Florida Medical Clinic
Your life. Our specialty.

Florida Medical Clinic
2237 Twelve Oaks Way Suite 103,
Wesley Chapel, FL 33544 (813) 973.1304

www.FMCMindBody.com

mind body integrated
Wellness from Within

Preparing for your appointment

These directions will help you get the most out of your time at your upcoming appointment with Dr Trivedi. Please read these instructions carefully and use the checklist below to prepare for your appointment.

Also, please see Dr. Trivedi in his on-line video welcome message on his website:

www.FMCMindBody.com

1. Please sit in a quiet place without interruptions to carefully review and complete the attached forms.
2. Carefully review each item and complete all of the attached forms. The information you provide is necessary for your doctor to customize your treatment specifically for you.
3. Plan to spend up to 2 hours at your initial appointment with your treatment team.
4. Please bring the following items to your appointment:

- ❑ Completed pre-evaluation forms.
- ❑ ALL of your current medication bottles.
- ❑ Current pharmacy information.
- ❑ ALL recent lab results and prior testing reports. (i.e. psychological testing reports, school records, vocational testing reports, etc.)
- ❑ Prior Psychiatric treatment records.
- ❑ Contact information for all of your treatment providers.
- ❑ Please feel free to bring to your appointment someone who has been involved in your treatment or who knows you well or is supportive of your wellness.

If you have any questions, please contact us at 813.973.1304. We look forward to seeing you at your appointment.

***** If you need to cancel the appointment for any reason, give us a 48 hour notice. If you fail to call and miss an appointment, you will NOT be rescheduled for another appointment.**

- Your MindBody Integrated Team

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PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____

LOCAL ADDRESS _____ DATE OF BIRTH _____/_____/_____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SOCIAL SECURITY _____ CELL PHONE ( ) _____

ETHNICITY: ___ NOT HISPANIC/LATINO ___ HISPANIC/LATINO ___ REFUSED HOME PHONE ( ) _____

RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___WHITE WORK PHONE ( ) _____

___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

___ OTHER ___OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

PREFERRED LANGUAGE _____ PHONE ( ) _____

____ MARRIED ____ SINGLE ____WIDOWED ____ DIVORCED EMPLOYER _____

____ EMPLOYED ____ RETIRED ____ FULL TIME STUDENT ADDRESS _____

PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ HOME PHONE ( ) _____

RELATIONSHIP _____ WORK PHONE ( ) _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE ( ) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT _____/_____/_____ Place of accident _____ How did accident happen? _____

CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME _____ EMPLOYER PHONE( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SIGNATURE _____ DATE _____

FLORIDA MEDICAL CLINIC, P.A.

Your Life, Our Specialty

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, P.A. *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The *Notice of Privacy Practices* for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This *Notice of Privacy Practices* also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices.*

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Medical Clinic, P.A.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials _____

Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPPA) and FMC's policies on use and disclosure of my protected health information.

_____ _____
Name of Patient Name of Guardian or Personal Representative

_____ _____
Signature of Patient Signature of Guardian or Personal Representative

_____ Florida Medical Clinic, P.A.
Date Zephyrhills, FL 33542

cg / FMC Consent for Treatment, Payment & Health Care Operations

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Patient's Personal History & Assessment

Date: _____

Name: _____Date of Birth: _____

Describe briefly why you are seeking treatment:

_____

_____

_____

Who were you referred by:_____

Have you had previous psychiatric treatment? Yes ____ No ____
If yes, when and where?_____

SOCIAL HISTORY:

Occupation:_____Are you retired? Yes ___ No ___ Disabled_____

Marital History: Single___ Married___ Divorced___ Separated___ Widowed___

Do you: Live alone___ Live with spouse___ Live with parents___

PERSONAL HABITS:

Have you ever smoked? Yes ___ No ___ Do you currently smoke? Yes ___ No ___

Check if you regularly drink:
Hard liquor: 1-3oz per day ___ Over 3oz per day ___

Beer: 1bottle per day___ 2 bottles a day___ 3 or more a day___

Have you ever used any of the following?
Marijuana:___ LSD:___ Heroin:___ Cocaine:___ Speed:___ Other:___

If so, are you currently using? Yes___ No ___ If yes, what are you using:_____

EDUCATION:
What is the highest grade you completed?_____

MEDICAL CONDITIONS:

List all medical diagnosis:

_____

_____

_____

_____

_____

Continue →

Name: _____Date of Birth: _____

MEDICATIONS:

Do you have any allergies? Yes ___ No ___

If yes, what: _____

What medications are you currently taking?

Name: Dose:

_____

_____

_____

_____

_____

Pharmacy Name: _____ Number: _____

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Readiness for Change Self Assessment

Many people think that a magic pill or a super-specialized doctor or therapist can remove all of their life's problems. This is certainly not true. Medicines are powerful substances that, when used properly, can be very helpful in overcoming problems. The provider, on the other hand, is an expert guide and an experienced coach. However, **it is the patients themselves ultimately who have the power within to heal themselves.**

A provider or a medicine CAN help the patient access and activate these natural abilities that each of person is born with. To access and activate this ability of the human body, the patients must push themselves into new frontiers of thinking, behavior and human interaction. These changes create new outcomes in their lives. When positive changes are sustained and perfected, healing and wellness happen naturally.

Complete the following self-questionnaire to assess your own readiness for making lasting positive changes.

None = 0	Trace = 1	Small = 2	Moderate = 3	Abundant = 4

Sense of necessity

How strongly do you desire change aimed at improving your situation?

0 **1** **2** **3** **4**

Ready for anxiety

How determined are you to work through your inner fears?

0 **1** **2** **3** **4**

Awareness

How good are you at identify problems about yourself without becoming emotional or defensive?

0 **1** **2** **3** **4**

Confronting the problem

How much courage do you have for focusing on your problems and facing them?

0 **1** **2** **3** **4**

Effort

How committed are you to being enthusiastic and persistent at making changes?

0 **1** **2** **3** **4**

Hope

How strongly do you believe that you can overcome your problems?

0 **1** **2** **3** **4**

Social support

How open are you to seeking support from a network of friends and adapting to changes in relationships?

0 **1** **2** **3** **4**

Now, add up all the numbers that you circled above to come up with a total score. _____
See the scoring guide below to determine your 'Readiness for Change.'

0 - 6
Change is unlikely unless the patient can shift where they are.

7 - 14
Change will be limited and slow. Patient must work to change the areas with lowest scores.

15 - 21
Change is steady and noticeable. Patient keeps eye on lowest scoring areas and constantly works to improve these.

22 - 28
Highly motivated. Change occurs easily.

The questionnaire is adapted from Fred J. Hanna, PhD's book titled
"Therapy With Difficult Clients: Using the Precursors Model to Awaken Change"

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Symptom Checklist Screen

Instructions: If you have experienced any of the following in an ongoing pattern, please check the appropriate box.

	Now	*In Past*
Feeling down/sad/empty most of day	☐	☐
Loss of interest & pleasure	☐	☐
Weight loss/gain; Appetite up/down	☐	☐
Insomnia or Sleeping too much	☐	☐
Feeling restless / Being slowed down	☐	☐
Lacking energy / Fatigued	☐	☐
Feeling worthless / guilty	☐	☐
Poor concentration, indecisiveness	☐	☐
Recurrent thoughts of death	☐	☐
Feeling ecstatic for no reason	☐	☐
Feeling irritable / easily angered	☐	☐
Grandiose/very high self-esteem	☐	☐
Feeling rested with < 3 hrs. of sleep	☐	☐
Talking too much, too loud, too fast	☐	☐
Thoughts going too fast	☐	☐
Being distracted	☐	☐
Doing too much at the same time	☐	☐
Excessive and reckless indulgence	☐	☐
Fail to pay attention, Carelessness	☐	☐
Can't concentrate	☐	☐
Don't listen	☐	☐
Don't finish things	☐	☐
Disorganized in tasks / activities	☐	☐
Avoid mentally challenging tasks	☐	☐
Often lose things	☐	☐
Easily distracted	☐	☐
Often forgetful	☐	☐
Restless, fidgety, squirm in seat	☐	☐
Can't stay seated when required	☐	☐
Run/climb in inappropriate places	☐	☐
Can't play quietly	☐	☐
Behave as if "driven by a motor'	☐	☐
Talk excessively	☐	☐
Answer before question is finished	☐	☐
Can't wait turn	☐	☐
Interrupt or intrude others	☐	☐
Lose temper often, Anger problem	☐	☐
Argue with Authority figures	☐	☐
Defy rules or request	☐	☐
Annoy people on purpose	☐	☐
Blame others for own mistakes	☐	☐
Easily annoyed by others	☐	☐
Often angry and resentful	☐	☐
Spiteful and vindictive	☐	☐
Bullying, threatening intimidating	☐	☐
Initiate fights, use weapons	☐	☐
Cruel to people / animals	☐	☐
Fire-setting, Theft	☐	☐
Legal Issues / Convicted of Crime	☐	☐
Drug use / Medication abuse	☐	☐
Drink alcohol regularly	☐	☐
Self-injuries behaviors (cutting, OD)	☐	☐
Tried to commit suicide	☐	☐

	Now	*In Past*
Feel nervous/worried more days than not	☐	☐
Hard to control worries	☐	☐
Very restless or on edge	☐	☐
Easily fatigued	☐	☐
Poor concentration / Mind goes blank	☐	☐
Irritability	☐	☐
Muscle tension	☐	☐
Trouble falling/staying asleep	☐	☐
Heart pounding / palpitations	☐	☐
Sweating	☐	☐
Trembling, shaking	☐	☐
Shortness of breath, smothering	☐	☐
Choking sensation	☐	☐
Chest pain, discomfort	☐	☐
Nausea or stomach distress	☐	☐
Feeling dizzy, lightheaded, faint	☐	☐
Feeling unreal / detached from self	☐	☐
Fear of losing control or going crazy	☐	☐
Fear of dying	☐	☐
Numbness, tingling sensations	☐	☐
Chills or hot flashes	☐	☐
Anxious where escape may be difficult	☐	☐
Avoid certain situations/places	☐	☐
Worry about having panic attacks	☐	☐
Change behavior due to panic attacks	☐	☐
Persistent, excessive & unreasonable fear	☐	☐
Afraid of something specific	☐	☐
Fear in social or performance situations	☐	☐
Avoiding feared situations or place	☐	☐
Recurrent anxiety provoking thoughts	☐	☐
Try to suppress w/ other thoughts/actions	☐	☐
Repetitive behaviors (checking, hand wash)	☐	☐
Repetitive mental acts (counting, etc.)	☐	☐
Have time-consuming rituals	☐	☐
Preoccupation with body size/shape	☐	☐
Fear of gaining weight while underweight	☐	☐
Binge-eating, Purge, Exercise excessively	☐	☐
Use of Laxatives to lose weight	☐	☐
Verbal abuse	☐	☐
Physical abuse	☐	☐
Sexual abuse	☐	☐
Experienced / witness severe trauma	☐	☐
Intrusive thoughts / flash - backs of trauma	☐	☐
Nightmares about trauma, poor sleep	☐	☐
Being vigilant / easily startled	☐	☐
Hearing voices that others can not	☐	☐
Seeing things that others can not	☐	☐
Paranoid, feel like being followed/watched	☐	☐
Thoughts about harming self or others	☐	☐
Previous psychiatric hospitalizations	# _____	

Name:_____ **Date Completed:**_____

Florida Medical Clinic, P.A.

Authorization to Use/ Disclose Protected Health Information

Patient Name:	DOB:
Account Number	SS#:

(Two Identifiers required)

I authorize the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure (fill in the name of the entity releasing/providing the records):

Florida Medical Clinic, P.A.
Psychiatry
2237 Twelve Oaks Way # 103
Wesley Chapel, Florida 33544

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

□ entire record	□ X-ray and imaging reports
□ medication list	□ consultation reports from (insert doctor's name)
□ list of allergies	□ problem list
□ immunization record	□ visits/encounters:
□ most recent history and physical	□ records from non-FMC providers
□ laboratory results	□ other (please specify):

I understand that the information in my health record may include information relating to sexually transmitted disease and other reportable diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral, psychiatric or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization (fill in the name of the person or organization to whom we are giving the copied record to. Include phone and fax number):

Name/Dept

Address/Telephone/Fax

For the purpose of:

Specify

I understand that I have a 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 Florida Medical Clinic. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

Specify

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Florida Medical Clinic's Privacy Officer at 352-567-0188.

Signature of Patient	Date:
Witness:	
If Signed by a Legal Representative, Relationship to the Patient	

it is expressly understood by me that the Provider is authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to the Provider.

Florida Medical Clinic, PA
Controlled Substance Agreement

Between Patient: _____ **and Doctor:** Maulik K. Trivedi, MD

The Florida Legislature has laws governing the prescription of controlled drugs. These drugs include all narcotics (such as codeine, hydrocodone and oxycodone),sleeping aids, benzodiazepines {such as valium, Xanax and Ativan), and ADHD medications such as concerta, metadata, Ritalin, and vyvanse). To comply with these laws, I acknowledge and agree to the following:

1. Prescriptions for most controlled substance medications can only be written for a 30 day supply.
2. I agree that only my physician will prescribe controlled substance medication. I will not obtain or use any controlled substances from a source other than my physician. I will instruct my other physicians to confer with my physician for any changes or need for additional controlled substance medication. If it Is discovered that other providers are prescribing medications for me, my physician reserves the right to discontinue prescribing medications and/or discharge me from the clinic.
3. Refills must be written {i.e., they cannot be faxed or phoned in). I will need to come in and pick up the prescription. All medicine should be filled at the same pharmacy, when possible. The pharmacy I have selected is:(name/phone)

   _____
4. My physician's office requires a 72 hour notice to refill prescriptions. Prescriptions can only be refilled during normal business hours. They will NOT be refilled at night or on weekends. I must provide proof of identity to pick up my prescription for controlled substances.
5. I must be seen by my doctor every 3 months to continue to get refills.
6. My physician's office is not responsible for any controlled substance medications that have been misplaced, lost or stolen. Controlled substances cannot be refilled before the renewal date.
7. Routine blood work and random urine drug screens may be part of my treatment plan. I agree to have them done on the day my physician requests it.
8. If I do not follow these policies, my physician will not be able to continue to prescribe these medications for me.
9. It is a crime to obtain narcotics under false pretenses. This could include getting medications from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). If my physician has reason to believe that I have violated this agreement, the physician has the right to notify and cooperate with law enforcement. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my records.
10. My physician has the right to discontinue controlled substance medications and discharge me from care if any of the following occur.
    - I trade, sell, misuse or share medication with others;
    - The clinic discovers I have broken any part of this agreement;
    - I do not go for blood work or urine tests when asked;
    - My blood or urine shows the presence of medications that my physician is not aware of, the presence of illegal drugs or does not show medications that I am receiving a prescription for;
    - I get controlled substances from sources other than Florida Medical Clinic physicians;
    - I exhibit any aggressive behavior toward the physicians or staff;
    - I consistently miss appointments.

I hold Florida Medical Clinic physicians harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Patient's Name DOB

_____

Witness

Welcome to the Florida Medical Clinic

Patient Portal!

Convenient, safe and secure patient connectivity website that allows you to communicate with your provider office anytime, day or night. Our goal is to be your first choice in patient healthcare, by providing convenience and accessibility to our practice. We are not only committed to offer the best possible medical care to our patients, but we strive to continue to meet the needs of our patients in ways that are convenient for you. This website – your patient portal- is one of the ways we can provide excellent patient care.

The Patient Portal offers our patients online health services that include the ability to request appointments, request medication renewals, access medical information, and much more. Coming soon is the ability to do on line bill pay, laboratory results, online patient visits (E-Visits) using secure messaging to your provider.

Your medical information is available to you on this web-site, and is secure, just as online banking and online stock accounts are secured via the Internet.

If you are currently a patient with our clinic, simply request your secure PIN number today from your participating physician office, go to our website at www.Floridamedicalclinic.com, click on the My Medical Records link, and follow the online instructions to "Get Connected".

Florida Medical Clinic, PA
Medicare Disclosure Requirements for In-Office Imaging Services

The Patient Protection and Affordable Care Act (ACA) created a new disclosure requirement for the in-office ancillary services exception to the Stark Self-Referral Law. Specifically, the ACA states that in respect to referrals for certain imaging services, payable by Medicare, the referring physician must inform a patient in writing at the time of the referral that the patient may obtain the service from a person other than the referring physician or someone in the referring physicians group practice and provide the patient with a list of suppliers who furnish the service within a twenty-five mile radius of the referring physician's office.

Providing this list of suppliers is required by law and is not intended as an endorsement or recommendation of these suppliers.

The lists of alternative suppliers are:

Tower Radiology Center
2324 Oak Myrtle Lane
Wesley Chapel, FL 33544
813-413-4579

Signet Diagnostic Imaging Service
4516 North Armenia Ave.
Tampa, FL 33603
813-348-6900

Signet Diagnostic Imaging Service
414 Robertson Street West
Brandon, FL 33511
813-657-6767

Signet Diagnostic Imaging Service
4325 Henderson Blvd.
Tampa, FL 33629
813-639-1674

Zephyrhills Diagnostic Center
7323 Green Slope Drive, Suite 101
Zephyrhills, FL 33541
813-715-6500

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Policy Update: Summer 2013

mind body integrated

Please read everything carefully before signing. This applies to all provider appointments at the MindBody Integrated offices at Florida Medical clinic.

NO SHOW POLICY: All cancellations of scheduled appointments require a 24 hours advanced notice and must be completed during business hours. Any patient who fails to show up for their scheduled appointment or cancels their appointment without a 24 hour notice will be considered No-Shows and assessed a $50.00 no-show fee.

Additionally, any patient who has two such no-shows will be considered to have dropped out of treatment and discharged from the practice. They will need to seek further treatment with a new provider on their insurance plan.

Please note that the automated reminder call is only a courtesy service we provide and is NOT to be relied upon as a reminder for your appointment. It is the patient's responsibility to remember their appointment.

FORMS POLICY: All forms that need to be completed by a provider require prepaid fee of $ 50.00 (for up to 2 pages) and $ 125.00 (for 3 or more pages). The forms will be completed within 5 to 7 days. The provider reserves the right to refuse to fill out any forms at their discretion.

PRESCRIPTION DENIAL POLICY: When the insurance company denies coverage of a medication prescribed by the doctor, it is the patient's responsibility to obtain names of alternate medications covered by their insurance plan formulary. In case the medication is too costly, it is also the patient's responsibility to find more affordable alternate treatment options covered by their insurance.

URINE ANALYSIS POLICY: Urine Screening and confirmation provides important information about how your medications are metabolized by your body. Urine screening also alerts us to the presence of any medication that is not prescribed or contraindicated. We monitor urine from time to time to assure proper use of prescribed medications on all our patients. We regularly monitor urine analysis on all patients being prescribed controlled medications. Additionally, all patients with any history of substance use will be subject to random urine drug testing as a condition of their treatment. You may be asked to submit a urine sample at any time during your treatment at the physician's discretion. Refusal to provide a sample when requested will result in discharge from the practice.

With my signature below, I acknowledge receipt of this policy update and agree to abide by it.

Patient Name: _____ DOB: _____

Parent/Guardian Name: ❑ Not Applicable _____

Signature: _____ Date: _____

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Family History

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	Mother	Father	Brother	Sister	Other
Atherosclerosis	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Arthiritis	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Asthma	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Coronary Artery Disease	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Cancer	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Cataract	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Depression	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Diabetes Mellitus	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Eczema	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Epilepsy	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Glaucoma	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Ischemic Heart Disease	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Hypertension	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Hyperlipidemia	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Macular Degeneration	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Mental Illness	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Migraine Headache	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Osteoporosis	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Renal Disease	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Stroke	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Thyroid Disease	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y
Other	☐ Y	☐ Y	☐ Y	☐ Y	☐ Y

Family History of Adopted	☐ Y	☐ N
Family history of Unknown/unreported	☐ Y	☐ N