Patient Information

Name: ____
Last First M.I.

Address: ____
Street City State Zip

DOB: __/__/____ Sex: M/F _____ Employer: ____________________________

SSN: ____________________ Email: ______________________________________

Home Phone: __________________ Cell Phone: __________________________

Optional: Race__________ Ethnicity: _________ Language: _______________

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner ☐

Emergency Contact

Name: ______________________________ Relation to Patient: _______________

Home Phone: ________________________ Cell: ___________________________

Name: ______________________________ Relation to Patient: _______________

Home Phone: ________________________ Cell: ___________________________

Insurance Information

Insurance Company: ____

Policy Number: _________________________ Group Number: ______________

Policy Holder: _____________________________ DOB: ____________________

Secondary Insurance Company: ____

Policy Number: _________________________ Group Number: ______________

Policy Holder: _____________________________ DOB: ____________________

ADULT HEALTH HISTORY

Name: ____________________________ **Date of Birth:** ____________________

Employer: ________________________ **Highest Level of Education:** _________

Reason For Visit: _______________________________

Hospitalizations: State year followed by illness or operation (Most recent first)

PAST MEDICAL AND FAMILY HISTORY

(Please check if you or any BLOOD relative has these conditions)

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
Recent Weight Loss			Kidney/Bladder Problem		
Migraine Headaches			Neurological		
Epilepsy/Convulsions			Arthritis		
Eye Disease			Osteoporosis		
Heart Disease			Stroke/TIA		
COPD/Emphysema			High Cholesterol		
Asthma			Coronary Artery Disease		
Seizure Disorder			Hypertension		
Head Trauma			Benign Prostatic Hyperplasia		
Sleep Apnea			Hiatal Hernia		
Parkinson's Disease			Pulmonary Embolism		
Fibromyalgia			Gastro Esophageal Reflux		

PAST MEDICAL AND FAMILY HISTORY

(Please check if you or any BLOOD relative have these conditions)

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
Gout			Kidney Disease		
Obesity			Restless Leg Syndrome		
Thyroid Disease			Heart Valve Replacement		
Insomnia			Anemia		
Diabetes Mellitus			Cardiac Arrhythmia		
Lupus			Heart Disease		
Chronic Pain			Cancer Type:		
Heart Attack			Liver Disease		
Depression			Hepatitis		
Bowel Issues			Respiratory Failure		
Memory Loss			Psoriasis/Eczema		

Please list any other illness that you have been diagnosed with:

____

____

FAMILY HISTORY

Mother: Alive ☐ Deceased ☐ Age at Death ____ Cause of Death ___________

Father: Alive ☐ Deceased ☐ Age at Death ____ Cause of Death ___________

SOCIAL HISTORY

Do you drink caffeine? Yes ☐ No ☐ Tobacco Use: Yes ☐ No ☐ Quit ☐How many daily? _______________ Packs Daily: __________________

Recreational Drug Use? Yes ☐ No ☐ Quit ☐ Alcohol Use? Yes ☐ No ☐ Quit ☐ List/ Frequency: ________________ Average per day: ______________

Last Time you Had:

Flu Vaccine _______ Tetanus Shot______ T.B. Test_____ Eye Exam____ Colonoscopy____

Stool Blood Test ______Pneumonia Shot ______ Dental Exam _____ Rectal Exam______

MEDICATIONS

Medication **Dose** **Time/Day** **Reason**

Allergies

Pharmacy

Trouble Falling Asleep Yes ☐ No ☐ Trouble Staying Asleep Yes ☐ No ☐
Trouble returning to sleep Yes ☐ No ☐ Snore Yes ☐ No ☐

MEN ONLY

Prostate Exam _____/ ____/ ____

WOMEN ONLY

Date of last Period ____/____/_____ Regular Y ☐ N ☐ Spotting Y ☐ N ☐ Birth Control Yes ☐ No ☐ Name/Type: ____________________________

Number of Pregnancies _______ Number of Births __________

Number of Abortions _______ Number of Miscarriages _________

YEAR OF LAST

Pap: __________ ☐Normal ☐Abnormal

Breast Exam: _______ ☐Normal ☐Abnormal

Mammogram: ______☐Normal ☐Abnormal

Bone Density: _____☐Normal ☐Abnormal

Additional Comments:

____

____

____

Allergy Questionnaire

Patient name____ D.O.B.______________________________

What problem brings you or your child to this appointment? ____

____

When did symptoms begin? ____

Are your symptoms getting worse? ☐ Yes ☐ No

Do you have any of these symptoms? (Please check)

☐ Cough	☐ Runny Nose	☐ Nasal Polyps	☐ Eczema
☐ Wheezing	☐ Nasal Congestion	☐ Poor Sense of Smell	☐ Hives/Swelling
☐ Shortness of Breath	☐ Itchy Nose	☐ Ear Infections	☐ Headaches
☐ Chest tightness	☐ Itchy/Watery Eyes	☐ Sinus Infections	☐ Snoring
☐ Sneezing	☐ Postnasal Drip	☐ Blocked Ears	☐ Fatigue
	☐ Phlegm/Sputum (color) ________________		☐ Other

Check any of the following which seem to trigger (or cause) symptoms or bother you:

☐ Grass	☐ Cats	☐ Cosmetics	☐ Drafts	☐ Nervousness
☐ Hay	☐ Dogs	☐ Aerosol sprays	☐ House dust	☐ Cold Air
☐ Mold and Mildew	☐ Horses	☐ Perfumes	☐ Smoke	☐ Humidity
☐ Basements	☐ Other animals	☐ Insecticides	☐ Pollution	☐ Weather changes
☐ Leaves	☐ Alcoholic Beverages	☐ Odors	☐ Exercise	☐ Latex (rubber)

Other ____

When are your symptoms worse? ☐ Year Round ☐ Seasonal

Are symptoms better away from home? ☐ Yes ☐ No If Yes, When? __________________

Occupation (current or former) ____

Any harmful exposure at work or school? ____

ENVIRONMENTAL SURVEY

Do you have pets (number) – Indoor or Outdoor ☐ None ☐ Cats ____ ☐ Dogs ____ ☐ Birds ____ ☐ Other ____

Are there any tobacco smokers in your home? ☐ Yes ☐ No

Do you have allergy proof encasing for pillow or mattress? ☐ Yes ☐ No

What type of pillows do you have? ____

What type of comforter do you have? ____

What type of floor covering do you have in your bedroom? ☐ Wall to wall ☐ Area Rug ☐ Animal skin ☐ Bare floor

How old is your mattress? ________________What is in your mattress? (i.e. cotton/horse hair) _____________

Do you have air conditioning? ☐ Yes ☐ No If yes, ☐ Window Unit ☐ Central

Do you have problems with roaches or mice? ☐ Yes ☐ No

Do you have water leaks, mold contamination? ☐ Yes ☐ No

Is your home/apartment excessively humid? ☐ Yes ☐ No

YOUR PAST MEDICAL HISTORY

Check all that apply:

☐ Eczema ☐ Upper Respiratory Infection ☐ Asthma ☐ Sinus Problems

☐ Emphysema

If yes to any of the above, please explain: ____

Do you smoke? ☐ Yes ☐ No how much? ________________________

Have you smoked in the past? ☐ Yes ☐ No When stopped? ______________________

If yes, how many years have you smoked? ____

Patient/Guardian Signature: ______________________________________ Date: ______________________

Patient Financial Responsibility

All patients or guardians are responsible for 100% of the charges incurred for treatment at PedIM Healthcare.

- The patient or guardian who signs the financial policy statement is the responsible party.
- Established patients who have health insurance benefits that have been verified will be expected to pay that portion of the charges not covered under their policy as well as any applicable co-payments under the terms of their policy.
- Patients who have health insurance benefits that have been verified will be responsible for all charges, paid in full on the day of service, until their policy out of pocket has been met.
- PedIM Healthcare is not responsible for incorrect information given by your insurance company.
- Patients who have health insurance benefits that have not been verified will be responsible for any portion of the charge that are not covered, as well as any applicable co-payments under the terms of their policy.
- Having an active health insurance policy in no way negates a patient's responsibility for payment of their medical charges, if these charges are denied or not covered by the patient's insurance carrier.
- Patients may pay their bills by cash, check, or credit.
- There will be a $20.00 charge applied to your account for patients who do not keep their appointments, including no-shows.
- Patients who fail to pay their outstanding balance within 90 days of the service being provided may be turned over to a collection agency. The patient will still be responsible for the charges as well as all collection agency costs and fees, including reasonable attorney fees.

PedIM Healthcare utilizes Transaction Central, Patient Payment Assurance to securely maintain your payment information in compliance with federal and state laws.

Your payment information filed with Transaction central will be saved for future processing of patient responsible portions not paid by insurance; miscellaneous healthcare fees such as but not limited to late, cancelled or missed appointments.

We have developed these financial policies in an effort to keep your medical costs down. Printing and mailing statements is an extremely time consuming and expensive undertaking. We ask that you adhere to these policies as part of your financial responsibility. Our staff will assist you in any way that we can. If you have any questions regarding our fees or your insurance coverage and filing of your insurance claims please ask to speak with one of the members of our billing and insurance department. Billing Department: (352) 563-0931.

I authorize PedIM Healthcare to process financial transactions to pay my account balance. I agree to be financially responsible for any and all related charges, if they are not covered by my insurance policy.

Controlled Substance Consent Form and Management Agreement

This agreement between the undersigned (patient) and Pediatric & Internal Medicine Specialists, Inc. is to establish clear conditions for the prescription and use of controlled substances prescribed by the doctor for the patient. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship. The patient agrees to and accepts the following conditions for the management of controlled substance prescribed by the doctor for the patient:

1. Controlled substance may be prescribed for me ONLY by Pediatric & Internal Medicine Specialists, Inc.

2. I will not solicit nor accept a prescription for controlled substance from any other physician without the prior written consent of Pediatric & Internal Medicine Specialists, Inc.

3. I will take the prescribed medication only at the dose and frequency, as prescribed.

4. I will not, under any circumstance, increase my dose or frequency without my doctor's permission.

5. I will and do consent to random drug screening at the doctor's request.

6. I will not use any illegal substances, including marijuana, cocaine, amphetamine, etc.

7. I will not use this medication with any alcohol-containing beverages.

8. I will not share, sell, or trade my medication for money, goods, or services.

9. I will not undergo any pain management procedures or injections without the preceding consent Pediatric & Internal Medicine Specialists, Inc. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.

10. I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my medication for a period of time, and may precipitate a re-evaluation of my competence to continue on these medications.

11. I understand that an important part of my treatment plan program may include non-drug treatment. If I fail to follow-through with my doctor's treatment program, I understand and agree that my prescription may be withdrawn.

12. In the case of prescribed narcotic (Opioid) medications. I understand that reduction in the intensity of my pain as well as improvement in my quality of life and function-ability is the desired goals of treatment. Should it become evident to my doctor that these objectives are not being met with the use of the prescribed medication, I agree to weaning and discontinuation of this medication.

I understand that the long-term advantages and disadvantages of chronic medication use have yet to be scientifically determined and that treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

I understand that all medications have potential side effects. I have been fully informed by the doctor of the potential side effects including, but not limited to: Physical dependence, pseudo-addiction, chemical dependence, addiction, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to organs.

In the case of prescribed narcotic (Opioid) medication treatment, a distinct clinical syndrome, "Hyperalgesia Syndrome", has been described in the literature and can result in increased pain from continual and escalated doses of controlled substance. If I take more medication than prescribed, a dangerous situation could result such as coma, organ damage, or even my death.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until my abilities have been properly evaluated and/or my medications have been held for four days.

I agree to waive any applicable privileges or right of privacy or confidentiality with respect to prescription medication and I authorize Pediatric & Internal Medicine Specialists, PA and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, in the investigation of any possible misuse, sale or other diversion of my medication. I understand that Pediatric & Internal Medicine Specialists, PA may utilize the EFORCSE website to further assess my compliance.

I agree to the following regarding prescription refills: Prescription refills of my medication will be made only during regular office hours, in person, once every month during a scheduled office visit, or more frequently as recommended by Pediatric & Internal Medicine Specialists, Inc. Refills will not be made on an emergency basis, nights, weekends, or holidays. I am free to visit an ER or other physician and have them contact my doctor in any emergency situation.

I agree to be evaluated by a psychologist and/or addiction specialist at any time during my treatment at my doctor's request. If, in their opinion, I am not a candidate for further narcotic treatment, I agree to weaning and treatment discontinuation.

(Females only): Narcotics are felt to have minimal risk for development of birth defects. However, if I continue to take these medications throughout pregnancy, my child will be born drug-dependent and need specialized care. I therefore agree that if I plan to become pregnant, or believe I have become pregnant while on these medications, I will immediately notify my obstetrician and Pediatric & Internal Medicine Specialists, Inc.

Doctor and patient agree that this agreement is essential to the doctor's ability to treat the patient effectively and that failure of the patient to abide by the terms of this agreement may result in the withdrawal of all prescribed medication by the doctor and the termination of the doctor-patient relationship.

Acknowledgement

I have read or have had the above form read to me and understand all of it. I have had a chance to have all my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment with controlled substance.

____

PRINT PATIENT NAME — **DATE OF BIRTH**

____

SIGNATURE/RELATIONSHIP TO PATIENT — **DATE**

AUTHORIZATION TO RELEASE MY MEDICAL CARE

I ______________________________ give Pediatric & Internal Medicine Specialists, Inc. permission to discuss my medical care and account information with the following person(s):

Name of authorized person	Relation	Phone
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________

______________________________ ____________

Signature of Patient Date

____

Printed Name of Patient

1990 N. Prospect Ave
Lecanto, FL 34461
www.pedimhealthcare.com

Pediatric & Internal Medicine Specialists, Inc. ©
PedI.M. Healthcare

Tel: 352-527-6888
Fax: 352-527-8818
info@pedimhealthcare.com

Healthcare for your entire family...

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

PedIM Healthcare is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. PedIM Healthcare is required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

The following describes how PedIM Healthcare may use your protected health information for treatment, payment or health care operations.

Treatment:

PedIM Healthcare may use health information about you to provide you with health care treatment or services. PedIM Healthcare may disclose health information about you to doctors, nurses, or other essential personnel who are involved in your care.

Payment:

PedIM Healthcare may use and disclose health information about you to receive payment for services provided to you. Under Florida law we must obtain your written consent in order to submit claims for services provided to you. Failure to sign may force us to decline you as a new patient or discontinue you as an active patient.

Health Care Operations:

PedIM Healthcare may use and disclose health information about you for operational purposes related to our office. We may also and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointments Reminders
Treatment Information
Disclosure to Department of Health and Human Services
Family and Friends
Notification
Disaster Relief
Health Oversight Activities
Abuse or Neglect
Judicial and Administrative Proceedings
Law Enforcement
Specialized government Functions
Coroners, Medical Examiner's and Funerals Directors
Organ Donation
Research
Public Health Activities
Public Safety
Worker's compensation
Business Associates

MINIMUM NECESSARY INCIDENTAL DISCLOSURES AND SUPER CONFIDNETIAL INFORMATION

Our staff will not use or disclose your medical information unless it is necessary to perform their jobs. We will follow both state and federal laws related to the use and disclosure of super-confidential information such as HIV/AIDS, alcohol/substance abuse and mental health records.

AUTHORIZATIONS and CONSENTS:

We will not use or disclose your medical information for any other purpose other than treatment, payment or health care operations without your written authorization. Once given, you may revoke your authorization in writing at any time. This consent is required under Florida law in order for our office to submit claims and other information needed to receive for services rendered to you or your family.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

- You may ask us to restrict certain uses and disclosures for your medical information. We are not required to agree to your request, but if we do we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by PedIM Healthcare during the last 6 yrs. Except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please require at the Registration desk (you will be directed to our Privacy Officer).
- To file a complaint with the U.S. Department of Health and Human Services you must submit your complaint in writing, within 180 of the alleged violation to:

Region I.V, Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W
Atlanta, GA 30303-8909
Voice phone 404-562-7886
Fax 404-562-7881

For the full version of PedIM healthcare privacy policy, view our website at www.pedimhealthcare.com

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PedI.M. Healthcare

Tel: 352-527-6888
Fax: 352-527-8818
info@pedimhealthcare.com

Healthcare for your entire family...

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:	**DOB:**

Previous Physician/Office Name:	
Specialty:	
Phone:	**Fax:**
City:	**State:**

I hereby authorize and release the custodian of my/my dependent's medical records to **PedIM Healthcare**, including psychological, psychiatric, develop-Mental/rehabilitative alcohol, and/or drug abuse human immunodeficiency virus (HIV) testing and treatment, ARC (AIDS related condition), and/or acquired immunodeficiency syndrome (AIDS) information.

Release To: PedIM Healthcare

☐ Dacelin St. Martin, MD ☐ Louis Bois, MD ☐ Lilia Shammas, MD ☐ Todor Toromanovski, MD

P.O. Box 2066 Lecanto, FL 34460 Phone:352-527-6888 Fax: 352-527-8818

*****IF RECORDS EXCEED 15 PAGES WE REQUEST THAT THEY BE MAILED******

Purpose of Use or Disclosure:	☐ Continuity of Care ☐ Other:

Information to be Released:	☐ Complete Chart ☐ Radiology Reports ☐ Lab Reports ☐ Diagnostic Testing ☐ Immunizations ☐ Other: ________
PATIENT INITIALS________	**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV, or AIDS information.**

-I understand that all medical, surgical, psychiatric, and psychological information is confidential and that the patient records are the property of Pediatric & Internal Medicine Specialists, PA and its related corporate entities. I will not hold Pediatric & Internal Medicine Specialist, PA, its employees, staff, or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.
-I understand that my authorization for release may be revoked at any time by written request to Pediatric & Internal Medicine Specialists, PA, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Pediatric & Internal Medicine Specialists, PA to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest your coverage.
-I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release Pediatric & Internal Medicine Specialists, PA, its employees, its staff, and representatives from all liability relating to or arising out of this release of information contained Pediatric & Internal Medicine Specialists, PA records.
-I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from Pediatric & Internal Medicine Specialists, PA. However, if the only purpose for providing the service is to obtain information in order to release information to myself or a t third party, then I understand that I must sign the authorization in order to receive the service.
-I understand that there may be a charge of $1.00 per page for the first 25 pages and then $.25 per page thereafter, plus postage and handling, for copy services unless copies provided by Pediatric & Internal Medicine Specialists, PA are sent directly to a physician or health facility for the purpose of continuity of care.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified below.
Expiration Date or Circumstance: ____________________

Patient Signature: ______________________ **Date:** ______________

Relationship to Patient If Not Self: ______________________

Witness/Requested By: **Date:**

PRIVACY POLICY, FINANCIAL RESPONSIBILITY AND CONSENT FOR TREATMENT

I, ____, hereby authorize Pediatric and Internal Medicine Specialists,
(**Printed** Patient Name)
Inc, it's affiliated physicians and other medical personnel in charge of my care to administer examinations, immunizations, treatments and view my prescription history from an external source as may be deemed medically necessary in the exercise of their professional judgment. Additionally, by signing this form I acknowledge that I have received a copy of the Privacy Policies and Financial Responsibility Policy for the office of Pediatric and Internal Medicine Specialists, Inc.

____ ____________________
(**Printed** Patient Name) (Date of Birth)

____ ____________________
(Patient Signature) (Date)

____ ____________________
Witness Signature (Date)

____
Patients Chart Number