Welcome to our Practice!

Thank you for selecting us to be your primary health care provider. We are looking forward to building a relationship with you.

Please complete the enclosed New Patient Packet forms to bring with you at the time of your first appointment. We ask that you arrive 30 minutes early for this first appointment so that we may copy your identification, insurance cards and review your paperwork.

The sections in your packet are:

Practice Procedures – This is general information for you to keep that will answer some questions that you may have about our practice.

Registration Form – Please complete this form that will assist us in establishing your account with us.

Insurance Authorization and Assignment Guarantee of Payment & Consent for Diagnostic and/or Therapeutic Procedures – Please sign these forms. They allow us to submit your claim to your health payor and allow the physician to exam you on your visit.

Prescription Renewal and Exam Room Escort Policy – Please review these important policies and health tips and sign for our records.

Advance Directive – This is general information about Advance Directives.

Patient Self Determination Act Questionnaire – This is the form that you complete to tell us if you have any advance directives. If you do have any of these in place please provide us copies for our records. You will be asked to update this form on an annual basis.

Patient Consent Form – Please sign this HIPAA form that allows us to use your personal health information to carry out treatment, payment and healthcare operations on your behalf.

Physical Exam History – Please complete this form your physician will review it with you at your visit.

Receipt of Privacy Practices – Our privacy practices are available for your review in our office or on our website www.suncoastfamilymed.com or you may
request a paper copy from our front desk staff in the office. Please sign this receipt concerning our privacy practices.

**Authorization for the Release of Information** – By completing this form it will allow us to obtain your medical records from your previous physician.

Again, we look forward to meeting you!

Sincerely,

Sue Haverty, CMM, CAPPM
Administrator
Suncoast Family Medical Associates  
Practice Procedures

Welcome to our practice. Our staff is committed to providing you with the highest quality care in our specialty of Family Medicine. Our physicians are board certified and fully trained to care for all your medical concerns.

To assure you of the best possible care please take a few minutes to review our daily practice procedures.

Office Hours

Our office opens at 8:00 a.m. Monday – Friday with lunch from 12:00 to 1:00. We close at 4:00 p.m. We do have extended hours on Monday, Tuesday and Thursday for chiropractic services.

Appointments

When you initially call our office, we will attempt to meet your request for the days and times for appointments and to keep waiting time to a minimum. However, our practice handles many emergencies. If an emergency occurs, our office staff will attempt to contact you to reschedule your appointment. We in turn, appreciate you contact us when you will not be able to make your appointment. Due to high overhead we must charge a $25 cancellation fee, if we do not receive 24-hour notice.

Medications

It is very important that the doctor knows every medication you take and its dosage. To prevent harmful contraindications please bring a list of all of your medications or bring all your medications with you on each of your visits.

Emergencies

Emergencies are handled 24 hours a day. A physician is on call if any emergencies arise, and can be contact by calling the office phone number.

Prescriptions

We ask that you contact your pharmacy and that they fax the request for your refill to our office. Refills must be called in during regular office hours only. Refills or request for narcotics will not be accepted after regular business hours. Prescription refills should be called in a minimum of two days prior to taking your last dose.
Referrals

If you participate in a managed care program that requires referrals to specialists, a two-day minimum notice for referrals is required. We do appreciate that you notify our office as far in advance as possible so that your referral can be completed and sent to the specialist before your appointment. Same day requests for referrals will not be accepted in non-urgent cases.

Test Results

It is our office policy to contact only those patients who have abnormal test results. In general all test results are reviewed with you at your next office visit.

Finances

This is a necessary part of our relationship. For your convenience we accept cash, checks, Visa, MasterCard, Discover and American Express. As a courtesy we will file your insurance claim for you. Our system allows sixty (60) days from billing for your insurance to pay. If we have not received payment within the sixty days the account balance may be transferred to you.

In order for us to file your insurance claim, all insurance companies require a signed authorization. This authorization is obtained at the time of your first visit and kept on file. Any co-payments, deductibles or non-covered charges are due at the time of service. You may be asked to sign a waiver of liability form at the time of service if we believe that your insurance may not pay for your service. If you are not covered by insurance full payment is due at the time of service.

Any balance not paid within a reasonable time from patient billing may be transferred to a collection agency.

Please call our office if you wish to confirm our participation in your plan.

In Closing

We look forward to the opportunity to service you. Please call us with any questions.
Suncoast Family Medical Associates
Registration Form

Date ___________________ Social Security Number ___________________

Patient Name ___________________ Date of Birth ___________________ Age ___

Sex _____ Single  Married  Divorced  Widowed  Primary Language ____________
Circled One

Home Address ___________________________________________ Apt/Lot # ___

City ___________________ State ________ Zip Code _______________

Home phone ___________________ Cell Phone _______________________

Referred by ___________________ E-mail address ___________________

If other family members are patients, please give their names: ____________

Employed by ___________________ Employer Phone ___________________

Business Address ___________________ Occupation ___________________

IMPORTANT: In case of emergency, who would we contact? ____________

Relationship _________________ Contact number _________________

Primary Health Insurance Company: _________________ Policy # _________________

Group # _________________ Name of insured if other than patient _________________

Relationship to insured _________________ Date of Birth of Insured _________________

Social Security number of insured _________________

Secondary Health Insurance company _________________ Policy # _________________

Group # _________________ Name of insured if other than patient _________________

Relationship to insured _________________ Date of Birth of Insured _________________

Social Security Number of Insured _________________
Insurance Authorization, Assignment and Guarantee of Payment

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Suncoast Family Medical Associates for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

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 of carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information).

I request that payment under the Medicare or other medical insurance program(s) be made to Suncoast Family Medical Associates for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by Suncoast Family Medical Associates from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Suncoast Family Medical Associates for services rendered.

I understand that I am responsible for payment of all charges and fees to Suncoast Family Medical Associates that they are entitled to collect that are not paid for by Medicare or other insurance.

Signature of Patient/Guardian __________________________ Date _________________

Consent for Diagnostic and/or Therapeutic Procedures

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunizations(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient/Guardian __________________________ Date _________________
Prescription Renewal Policy

Suncoast Family Medical Associate’s physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the medical assistants between the hours of 8 a.m. to 4 p.m. Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality medical care.

Patient Examination Room Escort Policy

To ensure your comfort, at your request, you may have an escort present with you during your examination. Escorts may be a friend or a family member, or we can furnish a member of our staff to be present during your examination. At the physician’s discretion, an escort may also be asked to be present at the time of the examination.

To maintain your good health it is important to us that you; our patient:

Not smoke
Lose weight (if necessary). Maintain your optimum weight.
Exercise daily – walk, swim, etc.
Follow a health diet:
    Decrease – cholesterol, calories, saturated fats, use salt substitutes.
Do not use alcohol or use in moderate amounts only.
Use your safety belts.
Use child safety belts.
Wear your bicycle helmet.
Get regular mammograms and pap smears (start paps with onset of sexual activity or age 18 years)
Have yearly eye exams
Stop use of illegal drugs, marijuana, designer drugs
Use safe sexual practices; HIV protection, venereal diseases
Regular prostate exams for the older male.

______________________________       __________________
Patient Signature                             Date
Advance Directive

What is it?
It is a statement which tells your doctor and family what care you would like to have when you are not able to make those decisions because of the seriousness of your injury or illness.

There are two kinds of Advance directives:
- A Living Will
- Durable Power of Attorney for Health Care

A Living Will - what is it?
It is a statement that lets you tell your doctor and family your wishes if there where no hope for your recovery and you become unable to make your own decisions. An example of this would be whether to continue to use a breathing machine to keep you alive if you were in a permanent coma following an automobile accident.

Durable Power of Attorney for Health Care - What is it?
It is a statement in which you appoint a person to make medical judgements for you if you become unable to make those decisions for yourself. That person should be someone you trust to make health decisions like the ones you would make yourself if you were able. Usually that person would be a close relative or close friend.

Is one better than the other?
They are different and are used for different things so they both are good. These statements are to help your family and your doctor make decisions concerning your healthcare at a time when you are not able to. You may use one or both of these forms of advance directives to provide direction for your medical care. You may combine them into a single statement that appoints a person to make medical decisions for you but also tells that person of your wishes if there is no expectation for reasonable survival.

Can I change my mind?
Yes! You can change your mind or cancel your statement at any time. Changes should be written, signed and dated. You can also make your change of opinion by telling someone (an oral statement).

Who should make out an advance directive?
Because we may have a serious illness or injury at any age, all adults should have an advance directive.
PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

**Declaration to Decline Life-Prolonging Procedure (LIVING WILL)**
- [ ] I have made such a declaration.
- [ ] I have NOT made such a declaration.

**Health Care Surrogate**
- [ ] I have designated a Health Care Surrogate.
- [ ] I have NOT designated a Health Care Surrogate.

**Durable Power of Attorney**
- [ ] I have appointed a Durable Power of Attorney for Health Care decisions.
- [ ] I have NOT appointed a Durable Power of Attorney for Health Care decisions.

---

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

<table>
<thead>
<tr>
<th>Please Print Full Name</th>
<th>Social Security #</th>
</tr>
</thead>
</table>

Signature: ___________________________  Date: ____________

Patient or Patient Representative

Relationship of Patient Representative (If applicable):

---

**YEARLY RECONFIRMATION**

I acknowledge that this information remains accurate.

<table>
<thead>
<tr>
<th>Signature of Patient or Patient Rep.</th>
<th>Date</th>
<th>Signature of Patient or Patient Rep.</th>
<th>Date</th>
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I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Rep: ___________________________  Date: ____________

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SUNCOAST FAMILY MEDICAL ASSOCIATES
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

[ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

[ ] Please check here if you do not want us to leave a voice/text message on your mobile device.

[ ] Please check here if you authorize us to send your healthcare information by email. Please understand that email may be an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to authorize in writing the transmission of your healthcare information to you by unsecured email.

- You may request a copy of and you have the right to read our “Notice of Patient Privacy Practices” prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):________________________

________________________   ______________________   ______________________
Signature   Print name of person signing if other than patient   Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a Healthcare Power of Attorney for the patient. Yes [ ] No [ ] RELATIONSHIP

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: ____________________________ Date: ____________
PHYSICAL EXAM – HISTORY

NAME ________________________________ Chart# _________ AGE _____ D.O.B. _________ TODAY’S DATE: ______________

I. CHIEF COMPLAINT: __________________________________________________________

II. HISTORY OF PRESENT ILLNESS: ____________________________________________

III. PAST MEDICAL HISTORY – Check (✓) all that apply

<table>
<thead>
<tr>
<th>Condition</th>
<th>Check</th>
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<tbody>
<tr>
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<tr>
<td>Diabetic Peripheral Neuropathy</td>
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<tr>
<td>Thyroid Disorder</td>
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<td></td>
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</tbody>
</table>

IV. MEDICATIONS

_________________________________________  ___________________________________________  ___________________________________________

V. ALLERGIES

Allergies to Anesthesia: Yes ______/No ______

VI. PAST SURGICAL HISTORY

_________________________________________

VII. PAST HOSPITALIZATIONS

_________________________________________

VIII. SOCIAL HISTORY:

Married? Yes ______/No ______/Other ______

Monogamous? Yes ______/No ______/Homosexual? _____

# Children _____ Residence ______________________

Live Alone? Yes ______/No ______ Retired? Yes ______/No ______

Occupation: __________________________________________________________

Industrial Exposures: ___________________________________________________

Ever Smoked? Yes ______/No ______ Packs/Day ______ #Years ______

Alcohol Drinker? Yes ______/No ______ Drinks/Day ______

Drug User? Yes ______/No ______

Calcium Suppl. _______________________________________________________

Dietary Hx ____________________________________________________________

Exercise _____________________________________________________________

Seatebts used _____ Flu Vaccine _____ Last DT _____ Pneumovax? ______

X. FAMILY HISTORY

Mom ________ Dad ________ Sibs ________

YES ______ NO ______ Who in Family?

___ ______ Premature C.A.D. ______

___ ______ Hypertension ______

___ ______ Diabetes Mellitus ______

___ ______ Thyroid Disorder ______

___ ______ Breast Cancer ______

___ ______ Colon Cancer ______

___ ______ Other ______

IX. REVIEW OF SYSTEMS ✓ = Normal

Heent: ___________________________

Pulmonary: ______________________

Cardiac: _________________________

GI: _____________________________

GU: _____________________________

GYN: ____________________________

MS: _____________________________

Last PAP ________ Last Mammo ______

Colonoscopy: _____________________

Dental Exam UTD ______ Eye Exam UTD ______

Drives Car? Yes ______ No ______

X. FAMILY HISTORY

Mom ________ Dad ________ Sibs ________

YES ______ NO ______ Who in Family?

___ ______ Premature C.A.D. ______

___ ______ Hypertension ______

___ ______ Diabetes Mellitus ______

___ ______ Thyroid Disorder ______

___ ______ Breast Cancer ______

___ ______ Colon Cancer ______

___ ______ Other ______

ASSISTIVE DEVICES:

Wheelchair: ______________________

Electric Scooter: ______________________

Walker: ______________________

Cane: ______________________

Crutches: ______________________

Eyeglasses: ______________________

Hearing Aids: ______________________

Dentures: ______________________
I, ____________________________, have received a copy of Suncoast Family Medical
(Print Name)
Associate’s Notice of Privacy Practices.

__________________________________________  ________________________
Signature of Patient                          Date
Suncoast Family Medical Associates
Authorization for the Release of Information

I hereby give my permission to (list physician/facility name and address):

__________________________________________________________________________
__________________________________________________________________________

To release a copy of my Protected Health Information (PHI) to:

___ N. Nicholas Engelman, D.O. ___ Krista M. Keith, D.O.  ___ Eugene M. DiBetta, Jr., D.O.
___ Enrique J. Urrutia, Jr., D.O. ___ R.L. DaSo, D.C.

I instruct the above named entity to produce the following information: (Check ONE only)

___ Release entire record
___ I would like specific records released: ______________________________________

Please forward records to the following location:

12020 Seminole Blvd.
Largo, FL 33778
(727) 588-9572   (727) 559-7181 fax

Unless otherwise noted this authorization expires one year from date signed. ____________

My PHI is to be disclosed for:
___ Continuation of care     ___ Other __________________________

The undersigned is a patient of Suncoast Family Medical Associates or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient’s examinations and treatments, including but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient’s total treatment, unless specified below, which may be a part of the medical records. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on the Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the discloser is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Print Patient Name: ________________________________  D.O.B.: __________________

Signature of Patient: ________________________________  Date: __________________

Signature of Guardian: ________________________________  Date: __________________

Relationship: ________________________________  Witness: ____________________