Florida Medical Clinic

Your life. Our specialty.

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
Your life. Our specialty.

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 _____

Florida Medical Clinic
Your life. Our specialty.

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

_____
Date

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

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

Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

Patient Name:	Second Form of Identification (SS#/DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____

Ira J. Guttentag, M.D.
Richard M. Gray, M.D.
Stephen J. Raterman, M.D.
Geoffrey A. Cronen, M.D.
Sean Willey, D. O.
James E. Riordan, PA-C, M.S.
Justin Bidwell, PA-C, ATC
Josh Gilliam, PA-C, ATC
Marlena Howe, ARNP-C

Florida Medical Clinic
Your life. Our specialty.

14547 Bruce B. Downs Blvd., Suite C
Tampa, FL 33613
813. 979.0440

38107 Market Square
Zephyrhills, FL 33542
813.780.1555

2100 Via Bella Blvd.
Land 0' Lakes, FL 34639
813. 979.0440

ORTHOPAEDIC DIVISION
PRESCRIPTION RENEWAL POLICY

Prescriptions and refills are issued only during regular office hours, between 8am-5pm daily, Monday through Friday. Prescriptions will not be prescribed or refilled after 5pm or on weekends. Some renewals can be authorized without the doctor seeing the patient, pending the type of prescription. Other prescriptions will not be renewed without an office visit because of the need to closely monitor the effects of the medication.

Our policy is that we require at least 24 – 48 hours notice in order to fill most prescriptions. Please keep in mind some insurance companies require a pre-Authorization by your physician's office which may delay your refills on some medications.

Please be aware that your physicians are in surgery 2 – 3 days a week from 7am – 7pm in most cases and are unable to address prescription refill requests until they return to the office, the next business day. You can also choose to refill your medication on our Florida Medical Clinic patient portal. Please request a PIN letter at our front desk and sign up at home. Simply submit your request on line and it will be filled within 24 – 48 hours of your request from our Florida Medical Clinic patient portal. We will make every effort to get your prescription taken care of in a timely manner.

Please remember:

1. **Prescriptions will not be refilled after 5pm or on the weekends.**
2. **Please call or submit your request on the Florida Medical Clinic patient portal at least 24 – 48 hours in advance for prescription refills.**
3. **Patients must be seen at least every three months to keep prescriptions current.**

Also, please be aware that we will not be responsible for any prescribed narcotics which have been misplaced. Narcotics will not be refilled before your renewal date. Florida Medical Clinic, PA has the authority to conduct random drug screens on any patient who has been prescribed narcotics.

I have read and I understand the above mentioned policy.

_____

Patient's Signature Date

_____

Print Patient's Name

_____

Witness Date

Florida Medical Clinic
Your life. Our specialty.

Orthopaedic Division

Date: _____

MEDICAL HISTORY FORM

Name:_____ DOB:_____ Sex: _____ Race:_____

MEDICAL HISTORY

	YES	NO
Heart		
Lung		
Stomach		
Liver		
Kidney		
Anemia		
Diabetes		
Mental Illness		
Cancer		
Bleeding Disorder		
Other		

Explain all answers:

_____

_____

SURGICAL HISTORY

List all procedures with Date, Place & Dr.

_____

_____

_____

MEDICATIONS

Give name & dosage

_____

_____

_____

ALLERGIES TO MEDICINE

_____

_____

_____

FAMILY HISTORY

	YES	NO
Heart		
Blood Pressure		
Diabetes		
Bleeding Disorder		
Cancer		
Other		

Explain all answers:

_____

_____

SOCIAL HISTORY

Most recent occupation:

_____

_____

_____

Smoking History: Chews☐ None ☐

Previously Smoked☐ ____ Packs per day

Alcohol History: Never☐Previously☐

Occasional☐Moderate to Heavy☐

Marital Status: Married☐Single☐

Separated☐Divorced☐Widowed☐

# of Children____ Presently Living Alone☐

REVIEW OF SYSTEMS

Have You Recently Had or Do You Now Have:

GENEARL	Yes	No
Normal		
Change in appetite		
Change in weight		
Chills, fever, sweats		
HEAD		
Normal		
Frequent headaches		
Recent Trauma		
EYES		
Normal		
Reading glasses		
Change in vision		
Double vision		

EARS/NOSE/THROAT/ MOUTH	Yes	No
Normal		
Loss of hearing		
Ringing in ears		
Gum problems		
Bleeding		
Nose bleed		
Hoarseness		
Difficulty swallowing		
Morning cough		
Toothache		

RESPIRATORY	Yes	No
Normal		
Difficulty breathing		
Cough		
Shortness of breath		
Coughing up blood		

HEART	Yes	No
Normal		
Chest pain		
Heart beating fast		
Difficult breathing w/ activity		

DIGESTIVE SYSTEM	Yes	No
Normal		
Abdominal pain		
Nausea		
Vomiting		
Bloating		
Diarrhea		
Constipation		
Blood in stool		
Frequent belching		

MUSCLES/BONES	Yes	No
Normal		
Pain		
Weakness		
Joint swelling		
Backache		
Degenerative Disease		

NERVOUS SYSTEM	Yes	No
Normal		
Dizziness		
Loss of consciousness		
Seizures		
Blackouts		
Nervous exhaustion		
Numbness/tingling		

SKIN	Yes	No
Normal		
Rash		
Non-healing lesion		
Emotional Status		
Normal		
Nervousness		
Mood changes		
Depression		
Insomnia		

ENDOCRINE/GLANDS	Yes	No
Normal		
Thyroid		
Heat intolerance		
Cold intolerance		
Diabetes		
Excessive thirst		
Excessive hunger		
Excessive urination		

BLOOD/LYMPTH SYSTEM	Yes	No
Normal		
Anemia		
Easily bruise		
Easily bleed		
Swollen glands		

ALLERGIES	Yes	No
None/Normal		
Hay fever/Seasonal allergies		

URINARY SYSTEM	Yes	No
MALE		
Normal		
Penile discharge		
Difficulty urinating		
Blood in urine		
Get up every night to urinate		
Prostate trouble		
FEMALE		
Normal		
Regular periods		
Menopausal - no periods		
Hysterectomy		
Vaginal discharge		
Difficulty urinating		
Blood in urine		