Date:_____

_____

Last Name **First Name** **Middle Initial** **Gender**

_____

Address **City** **State** **Zip**

_____ _____ _____

Email address **Date of Birth** **Social Security Number**

(_____)_____ (_____)_____

Home Phone **Cell Phone**

_____ _____ (_____)_____

Emergency Contact **Relationship** **Phone**

Employer Name: _____Employer Phone_____

How did you hear about us? □ Website □ Newspaper □ Magazine □ Physician Referral
□ Friend/Family □ ER/Hospital □ Insurance Plan □ Worker's Comp Adjustor

Do you have a Seasonal Address?

_____

_____

What is your preferred communication?
□ Phone □ E-mail □ Postal Mail □ Fax □ Patient Portal □ Decline

What is your Ethnicity? □ Hispanic or Latino □ Not Hispanic or Latino □ Decline

What is your race? □ American Indian □ Alaskan Native □ Asian □ National Hawaiian
□ Pacific Islander □ White □ Black (African American) □ Other □ Decline

_____ _____

Occupation/Former Occupation **Age at last birthday**

Primary Care Physician_____ Referring Physician_____

Pharmacy Name: _____ Pharmacy Phone: _____

Consent to request medication history □ Yes □ No

Reason For Today's Visit: _____

Was this related to an Auto Accident? □ Yes □ No **Worker's Comp accident?** □ Yes □ No

If so, what was the date of your injury? _____In what State did your accident occur? _____
INSURANCE INFORMATION (Please present your insurance cards to be scanned.)
Primary Insurance: _____Secondary Insurance: _____

Other Insurance Coverage: _____

CURRENT ILLNESS

Describe in your own words your medical illness. Please include the date of onset, symptoms, previous similar occurrences, names of other physicians already consulted, any tests or medications prescribed.

_____

_____

Past Medical History

Condition	Yes	No	Condition	Yes	No
Allergies	____	____	High Cholesterol	____	____
Anemia	____	____	HIV infection	____	____
Arthritis	____	____	Kidney disease	____	____
Asthma	____	____	Lymphedema	____	____
DVT or PE *indicate where below	____	____	Lymphoma	____	____
Cancer *indicate type below	____	____	**Neuro/muscular disease *specify below**		
Depression, anxiety	____	____	Phlebitis	____	____
Diabetes I or II (circle)	____	____	Seizures	____	____
Emphysema	____	____	Sleep apnea	____	____
Heart disease	____	____	Stroke	____	____
Hepatitis *indicate type below	____	____	T.B.	____	____
High blood pressure	____	____	Thyroid problems	____	____

***What type of Cancer? _____ *DVT or PE WHERE? _____**

***Neuro/muscular specify type_____ *What type of Hepatitis? □B □C**

Past Surgical History List any major operations, hospitalizations:

	Surgery	Date	Name of Hospital/location
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Have you had any adverse reactions to anesthesia? Yes ___ No ___

If yes, explain: _____

Do you have any bleeding tendency or clotting disorder? Yes ___ No ___

If yes, explain: _____

List all ALLERGIES to medicines, latex, adhesives, etc.: No Known Allergies □

1._____ 3._____ 5._____ 7._____ ____

2._____ 4._____ 6._____ 8._____

List all <u>MEDICATIONS</u>, <u>SUPPLEMENTS</u>, <u>HERBS</u> and <u>OVER THE COUNTER MEDS</u> such as Aspirin, Advil, Ibuprofen, etc. List the DOSE, FREQUENCY and REASON for use:

Medicine	Dose & how often	Reason for use
Example: Xanax	*0.5 mg once daily*	*Anxiety*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Family History Please indicate if anyone in your immediate family has had cancer below:

	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer						
Breast Cancer						
Ovarian Cancer						
Stroke						
Heart Attack <55yrs						
Vascular Disease						
Aneurysm						

Is there any other cancer in your family? Yes □ No □

If yes, what type of cancer? _____

What relative (Aunt/Uncle/Cousin, etc): _____

Age of diagnosis: _____

Social History

Do you use tobacco products? Yes _____No _____How much_____

Former ____ Start Date _____Stop Date _____

Do you do any recreational drugs? Yes _____No _____What? _____

Have you had a Mammogram with the past 27 months? Yes □ No □

Have you had colorectal cancer screening? Yes □ No □

If yes, what type? Fecal Occult Blood Test □ FIT □

Cologuard □ Colonoscopy □ Flexible Sigmoid □

Have you had a Flu Shot within the last 12 months? Yes □ No □

Review of Systems

Are you currently experiencing any of the below symptoms?

CONSTITUTIONAL SYMPTOMS

____ Fever ____ Infection ____ Night sweats
____ Fatigue ____ Other general problems _____

EYES

____ Blindness ____ Glaucoma ____ Retinal problems
____ Cataracts ____ Other eye problems _____

EARS, NOSE, MOUTH, AND THROAT

____ Earaches ____ Ringing in the ear ____ Sensation of spinning
____ Ear problems ____ Nose bleed ____ Sinus problems
____ Sore tongue ____ Dental problems ____ Bleeding gums
____ Sore throat ____ Painful swallowing ____ Difficulty swallowing
____ Change in voice ____ Other head or neck problems _____

GYNECOLOGY (women only) _____Abnormal Pap _____Endometriosis _____ Abnormal vaginal bleeding _____
Last Gynecological Exam/Date: _____ Age of menstruation: _____ Age of menopause: _____
Have you had a hysterectomy? ____ Yes ____ No Are your ovaries removed? ____ Yes ____ No

CARDIOVASCULAR

____ Heart disease ____ High blood pressure ____ Shortness of breath
____ Chest pain ____ Ankle swelling ____ Leg pain when walking
____ Rheumatic fever ____ Fast heart beats ____ Irregular heart beats
____ Heart murmur ____ Congestive heart failure ____ Myocardial infarctions
____ Pulmonary Embolism ____ Thrombophlebitis ____ Venous or Arterial Thrombosis
____ Other heart problems_____

RESPIRATORY

____ Asthma ____ Chronic cough ____ Coughing up blood
____ Emphysema ____ Tuberculosis ____ Shortness of breath

GASTROINTESTINAL

____ Weight loss ____ Decreased appetite ____ Difficulty swallowing
____ Weight gain ____ Hiatal hernia ____ Peptic ulcers
____ Esophagitis ____ Nausea/vomiting ____ Vomiting blood
____ Gastritis ____ Liver disease ____ Hepatitis
____ Gallstones ____ Crohn's disease ____ Cirrhosis
____ Ulcerative colitis ____ Black stools ____ Bloody stools
____ Hemorrhoids ____ Anal problems ____ Diverticulitis
____ Other stomach or intestinal problems_____

GENITOURINARY

_____ Kidney stones _____ Frequent urination _____ Painful urination
_____ Blood in urine _____ Kidney disease _____ Enlarged prostate
_____ Kidney infection _____ Bladder infection
_____ Leaking/Incontinence _____ Other kidney/bladder problems_____

SKIN

_____ Psoriasis

_____ Melanoma _____ Other skin problems _____

NEUROLOGICAL

____ Headaches _____ Slurred speech _____ Weakness on one side
____ Seizures _____ Stroke _____ Temporary eye blindness
____ Migraines _____ Other brain or nerve problems_____

MUSCULOSKELETAL

_____ Arthritis _____ Osteoporosis _____ Neck pain
_____ Back pain _____ Artificial joints _____ Disc problems
_____ Other muscle or bone problems_____

ENDOCRINE

____ Diabetes _____ Hypoglycemia _____ Goiter/Thyroid surgery
____ Thyroid medications _____ Heat/Cold intolerance
____ Other endocrine problems _____

PSYCHIATRIC

____ Mental illness _____ Depression _____ Drug/alcohol abuse
____ Other psychiatric problems _____

HEMATOLOGIC/LYMPHATIC

_____ Anemia _____ Sickle cell disease _____ Enlarged lymph nodes
_____ Hemophilia _____ Easy bruising _____ Blood clotting problem
_____ Daily aspirin _____ Other blood or lymph gland problems_____

ALLERGY/IMMUNE SYSTEM

____Immune deficiency _____ Plant/animal allergy ____ AIDS/HIV
____ Other allergy/immune problems_____

Patient Signature _____ Date _____

Reviewed by: _____ Date_____
Physician/Provider

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

Name & Relationship:_____ Phone number_____
Name & Relationship:_____ Phone number_____
Name & Relationship:_____ Phone number_____
Name & Relationship:_____ Phone number_____

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

Name & Relationship:_____ Phone number_____
Name & Relationship:_____ Phone number_____
Name & Relationship:_____ Phone number_____
Name & Relationship:_____ Phone number_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home***. **(Confidential Communications)**

_____
_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL":** **Yes:** □ **No:** □

5. Please print the telephone number or email address where you want to receive calls about your appointments and other health care information ***if other than your home phone number***:

(____)_____-_____ Email Address:_____@_____

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? Yes: □ No □

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME:_____(guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Financial Policy

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy.

CO-PAYMENTS AND DEDUCTIBLES: These payments must be made at check-in. Bay Surgical Specialists accepts cash, personal checks (in-state only), VISA, MasterCard, American Express and Discover. There is a service charge for returned checks. Patients with an outstanding balance referred to collection must make arrangements for payment in full prior to scheduling appointments. If you need assistance or have questions, please contact **Ashley Stewart, Billing Manager, between 8:30 a.m. and 5:00 p.m., Monday through Friday at 727-821-8101 ext 309.**

MANAGED CARE: If you are enrolled in a managed care insurance plan (i.e., HMO), you must obtain a referral from your Primary Care Physician before you can be seen at Bay Surgical Specialists. Retroactive referrals are not always granted by the Primary Care Physician. It is your responsibility to ensure that your visit has been authorized prior to your appointment.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand Bay Surgical Specialists' Financial Policy. I agree to assign insurance benefits to Bay Surgical Specialists' Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative: _____

Date: _____

CONSENT AND ASSIGNMENT OF BENEFITS

Bay Surgical Specialists, LLC is contracted to various health insurance programs, including Medicare, and accepts assignments only for those health insurances. If a contract exists between my insurance company and Bay Surgical Specialists, LLC, Bay Surgical Specialists, LLC will file my health insurance. I request that payment be made by my insurance on my behalf to Bay Surgical Specialists, LLC. I agree to pay any portion of my charges rendered by Bay Surgical Specialists, LLC that my contracted health insurance determines is my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time service is rendered.

If I do not have a health insurance plan that Bay Surgical Specialists, LLC is contracted with, I agree to pay all fees in full at the time services are rendered.

I understand that I am ultimately responsible for payment of my medical bill. If it becomes necessary for Bay Surgical Specialists, LLC to collect payment, I understand that I will be responsible for legal costs, including attorney's fees.

I understand that as a result of refusal to sign this form, or if I have altered this form in any way, Bay Surgical Specialists, LLC may refuse to diagnose and treat me. I have the right to revoke this consent and assignment of benefits in writing except for services that have already occurred.

_____

Printed Patient Name or Personal Representative Date _____

_____

Signature of Patient or Personal Representative **Date**

MEDICARE PATIENTS (only) MUST ALSO READ AND SIGN BELOW

I request that payment of authorized Medicare services rendered by Bay Surgical Specialists, LLC be paid to Bay Surgical Specialists, LLC. I agree to pay any portion of my charges rendered by Bay Surgical Specialists, LLC that Medicare determines to be my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time services are rendered.

_____

_____

Patient Signature **Date**

_____

Witness Signature Date

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.

Your Rights

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- • File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- • Raise funds

Our Uses and Disclosures

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

• You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes • Most sharing of psychotherapy notes • Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Baycare 2) HCA

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

• Preventing disease • Preventing or reducing a serious threat to anyone's health or safety

• Helping with product recalls • Reporting suspected abuse, neglect, or domestic violence

• Reporting adverse reactions to medications

Do research, Comply with the law, Respond to organ and tissue donation requests, Work with a medical examiner or funeral director.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

• For workers' compensation claims • For law enforcement purposes or with a law enforcement official

• With health oversight agencies for activities authorized by law

• For special government functions as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be

available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

• If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.

• or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html • We will not retaliate against you for filing a complaint.

Bay Surgical Specialists, L.L.C.

HIPAA Compliance Officer: Jade Duncanson

Phone: 727-821-8101

This Notice of Privacy Practices is effective December 1, 2016

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Bay Surgical Specialists, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Bay Surgical Specialists, P.A., provides at no cost aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters, written information in other formats (large print, audio, accessible elec. formats, other formats). Provides at no cost language services to people whose primary language is not English, such as: qualified interpreters; information written in other languages. If you need these services, please tell our front desk or any staff member.

If you believe our practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator: Jade Duncanson, 960 7th Avenue North, St. Petersburg, Florida 33705, 727-821-8101. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. 1 -800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

Proficiency of Language Assistance Services

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, are available to you.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
번으로 전화해 주십시오.

هال PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

لحوظة: م إذا نت ك تحدث ت ر اذك ة، غ ل ل غو ال م ساعدة خدمات ف إن ال ر ةيال ل تواف ت ك ل مجان ب.ال صل ات م رق ب رق م .كم: ب وال صم

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod Numer.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

sprachliche.ه وج ت :ر اگ ه ان ب زب ارس فت یف وگ ن یم گ ،یک سه د تیت ان ال یزب ت صورت انیرا ب راگ یب شما .گ یب یر دی م ت

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____