NEW TAMPA MEDICAL CENTER

Babatola Durojaiye, MD.
5381 PRIMROSE LAKE CIRCLE
TAMPA, FL 33647

General Patient Information

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]
❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize New Tampa Medical Center or insurance company to release any information required to process my claims. I agree and understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any cost incurred in collection of said balance should that become necessary. I have read and understand the above and agree to comply.

Patient/Guardian signature ________ *Date* ________

Signature Required

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
MARITAL STATUS:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
PREVIOUS OR REFERRING DOCTOR:	**DATE OF LAST PHYSICAL EXAM:**	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Question	Yes	No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Question	Yes	No
Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Question	Yes	No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas currently or within the last year to a significant degree and briefly explain.

General

☐ Chills	☐ Headache	☐ Recent changes in:
☐ Depression	☐ Loss of Sleep	☐ Weight
☐ Dizziness	☐ Loss of Weight	☐ Energy level
☐ Fainting	☐ Nervousness	☐ Ability to sleep
☐ Fever	☐ Numbness	☐ Other pain/discomfort:
☐ Forgetfulness	☐ Sweats	

Muscle /Joint /Bone	**Genito- Urinary**	☐ Vomiting Blood
Pain , weakness, numbness in:	☐ Blood in Urine	☐ Vomiting
☐ Arms	☐ Frequent Urination	☐ Excessive Hunger
☐ Back	☐ Lack of Bladder Control	☐ Excessive Thirst
☐ Feet	☐ Painful Urination	☐ Gas
☐ Hands	**GASTROINTESTINAL**	☐ Hemorrhoids
☐ Hips	☐ Poor Appetite	☐ Indigestion
☐ Legs	☐ Bloating	☐ Nausea
☐ Neck	☐ Bowel Changes	☐ Rectal Bleeding
☐ Shoulders	☐ Constipation / Diarrhea	☐ Stomach Pain

Cardiovascular	☐ Bleeding Gums	☐ Sinus Problems
☐ Chest Pain	☐ Blurred Vision	☐ Vision – Flashes
☐ High Blood Pressure	☐ Crossed eyes	☐ Vision – Halos
☐ Irregular Heart Beat	☐ Difficulty Swallowing	**Skin**
☐ Low Blood Pressure	☐ Double Vision	☐ Bruise Easily
☐ Poor Circulation	☐ Earache	☐ Hives
☐ Rapid Heart Beat	☐ Hay Fever	☐ Itching
☐ Swelling	☐ Hoarseness	☐ Change in Moles
☐ Varicose Veins	☐ Loss of Hearing	☐ Rash
Eyes / Ears/ Nose/ Throat	☐ Persistent Cough	☐ Scars
☐ Nose bleeds	☐ Ringing in ears	☐ Sore that won't heal

Conditions Check conditions you have or have had in the past.			
☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Glaucoma	☐ Measles	☐ Stroke
☐ Arthritis	☐ Goiter	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Gonorrhea	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Gout	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Heart Disease	☐ Multiple sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Hepatitis	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hernia	☐ Pace Maker	☐ Ulcers
☐ Cancer	☐ Herpes	☐ Pneumonia	☐ Vaginal Infection
☐ Cataracts	☐ Epilepsy	☐ Polio	☐ Venereal Disease

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VACCINATIONS

I've Been Immunize!

Name: ____Date: ___________
Please update my patient file to include the following immunizations:

☐ Influenza
This once-a-year vaccine is given In the fall months to prevent Complications from the flu. You may have received this at a health fair, pharmacy, residential living facility, school, or workplace.

Month and year you received These shots:_____/_______

☐ Pneumococcal
This vaccine is usually given only once to people 65 or older, or people of any age who have conditions that put them at risk of pneumonia and other pneumococcal infections.

Month and year you received These shots:_____/_______

☐Tetanus- Diphtheria (TD)
Have you been treated in the hospital for an injury recently? You may have received this vaccine. Otherwise, it's Recommended once every 10 Years to boost your immunity against these infections.
Month and year you received These shots:_____/_______

☐ Meningococcal
If you're a college student living In a dorm, or work on campus or in a similar setting, you might have received this vaccine to protect you from this highly contagious infection.

Month and year you received These shots:_____/_______

☐ Varicella (Chicken Pox)
You may have received this one-time vaccine at school, a health fair or pharmacy. If you've already had chicken pox, you don't need this vaccine.

Month and year you received These shots:_____/_______

☐ Hepatitis A ☐ Hepatitis B
You may have received these vaccines if you were identified as at-risk for these viruses that infect the liver. People at risk include health care workers, international travelers, Native Americans, Alaskan natives, immigrants, intravenous drug users, men or women with multiple sex partners or men with same sex partners, and persons with chronic liver disease.

Month and year you received *These shots:_____/_______*

The Following Immunizations are common for International travelers- please indicate any you received in preparation for travel.

☐ Malaria
☐ Hepatitis A
☐ Hepatitis B
☐ Meningococcal
☐Yellow Fever
☐ Pollo
☐ Japanese Encephalitis
☐ Typhoid

Had a shot but can't remember exactly what it was or what it is for?

Tell your internist – he or she may be able to help you determine which vaccine you've received.

Think you might be due for one of these immunizations?

Be sure to talk to your internist during your visit.

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APPOINTMENT POLICY

(Effective 01/01/2008)

As we continuously seek to improve the quality of the services we provide to our patients, we expect that patients would keep appointments on schedule and as scheduled.

As a courtesy, we would provide a reminder call to the phone number on record, twenty four (24) to forty eight (48) hours prior to your appointment. Please notify us if your phone number or address changes.

We would expect confirmation or cancellation calls no less than 24 hours prior to scheduled appointments.

Our appointment and cancellation phone number is (813) 615-2599.

Appointments not confirmed cannot be guaranteed. We reserve the right to assign that scheduled time to another patient with an urgent matter.

We reserve the right not to schedule future appointments for patients who do not cancel appointments and who do not show for appointments (no-shows).

Thank you,

Signature Required

I have read and understand the terms of the appointment policy and agree to the above statement.

This policy was signed by: ____

Print Name: Patient or Representative

Date: ___/____/___

Relationship to Patient (if other than patient):______________________________________

Witness: ____

Print Name: Patient or Representative

Date: ___/____/____

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FINANCIAL POLICY

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. If so co-payment is due upon signing in. We accept Visa, Master Card, American Express and (Master Card at St. Isabel office only). We also accept personal checks with valid ID.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. We advise all our patients to read their insurance booklet and find out what their deductibles, coinsurance and co-payments are. We also advise that our patients know what is covered and not covered by their individual plans, and if pre-existing clauses exist. As a service to you, we will file your insurance claim. If your insurance company does not pay the practice within a reasonable period of time, we will have to bill you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay your portion (co-pay or deductible) at the time of your visit. We will compute your portion by carrier fee schedule or by calling your carrier. If your portion is unpaid we expect payment promptly upon notification by our statement; likewise, if you have overpaid, we will refund you promptly.
4. If you are insured by a plan that we do not have prior arrangement with, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event you insurance plan determines a service not to be covered, you will be responsible for the complete charge. Payment is due upon receipt of billing statement from our office. Statements are sent with any account changes.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due as required by your insurance plan.

Signature Required

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. Since we handle a large number of claims your cooperation is appreciated and necessary.

____ ________________________________
Signature of patient (or responsible party, if minor) Date

____
Please Print the Name of Patient

New Tampa Medical Center

Email Authorization

I ____ authorize New Tampa Medical Center to use the following email address in order to communicate Patient Portal alerts. I understand that it is my responsibility to control access to this email account in order to assure my privacy is maintained. I understand that New Tampa Medical Center will attach this document to my medical record electronically and destroy this original in accordance with HIPAA policy.

Signature Required

Email address ____

Signed _____________________________ Date _____/_____/_______

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PATIENT CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to these restrictions, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. **The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1966 (HIPPA).**

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy Policies and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will the cease
- The practice may condition treatment upon the execution of this consent.

This Consent was signed by:____
Please Print Name- Patient or Representative

Patient or Representative Signature:____________________________ Date:______________

Relationship to Patient (if other than patient):____________________ Date:________________

Witness:______________________________Signature:__________________ Date:________
Print Name- Practice Representative

Signature Required

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies which extend to:

- Any health care professional authorized to enter information into your chart
- All areas of practice (front desk, administration, billing and collection, etc.)
- All employees, staff, and other personnel that work for or with the Practice
- Our business associates (billing services, facilities referred to), on-call physicians, and so on

The Practice provides this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient Copy

OUR THOUGHTS ABOUT PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

Practice Name: Dr. Babatola Durojaiye M.D., F.A.C.P.

Compliance/ Privacy Officer: John D'Onofrio

Date of Last Revision: 03-15-2013 Effective Date: 03-19-2013

We are required by law to:

- Make sure that the protected health information about you is kept private
- Provide you with a Notice of our Privacy Policies and your legal rights with respect to protected health information about you
- Follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- **Medical Treatment**- We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you to for ongoing or further care may need your medical record. Different areas of the practice may also share medical information about you including your record(s), prescriptions, requests of lab work, and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who

may be involved in your medical care after you leave the Practice; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent.)

- **Payment-** We may disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any third party. For example, we may need to give your health care information, about treatment you received at the practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of referring physician, or the like.
- **Health care operations-** we may use and disclose medical information about you so that we can run our practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.
  We may also disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their contained obligation to maintain the privacy of our medical records.
- **Appointment and patient recall reminders-** we may ask that you sign in writing at the receptionist's desk, a "Sign in Log" on the day of your appointment with the practice. We may use or disclose medical information to contact you as a reminder that you have an appointment for medical care with the practice or that you are due to receive periodic care from the practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving of an e-mail, or message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.
- **Emergency Situations-** in addition , we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status, and location.
- **Research-** under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.
- **Required by Law-** we will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety-** we may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Organ and Tissue Donation-** if you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplant or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Workers Compensation-** We may release medical information about you for workers compensation or similar programs. These programs provide benefits for work related injuries or illnesses.
- **Public Health Risks-** Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;

Patient Copy

  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Investigations and Government Activities-** We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payer, the government, and other regulatory agencies to monitor health care systems, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes-** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.
- **Law Enforcement-** We may release medical information if asked to do so by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain a person's agreement
  - about a death we believe may be the result of criminal conduct;
  - about criminal conduct at the practice; and
  - in emergency circumstances to report a crime; the location of the crime or victims; or the identity; description or location of the person who committed the crime.
- **Coroners, Medical Examiners, and Funeral Directors-** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the practice to funeral directors as necessary to carry out their duties.
- **Inmates-** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution.

Changes to This Notice

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the practice. The notice will contain on the first page, in the top right-hand corner, the date of the last revision and effective date. In addition, each time you visit the practice for treatment or health care services you may request a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.
You will not be retaliated on for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

Patient Copy

New Tampa Medical Center

5381 Primrose Lake Circle
Tampa FL 33647
813-615-2488

Controlled substance medications are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to improve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medication to help manage my pain, I agree to the following:

- **I am responsible for the controlled substance medication prescribed to me.** If my prescription is, misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced.
- **Refills of controlled medications:**
  -Will be made only during regular office hours **Monday through Friday**, in person, once a month, and during your scheduled office visit.
  -Will not be made without an office visit
- If my medication was misplaced, lost or ran out early, it will be necessary to file a police report in order for medication to be filled.
- I will not share, sell, or trade my medication with anyone.
- It may be deemed necessary by my doctor that I see a medication-use specialist at the time while I am receiving controlled substance medication. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled.
- I agree to comply with random urine drug testing, documenting the proper use of any medications and that it is my responsibility to comply with the laws of the state while taking prescribed medications. If my drug testing results reveal mediation that is not prescribed to me, including but not limited to illicit drugs, or absence of medication that is prescribed to me is a violation of this agreement.
- I understand if I violate any of the conditions in this agreement, my prescriptions for controlled medications will be terminated immediately and I will be given a 30 day notice of discharge from the practice.
- I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances and that my physician will advise me of advances in the field and will make necessary treatment changes.

I have thoroughly read this agreement and the same has been explained to me by my doctor at New Tampa Medical Center. In addition, I understand the consequences of violating this agreement.

Date:_________________

Patient Name:____

Patient Signature:____

Provider Name:____

Provider Signature:____

NEW TAMPA MEDICAL CENTER

INTERNAL MEDICINE ⬬ PRIMARY CARE
5381 PRIMROSE LAKE CIRCLE
TAMPA, FL 33647

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I ______________________, have received a copy of this offices Notice of Privacy Practices.

____ ______________________
Signature of patient or patient's representative Date

____ ______________________
Signature of patient or patient's representative Date

Relationship to Patient: Mother Father Guardian Self Other

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

______ Individual Refused to Sign

______ Other ____
____
____
____
____
____

Signature Required

NEW TAMPA MEDICAL CENTER

INTERNAL MEDICINE • PRIMARY CARE
5381 PRIMROSE LAKE CIRCLE
TAMPA, FL 33647

PATIENT QUESTIONAIRE

1. Would you like to provide New Tampa Medical Center with a list the family member(s) or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

   No – Please Initial ____________________

   Yes – Proceed to step 2

2. Please list the family member(s) or significant other(s), if any, whom we may inform about your medical condition only in emergency:

   Name:_________________________________Phone #:________________________

   Name:__________________________________Phone #:_______________________

3. Please print the address of where you would like your billing statements and/ or correspondence from our office to be sent other than your home.
   ____
   ____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "Confidential".
   Yes__________ No_________

5. Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results, or other health care information if other than your home phone number.

   Phone Number: ________________________________

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?
   Yes________No__________

Patient Name:____(Guardian, if under 18)

____ ____________________
Patient / Guardian Signature Date

Signature Required

ATTENTION PATIENTS:

PLEASE BE AWARE THAT YOUR INSURANCE MAY NOT COVER ALL MEDICATION PRESCRIBED TO YOU.

YOUR INSURANCE DOES PROVIDE YOU WITH A YEARLY FORMULARY OF APPROVED MEDICATIONS. PLEASE FEEL FREE TO BRING IT IN TO THE OFFICE AT THE TIME OF YOUR VISIT TO AVOID ANY DELAYS IN OBTAINING YOUR PRESCRIPTIONS, AS WE DO NOT HAVE ACCESS TO THAT INFORMATION. MOST INSURANCES WILL NOT PAY FOR MEDICATIONS EVEN IF WE DO A PRIOR AUTHORIZATION, IF YOU HAVE NOT BEEN ON AT LEAST 2 OF THE MEDICATIONS ON THE FORMULARY. IN THE CASE THAT YOU REQUEST A PRIOR AUTHORIZATION INSTEAD OF CHANGING TO APPROVED MEDICATIONS, YOU WILL HAVE TO COME IN FOR AN OFFICE VISIT TO COMPLETE THIS PROCESS.

REFERRALS AND AUTHORIZATION TO OTHER PHYSICIANS

PLEASE BE SURE TO INFORM US OF YOUR APPOINTMENT WITH SPECIALISTS AT LEAST 5 BUSINESS DAYS BEFORE THE DAY OF YOUR APPOINTMENT. WE NEED ADEQUATE TIME TO COMPLETE REFERRALS AND IF WE RECEIVE LATE NOTICE YOU MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.

THANK YOU FOR YOUR COOPERATION

New Tampa Medical Center

5381 Primrose Lake Circle Tampa, FL 33647
P: 813-615-2488 **F**: 813-615-2504

AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

Patient's Name: ____
(Please Print)

__I hereby give permission for New Tampa Medical Center to leave detail messages regarding:

____

(Please check all that apply)

__Appointment Confirmations
__Medical Information
__Billing Information

At this phone number: ____________________

____

__I DO NOT give my permission to New Tampa Medical Center to leave any medical related information on voice message.

____

________________________________ ____________________

Patient's Signature Date

******************************FOR INTERNAL USE****************************

SCAN INTO COSENT SECTION AND PLACE A NOTE IN THE CONTACT SECTION THAT THIS FORM WAS RECEIVED