.00**

Please make sure you notify us **ASAP** if you are unable to make it to your scheduled appointment time.

Thank you in advance,

Dr. Som and Staff

_____ _____

Signature of Patient Date