We respect your time and would like to make your visit as efficient as possible.

Arrive 15 minutes before your scheduled appointment time.

To avoid delays when you arrive, **please complete the enclosed forms in advance then mail, fax 813-849-9301 or drop them off before your appointment to our office.**

Please note: Bring your insurance card, ID Card, prescription and non-prescription medication list.

Thank you,
Tampa Bay Family Physicians
Management

TAMPA BAY family PHYSICIANS

Tampa Bay Family Physicians, Inc.
REGISTRATION FORM

(Please give your photo ID and insurance card to the receptionist)
(Please Print)

Patient's Last Name:	**First Name:**	**Middle :**	**Marital status (circle one)** Single / Married / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ☐ M ☐ F

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report/Unreported	**Social Security No.** _____	**Primary Language:**	☐ English ☐ Spanish ☐ Other, specify :_____

RACE: ☐ American Indian or Alaska Native	☐ White	☐ Asian	☐ African American	☐ Native Hawaiian or other Pacific	☐ Refuse to report/Unreported	☐ Other _____

Street address:	**City:**	**State:**	**ZIP Code:**	**E-mail:**

Mailing Address (if different than physical address) P.O. box:	**City:**	**State:**	**ZIP Code:**

Home Phone: ☐ Y ☐ N Can leave message. ( )
Cell Phone: ☐ Y ☐ N Can leave message. ( )
Work Phone: ☐ Y ☐ N Can leave message. ( )

Living Situation: ☐ Own home ☐ Assisted Living ☐ Senior Citizen Housing ☐ Condo or apartment ☐ Nursing home ☐ Mobile home ☐ Retirement home ☐ W/family member ☐ Other, specify

How did you hear about us (please check one box):	☐ Tampa Bay Times	☐ Family/Friend	☐ Insurance Plan	☐ Hospital

☐ The Sun News (Tampa Tribune)	☐ Post Card	☐ Flyer	☐ News of Sun City Center	☐ The South Shore News (Tampa Tribune)	☐ News of Kings Point	☐ The SCC Observer

Preferred Pharmacy:
Address:

Mail Order Pharmacy:

BILLING & INSURANCE INFORMATION

Person responsible for bill:	**Birth date:** / /	**Address** (if different):	**Home phone no.:** ( )

Is this person a patient here? ☐ Yes ☐ No **Relationship**:

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Medicare	☐ TriCare	☐ Blue Cross Blue Shield	☐ United HealthCare	☐ Aetna

☐ Avmed ☐ Other (please check at front desk if we are in network with your insurance or call your insurance)

Subscriber's name (if different than patient):	**Subscriber's S.S. no.:**	**Birth date:** / /	**Policy no./Member ID:**	**Group no.:**	**Co-pay:** $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Policy no./Member ID:**	**Group no.:**

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient**:	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize medical services be rendered to me by Tampa Bay Family Physicians, Inc. I authorize my insurance benefits be paid directly to Tampa Bay Family Physicians, Inc. for services rendered. I understand that I am financially responsible for any balance. I also authorize Tampa Bay Family Physicians, Inc. or insurance company to release any information required to process my claims

_____ _____

Patient/Guardian signature ***Date***

Tampa Bay Family Physicians, Inc.

PATIENT INITIAL INTAKE QUESTIONNAIRE

Please show your answer by filling up the bubble signs e.g. ●

Name: _____ **DOB:** _____ **Sex:** ○ **M** ○ **F**

Who was your previous primary care provider? _____

CURRENT MEDICATIONS (Please list all of your medications):

Name of Medication	Dosage/Strength	Frequency/dosing Instructions
Example: Tylenol	*Example:500 mg*	*Example: 1 pill three times a day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Note: this information may be taken directly from the pharmacy label on prescription bottles

ALLERGIES (Are you allergic or sensitive to any medication?)

○ No Known Allergies ○ Medication Allergies ○ Environmental/Seasonal Allergies ○ Latex Allergy

Allergies	Reaction
Example: Dust, pollen, ibuprofen, amoxicillin etc.	*Example: skin rash, itchy eyes, hives, face bumps etc.*

PERSONAL MEDICAL HISTORY: Only **select** whatever applicable?

○ NONE

Condition	Yes	Comments	Condition	Yes	Comments
Alcohol/Drug abuse	○		Blood Transfusion	○	
Allergy (Hay Fever)	○		Breast Lump (benign)	○	
Anemia	○		Coronary Artery Disease	○	
Angina	○		Cancer (What Type)	○	
Anxiety	○		Chicken Pox	○	
Arthritis (Rheumatoid)	○		Colon Polyp	○	
Arthritis (osteoarthritis)	○		Depression (Major) (Bipolar)	○	
Asthma	○		Diabetes (type I) (type II)	○	
Bladder/Kidney Problems	○		Diverticulosis	○	
Blood Clot (leg) (lung)	○		Emphysema (COPD)	○	

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

Revised: 12/11/2014

Patient Initials _____ DOB: _____ Date: _____

Condition	Yes	Comments	Condition	Yes	Comments
Fractures (broken bones) (Specify)	○		Osteoporosis	○	
GERD/Acid Reflux/Heartburn	○		Prostate (enlargement) (nodules)	○	
Heart Attack / Myocardial Infarction (year)	○		Seizure/Epilepsy	○	
Hepatitis- (specify type)	○		Skin Condition (specify)	○	
High Blood Pressure/Hypertension	○		Sleep Apnea	○	
High Cholesterol	○		Stomach Ulcer	○	
Irritable Bowel Syndrome (IBS)	○		Stroke	○	
Chronic Kidney Disease / Failure (CKD)	○		Thyroid disease	○	
Kidney Stones	○		Other (list)	○	
Liver Disease	○		Other (list)	○	
Migraine Headaches	○		Other (list)	○	

PAST SURGICAL HISTORY (Have you had any of the following surgical procedures?): ○ None.

Surgical Procedure	Yes	Year	Surgical Procedure	Yes	Year
Appendectomy (Appendix removal)	○		Hysterectomy (total, including ovaries)	○	
Spine/back Surgery (lumbar)	○		Hysterectomy (partial, ovaries left)	○	
Breast Surgery	○		Knee Replacement	○	
Pacemaker	○		LEEP (Cervix Surgery)	○	
Coronary Stent	○		Neck Surgery	○	
EGD (Stomach Endoscopy)	○		Ovary Ligation("Tubal")	○	
Cataract Surgery	○		Ovary Removal/oopherectomy	○	
Gallbladder Removal/Cholecystectomy	○		Tonsillectomy	○	
Heart Surgery /coronary artery bypass	○		Other (list) _____	○	
Hip Replacement	○		Other (list)_____	○	

PAST HOSPITALIZATIONS:

DATE	Reason

FAMILY HISTORY:

Adopted — ○ Yes ○ No (please Check) if yes and you do <u>not</u> know your family history skip this section and continue to next page.

Indicate which relative has had the following diseases (parents and siblings are most important)

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

Family Members	Status (alive, deceased, or unknown)	Age (yrs)	Conditions
Father			
Mother			
Siblings			
Other Relatives			
Other Relatives			

SOCIAL HISTORY

Personal History

Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ No Answer

Adults in household: _____

Children: ○ Yes ○ No Number of Children: _____ Ages if under 18 years: _____

Living Situation: ○ Live Alone ○ With Significant Other/Spouse ○ With Children/Family Members ○ Others

Employment status: ○ Employed ○ Unemployed ○ Retired

Hobbies/Interests: ○ Fishing ○ Biking ○ Reading books ○ Traveling
○ Other outdoor activities ○ Cooking ○ Other _____

Tobacco

Are you a: ○ Current Smoker ○ Former Smoker ○ Never Smoker (if you never smoked, please go to alcohol use question now)

If former smoker:

How long has it been since you last smoked?

○ <1 month ○ 1-3 months ○ 3-6 months ○ 6-12 months ○1-5 years ○5-10 years ○ >10 years

If current smoker:

Are you interested in quitting?

○ Ready to quit ○ Thinking about quitting ○ Not ready to quit

How many cigarettes a day do you smoke?

○ 5 or less ○ 6-10 ○ 11-20 ○ 21-30 ○ 31 or more

How soon after you wake up do you smoke your first cigarette?

○ Within 5 mins ○ 6-30 mins ○ 31-60 mins ○ after 60 mins

How often do you smoke cigarettes?

○ every day ○ some days, but not every day

Alcohol

Do you drink alcohol in the last year? ○ Yes ○ No

If yes:

How often did you have alcoholic drink?

○ Never ○ Monthly or less ○ 2-4 times a month ○ 2-3 per week ○ 4 or more per week

How many drinks did you have on a typical day when you were drinking?

○ 1 or 2 drinks ○ 3 or 4 drinks ○5 or 6 drinks ○ 7 or 9 drinks ○ 10 or more drinks

How often did you have 6 or more drinks on one occasion?

○ Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily

Illicit Drugs

Patient Initials _____ DOB: _____ Date: _____

Do you use any drugs or prescription medications not prescribed to you? ○ Yes ○ No
If yes please specify type of drug and frequency of use - _____

Diet/Activity
How would you rate your diet? ○ Good ○ Fair ○ Poor
Are you on any special diet? ○ Yes ○ No
If yes, how would you describe your diet? _____
Do you exercise regularly? ○ Yes ○ No
If yes:
How frequently:
○ Daily ○ Every other day ○ three days a week ○ weekly ○ only few days a month
Intensity is:
○ Mild ○ Moderate ○ Mild to Moderate ○ Moderate to Severe ○ Severe
How long?
○ 5-10 mins ○ 10-15 mins ○ 15-30 mins ○30-60 mins ○ more than 1 hr

Sexual Activity
Sexually involved currently: ○ Yes ○ No
If yes:
Sexual Partner(s) is: ○ male ○ female
Do you use protection? ○ Yes ○ No
If yes, how often? ○ All the time ○ most of the time ○ Half the time ○sometimes
Protection method: ○ Abstinence ○ Condoms ○ Other
Have you ever had a Sexually Transmitted Disease? ○ Yes ○ No
If yes, which?
○ Chlamydia ○ GC ○ Syphilis ○ Herpes ○ Other

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients:
Last Complete Physical Date: _____ By: _____
Last Tetanus Booster ○ Within past 10 years ○ More than 10 years ago ○ Unknown
Last Eye Exam Date: _____ ○ Normal ○ Abnormal ○ Unknown
Last Hearing Exam Date: _____ ○ Normal ○ Abnormal ○ Unknown Cir
(Please circle one) Last Sigmoidoscopy or Colonoscopy
Date: _____ ○ Normal ○ Abnormal
Last DEXA Bone Scan Date: _____ ○ Normal ○ Abnormal ○ Unknown
Last Pneumonia Vaccine Date: _____ ○ Normal ○ Abnormal ○ Unknown
Flu shot this season? ○ Yes ○ No

Only Women:
Last Pap Smear Date: _____ ○ Normal ○ Abnormal ○ Unknown
Last Mammogram Date: _____ ○ Normal ○ Abnormal ○ Unknown

Only Men:
Last Prostate Specific Antigen-PSA Date: _____ ○ Normal ○ Abnormal ○ Unknown
Last Prostate Exam Date: _____ ○ Normal ○ Abnormal ○ Unknown

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.
Revised: 12/11/2014

List of Current/Previous Providers involved in your care:

NAME, ADDRESS, PHONE and FAX

1. Previous PCP: _____
2. Eye Specialist: _____
3. **Cardiologist:** _____
4. **Pulmonologist:** _____
5. **Gastroenterologist:** _____
6. **Other Specialists:** _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

Revised: 10/01/2014

Tampa Bay Family Physicians, Inc.

Please complete only if 65-year-old and above, or on Medicare.

Patient Name: _____
DOB: _____

Functional Status Assessment

Cognitive Status		O Good	O Fair	O Cognitive Impairment	O Dementia	O Alzheimer's	O Parkinson's
Ambulatory Status		O Independent	O Needs assistive device				O Non Ambulatory
			O Cane	O Walker	O Wheel Chair	O Scooter	
Sensory Ability	**Hearing**	O Good	O Fair	O Poor	O Hearing Aids/Device		
	Vision	O Good	O Fair	O Poor	O Glasses	O Contacts	O Blind
	Touch	O Good	O Fair	O Poor			
	Taste	O Good	O Fair	O Poor			
	Smell	O Good	O Fair	O Poor			

Activities of Daily Livings (ADLs)

Do you need help with following ADLs? O **None** (Fill in only Those that apply)

O Grooming	O Dressing	O Toilet Use	O Housework
O Preparing Meals	O Eating	O Walking	O Bathing
O Taking Meds	O Shopping or Errands	O Others	_____

Advance Care Planning

Do you have the following?

O Living Will O Advance Directives O Surrogate Decision Maker O DNR order

Pain Assessment

Does the patient have any "Chronic pain(s)"? O Yes O No (if no skip rest of this section)

If Yes:

Intensity: On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how much does it hurt right now.

No pain Moderate Worst pain

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Location: O Left Side

O Neck O Shoulder O ElbowO Forearm O Wrist O Hand O Knee O Foot O Upper back O Lower back

O Right Side

O Neck O Shoulder O ElbowO Forearm O Wrist O Hand O Knee O Foot O Upper back O Lower back

Current treatment: O On Pain Meds O Under Pain Mgmt

Depression Screening

In the last two weeks have you been bothered by:

Little interest or pleasure in doing things? O Yes O No

Feeling down, depressed, or hopeless? O Yes O No

_____ _____

Patient Signature Date

Tampa Bay Family Physicians, Inc.

FINANCIAL/OFFICE POLICIES

For patients to take home

The following is a listing of our office policies. If the patient has any questions regarding them, please contact us at 813-633-2000.

Office visit:

- An updated photo ID is required for the patient's first visit. In case of minor, guarantor's photo ID is required.
- The patient is required to give his/her insurance card(s) to front desk to update the patient's account for any changes in their insurance plan.
- To keep the patient's information current at all times, it is patient's responsibility to inform the front office of any address, contact or insurance information changes.
- All self-pay or insurance co-payments, Corporation-insurances and deductibles will be collected at the time of service. Payable by cash, check (with driver's license) or credit card (Visa, MasterCard or Discover).
- A returned check will result in a minimum service charge of $35.00 and check will not be accepted for future payment(s). Unpaid returned checks will be turned over to the state attorneys office.
- If the patient feels ill after hours, on the weekends, or while the patient is out of area, please contact our after hour answering service and have a doctor paged. Our doctors are on call 24 hours a day.

Forms/Medical Records:

- There is a $20 fee for FMLA form and all other forms (parking permits, physical forms, disability forms, or any special forms requested).
- For medical records there is a $15.00 processing fee (cost of supplies, labor and postage), $1.00 per page for copies up to 25 pages, $0.25 per page for copies of pages 26 and greater.
- Request of medical records/forms requires a minimum of ten (10) working days notice.
- Request of medical record review requires an appointment with a minimum of seven business days notice.

Appointments:

- Minimum of 24-hour notice is required to reschedule or cancel appointment.
- Arriving late for an appointment, staff will try to accommodate if there is sufficient time to complete visit. Patient may be asked to reschedule appointment.

Referrals:

- Before being referred to a specialist, the patient must first have an evaluation from the patient's primary care physician.
- Referrals may take up to five (5) business days to get approved by the patient's insurance company.
- Once the referral has been authorized, it is valid for one evaluation from the specialist. If additional testing or visits are required by the specialists, orders for such tests must be made available to the patient's primary care physician for authorization BEFORE tests and/or visits are conducted.
- It is the patient's responsibility to ALWAYS consult with the patient's primary care physician first to avoid any out of pocket expenses for specialist visits and/or testing.
- Each time the patient visit a specialist, the patient must make the patient's follow up appointment with the patient's primary care provider.
- Tampa Bay Family Physicians, Inc. has developed a network of physicians for each patient's specific needs. Please consult our Referral Coordinator before the patient make an appointment to verify that the physician the patient would like to see is in our network.

Prescriptions:

- The patient is required to bring all new medications, prescribed by other providers, to the patient's scheduled appointment in order to keep their medication log current.
- **Prescription refills require three-five business days notice.**
- It is the patient's responsibility to inform front desk which pharmacy the patient wants to send a particular prescription when the patient requests a refill.
- Controlled substances **WILL NOT** be filled after 5:00 pm or on weekends.
- **Class 2 and Class 3 narcotics & tranquilizers** are controlled medications: therefore, the patient must be seen by the patient's physician at least once every month.

- No request for a refill of prescription will be entertained if that particular medication was never prescribed by the primary care physician.

Messages:

- Telephone messages will have a 48 hour turn around time.

Billing:

- It is the patient's responsibility to inform us of any changes in the patient's insurance for accurate and timely billing.
- On the patient's office visit, we attempt to verify benefits with the patient's insurance policies; however, please be advised that this is just an estimate of the coverage based on the information given at the time of inquiry and not a guarantee of payment from the patient's insurance.
- The patient is responsible for any non-covered charges not payable by the patient's insurance policy.
- If the patient already has a PCP assigned to the patient other than our office, it is the patient's responsibility to get an auth or referral for the visit from the patient's PCP; otherwise, the patient will be fully responsible for whole visit charge.
- Any unpaid balance older than 90 days of first statement may be subject to a 1.5% interest per month.
- In the event of any default of payment on patient's account, all costs of collection, including collection agency fees, attorney fees, court costs, and any other costs to collect this debt is patient's responsibility.
- Tampa Bay Family Physicians may retain a collection agency to handle delinquent accounts. All necessary legal action will be retained to collect this debt if a default occurs.
- In the event that a patient does not meet their financial obligation, the patient will be discharged from the practice.
- All delinquent accounts will be reported to the credit bureau.

Tampa Bay Family Physicians, Inc.

FINANCIAL/OFFICE POLICIES

For practice to file in patient chart

ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICY

I, _____, have read and understand the Financial/office Policy of Tampa Bay Family Physicians, Inc. and agree to meet all financial obligations. I have been given a copy of the same.

PAYMENT AGREEMENT

I, _____, understand that any unpaid balance not covered by my policy will be payable by me. I authorize Tampa Bay Family Physicians, Inc. to leave recorded messages on my voice mail or telephone answering machine regarding my care and billing. In the event of my default of payment on my account, I understand and agree that I am legally liable for 1.5% simple interest per month and all costs of collection, including collection agency fees, attorney fees, court costs, and any other costs to collect this debt. Tampa Bay Family Physicians may retain a collection agency to handle delinquent accounts. All necessary legal action will be retained to collect this debt if a default occurs. All delinquent accounts will be reported to the credit bureau.

By signing below I, _____, confirm that I have read and understood the above-mentioned policies and procedures.

_____ _____

Patient/responsible party Signature Date

_____ _____

Print Patient Name Responsible Party Name

TAMPA BAY FAMILY PHYSICIANS, INC.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day business activities and management of your physician's practice. These activities includee, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arraging for other business activies. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. we may also call you by name in the waiting room when your physician is ready to see you.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Tampa Bay Family Physicains Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Patsy Chavez or Dr. Gary Kraus. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Khushi A. Dhaliwal
Tampa Bay Family Physicians, Inc.
4874 Sun City Center Blvd.
Sun City Center, FL 33573

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Amandeep Kaur at aman@tbfpfl.com

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practice.

Effective Date: This notice is effective on or after 03/04/2013.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Tampa Bay Family Physicians's ("TBFP") Notice of Privacy Practices ("Notice"):

- It tells me how TBFP will use my health information for the purposes of my treatment, payment for my treatment, and TBFP's health care operations.
- The Notice explains in more detail how TBFP may use and share my health information for other than treatment, payment, and health care operations.
- TBFP will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____

(please print)

Patient's DOB: _____ Date: _____

Signature: _____
(Patient or legal representative*)

*May be requested to show proof of representative status

Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

I. My Authorization

You, Tampa Bay Family Physicians, may use or disclose the following health care information:

□ **ALL** my health information maintained by you.
□ My health information relating to the following treatment or condition: _____
□ My health information for the date(s):_____
□ Other: _____

to:
Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

This Authorization ends: □ on (date) _____
□ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to this medical group at the address provided below. If I do, it will not affect any actions already taken by this office based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

- 4874 Sun City Center Blvd, Sun City Center, FL 33573

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disabled, etc.) _____

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Tampa Bay Family Physicians can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Tampa Bay Family Physicians to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient

TAMPA BAY FAMILY PHYSICIANS, INC.
ADVANCE DIRECTIVE QUESTIONNAIRE

Patient Name _____DOB:_____

Tampa Bay Family Physicians would like to encourage all patients to have an Advance Directive on file with our office.

Under the Patient Self-Determination Act of 1990, each individual has the right to determine the course of his/her medical care and treatment. You make these choices now so that when you become unable, your decisions are known. Advance Directives only take effect if, in the future, you lose the capacity to speak for yourself. It has no effect on your current health care as long as you are able to speak for yourself.

Advance Directives for Health Care consist of three parts:
Health Care Proxy, Living Will and Other Wishes.

Health Care Proxy: Designates another person to make medically related decisions for you.
Living Will: Designates your future health care treatment choices.
Other Wishes: Designates your wishes regarding Death, Organ Donation and Autopsy.

You may, at any time, complete any section and our office will keep a copy of your wishes on file for you. If you are not ready today please ask at any time for the form. We will review this annually with you.

	Circle One
Do you have a living will?	YES NO
Do you have a Health Care Proxy?	YES NO
If no, would you like the form to fill out?	YES NO
If yes, would you like to have a copy in our chart for you?	YES NO

I am not ready to fill out this form. Please ask me about this in the future. _____

_____ _____
Patient Signature Date

Office use:

Gave patient Advance Directives form_____
Patient completed form and filed in chart_____
Reviewed with Patient _____

TAMPA BAY FAMILY PHYSICIANS, INC.

Patient Portal Policy and Procedures

DO NOT use Portal to communicate if there is an emergency.

Proper subject matter:

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow- up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc.) are not permitted
- We do not refill controlled substance medications drugs on the patient portal. You can request a refill but MUST come in to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message.

Current functionality of Patient Portal:

√ Email and secure messaging for non-urgent needs.
√ Refill request (***must*** include pharmacy information)
√ Viewing of lab results that have been sent to you.
√ Viewing and printing of continuity of health record.
√ Viewing and updating of health information.
√ Viewing of selected health information (allergies, medications, current problems, past medical history). * Note- You can make changes/additions to your health records, medication list, etc. but this will not change your permanent record without our review of the information.
√ Referral requests
√ Appointment request
√ Billing questions
√ Updating your demographic information (address, phone # etc.) and updating insurance information.

All communication via portal will be included in your chart.

Privacy:

- All messages sent to you will be encrypted.
- Messages from you to the staff should be through this portal or they will not be secure.
- We will keep all email lists confidential and will not share this with other parties.
- Any member of our staff may read your messages or reply in order to help the Physician that has been e-mailed. This is similar to how a phone message is handled.
- Our system will check when messages are viewed, so you do not need to reply that you have read it.

Response Time:

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need an immediate response.

TAMPA BAY FAMILY PHYSICIANS, INC.

Patient and Family Request for Patient Portal

I hereby request access to the Patient Portal maintained by Tampa Bay Family Physicians, PA for the patient named below. I understand that Tampa Bay Family Physicians takes seriously its responsibility to safeguard the privacy of its patients and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign-on and password that I am assigned and will not share my log-in information with anyone else. I agree that Tampa Bay Family Physicians will not be liable for any disclosure of information due to unauthorized use of my sign-on and password. If I feel my sign on and password combination has been compromised, I will contact Tampa Bay Family Physicians immediately or go to the portal and request a new password.

I understand that the Patient Portal will only allow me to view my records for the patient. If I accidently gain access to another patient's information, I will cease to view it and notify Tampa Bay Family Physicians immediately. In no event will I deliberately attempt to access information for any person other than myself. I represent to Tampa Bay Family Physicians that I am a personal representative of the Patient with the right to access the Patient's health information, or that the patient has expressly authorized me to have access. If my status as personal representative changes so that I no longer have such rights, or if the Patients authorization expires or is revoked, I will immediately cease using the Patient Portal to access the Patient's information and will notify Tampa Bay Family Physicians.

Patient Name (print):_____ DOB: _____

Email Address: _____

Patient signature: _____

-OR -

Parental Guardian: _____

Khushi A. Dhaliwal, M.D.

TAMPA BAY FAMILY PHYSICIANS, INC.

4874 Sun City Center Blvd, Sun City Center, FL 33573
Phone: 813-633-2000; Fax: 813-849-9301

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name
(if any): _____

Social Security #: _____

I request and authorize release of my healthcare information to the above-mentioned provider from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____
_____

☐ All Records

☐ Other: _____

I authorize the release of my entire medical record via either telephonic, face-to face, or written communications to the above named individuals (s). Unless otherwise indicated, my authorization includes the release of the following, please strike through those you wish to exclude, if any:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment.
- Genetic test results and/or related treatment.
- Other: _____

If patient is unable to give consent because of physical/mental condition or age, complete the following:

Patient is : [ ] a minor _____ years of age
Patient is : [ ] is unable to give authorization because _____

Date: _____ Signed: _____
Please circle one of the following selections which applies:
Parent - Guardian - POA - Other
Personal Representative(s) must provide appropriate documentation to verify your legal authority to act on this patient's behalf.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Patient Signature: _____ Date: ____/____/_____