Thank you for choosing The Comprehensive Breast Care Center of Tampa Bay.

Appointment Location

___ Axelrod Pavilion
400 Pinellas Street
Suite 200
Clearwater, Florida 33756
(727) 462-2131

Appointment Date: __________________
Please arrive at: _________ : ________ am/pm

___ Morton Plant Mease Outpatient Center
2102 Trinity Oaks Boulevard
Suite 204
Trinity, FL 34655
(727) 462-2131

Please bring the following information to the appointment with you:

Photo ID

Insurance Card(s)

Completed paperwork

Disks and reports from imaging center outside of Morton Plant (example: SDI, Rose Radiology, Gateway Radiology, Palm Harbor MRI, Westcoast Radiology)

Failure to bring completed paperwork and imaging reports/disks may result in your appointment being rescheduled.

Thank You!

The Comprehensive Breast Care Center of Tampa Bay

Rev. 3/2017
Patient Registration Form

**Patient Information**

Name: ___________________________________________  Preferred first name: ___________________________________________

DOB: ___________________________________________  □ Female □ Male  SSN: ___________________________________________

Primary phone: ___________________________  Type: □ Home □ Cell □ Work  Marital status: ___________________________

Primary patient notification preference: □ Primary phone □ Secondary phone □ Mail

Ethnicity: □ Hispanic or Latino  □ Not Hispanic or Latino  Race: □ American Indian or Alaska Native □ Asian
□ Black or African American  □ Native Hawaiian or Other Pacific Islander □ White □ Other

Primary language: ___________________________  □ Native Hawaiian or Other Pacific Islander □ White □ Other

Primary address: ___________________________________________

City: ___________________________  State: ___________________________  Zip: ___________________________

Country of primary address: ___________________________________________

Secondary phone: ___________________________________________  Type: □ Home □ Cell □ Work

Personal email*: ___________________________  Preferred method of notification: □ Phone □ Email

*Personal email is required for access to the patient portal

Secondary address: ___________________________________________

City: ___________________________  State: ___________________________  Zip: ___________________________

**Additional Patient Information**

Primary care physician: ___________________________________________

Person financially responsible: ___________________________  Relationship: ___________________________

Referring physician (if different from primary care): ___________________________________________

How did you hear about us? ___________________________________________

Employer: ___________________________________________

Employer address: ___________________________________________

City: ___________________________  State: ___________________________  Zip: ___________________________

Phone: ___________________________  Ext: ___________________________

Emergency contact: ___________________________  Emergency contact: ___________________________

Relationship to contact: ___________________________  Relationship to contact: ___________________________

Contact phone: ___________________________  Contact phone: ___________________________

Employment status: ___________________________________________
Patient Registration Form

Insurance Information

Primary: ________________________________ Secondary: ________________________________

Policy holder ID: __________________________ Policy holder ID: __________________________

Policy holder name: __________________________ Policy holder name: __________________________

Policy holder DOB: __________________________ Policy holder DOB: __________________________

Policy holder’s employer: __________________________ Policy holder’s employer: __________________________

Patient relationship to policy holder: __________________________ Patient relationship to policy holder: __________________________

Policy holder sex: ☐ Female ☐ Male  
Policy holder sex: ☐ Female ☐ Male

Copay amount: ________________________________

Pharmacy: __________________________ Location: __________________________

Pharmacy phone: ________________________________

Extended Information

Do you have a visual impairment that will prevent you from reading written material from your doctor? ☐ Yes ☐ No

Do you have a hearing impairment that will complicate spoken communication with your doctor?  ☐ Yes ☐ No

Have you seen a specialist since your last visit with your primary care doctor?  ☐ Yes ☐ No

If yes, please indicate the name of the provider(s) below.

Provider: ______________________________________

Provider: ______________________________________

Patient signature: ______________________________________

Date: ___/___/____

Printed name: ______________________________________

BayCare Medical Group
Health Information Questionnaire

Name: ___________________________________________________________ Date: __/__/__

DOB: ___________________________________________________________ Age: ___________  □ New patient  □ Established patient

What medical/health concerns bring you to our office today? ____________________________________________

Medical History

Have you ever had or been diagnosed to have (check all that apply):

□ Alzheimer’s disease  □ Chicken pox  □ Hemorrhoids  □ Rheumatic fever
□ Anemia  □ Colon polyps  □ High blood pressure  □ Seizures/epilepsy
□ Anxiety  □ Depression  □ High cholesterol  □ Stroke
□ Arthritis  □ Diabetes/prediabetes  □ Irritable bowel syndrome  □ Syphilis
□ Asthma  □ Fracture  □ Jaundice/liver disease  □ TB/lung disease
□ Atrial fibrillation  □ Glaucoma  □ Kidney disease  □ Thyroid disease
□ Bleeding disorder  □ Heart attack  □ Migraines/headache  □ Ulcers
□ Blood transfusion  □ Heart disease  □ Osteopenia  □ Urinary incontinence
□ Cancer: What kind?  □ Heart failure  □ Osteoporosis  □ Other: ____________
□ Cataracts  □ Heart murmur  □ Pneumonia  □ Prostate problems

OB/GYN History (females only):

Age of menses: _____ Age of menopause: _____ Method of birth control: _____________________________

How many pregnancies: _____ How many children: ___________ Vaginal or C-section _______________

Hospitalizations and Surgeries

List any hospitalizations, surgeries or procedures you have had performed.

<table>
<thead>
<tr>
<th>What</th>
<th>Date</th>
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<th>Date</th>
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<tbody>
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</table>

Specialists

List any other doctors involved in your care.

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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</table>
Health Information Questionnaire

Medications
List all medications you take on regular basis (include over-the-counter, herbal or natural remedies).

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Daily Frequency</th>
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<tbody>
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</table>

Allergies
Are you allergic to any medications?  Yes  No
If yes, please list: ________________________________

Health Maintenance
If you’ve had a test or vaccine done, list when last performed:

- Bone density test: ________________
- Cholesterol screen: ________________
- Colonoscopy: ________________
- Diabetes screen: ________________
- Eye exam: ________________
- Flu vaccine: ________________
- Hep A vaccine: ________________
- Hep B vaccine: ________________
- HIV testing: ________________
- HPV vaccine: ________________
- Mammogram (females only): ________________
- Pap smear (females only): ________________
- Pneumonia vaccine: ________________
- Shingles vaccine: ________________
- Tetanus vaccine: ________________

Family History
Please indicate if your blood relative(s) have had/currently have the following by placing an X in appropriate column:

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Alcoholism</th>
<th>Mental Health Issues</th>
<th>Heart Attack/Disease</th>
<th>High Cholesterol</th>
<th>High Blood Pressure</th>
<th>Diabetes</th>
<th>Thyroid Disease</th>
<th>History of Bowel Problems</th>
<th>Allergies</th>
<th>Osteoporosis</th>
<th>Alzheimer’s Disease</th>
<th>Seizure</th>
<th>Stroke</th>
<th>Cancer (what kind)</th>
<th>Other</th>
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<tr>
<td>Mother (age ____)</td>
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<td>Brother(s) (age __)</td>
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<td>Sister(s) (age __)</td>
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<td>Grandparents</td>
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<td>Biological children</td>
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<tr>
<td>Other: ___________</td>
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</tbody>
</table>
New Patient Health Questionnaire

Social History

Do you drink alcohol? [ ] Yes [ ] No

It you answered yes, answer these additional questions:
- What type of alcohol? ______________________
- How frequently? ______________________
- How many drinks does it take to get you high? ______
- Have people annoyed you by criticizing your drinking? [ ] Yes [ ] No
- Have you ever felt you should cut down on your drinking? [ ] Yes [ ] No
- Have you ever had a drink first thing in the morning to steady your nerves? [ ] Yes [ ] No
- Have you ever had a substance abuse problem? [ ] Yes [ ] No

If you answered yes, answer these additional questions:
- What type of drugs do you use? ______________________
- How frequently? ______________________

Have you ever smoked? [ ] Yes [ ] No

If you answered yes, answer these additional questions:
- Do you still smoke? [ ] Yes [ ] No
- How many cigarettes/day? ______________________
- How many years have you smoked? ______________________
- If you recently stopped smoking, when did you quit? ______________________

Occupation: ____________________________________________ [ ] Full-time [ ] Part-time

If retired, what was your former occupation: ____________________________________________

Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other: ____________________________

Education through grade: __________________________________________

Do you regularly exercise? [ ] Yes [ ] No

What type of exercise (e.g. biking, walking, running, swimming, etc.)? ______________________ How often? ____________

Number of children: ______________________ Number of persons in household: ______________________

What type of living arrangement: [ ] House [ ] Apartment [ ] Condo [ ] Dorm [ ] Other: ____________________________

Do you feel safe in your home environment? [ ] Yes [ ] No

Do you eat a healthy diet? [ ] Yes [ ] No

Are you on a special diet? [ ] Yes [ ] No

Do you use caffeine on regular basis? [ ] Yes [ ] No

Do you have any sleeping problems? [ ] Yes [ ] No

Do you have a high level of stress in your life? [ ] Yes [ ] No

Do you lack interest or pleasure in doing things you used to do? [ ] Yes [ ] No

Are you sexually active? [ ] Yes [ ] No

First active at age: ___________ Current # of partners: ________________ Number of live partners: ____________

Self-described orientation: ______________________

Use of contraception: [ ] Condoms [ ] Birth control [ ] Other: ____________________________
**New Patient Health Questionnaire**

**General Information**
- Who completed this health form? 
- What is your preferred language for health care information? 
- What is the best way for the office to contact you?  
  - Phone  
  - Email  
  - Other: 
- Are you disabled?  
  - Yes  
  - No 
- If yes, what is the nature of your disability? 
- Do you have a living will or an advance directive?  
  - Yes  
  - No 
- If yes, what type? 

If you experienced any of these issues in the last 10 days, place a check mark next to the symptom.

<table>
<thead>
<tr>
<th>General</th>
<th>Mental Health</th>
<th>Endocrine</th>
<th>Cardiovascular</th>
<th>Gastrointestinal</th>
<th>Reproductive - Women</th>
<th>Reproductive - Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent fever</td>
<td>Thoughts of suicide</td>
<td>Unusual intolerance of heat</td>
<td>Abnormal/irregular heart beat</td>
<td>Unable to eat certain foods</td>
<td></td>
<td></td>
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<tr>
<td>Excessive fatigue</td>
<td>Marital problems</td>
<td>Unusual intolerance of cold</td>
<td>Chest pain</td>
<td>Loss of appetite/weight</td>
<td></td>
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<tr>
<td>Unexplained weight loss/gain</td>
<td>Trouble sleeping</td>
<td>Excessive thirst</td>
<td>Awaken at night with breathing problems</td>
<td>Food sticks in throat</td>
<td></td>
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<tr>
<td>Eyes</td>
<td>Panic attacks</td>
<td>Excessive hunger</td>
<td>Passing out</td>
<td>Painful swallowing</td>
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<tr>
<td>Discharge</td>
<td>Anxiety</td>
<td></td>
<td>Shortness of breath</td>
<td>Heartburn</td>
<td></td>
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<tr>
<td>Pain or burning</td>
<td>Thoughts of harming others</td>
<td>Urinary</td>
<td>Swelling of ankles</td>
<td>Indigestion</td>
<td></td>
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<tr>
<td>Blurred vision</td>
<td>Skin</td>
<td>Pain/burning with urination</td>
<td>Leg pain/resting</td>
<td>Nausea</td>
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<tr>
<td>Loss of sight</td>
<td>Change in nails</td>
<td>Frequent urination</td>
<td>Leg pain/walking</td>
<td>Vomiting blood</td>
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<tr>
<td>Itching or watering</td>
<td>Lumps</td>
<td>Blood in urine</td>
<td></td>
<td>Abdominal or stomach pain</td>
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<tr>
<td>Breast</td>
<td>Recurrent rashes</td>
<td>Trouble starting to urinate</td>
<td></td>
<td>Diarrhea</td>
<td></td>
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<tr>
<td>Pain</td>
<td>Sores that will not heal or that bleed</td>
<td>Waking up to urinate</td>
<td></td>
<td>Constipation</td>
<td></td>
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<tr>
<td>Lumps</td>
<td>Moles that are changing</td>
<td>Leakage of urine</td>
<td></td>
<td>Recent change in bowel habits</td>
<td></td>
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<tr>
<td>Nipple discharge</td>
<td></td>
<td>Change in stream</td>
<td></td>
<td>Blood in stools</td>
<td></td>
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<tr>
<td>Respiratory</td>
<td>Ears</td>
<td>Nervous System</td>
<td></td>
<td>Black stools</td>
<td></td>
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<tr>
<td>Cough</td>
<td>Hearing loss</td>
<td>Headaches</td>
<td></td>
<td>Musculoskeletal</td>
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<tr>
<td>Coughing up blood</td>
<td>Ringing</td>
<td>Seizures/convulsions</td>
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<tr>
<td>Shortness of breath</td>
<td>Earache</td>
<td>Fainting spells</td>
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<tr>
<td>Wheezing</td>
<td>Feeling of ear tullness</td>
<td>Frequent memory loss</td>
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<tr>
<td>Snoring</td>
<td></td>
<td>Weakness</td>
<td></td>
<td>Joint pain</td>
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<tr>
<td>Reproductive - Women</td>
<td>Mouth and Throat</td>
<td>Shakiness or tremor</td>
<td></td>
<td>Joint stiffness</td>
<td></td>
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<tr>
<td>Irregular periods</td>
<td>Dry mouth</td>
<td>Loss of sensation/numbness</td>
<td></td>
<td>Muscle soreness</td>
<td></td>
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<tr>
<td>Spotting between periods</td>
<td>Soreness or bleeding</td>
<td>Feeling of tingling in limb</td>
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<td>Blood Disorders</td>
<td></td>
<td></td>
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<tr>
<td>Vaginal discharge/burning/itching</td>
<td>in mouth area</td>
<td>Speech difficulty</td>
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<tr>
<td>Unusually painful periods</td>
<td>Sore throat</td>
<td>Nose and Sinuses</td>
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<tr>
<td>Pain/trouble during intercourse</td>
<td>Mouth ulcers</td>
<td>Bleeding</td>
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<tr>
<td>Reproductive - Men</td>
<td>Hoarseness</td>
<td>Nasal congestion</td>
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<tr>
<td>Discharge from penis</td>
<td>Dental issues</td>
<td>Sneezing</td>
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<tr>
<td>Pain or swelling of testicles</td>
<td></td>
<td>Loss of sense of smell</td>
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<tr>
<td>Pain/trouble during intercourse</td>
<td>Neck</td>
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<tr>
<td>Problems with erection</td>
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</tbody>
</table>
Please complete the following personal and family history to better assess your breast cancer risk

<table>
<thead>
<tr>
<th>Family</th>
<th>Deceased Y/N</th>
<th>Age of Diagnosis</th>
<th>Breast</th>
<th>Ovary</th>
<th>Pancreas</th>
<th>Uterus</th>
<th>Colon Rectum</th>
<th>Stomach or Small Bowel</th>
<th>Melanoma</th>
<th>Thyroid</th>
<th>Other</th>
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<tbody>
<tr>
<td>You</td>
<td>N/A</td>
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<td>Your Daughter</td>
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<td>Paternal Grandmother</td>
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</table>

Have you or any family member ever had genetic testing?  ☐ Yes  ☐ No  If yes, please list type and results:

Are you of Ashkenazi ancestry?  ☐ Yes  ☐ No  ☐ Unknown

Office Use Only:
Outcome: Genetic Testing/Counseling Offered/Refused  Initials __________  Date __________

BayCare Medical Group
Breast Care Questionnaire

Name ___________________________________________________________ DOB __________ Date: ________________

PREGNANCY:
Age of first live birth: __________
Number of living children: __________
Did you breastfeed?  ☐ Yes ☐ No

MENSTRUAL PERIODS:
Age of your first menstrual period: __________
Are your periods regular?  ☐ Yes ☐ No
Date last period began? __________
Age at menopause? __________

BIRTH CONTROL:
Have you ever taken birth control pills?  ☐ Yes ☐ No
When and for how long? __________

HORMONE THERAPY:
Have you ever taken hormones?  ☐ Yes ☐ No
What drug: __________
(e.g. Premarin/Premprio/Bioidenticals)
When and for how long? __________

SURGICAL HISTORY:
Hysterectomy  ☐ Yes ☐ No 
Date: __________ Age: __________
Ovaries Removed  ☐ Yes ☐ No
Right / Left/ Both Date: __________ Age: __________
Breast Biopsy  ☐ Yes ☐ No
Right / Left Date: __________ Age: __________
Previous Chest Wall Radiation  ☐ Yes ☐ No
If so, when and where? __________

CURRENT PROBLEM:  When did you first notice?
Lump you can feel  ☐ Yes ☐ No
Pain  ☐ Yes ☐ No
Nipple Discharge  ☐ Yes ☐ No
Breast Trauma  ☐ Yes ☐ No
Abnormal Mammogram  ☐ Yes ☐ No
Abnormal Ultrasound  ☐ Yes ☐ No
Other  ☐ Yes ☐ No

IMAGING:
When and where was your last mammogram? __________
When and where was your last breast ultrasound? __________

PHYSICIAN NOTES:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Uses and Disclosures of Your Protected Health Information (PHI)

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff

I have been provided with a “Notice of Patient Privacy Practices” that provides a more complete description of information uses and disclosures.

Tell us with whom we may discuss your protected health information: (Name and relation - Example: Jane Doe, Wife; Jan Doe, Daughter) ____________________________________________________________

Messages or Appointment Reminders
Messages will be of a non-sensitive nature, such as, appointment reminders.

May we leave a message on your voice mail using doctor's/practice name?  
Yes ☐ No ☐

May we leave a message with another individual using doctor's/practice name?  
Yes ☐ No ☐

May we leave a message at your work using doctor's/practice name?  
Yes ☐ No ☐

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

_________________________________________          ________________________________
Patient/guardian signature                  Date

Print name of person signing

If other than the patient (patient name) ___________________________________________ is signing, are you the legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or health care operations?  Yes ☐ No ☐
Request for Care and Consent for Treatment

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered to the patient under the general and special instructions of the patient's physician. BayCare Medical Group has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Assignment of Insurance Benefits

I authorize payment directly to BayCare Medical Group of any insurance benefits otherwise payable to me for services, at a rate not to exceed BayCare Medical Group regular charges for such services.

Releasing Medical Information

I understand that BayCare Medical Group, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal health care operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Facility and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review BayCare Medical Group's Notice of Privacy Practices.

Permission for Treatment

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below such medical and surgical treatment as is deemed necessary.

The undersigned certifies that he/she has read the forgoing, received a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Patient (print name): _____________________________________________________________
Signature of patient or authorized person: ____________________________________________ Date: ______________
Relationship: _______________________________________________________________ Date: ______________
Witness signature: __________________________________________________________ Date: ______________
If the patient did not sign, please state reason: _______________________________________

BayCare Medical Group
Financial Responsibility
Important Information Regarding Your Account

Statement of Financial Responsibility
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of “Non-Covered” Services
I am aware that some services performed by the Practice may be considered “non-covered” by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

Waiver of “Usual, Customary and Reasonable” Clauses (For patients with "Out-of-Network" coverage)
I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered “usual, customary and reasonable,” due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill To/Payment Instructions
_____ Commercial Insurance/Third Party Payor _____ Medicare _____ Medigap*
Initial Initial Initial

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to be made to the Practice on my behalf.

*If Medigap
Name of Beneficiary ____________________________ Medigap Policy Number ____________________________ Health Insurance Claim Number ____________________________

List Names of Those with Whom You Want Us to Share Your Financial Responsibility Information:

Name: ____________________________ Relationship: ____________________________
Name: ____________________________ Relationship: ____________________________
Name: ____________________________ Relationship: ____________________________

Financial Agreement
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Patient's name: ____________________________________________________________
(please print)

Patient (or legal guardian's) signature: __________________________________________

Date: ____________________________

If legal guardian, relationship to the patient: __________________________________________
Authorization to Use or Disclose Protected Health Information

☐ Physician

I hereby authorize the above physician(s) to use or disclose the following information from the health records of the individual whose name is described below.

Patient Name: ___________________________ Date of Birth: ____________________
(Please Print)

Address: ___________________________________________________________________

(City)    (State)   (Zip) Phone Number: _______________________________
Social Security #: ____________________________

I authorize the above physician(s) to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name: _____________________________________________________________________
Address: __________________________________________________________________
(City)    (State)   (Zip)

• This information for which I’m authorizing disclosure will be used for the following purpose:
Description: __________________________________________________________________

Dates of service to be released: __________________________________________________________________

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated). Copy medical records to ☐ Electronic medium or ☐ Paper

☐ Office Notes ☐ Radiology Results
☐ Immunization Record ☐ Lab Results
☐ EKG ☐ Medications
☐ Other: (please describe) __________________________________________________________________

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signed ___________________________ Date: ____________________
Patient or Authorized Person, ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney
☐ Photo ID checked

Witness: ___________________________ Date: ____________________

Copied by: ___________________________ Date: ____________________ Pages copied: __________