Suncoast Family Medical Associates

12020 Seminole Boulevard, Largo, FL 33778
(727) 588-9572 Fax (727) 369-6001
SuncoastFamilyMed.com

Please bring the following to your first appointment:

1. Paperwork completely filled out. If it does not apply to you, please put N/A.

2. All medications and supplements that you take in the original containers.

3. List of all doctors you may have seen in the past two years. Please include name and phone number so we may request records.

4. Please provide us with the name and phone number of your local pharmacy.

5. Your current insurance card, we need to update this information yearly.

Thank you,

The Physicians and Staff of Suncoast Family Medical Associates

Suncoast Family Medical ASSOCIATES

In order to properly thank your friends and acquaintances, please check all that apply:

How Did You Hear About Us?

_____ Friend or Relative _____ Name

_____ Letter or Postcard

_____ Newspaper Ad

_____ Online Advertisement

_____ Humana.com

_____ Medicare.gov

_____ Insurance Agent _____ Name

_____ Billboard

_____ TV or Radio Ad

_____ Community Newsletter

If you are a Humana member, how did you enroll?

_____ Agent _____ Online _____ Educational Talk _____ Telephone _____ Called Medicare

If you enrolled with an agent, what is his/her name? _____

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New Patient Verification

Welcome to Suncoast Family Medical Associates. If you need any assistance, please let the receptionist know.

Patient_____
Last Name First Name Middle initial

SS#_____ Birth date_____

Home Phone #_____ Cell #_____

Street Address_____

City_____ State_____ Zip_____

Sex □ M □ F Age_____ Significant other □ Yes □ No Name: _____

Do you have any specialist appointments scheduled? □ Yes □ No

- Where & When _____

Prior Doctor and Phone Number:

_____

_____

_____

Insurance:_____

_____

Office Use Only: Availity Done □ Yes □ No

ID/License Scanned □ Yes □ No

Med Records Requested □ Yes □ No

Labs: _____

Dr:_____

Suncoast Family Medical Associates

Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give Suncoast Family Medical Associates consent to perform medical treatment.

Prescription Renewal Policy

Suncoast Family Medical Associates physicians are available for emergencies 24 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 a Medical Assistant during normal business hours of Monday thru Friday.

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 to 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 a healthcare administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permitted copy of this authorization to be used in place of the original comma and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare 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 a 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.

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 they're not paid for by Medicare or other insurance.

_____	_____
Patient Name Printed	Date of Birth
_____	_____
Patient Signature	Date

Suncoast Family Medical Associates

Patient authorization for use and disclosure of protected health information (PHI) for purposes requested by the practice.

(HIPAA Release of information)

Name: _____ Date of Birth: _____/_____/_____

(Please Print)

By signing this authorization, I authorize Suncoast Family Medical Associates to release/ disclose my medical information, medical history; progress notes with diagnosis; laboratory data; imaging studies and claims information. "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 heath 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 health care professionals, laboratories, hospitals etc.) or to others as may be required by law or a 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 or 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 individuals for payment of our services and treatment we provide for you.
- To discuss your healthcare payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your health care treatment or payments.
- To leave appointment reminders or other minimum necessary information related to your health care or health care payments on your answering machine, mobile voicemail 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 do not authorized to send your health care information by email (please understand the 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 reading the transmission of your health care information to you by unsecured email.

- You may request a copy of an 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.

This information may be released to:

[ ] My Spouse/Partner_____
Name(s) Phone #

[ ] My Child(ren)_____
Name(s) Phone #

[ ] Other_____
Name(s) Phone #

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to **Suncoast Family Medical Associates 12020 Seminole Blvd Largo FL 33778**. This practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Suncoast Family Medical Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed By: _____ Date_____/_____/_____

Signature of Patient or Legal Guardian

Suncoast Family Medical Associates

Privacy Policy

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of *protected health information* (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, our physicians and staff have the necessary medical and PHI to provide the highest quality of medical care possible. Our facility will always protect the confidentiality of the PHI of our patients to the highest degree possible. Our patients should not be afraid to provide information to our practice, its physicians and staff for purposes of *treatment, payment and health care operations* (TPO).

To that end, our practice, its physicians and our staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patients covenants and/or authorizations, as appropriate. Our practice, its physicians and staff will not use or disclose PHI for uses outside of our practice's TPO; such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us to not to do so.
- Recognize that PHI collected about the patients must be accurate, timely, complete and available when needed.
- Our practice and its physicians and staff will implement reasonable measure to protect the integrity of all PHI maintained about patients.
- Recognize that patients have the right to privacy. Our practice, its physicians and staff respect the patient's individual dignity at all times. Our practice, its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential information. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements. Not disclose PHI data unless the patient has properly authorized the release or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. This may generate a bill according to Rule 64B8-10.003, Florida Administrative Code. In addition, patients have a right to request an amendment to his/her medical record if they believe his/her information is inaccurate or incomplete.

Suncoast Family Medical Associates

Privacy Policy Contd.

- Permit our patient access to their medical records when their written request is approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site health care professional review the patient's appeal,
- Provide the patient an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPPA rules. We will provide this list to the patient upon request, as long as the request is in writing.
- All physicians and staff in our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, in accordance with our practice rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy. As always, the privacy policy will be made available to patients upon request.

Effective 2016

Suncoast Family Medical Associates

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Suncoast Family Medical Associates privacy practice notice.

_____ _____

Signature of Patient Date

Suncoast Family Medical Associates

12020 Seminole Boulevard, Largo, FL 33778
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Release of Medical Information

I, _____, with a date of birth,_____, give my permission for
(Patient name) (Patient's DOB)

_____to give my medical records (as described) to the above referenced doctor
(Doctor's or hospital name that has records)

and /or organization so that he/she can better understand my condition and continuity of my healthcare.

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

(Please Initial *ALL* Lines)

_____ My mental health,
_____Transmittable disease I may have like HIV/AIDS,
_____Genetic records, and/or
_____Drug and alcohol records.

I understand that:

- **I do not have to give my permission to share these records.**
- **If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.**
- **This form is only good for 1 year from the date I sign it.**

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other _____

Patient's Full Name_____
(Please Print)
Patient's Social Security Number_____ Date Of Birth: _____

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____

Suncoast Family Medical Associates

For HUMANA HMO Patients ONLY

Understanding your insurance and the referral process:

If the insurance plan you have selected is a HMO/managed care plan.

1. Your Primary Care Physician (PCP) will be able to see the total picture of your overall health. This allows your provider to make the best decisions in managing your health and wellbeing.

2. While your Primary Care Provider (PCP) can provide most of your care, if you do need a specialist your PCP manages the care you receive from these healthcare specialists within the network.

3. Your Primary Care Physician (PCP) needs to issue a referral for you before you see any specialist.

4. Your Primary Care Provider (PCP) will choose a specialist that will best suit your needs within your HMO Network.

5. Within the HMO there are a select number of Providers that have demonstrated outstanding care and improved outcomes.

6. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

7. The referral process serves as a way for your PCP and your specialist to communicate with each other. When a referral is issued for you to see a specialist, your PCP will inform the specialist of the reason(s) for the referral as well as the goal(s) for the visit. In other words, your PCP will help coordinate your visit; the referral helps ensure you receive the proper care when seeing a specialist.

Thank you for joining our practice!

_____ _____

Signature Date

INFORMED CONSENT AND AGREEMENT FOR APPROPRIATE BEHAVIOR

IN THE PHYSICIAN OFFICE & WITH PHYSICIAN STAFF

Member Name: _____

The Behavior in Question: _____

Your Rights: As a patient, you have the right to accept or refuse medical treatment, including the use of prescribed substances and therapies, for the treatment and management of conditions impairing and/or affecting your health and well-being.

You also have a right to be informed about the potential benefits, risks and hazards involved with using any prescribed therapies in the treatment and management of your illnesses and/or conditions, so that you may make the decision whether or not to undergo this treatment. You have a right to be informed of any alternative treatments and procedures which may be available to manage your health and illnesses. Finally, you also have the right to change your mind at any time.

Your Responsibilities: As a patient in this office, you also have a responsibility for conducting yourself in a manner consistent with appropriate behavior. "Appropriate behavior" is defined, but not specifically limited to, the following:

- You will neither threaten nor carry out any form of physical abuse to any physician or other staff members involved in your care in this office.
- You will not touch any physician or other staff members involved in your care, that doesn't want to be touched.
- You will not emotionally, psychologically or mentally abuse any physician or other staff member involved in your care. Examples of such activities include, but are not limited to, swearing, bullying, insulting, demeaning, degrading or otherwise using offensive language during the course of office visits, telephone calls, e-mails or other communication with the office staff during the course of your seeking care. Such behavior will not be tolerated at any time and may result in your being transferred from the office's care.
- You will also conduct yourself appropriately with other patients seeking care in the office. Failure to do so will be considered the equivalent of acting with inappropriate behavior to the staff.
- You will accept the responsibilities noted here with respect to standards for "appropriate behavior" OUTSIDE of the office setting. In other words, should you see any of the physicians or other staff who provide care to you in a venue outside of the office, you will conduct yourself in a manner consistent with appropriate behavior.

Our Commitment & Responsibilities to You

We are committed to doing all we can to treat your health conditions. We consider our working with you to be a partnership where we will work together cordially and respectfully to help you

achieve your best health. As a part of that commitment, we will offer you recommendations as to treatments and/or therapies to help you achieve your best health. Moreover, we will respect your choices and decisions with respect to how you wish to manage and address your health.

As a part of our partnership, we provide this "Informed Consent and Agreement for Appropriate Behavior in the Physician Office and with Physician Staff" to protect you and us by establishing expectations as to what is, and is not, considered "appropriate behavior" with respect to what will be tolerated in our office.

Patient Statements

I have been informed per my physician, _____, MD/DO that in order to remain a patient of the practice, I need to conduct myself so that my behavior is appropriate within the office setting. Appropriate behavior needs to be exhibited to any physician who practices in the office as well as to the office staff. Appropriate behavior also needs to be exhibited towards other patients on the premises who are seeking care for their own maladies.

I have been informed and understand that, while my physician will make recommendations as to treatments and/or therapies that could improve my health, my physicians will ultimately respect my decisions with regard to management of my health and well-being.

Termination/Discontinuance of Treatment

With respect to the above agreements, I agree and accept the right of Suncoast Family Medical Associates and/or my provider to discontinue my treatment within the office and to request that I be a "transfer for cause" for the following reason:

• I do not comply with or violate the terms of this "Informed Consent and Agreement for Appropriate Behavior in the Physician Office and with Physician Staff."

In addition, I authorize Suncoast Family Medical Associates to provide a copy of this agreement to my pharmacy, other healthcare providers, or insurance carrier upon request. I also authorize and consent to allow my physician/physician assistant and any other Suncoast Family Medical Associates personnel to disclose or share my medical information and treatment received with any other third parties for purposes of treatment and/or payment purposes. In addition, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to authorizing Suncoast Family Medical Associates and its personnel to cooperate fully with any state or federal law or any state or federal agency (e.g., CMS).

By signing below, I acknowledge and agree that: (i) I have read and fully understand this Informed Consent and Agreement for Appropriate Behavior in the Physician Office and with Physician Staff; (ii) I have been given the opportunity to ask questions about the definition of "appropriate behaviors" (including examples of inappropriate behaviors) as well as potential risks and benefits of non-compliance with appropriate behaviors; (iii) I knowingly accept and agree to assume any potential risks of my non-compliance with recommendations for both treatments and behaviors; and (iv) I agree to abide by the terms herein.

Patient Initials: _____

_____ _____ _____

Signature of Patient Date Signature of Witness

_____ _____

If Patient Unable to Sign, Signature of Other Witness Address

Legally Responsible Person and Relationship to Patient _____

City_____ State_____ Zip Code_____

If necessary, this Form has been translated to the Patient/or other Legally Responsible person by: _____

Signature

I HAVE DISCUSSED THE RISKS, HAZARDS, LIMITATION AND BENEFITS, AS WELL AS ALTERNATIVE TREATMENT POSSIBILITIES WITH THE PATIENT AND ANSWERED ALL QUESTIONS ASKED OF ME.

_____

Physician Signature

_____

Date

Suncoast Family Medical Associates

HEALTH HISTORY QUESTIONNAIRE

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

Primary Language:	**Interpreter Needed?** ☐ Y ☐ N
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:**
EMERGENCY CONTACT: **Contact #:**	
Can we send you our newsletter? ☐ Y ☐ N	**Email:**
Can you afford your medicine? ☐ Y ☐ N ☐ Potential referral to assistance program _____	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Influenza	☐ Chickenpox	☐ Shingles
	☐ Hepatitis	☐ Pneumonia	☐ MMR *Measles, Mumps, Rubella*	

HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES?

Amputation	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Alcohol Overuse	☐ Yes	☐ No
Allergies (Other than Medications)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Location:		
Cardiac Arrhythmias	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No

CVA/TIA	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema/COPD	☐ Yes	☐ No
Falls	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Heart Attack/ MI	☐ Yes	☐ No
Other Heart Disease (CHF/CAD)	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No

Migraine Headaches	☐ Yes	☐ No
Nervous Breakdown	☐ Yes	☐ No
Ostomies	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Sleep Disorder	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Vascular Disease	☐ Yes	☐ No

OPERATIONS, SERIOUS INJURIES, HOSPITALIZATIONS AND DIAGNOSTIC TESTS/EXAMS (PLEASE LIST REASONS AND APPROXIMATE YEAR)

		OTHER:

Durable Medical Equipment? ☐ Yes ☐ No ☐ Wheelchair ☐ Oxygen ☐ Walker/Cane ☐ Nebulizer ☐ CPAP/BIPAP ☐ Other:_____

Provider Signature: _____ Date_____

Suncoast Family Medical Associates

FAMILY HISTORY-HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING AND THEIR RELATIONSHIP

ILLNESS	YES/NO		RELATIONSHIP
Arthritis	☐ Yes	☐ No	
COPD	☐ Yes	☐ No	
Bleeding Tendency	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Colitis	☐ Yes	☐ No	
Congenital Heart Disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Heart Attack	☐ Yes	☐ No	

ILLNESS	YES/NO		RELATIONSHIP
High Blood Pressure	☐ Yes	☐ No	
Intestinal Polyps	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Leukemia	☐ Yes	☐ No	
Nervous Breakdown	☐ Yes	☐ No	
Stomach Ulcers	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Suicide	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Other:			

PREVENTATIVE SERVICE HISTORY-HAS THE FOLLOWING TESTING: NEVER BEEN DONE (NO), OR, HAS BEEN DONE (YES). IF YES, YOUR BEST ESTIMATE OF THE MONTH/YEAR THE TEST WAS PERFORMED AND THE RESULT.

Preventative Service	YES/NO		Month/Year	Result
Bone Mass Measurement (Bone Density)	☐ Yes	☐ No		
Bloodwork	☐ Yes	☐ No		
Colorectal Cancer Screening: Colonoscopy	☐ Yes	☐ No		
Colorectal Cancer Screening: Fecal Occult Blood Test (Stool Card)	☐ Yes	☐ No		
Vision Screening: Eye Exam	☐ Yes	☐ No		
Female Screening: PAP & Pelvic Examination	☐ Yes	☐ No		
Female Screening: Mammogram	☐ Yes	☐ No		
Male Screening: PSA – Prostate Specific Antigen	☐ Yes	☐ No		
Other:	☐ Yes	☐ No		

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	☐ Occasional exercise	☐ Regular vigorous exercise
Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Alcohol /Drugs	Do you drink alcohol? ☐ Y ☐ N - #/day	Do you use the following? ☐ CBD ☐ Marijuana
	Do you use drugs? ☐ Y ☐ N	☐ Cocaine ☐ Meth ☐ LSD ☐ Ecstasy/MDMA ☐ Other_____
Sex	Are you sexually active?	☐ Yes	☐ No
	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? [ ] Apartment [ ] Mobile Home [ ] House [ ] Asst. Living [ ] Ind. Living	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have problems with speech?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No

Provider Signature: _____ Date_____

Suncoast Family Medical Associates

MY MEDICATION LIST

Name:	Birth Date:
Pharmacy:	Pharmacy Phone:
Allergies:	

Latex Allergy	☐ Yes ☐ No	**PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT. Nitrile Gloves are available.**
Iodine Allergy	☐ Yes ☐ No	

Name of Medication	Strength (ex. mg, units …)	How to Take (ex. Take 1 tablet by mouth 2 times daily)	When to take medication

Provider Signature: _____ Date_____

Humana

Care for Older Adults assessment

Patient name:_____ Date of service:____/____/_____(mm/dd/yyyy)

Member ID: _____ Date of birth: ____/____/_____(mm/dd/yyyy)

Physician name: _____

This document is intended to capture requested clinical quality information only. Other write-in information will not be considered.

1159F AND 1160F

Prescription (Rx)	Dosage	Disease being treated/reason for medication	Side effects discussed
			☐
			☐
			☐
			☐
			☐

INTERNAL OFFICE USE ONLY

PLEASE CONTINUE TO THE NEXT SECTION BELOW

Functional assessment: Does patient have difficulties performing the following activities? Date assessed: ____

Bathing	☐ Yes	☐ No	☐ N/A	Transferring	☐ Yes	☐ No	☐ N/A	
Dressing	☐ Yes	☐ No	☐ N/A	Using the toilet	☐ Yes	☐ No	☐ N/A	
Eating	☐ Yes	☐ No	☐ N/A	Walking	☐ Yes	☐ No	☐ N/A	

Treatment plan discussed with patient

1170F

☐ Occupational therapy referral ☐ Review of Rx ☐ Physical therapy referral ☐ Assistive device evaluation

Physical activity assessment Date assessed: ____

Patient is physically active	☐Yes ☐No	Patient is active 30 minutes a day most days of the week	☐Yes ☐No
Patient plans to become active in the next few months	☐Yes ☐No	Patient expresses fear to become active or participate in physical activity	☐Yes ☐No
Patient participates in activity regularly	☐Yes ☐No	If so, what type? _____	

1158F

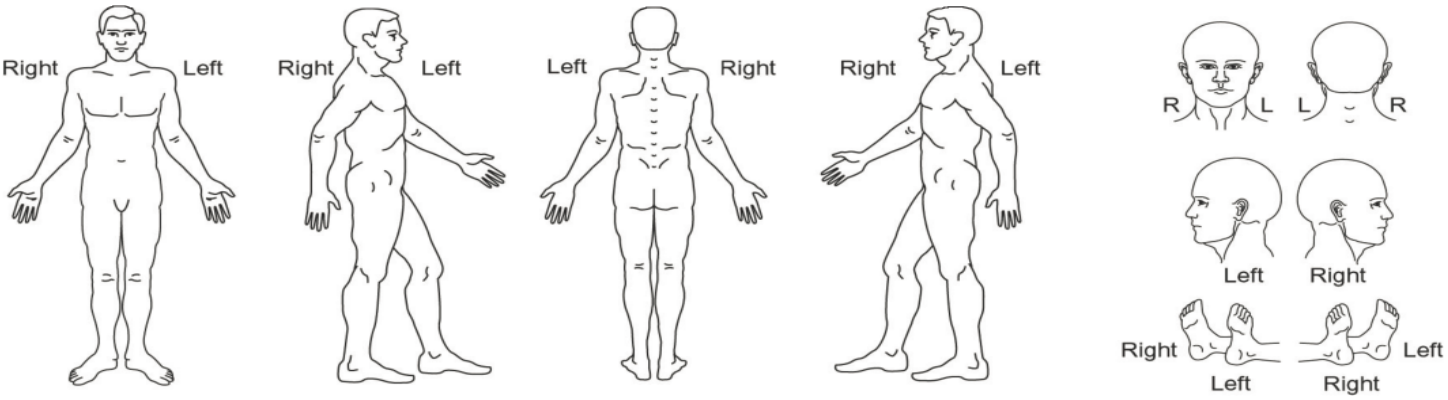
Patient advised: ☐ Daily walks ☐ Stretching ☐ Start taking the stairs ☐ Increase walking as tolerated

1157F *OR*

Advance care planning: ☐ Advance directive in medical record Discussion on ____/____/____

Pain assessment Date assessed: ____

1125F Pain OR 1126F No Pain



Pain intensity (0 lowest to 10 highest)_____ Present pain_____ Worst pain_____ Best pain _____

Quality of pain: _____ Onset, duration, variation and rhythms? _____

What causes the pain? _____ What relieves the pain?_____

Physician name and credentials:

Suncoast Family Medical Associates

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
Several days (#) _____ x 1 = _____
More than half the days (#) _____ x 2 = _____
Nearly every day (#) _____ x 3 = _____

Total score: _____

Provider Signature: _____ Date_____

Humana

Patient name: _____ Date of service: ____/____/____(mm/dd/yyyy)

Member ID: _____ Date of birth: ____/____/____(mm/dd/yyyy)

Affirmation statement:

The physician acknowledges and agrees that Humana may update and adjust this template form as necessary. Updated forms are available at Humana.com/provider/medical-resources/clinical/quality-resources, under the Preventive Care tab.

Medicare payment to Medicare Advantage organizations is based, in part, on each patient's diagnosis, as attested to by the patient's attending physician by virtue of his or her signature on this medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to a fine, imprisonment or civil penalty under applicable federal laws.

By signing this document, you attest to reviewing the medical documents to complete the form, using the best of your medical knowledge, placing the completed original of this form in the patient's medical record and ensuring fully-documented proof of service of all completed fields is contained in the patient's medical record. (Note: If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record.)

To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

Physician name and credentials (printed) *Physician signature and credentials (signed)* *Date*

Provider office number: (727) 588-9572 Provider: _____ Type: _____

Billing provider ID: _____ National provider ID: _____ Tax ID number: _____

Provider address: 12020 Seminole Blvd

Street address

Largo Florida 33778

City State ZIP

SUNCOAST FAMILY MEDICAL ASSOCIATES

Contract for Controlled Substances 2023

Jeffrey S. Grove, D.O., FACOFP	Ty L. Tvedten, D.O.	Eugene M. DiBetta, D.O.
Karen C. Joseph, M.D., FAAFP	Enrique J. Urrutia, D.O.	Krista M. Keith, D.O.
Tyler T. Otto, D.O.	Alicia G. Pratt, APRN	Lena A. Patel, M.D.

Patient Name: _____ Date: _____

Date of Birth: _____

Controlled substances can be useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Patients who are prescribed controlled substances will have regular follow up appointments every 3 to 6 months in order to be prescribed and continue the use of controlled substances. Because my physician is prescribing controlled substances to help manage my pain, I understand and voluntarily agree that **(initial each statement after reviewing):**

____ 1. I am responsible for the controlled substances prescribed to me and understand that I must keep the medication safe, secure, and out of reach of children at all times. If my prescription is misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced.

____ 2. I will request refills of controlled medications during regular office hours Monday through Friday, or during a scheduled office visit. **Refills will not be made at night, weekends, or during holidays.**

____ 3. I agree to provide a sample (urine or blood) for a drug screen at any appointment. I agree that it is my responsibility to make these appointments and to be on time for all scheduled appointments.

____ 4. I agree to sign a release form to let my doctor speak to all other providers that I see and to notify my doctor of any new medications that have been given to me by another doctor.

____ 5. I agree to use a single pharmacy in the State of Florida for all my controlled substance prescriptions. In the event my prescribed medication is unavailable, I will immediately notify Suncoast Family Medical Associates prior to filling my prescription at a different pharmacy.

____ 6. I will not share, sell, or trade my medication with anyone. I will take only as prescribed to me.

____ 7. It may be deemed necessary by my doctor that I see a medication-use specialist while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.

____ 8. I understand if my drug testing results **reveal** medication that is not prescribed to me, including but not limited to illicit drugs, or absence of medication that is prescribed to me, I will be in violation of this agreement.

____ 9. I understand if I **violate** any of the conditions in the agreement, my prescriptions for controlled medications will be terminated immediately and I will be given a 30-day notice of discharge from the practice. If the violation involves obtaining these medications from another individual, or combining use of non-prescription illicit (illegal) drugs, including but not limited to heroin, cocaine, marijuana, or amphetamines, etc., it may also be reported to all my physicians, medical facilities, pharmacies, and the appropriate authorities. I understand that controlled

substances should not be mixed with alcohol, as this could be fatal. If I am found to be mixing alcohol with controlled substances, I will be in violation of this agreement, and may be discharged from the practice.

____ 10. I understand that the main treatment goal is to reduce pain and improve my ability to function. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

____ 11. I understand that the long-term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. 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.

____ 12. I will treat the staff at the office respectfully at all times, I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

____ 13. I understand that I may lose my right to treatment in this office if I break any part of this agreement or my doctor decides that this medication is not providing the correct benefit.

According to Florida State Law (893.13) Section 7, it is illegal for persons to see multiple physicians to obtain controlled substance medications. To do so is in clear violation of Florida laws regarding drug abuse and can result in arrest. We, at Suncoast Family Medical Associates will assist the Sheriff's office in all aspects regarding this law. I give my consent to Suncoast Family Medical Associates and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Suncoast Family Medical Associates. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by Suncoast Family Medical Associates without order of clerk of court.

I have been fully informed by Suncoast Family Medical Associates regarding psychological dependence (addiction) of controlled substances. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and that is a risk of becoming physically dependent on the medication. This will occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.

I have thoroughly read this agreement and understand the consequences of violating this agreement:

DATE: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PROVIDER NAME: _____

PROVIDER SIGNATURE: _____