PATIENT REGISTRATION FORM

Appointment date:				
PATIENT INFORMATION				
Patient's Name Last First MI				Marital Status
Date of Birth	Age	Gender	Social Security #	
Street address City, State, Zip				
Phone (Home)	Phone (Cell)		Email address	
Race/Ethnicity	Veteran or Active Military		Primary Language	
Pharmacy Name	Pharmacy Address		Pharmacy Phone	
IN CASE OF EMERGENCY				
Emergency Contact			Relationship to patient	
Street address			City, State, Zip	
Phone (Home)			Phone (Cell)	
INSURANCE INFORMATION				
☐ **Medicare** ☐ **HMO** ☐ **PPO** ☐ **Other** _____				
Primary Insurance			**Secondary Insurance**	
Address			Address	
City, State, Zip			City, State, Zip	
Phone	Fax		Phone	Fax
Policy Subscriber Name			Policy Subscriber Name	
Patient's relationship to subscriber			Patient's relationship to subscriber	
Subscriber ID# or Social Security #			Subscriber ID# or Social Security #	
Plan Name			Plan Name	
Policy #	Group #		Policy #	Group #
EMPLOYMENT INFORMATION				
Employer			Occupation	
Street Address			City, State, Zip	
Phone	Fax		Email	

HOW WERE YOU REFERRED TO OUR OFFICE?

□ Letter or postcard	□ Insurance Agent _____
□ Newspaper Ad	□ Billboard
□ Online Advertisement	□ TV or Radio AD
□ Humana.com	□ Community Newsletter
□ Medicare.gov	□ Friend/Relative _____

HEALTH HISTORY QUESTIONNAIRE

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

Patient Name: Last First MI

Today's Date: Reason for Visit:

Previous or referring doctor: Gender ☐ M ☐ F DOB:

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

☐ AIDS/HIV +	☐ Cataracts	☐ Gout	☐ Migraine Headache	☐ Tuberculosis
☐ Anemia	☐ Chicken Pox	☐ Heart Disease	☐ Neuropathy	☐ Stomach Ulcers
☐ Anxiety	☐ Depression	☐ Hepatitis	☐ Pneumonia	**LIST ANY OTHERS**
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Prostate Problem	
☐ Asthma	☐ Eating Disorder	☐ High Cholesterol	☐ Rheumatic Fever	
☐ Bleeding Disorders	☐ Emphysema/COPD	☐ Hypertension	☐ STD	
☐ Breast Lump	☐ Epilepsy	☐ Kidney Disease	☐ Stroke	
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Problems	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you know your blood type? ☐ Yes ☐ No Type:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Drug Name	Strength	Frequency Taken
1			6		
2			7		
3			8		
4			9		
5			10		

Allergies

Drug Name	Reaction You Had	Drug Name	Reaction You Had
1		3	
2		4	

PATIENT NAME:		DOB:	

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)

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?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco? Or have you ever?			☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	☐ Vape/E-Cigarette
	☐ # of years: ____	☐ Or year quit: _____			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever used recreational or street drugs?			☐ 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
	Physical and/or mental abuse have 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 doctor or staff?			☐ Yes	☐ No

WOMEN ONLY			
Age at menstruation:	Date of last PAP smear: / /	☐ Normal	☐ Abnormal
Number of pregnancies __ Number of live births _____	Age at last menstruation:		
Last Mammogram: / /		☐ Normal	☐ Abnormal
Bone Density Screening: / /		☐ Normal	☐ Abnormal
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No
Do you have any bladder leakage or incontinence?		☐ Yes	☐ No

MEN ONLY		
Do you usually get up to urinate during the night? If yes, # of times __	☐ 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 PSA test (if any): / /	☐ Normal	☐ Abnormal

PATIENT NAME: **DOB:**

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/welts
- ☐ Itchiness
- ☐ Allergic asthma

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting/Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Irregular heartbeat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

SCREENINGS (please indicate most recent date)

Last Colonoscopy: / / ☐ Normal ☐ Abnormal	Cholesterol Screening: / /	☐ Normal	☐ Abnormal
Test for blood in stools: / / ☐ Normal ☐ Abnormal	Electrocardiogram: / /	☐ Normal	☐ Abnormal

FAMILY HEALTH HISTORY

RELATION	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

Patient signature _____ Date _____

Provider/APRN signature _____ Date _____

Suncoast Family Medical Associates

Authorization for the Release of Information

I hereby give my permission to

Facility/Dr. (First, Last) _____ **Specialty**: _____

Address: _____

Phone # _____ **Fax #** _____

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

___ Jeffrey S. Grove, D.O.
___ Tyler T. Otto, D.O.
___ Enrique J. Urrutia, Jr., D.O.
___ Bryan M. Clark, D.O.
___ Ty L. Tvedten, D.O.
___ Eugene M. DiBetta, Jr., D.O.
___ Mary E. Martino, M.D.
___ Karen C. Joseph, M.D.
___ Daniel A. Eckstein, M.D.
___ Alicia G. Pratt, APRN
___ Joseph Plantier, APRN
___ Crystal Khang, APRN
___ Amanda Jennison, APRN

___ Release entire record
___ I would like specific records release: _____

Please forward records to the following location:
12020 Seminole Blvd.
Largo, FL 33778
Phone: (727) 588-9572 Fax: (727) 369-6001

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/AIDS, 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 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 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: _____

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)

  ☐ I have ☐ I have NOT made a Living Will

- Health Care Surrogate

  ☐ I have ☐ I have NOT designated a Health Care Surrogate

- Durable Power of Attorney

  ☐ I have ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may <u>verbally</u> inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address**:** _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Confidential messages (i.e., appointment reminders)

☐ May ☐ May **<u>not</u>** be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:

_____

I am fully aware that a cell phone is not a secure and private line.

_____ _____

PLEASE *PRINT* PATIENT NAME **DATE OF BIRTH**

_____ _____

LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **TODAY'S DATE**

CONSENT TO TREAT

I, the undersigned, voluntarily give consent to Suncoast Family Medical Associates to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ **Date:** _____ **DOB:** _____
Patient Printed Name

_____ **Relationship to Patient:** _____
Signature of Patient/Legal Representative

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of Suncoast Family Medical Associates, Notice of Privacy Practices.

_____ **Date:** _____
Signature of Patient/Legal Representative

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Suncoast Family Medical Associates to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Suncoast Family Medical Associates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ **Date:** _____
Signature of Patient/Legal Representative

Consent for Transfer of Biological Specimen

Florida law (Section 817.5655, Florida Statutes) and Suncoast Family Medical Associates, prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care with Suncoast Family Medical Associates, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Suncoast Family Medical Associates, to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date of Birth

Consent to Text Message Updates

I, _____, date of birth_____,
(Patient Name)
consent to have Suncoast Family Medical Associates, contact me by text message for the purpose of health updates and appointment reminders.

☐ I allow text messages for health updates / appointment reminders

☐ I do not allow text messages

I acknowledge that appointment reminders by text are an additional service, and attending or canceling an appointment is still my responsibility.

I agree to advise the practice if my mobile number changes or if it is no longer in my possession. I can cancel these text reminders at any time.

Texts messages are generated using a secure facility. I understand that they are transmitting over a public network on to a personal device that may not be secure. SMS data rates may apply.

Patient Signature: _____

Date: _____ Mobile Phone Number: _____

Financial Policy

The information listed below was designed to provide our patients with a detailed explanation of our financial policies. We realize this information may not always address your specific situation and encourage you to speak with a member of our billing department whenever you have any questions or concerns regarding your account.

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.

Registration

Information gathered provides us with contact information as well as ensures your claims will be filed to the correct insurance company.

Upon arrival for your appointment, you will be asked for basic information:

- Current patient information: name, address, telephone number, employer, date of birth, social security number, and emergency contact.
- Current Insurance Card.

Please arrive at least fifteen (15) minutes prior to your appointment time. Having information readily available will assist us in making the check-in process easier for you. Information obtained in the registration process is kept in your confidential medical record.

You will be asked to make co-payments at the time of service. For your convenience, we can also handle your payments on your account at the registration desk. We accept cash, check, debit cards and major credit cards (MasterCard, Visa, and Discover).

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 through Friday.

Patient Signature: _____ Date: _____

Physician/APRN Signature: _____ Date: _____

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.

Questions Regarding Your Account

If you have questions regarding your account or wish to make a payment using MasterCard, Visa, Discover or Debit Card, please contact our Billing Department during the hours of 8:00 am and 4:00 pm, Monday through Friday, at 727-588-9572.

Thank you for your cooperation in helping us serve you with the highest quality, accessible and cost effective health care services.

Care for Older Adults assessment

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

Physician name: _____ Date of birth: ____/____/_____(mm/dd/yyyy)

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
			☐
			☐
			☐
			☐
			☐

1170F

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

☐ 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? _____	

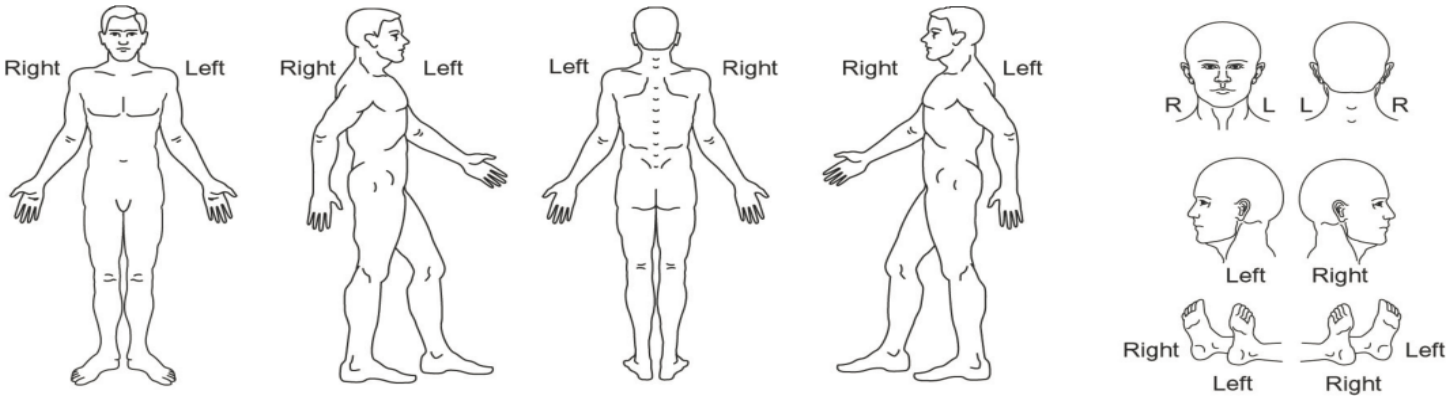
1158F OR 1157F

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

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

1125F Pain OR 1126F No Pain

Pain assessment Date assessed:



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 of Birth:** _____

	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: _____

5 minutes was spent reviewing this form with patient

Physician/APRN Signature: _____ **Date:** _____

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

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 FL 33778

City State ZIP

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

Patient Initials: _____

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 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 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 SFMA and its personnel to cooperate fully with any state or federal law or any state or federal agency (eg. 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 is unable to sign, signature of other witness/
legally responsible person and relationship to patient

_____ _____

Signature of Witness Relationship to patient

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

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/APRN signature

_____

Date

SUNCOAST FAMILY MEDICAL ASSOCIATES

Contract for Controlled Substances 2026

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. Daniel A. Eckstein, M.D.
Bryan M. Clark, D.O. Tyler T. Otto, D.O. Mary M. Martino, D.O. Alicia G. Pratt, APRN
Joseph Plantier, APRN Crystal Khang, APRN Amanda Jennison, APRN

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: _____

Social Determinants of Health Screening

Your physician may ask you follow up questions.

Domain	Question	Response
Living Situation	What is your living situation today?	○ I have a place to live today, but I am worried about losing it in the future ○ I do not have a steady place to live now or in the past 12 months ○ I have a steady place to live
	Have you ever been displaced from your home?	○ Yes ○ No
	If you live alone, do you have issues with mobility, cooking, cleaning, or worrying about safety issues?	○ Yes ○ No ○ I do not live alone
Food	Within the past 12 months, have you not had enough food or worried that your food would run out before you have enough money to buy more?	○ Often true ○ Sometimes true ○ Never true
Transportation	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	○ Yes ○ No
Material/Financial Hardship	In the past 12 months have you had issues paying for your electricity, gas, oil, water or any other basic needs such as food, housing, medical care, and heating?	○ Yes ○ No
Social Support	How often do you feel lonely, excluded, or isolated from family, friends or your community?	○ Always ○ Sometimes ○ Never

_____ _____ _____

Patient Name Patient Signature Date

5 minutes was spent reviewing this form

_____ Physician/APRN Signature