



Florida Medical Clinic
(813) 973.1304
fmcmindbody@floridamedicalclinic.com

www.FMCMindBody.com

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



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, Financial Responsibility 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

This is an agreement between Florida Medical Clinic, P.A., a Florida Corporation, as a creditor, and the Patient/Debtor named on this form.

In this agreement the words "I", "you," "your," and "yours" mean the Patient/Debtor. The word "account" means any account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Florida Medical Clinic, P.A. (FMC) and/or its affiliated entities.

Insurance: Insurance is a contract between you and your insurance company. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fact, insurers will routinely stall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of FMC. We will NOT under any circumstance falsify or change a diagnosis or symptom in order to convince an insurer to 'pay' for care that is not covered, nor do we delete or change the content in the record that may prevent, or cause, it to be considered covered.

_____ Initials HMO Plans: Any co-payments required by an insurance company must be paid at the time of service. Should FMC render services and I am unable to pay my co-payment at the time of service, I understand that I may be billed an administrative fee.



_____ Initials PPO Plans: FMC has agreed to accept the discounted rate from your plan, and we will **estimate** balances to the best of ability. However, since these are **estimates** only, I understand that any remaining balances due to deductibles, co-insurance, and non-covered claims are my responsibility to pay FMC. Your appointment may be rescheduled if your estimated amount due is not paid at check in.

_____ Initials Missed Appointment Fee: I understand that *Appointment Reminders are a courtesy*. Failure to show up for, or cancellation of an appointment with less than 24 hour notice (48 hour notice for FMC Ambulatory Surgery Center procedures), may result in a no show fee assessed to my account. The no show fee varies by FMC practice location and is subject to change. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be discharged from the FMC practice location.

_____ Initials After Hours Services: Please be advised additional fees may be subject for services rendered after hours, which includes evenings (after 5pm), weekends, and holidays.

_____ Initials Administrative Charges: I understand that additional administrative charges may apply for items such as the completion of medical forms, telephone consultations, and physician letters.
(This is not an exhaustive list)

Guarantee of Payment:

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay FMC all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge or upon presentation of the first bill by FMC. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. I understand and agree that if FMC is required to bring a claim or file an action to enforce this agreement, FMC shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed FMC for its services. Based on permissible purpose under the Fair Credit Reporting Act, FMC reserves the right to run a credit report for the sole purpose of determining my ability to meet incurred expenses directly related to my treatment.

Payments received will be posted to the oldest outstanding balance on your account.

Returned Checks: A Returned check will result in a service fee based on the face value of the check and may require all future payments to be made by cash or credit card. A collection agency may be used in the recovery of debt attributed to returned checks, in addition to the payment of the check plus any court cost, reasonable attorney fees and any bank fees incurred by the payee in taking action as pursuant to *Florida Statute 68.065*.

Divorce, Dependent and Child Custody Cases: Regarding divorce, the presenting guardian accompanying the person (minor or disabled adult) who receives care at FMC is responsible for payment of copays, co-insurance and/or deductibles at the time of service.

Assignment of Benefits:

I hereby assign, grant and transfer to FMC, now and in the future, all of my rights and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payer for those costs I incur in receiving services from FMC. The included insurance policies and insurer would include, but are not limited to, health, auto, UM and PIP; and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to FMC was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to FMC the amount due me in any potential or pending claim for medical benefits under the respective policies, expressly including all PIP policies. I agree that should the amount received by FMC be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services rendered by FMC are not covered by said insurance policy, I am responsible to FMC for payment of the entire bill.

_____ 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 (HIPAA) 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.



Your life. Our specialty.

Florida Medical Clinic
(813) 973.1304
fmcmindbody@floridamedicalclinic.com
www.FMCMindBody.com



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: 1 bottle 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:

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: _____



Your life. Our specialty.

Florida Medical Clinic
 (813) 973.1304
 fmcminbody@floridamedicalclinic.com
www.FMCMindBody.com



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

	0	1	2	3	4
Sense of necessity					
How strongly do you desire change aimed at improving your situation?					
Ready for anxiety					
How determined are you to work through your inner fears?					
Awareness					
How good are you at identify problems about yourself without becoming emotional or defensive?					
Confronting the problem					
How much courage do you have for focusing on your problems and facing them?					
Effort					
How committed are you to being enthusiastic and persistent at making changes?					
Hope					
How strongly do you believe that you can overcome your problems?					
Social support					
How open are you to seeking support from a network of friends and adapting to changes in relationships?					

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.

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

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

22 - 28
 Highly motivated. Change occurs easily.



Your life. Our specialty.

Florida Medical Clinic
 (813) 973.1304
 fmcmindbody@floridamedicalclinic.com
 www.FMCMindBody.com



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

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

2352 Bruce B Downs Blvd Ste. 304, Wesley Chapel, FL 33544

1602 Oakfield Drive Ste. 205, Brandon, FL 33511

3610 Madaca Lane, Tampa, FL 33618

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

<input type="checkbox"/> entire record	<input type="checkbox"/> X-ray and imaging reports
<input type="checkbox"/> medication list	<input type="checkbox"/> consultation reports from (insert doctor's name)
<input type="checkbox"/> list of allergies	<input type="checkbox"/> problem list
<input type="checkbox"/> immunization record	<input type="checkbox"/> visits/encounters:
<input type="checkbox"/> most recent history and physical	<input type="checkbox"/> records from non-FMC providers
<input type="checkbox"/> laboratory results	<input type="checkbox"/> 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, metadate, 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
4325 Henderson Blvd.
Tampa, FL 33629
813-639-1674

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

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

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



Policy Update: Summer 2013



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: _____

Family History

	Mother	Father	Brother	Sister	Other
Atherosclerosis	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Coronary Artery Disease	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Cataract	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Depression	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Diabetes Mellitus	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Eczema	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Epilepsy	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Ischemic Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Hypertension	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Hyperlipidemia	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Macular Degeneration	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Mental Illness	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Migraine Headache	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Osteoporosis	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Renal Disease	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Thyroid Disease	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Other	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
Family History of Adopted	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Family history of Unknown/unreported	<input type="checkbox"/> Y	<input type="checkbox"/> N			