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, LLC

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, LLC 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, LLC. I understand that diagnosis or treatment of me by Florida Medical Clinic, LLC 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, LLC *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, LLC *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, LLC. The *Notice of Privacy Practices* for Florida Medical Clinic, LLC 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, LLC with respect to my protected health information. Florida Medical Clinic, LLC 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, LLC.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, LLC 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, LLC (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, LLC (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, LLC 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, LLC
Zephyrhills, FL 33542

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

Florida Medical Clinic **Rheumatology**

Your life. Our specialty.

2100 Via Bella Blvd
Land O'Lakes, FL 34639
Suite 201

38135 Market Square
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O: 813.782.1234
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Alicia Fierro D.O.
Ernesto Rodriguez, M.D.
David Rivera, M.D.
David Sikes, M.D.
Christina Arnold, PA-C
Tina Heinrich, ARNP
Nathan Meyer, PharmD
Dimple Desai, PA-C

Dear New Patient:

Welcome to Florida Medical Clinic Rheumatology. We look forward to meeting you. This letter will introduce you to our practice and allow you to complete a medical history form to aid in your care.

If you cannot keep the appointment on the attached card, please notify us within 48 hours of your appointment time. We attempt to confirm all new patient appointments 24 hours in advance. Our office may contact you via phone, mail, or through the Patient Portal. When we contact you we will discuss your care (e.g. appointment reminders, lab results, etc). Our office is open *Monday through Friday 8AM-5PM.* You may contact our office at any time (day or night). You will be forwarded to our on-call provider who can assist you after normal business hours.

Your Rheumatologist strives to coordinate your care with your primary care provider and other specialist. At each office visit please advise your Rheumatologist if you have seen another specialist or have been in the hospital recently. This information may be vital to providing optimal care to you.

ATTENTION NEW PATIENTS:

1. If you are more than 15 minutes late, your appointment will have to be rescheduled.
2. If you cancel and reschedule 3 times, office policy states you will not be allowed to reschedule.

Before your appointment:

1. Please complete the health history form and bring it with you to your first visit.
2. **YOU ARE RESPONSIBLE FOR BRINGING ALONG ANY RECORDS AND/OR RECENT BLOOD TEST RESULTS FROM PREVIOUS DOCTORS THAT MIGHT HELP US.** If you ask your doctor to fax these records to us, call their office the day before your appointment to verify they have been sent.

Insurance Issues:

To insure your visit proceeds in a timely fashion, we ask for your help at the time of the first and all subsequent visits:

1. If you intend to use insurance, please provide our staff with your insurance information card. If your insurance changes, prompt notification to the staff will ensure accurate billing.
2. If your insurance requires an authorized referral for care at our practice please secure this referral from your primary physician **prior** to your arrival at the office. Your visit cannot begin until a referral is received.

Thank you,

Florida Medical Clinic Rheumatology Staff

PAIN SCORE

Please rate your pain as follows:

Circle one of each

NOW ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

BEST ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

AVERAGE ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

WORST ☺no pain -**1-2-3-4-5-6-7-8-9-10**- worst possible pain☹

Name: _____

MDHAQ En

1. Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3
Get a good night's sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
Deal with feelings of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3

2. How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN ○○○○○○○○○○○○○○○○○○○○ **PAIN AS BAD AS IT COULD BE**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. When you awakened in the morning **OVER THE PAST WEEK,** did you feel stiff? ☐ **No** ☐ **Yes**
If **"Yes,"** please indicate the number of minutes_____, or hours_____ until you are as limber as you will be for the day

4. How much of a problem has **UNUSUAL** fatigue or tiredness been for you **OVER THE PAST WEEK?** Please indicate below:

FATIGUE IS NO PROBLEM ○○○○○○○○○○○○○○○○○○○○ **FATIGUE IS A MAJOR PROBLEM**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

5. How do you feel **TODAY** compared to **ONE WEEK AGO?** Please check (✓) only one.
(1) **Much Better** ☐, (2) **Better** ☐, (3) the **Same** ☐, (4) **Worse** ☐, (5) **Much Worse** ☐

6. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○○○○○○○○○○○○○○○○○○○○ **VERY POORLY**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

FN (1) ☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

PN (2) ☐

PTGL (6) ☐

RAPID3 ☐ **(0-30)**

Category
HS=>12
MS=6.1-12
LS= 3.1-6
R= ≤3

PATIENT'S PERSONAL HISTORY & HEALTH ASSESMENT

Date: _____

Name: _____ DOB: _____

DRUG ALLERGIES

Are you allergic to any medications? What reaction do you have?

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

MEDICATIONS

What medications are you currently taking?

Name	Dose	Name	Dose

PAST MEDICAL HISTORY

Hospitalizations / Previous Surgeries - please list.

19 _____ Reason _____ Where _____

19 _____ Reason _____ Where _____

19 _____ Reason _____ Where _____

20 _____ Reason _____ Where _____

20 _____ Reason _____ Where _____

20 _____ Reason _____ Where _____

Do you have high blood pressure? Y / N How Long? _____

Do you have high cholesterol? Y / N How Long? _____

Do you have diabetes mellitis? Y / N How Long? _____

If yes, are you on a diabetic diet? Y / N How Long? _____

OBSTETRIC HISTORY

How many pregnancies have you had? _____

How many premature births have you had? _____

How many miscarriages/abortions have you had? _____

How many living children do you have? _____

Grandchildren? _____

Great Grandchildren? _____

When was your last menstrual period? (date if still having periods; age if past menopause) _____

FAMILY HISTORY

Father: Living _____ List known illnesses _____

Deceased _____ Cause of death _____

Mother: Living _____ List known illnesses _____

Deceased _____ Cause of death _____

Brothers:

(name, age, illnesses)

_____

_____

_____

_____

_____

Sisters:

(name, age, illnesses)

_____

_____

_____

_____

_____

If any of your blood relatives have had the following conditions, please check and designate relationship:

(F = Father, M = Mother, S = Sister, B = Brother, O = Other)

Emphysema	_____	Cancer	_____	Kidney Disease	_____	Stroke	_____
Anemia	_____	Lupus	_____	High Blood Pressure	_____	Fused Spine	_____
Gout	_____	Diabetes	_____	Back Problems	_____		
Tuberculosis	_____	Athritis	_____	On Kidney Dialysis	_____		
Breast Cancer	_____	Colon Cancer	_____	Early Heart Disease	_____		
Gall Stones	_____						
Gall Bladder Disease	_____						

SOCIAL HISTORY

Never Married ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )

Spouse: Alive/age _____ Deceased/age _____

Major illnesses _____

Your occupation _____

Education:

What was the highest grade completed? _____

Smoking:

Do you smoke? _____ How much in a day? _____ For how long? _____

What do you smoke? _____ If no, have you quit? _____ When? _____

For how long did you smoke? _____

Alcoholic Beverages:

Do you drink? _____ How many per day? _____

Do you wear a seat belt? Y / N If no, why not? _____

Do you have a living will? _____

PROCEDURES

When was the last time you had the following tests?

Rectal Exam _____ Pelvic and Pap _____

Mammography _____ Check for blood in stool _____

Sigmoidoscopy or Colonoscopy _____

PSA -

IMMUNIZATIONS

Please give date:

Hepatitis B _____ Flu _____

Tetanus _____ Pneumococcal _____

REVIEW OF SYSTEMS

Have you experienced any of these symptoms in the last 3 months? Check all YES answers, leave all NO answers blank, if you are not sure make a "?".

SKIN
____ Rash
____ Lump or growth
____ Skin cancers
____ Jaw pain on chewing
____ Swollen lymph nodes

EYES
____ Glasses
____ Glaucoma
____ Change in vision
____ Pain in eyes
____ Halo around lights
____ Conjunctivitis
____ Iritis
____ Red eyes

NOSE AND THROAT
____ Hoarseness
____ Sinus problems
____ Sores in mouth

BREAST
____ Lump
____ Discharge
____ Pain

MUSCULOSKELETAL
____ Broken bones
____ Back pain
____ Painful joints
____ Sore muscles

DIGESTIVE
____ Loss of appetite
____ Vomiting blood
____ Passing blood in bowels
____ Black stools
____ Jaundice
____ Frequent heartburn
____ Frequent nausea / vomiting
____ Stomach pain
____ Constipation
____ Stomach ulcers
____ Hemorrhoids

GENITOURINARY
____ Difficulty starting urine stream
____ Painful urination
____ Blood in urine
____ Discharge (penile / vaginal)
____ Blood or pus in urine
____ unexpected vaginal bleeding after menopause
____ Difficulty controlling urine

ENDOCRINE
____ Frequent urination
____ Unusual thirst
____ Thyroid problems or goiter

NEUROLOGIC
____ Convulsions / epilepsy
____ Migraine headaches
____ Frequent headaches
____ Fainting
____ Dizziness
____ Depressed
____ Stroke / paralysis
____ More nervous than average person
____ Difficulty sleeping most nights

GENERAL
____ Unusual fatigue
____ Unusual weakness
____ Night sweats
____ Anemia
____ Cancer

HEART AND LUNG
____ Chest pain
____ Shortness of breath
____ Blood in sputum
____ Wheezing
____ Unusual heart beat
____ Heart attack
____ Swollen ankles
____ Murmur
____ Rheumatic fever
____ Pneumonia
____ Emphysema

PHYSICIAN COMMENTS

Old records requested: ☐ No ☐ Yes

Physician's Signature

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RHEUMATOLOGY DIVISION

PRESCRIPTION RENEWAL POLICY

Prescriptions and refills are issued only during regular business 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 24-72 hour 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 clinic 5 days a week from 7:30am-5pm in most cases and are unable to address prescription refill requests until they finish clinic, or the next business day. 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 of on the weekends**
2. **Please call of submit your request 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, P.A. 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, LLC
Authorization to Verbally Share Protected Health Information

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

I authorize FLORIDA MEDICAL CLINIC to verbally share protected health information with the following persons:

Last Name	First Name	Relationship	Phone #
1.			
2.			
3.			

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 _____

FMC Personnel_____ Date _____

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38135 Market Square
Zephyrhills, FL 33542

AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB	Phone#	

COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS NOT THE PATIENT

Name of Representative	
Relationship to Patient (parent, health proxy, etc.)	Phone #
Email Address	

I AUTHORIZE FLORIDA MEDICAL CLINIC,LLC TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:

METHOD	CONTACT INFORMATION
☐ TEXT	
☐ EMAIL	
☐ VIDEO CONFERENCE	

☐ I do not authorize Florida Medical Clinic, LLC to communicate with me via electronic means

This Authorization to Communicate PHI via electronic means expires

☐Upon written revocation ☐Other

COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS NOT THE PATIENT

I understand by selecting the method of communication above and signing below, I authorize Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.

I understand Florida Medical Clinic may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers at Florida Medical Clinic.

I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic cannot sell or distribute my communication method or information with any third-party without my prior consent.

I understand that, by federal law, the Florida Medical Clinic may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic's Notice of Privacy Practices.

I hereby release Florida Medical Clinic and its employees from any and all liability that may arise from the release of information as I have directed.

I understand emailing and texting are not secure forms of communication and I release Florida Medical Clinic from any liability.

I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Notice of Billing Efforts Conducted Via Electronic Means		
I understand that in its regular course of billing and collection efforts, Florida Medical Clinic LLC may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to Florida Medical Clinic LLC may be used for these purposes. I consent to the use of e-mail, text or automated voicemail communication by Florida Medical Clinic, LLC if I have any balances due on my account, regardless of my Preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system" or "autodialer". I understand that message and data rates may be assessed by my mobile provider. By signing this form, you represent that you are the cellular subscriber or customary user with respect to the cellular number(s) provided and that you have the authority to provide consent..		
Signature		Date
Print Name:	Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative	