GMS Florida West Coast, Inc.

A Physician Group Practice

The offices of GMS, and their staff, welcome you to our practice. We strive to provide you excellent medical care and make your visit as convenient as possible.

We would like to bring to your attention that health care benefits today have become extremely complicated. Benefit packages vary greatly based on company and individual selection. For this reason, as well as the ever changing federal healthcare law, our office has found it necessary to adopt the following policies:

- Please realize our office does not know and cannot determine your individual healthcare benefits. We will do our best to maximize coverage for your visit within accepted rules and regulations. However, knowing your benefits and financial liability is ultimately your responsibility.
- Please inform our office of any insurance, address or telephone number changes.
- Our office performs what we feel is medically necessary for your health care based on established medical guidelines and discussions with you.
- Our office will prescribe and recommend those medications which we feel are best for your health. We will do our best to work within any known restrictions. However, please realize any problems concerning the cost or coverage of your medication is between you and your prescription plan. These are financial issues not medical (i.e. prior authorizations).
- Preventative care benefits vary from plan to plan and we advise you to check your preventative benefits prior to being seen for a preventative visit. Not all services are covered benefits with all insurance plans. Any treatment, including the writing of prescriptions, is not covered under preventative care.
- You should always be aware of the services being performed and discuss them with the provider.
- You are responsible for applicable charges as per your insurance agreement (such as deductibles, percentages, after hours fees, copays, etc.) or any performed services not covered by your insurance policy.
- If you are turned over to a collections agency or write a bad check, you will be responsible for any costs incurred in collecting that balance.
- Be aware that payment is expected at the time of service and that our office accepts cash, check, Visa, MasterCard and Discover.
- If you have an outstanding balance from a previous visit, you will be asked for payment at your next visit.
- There may be a fee for completion of paperwork (disability forms, FMLA, prior authorization, etc.)

As your primary care physicians, our relationship is with you and not your insurance company. We realize that problems may arise and we will do our best to work with you through these situations. Please do not hesitate to ask us if you have any questions as we are here to help you.

I have read and understood the above policy and I agree to meet all my obligations.

_____	_____	_____
Patient Name	Patient Signature	Date

GMS FLORIDA WEST COAST, INC. - PATIENT HISTORY FORM

DATE: _____ DATE OF BIRTH: _____

NAME: _____ AGE: _____

Family History: For each family member below mark an "x" for all that apply to that person's health.

	HEALTH			Cause of death	Allergies/ Asthma	Stress/ depression	Kidney problems	Diabetes	High blood pressure	Heart trouble	Anemia Bleeding Issues	Cancer /Tumor
	Good	Poor	Deceased									
Father:												
Mother:												
Sibling:												
Sibling:												
Sibling:												
Sibling:												

Your Health History

Do you smoke? ( )Yes ( )No ( )Quit-When_____ How many packs per day? _____ How many years? _____

Do you drink alcohol/beer? ( )Yes ( )No How many drinks per day? _____ How many years? _____

Additional Illnesses: Mark an "X" in the boxes of the illnesses that you have or have ever had.

☐ eczema	☐ bronchitis	☐ pancreatitis	☐ mononucleosis	List Others Below:
☐ asthma	☐ measles	☐ liver disease	☐ german measles	☐
☐ malaria	☐ pneumonia	☐ neuritis	☐ kidney trouble	☐
☐ mumps	☐ hemorrhoids	☐ chicken pox	☐ yellow jaundice	☐
☐ polio	☐ emphysema	☐ scarlet fever	☐ venereal disease	☐
☐ hives/ rash	☐ diverticulosis	☐ thyroid disease	☐ rheumatic fever	☐

Have you ever been turned down for life insurance, military service or employment because of your health? ☐ yes ☐ no

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation write them below starting with the most recent. (Do not include normal pregnancies.) ☐ Check this box if you have had more than three hospitalizations.

	Year hospitalized	Operation or illnesses	Name of hospital	City and state
1)				
2)				
3)				

Allergies / Reaction:

_____

_____

_____

_____

Current Medical Problems

_____

_____

_____

_____

_____

Current Medications (Including Strength and Dosage):

_____

_____

_____

_____

_____

GMS FLORIDA WEST COAST, INC.

FAMILY IDENTIFICATION & BUSINESS INFORMATION: DATE _____

Patient Name _____ Birth Date _____ Age___
Spouse/Parent/Guardian _____ Birth Date _____ Age___
Address _____ City _____ ST _____ Zip _____
Alternate Address _____ City _____ ST _____ Zip _____
Social Security #: _____ Marital Status:( )Married ( )Divorced ( )Widow ( )Single
Phone #: _____ Cell #: _____

Patient's Employer: _____ Occupation: _____
Phone Number: _____
Spouse's Employer: _____ Occupation: _____
Phone Number: _____

Referred By: _____

Emergency Contact: _____ Relationship: _____
Phone Number: _____ Alternate Phone Number: _____

Primary Insurance: _____ Secondary Insurance: _____
ID #: _____ ID #: _____
Covered by ( )Self ( )Spouse ( )Parent Covered by ( )Self ( )Spouse ( )Parent
Policy Holders Name: _____ Policy Holders Name: _____
Policy Holders Date of Birth: _____ Policy Holders Date of Birth: _____
Policy Holders Address: _____ Policy Holders Address: _____

Do you have Medicare? ( )Yes ( )No If Yes, Policy #: _____

You may release my medical information to:

_____ _____ _____
Name and relation Name and relation Name and relation

I give my permission to leave test results or other medically related communications on my answering machine or voice mail. ( )Yes @ #:_____ ( )No

_____
SIGNATURE OF PATIENT

PLEASE PRESENT ALL INSURANCE CARDS, COPAYMENTS AND RESIDUAL BALANCES TO THE RECEPTIONIST EACH TIME YOU COME IN TO BE SEEN.

I UNDERSTAND THAT ALL CHARGES (INCLUDING THOSE NOT PAID BY INSURANCE), COLLECTION FEES, BANK AND RETURNED CHECK FEES, LEGAL FEES, FAILURE TO KEEP APPOINTMENT FEES AND LATE FEES ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT (OR THE PARENT/GUARDIAN IN THE CASE OF A MINOR). I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ALL INFORMATION CONCERNING MY ILLNESS(ES) AND TREATMENT TO MY INSURANCE CARRIERS/HEALTH PLANS. IN THE EVENT THAT THIS OFFICE PARTICIPATES WITH MY INSURANCE CARRIER/ HEALTH PLAN, I HEREBY ASSIGN ALL AVAILABLE BENEFITS AND PAYMENTS DIRECTLY TO THEM FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT COVERED BY MY INSURANCE CARRIER/HEALTH PLAN, AND I AUTHORIZE THIS OFFICE TO CHARGE MY CREDIT/DEBIT ACCOUNT FOR THE FULL AMOUNT OF ANY UNPAID BALANCE. I ACKNOWLEDGE NOTIFICATION OF HIPAA'S PRIVACY RULE AND PRACTICES AND UNDERSTAND THAT I MAY REQUEST A COMPLETE COPY AT ANY TIME.

_____
SIGNATURE DATE

DO YOU HAVE A LIVING WILL OR WISH TO DISCUSS ONE? ( )HAVE ONE ( )DISCUSS ( )NOT INTERESTED

GMS Florida West Coast, Inc.

15320 Amberly Dr. Suite B Tampa, FL 33647
(813) 977-0733
Website: gmsdocs.com

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.

THE EFFECTIVE DATE OF THIS PRIVACY NOTICE IS September 1, 2013.

GMS Florida West Coast, Inc. ("Facility", "us" or "we") is required under the federal healthcare privacy rules (the "Privacy Rules"), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history (collectively, "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies and procedures to protect and maintain the privacy of your Health Information. We are required to follow the terms of this Privacy Notice unless (and until) it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will make a revised copy of the notice available to you. Any revised Privacy Notice will be available at our Facility(ies) for individuals to take with them and we will post a copy of a revised Privacy Notice in a prominent location in our Facility(ies). This Privacy Notice will also be posted and made available electronically on our website.

PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

1. **General Uses and Disclosures.** Under applicable law, we are permitted to use and disclose your Health Information for the following purposes, without obtaining your permission or Authorization:

   - **Treatment.** We are permitted to use and disclose your Health Information in the provision and coordination of your healthcare. For example, we may disclose your Health Information to your primary healthcare provider(s), consulting providers, and to other healthcare personnel who have a need for such information for your care and treatment.

   - **Payment.** We may use and disclose your Health Information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or other third party, including determining the applicability of any health insurance coverage. For example, a bill sent to your insurance company may include information that identifies you, your medical information, and the procedures and supplies used in your treatment.

   - **Healthcare Operations.** We are permitted to use and disclose your Health Information for certain administrative, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and

for educational purposes. For example, we can use your Health Information to internally assess our quality of care provided to patients.

- **Uses and Disclosures Required by Law.** We may use and disclose your Health Information when required to do so by law, including, but not limited to reporting abuse, neglect and domestic violence, in response to judicial and administrative proceedings, in responding to a law enforcement request for information; or in order to alert law enforcement to criminal conduct on our premises.

- **Public Health Activities.** We may disclose your Health Information for public health reporting, including, but not limited to reporting child abuse and neglect; reporting communicable diseases and vital statistics; product recalls and adverse events; or notifying person(s) who may have been exposed to a disease.

- **Abuse, Neglect, or Domestic Violence.** We may disclose your Health Information to a local, state, or federal government authority if we have a reasonable belief of abuse, neglect or domestic violence.

- **Regulatory Agencies.** We may disclose your Health Information to a healthcare oversight agency for activities authorized by law, including, but not limited to, licensure investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the healthcare system, government programs, and compliance with civil rights.

- **Judicial and Administrative Proceedings.** We may disclose your Health Information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.

- **Law Enforcement Purposes.** We may disclose your Health Information to law enforcement officials when required to do so by law.

- **Coroners, Medical Examiners, Funeral Directors.** We may disclose your Health Information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your Health Information to funeral directors, as necessary, to carry out their duties.

- **Organ Donation.** We may disclose your Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissues.

- **Research.** Under certain circumstances, we may disclose your Health Information to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your Health Information.

- **Threats to Health and Safety.** We may use or disclose your Health Information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.

- **Specialized Government Functions.** We may disclose your Health Information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations. We may also disclose your Health Information to authorized federal officials for the provision of protective services to the President of the United States or to foreign heads of state or to conduct related investigations. If you are a member of the U.S. Armed Forces, we may disclose your Health Information as required by military command authorities.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with healthcare; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.

- **Workers' Compensation.** We may disclose your Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illnesses without regard to fault.

- **Fundraising.** We may use or disclose your Health Information to make a fundraising communication to you for the purpose of raising funds for our own benefit. With each fundraising communication, we will provide you with an opportunity to elect not to receive any further fundraising communications. We will also make reasonable efforts to ensure that if you opt out of such communications you are not sent future fundraising communications. We may also use, or disclose to a business associate or to an institutionally related foundation, the following Health Information for the purpose of raising funds for our own benefit: (a) demographic information relating to you, including your name, address, other contact information, age, gender, and date of birth; (b) the dates of healthcare provided to you; (c) the department or area of service that provided you treatment; (d) your treating physician; (e) outcome information; and (f) your health insurance status.

- **Marketing.** We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.

- **Refill Reminders, Care Coordination, Alternative Therapies.** We may provide you with refill reminders about a drug or biologic that is currently being prescribed for you, but only if any financial remuneration received by us in exchange for making the communication is reasonably related to our cost of making the communication. Except where we receive financial remuneration in exchange for making the communication, we may communicate with you for the following treatment and healthcare operations purposes: (a) for your treatment including case management or care coordination, or to direct or recommend alternative treatments, therapies, healthcare providers, or settings of care; (b) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits, including communications about a healthcare provider network or health plan network; replacement of or enhancements to, a health plan; and or (c) for case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities are not considered treatment.

- **Business Associates.** We may disclose your Health Information to business associates who provide services to us pursuant to a written agreement that contains terms regarding protection of your Health Information. Our business associates are required to protect the confidentiality of your Health Information.

- **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by applicable law.

2. **Uses and Disclosures Which Require Patient Opportunity to Verbally Agree or Object.** Under applicable law, we are permitted to use and disclose your Health Information: (a) for the creation of facility directories, (b) to disaster relief agencies, and (c) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.

3. **Uses and Disclosures Which Require Written Authorization.** As required by applicable law, all other uses and disclosures of your Health Information (not described above) will be made only with your written permission, which is called an Authorization. For example:

   - **Psychotherapy Notes.** If we maintain psychotherapy notes, we must obtain your Authorization for any use or disclosure of such psychotherapy notes, except to carry out the following treatment, payment, or healthcare operations: (a) use by the originator of the psychotherapy notes for treatment; (b) use or disclosure by us for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (c) use or disclosure by us to defend ourselves in a legal action or other proceeding brought by you.

   - **Certain Marketing Purposes.** If we receive financial remuneration in exchange for making a marketing communication we must obtain your Authorization for any use or disclosure of Health Information other than a face-to-face communication made by us to you, or for a promotional gift of nominal value provided by us.

   - **Sale of Health Information.** We must obtain your Authorization for any sale of your Health Information and such Authorization will state that the disclosure will result in our receiving remuneration.

4. **Revoking Your Authorization.** You may revoke your Authorization in writing at any time. The revocation of your Authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the Authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.

PATIENT RIGHTS.

You have the following rights concerning your Health Information:

1. **Right to Receive Written Notification of a Breach of Your Unsecured Health Information**. You have the right to receive written notification of a breach of your unsecured Health Information if it has been accessed, used, acquired, or disclosed in a manner not permitted by the Privacy Rules. We will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable by law or you may request in writing to receive a notification of a breach by electronic mail.

2. **Right to Inspect and Copy Your Health Information.** Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set maintained by or for us. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information that we maintain. For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that we review certain denials to inspect and copy your Health Information. Instead of copies, we can provide you with a summary of your Health Information if you agree to the form and cost of such summary. If you request a paper copy or summary explanation of your Health Information, we may charge you a reasonable fee for copying costs, postage, and any other costs associated with preparing the summary or explanation. Instead of paper copies, if your Health Information is maintained in an electronic health record, you may request that we provide the information in electronic form to either you or to a designated third-party if such designation is clear, conspicuous, and specific. We may charge you a reasonable cost-based fee for an electronic copy, which shall not exceed our labor costs in responding to the request. We may, in some cases, deny your request to inspect and copy your Health Information and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial reviewed.

3. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your Health Information for treatment, payment and healthcare operations. We will consider, but do not have to agree to, such requests. However, we must agree to restrict a disclosure of Health Information about you to a health plan if: (a) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law; and (b) the Health Information pertains solely to a healthcare item or service for which you, or someone other than the health plan on your behalf, has paid in full.

4. **Right to Request an Amendment of Your Health Information.** You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.

5. **Right to an Accounting of Disclosures of Your Health Information.** You have the right to receive an accounting of disclosures of your Health Information made by us. With respect to Health Information contained in paper form, our accounting will not include: disclosures related to treatment, payment or healthcare operations; disclosures to you; disclosures based upon your Authorization; disclosures to individuals involved in your care; incidental disclosures; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories;

disclosures that are part of a Limited Data Set; or disclosures that occurred prior to April 14, 2003 or as otherwise allowed by the Privacy Rules. With respect to Health Information contained in an electronic health record, unless otherwise specified by law, the accounting will not contain disclosures made to you upon your request; based upon your Authorization; to individuals involved in your care; or as allowed by law. You may request an accounting of applicable disclosures made by us within six (6) years prior to the date of your request for Health Information stored in paper form and made within three (3) years prior to the date of your request (but not for any disclosures made prior to implementation of our electronic health records system) for Health Information stored in an electronic health record. If you request an accounting more than once in a 12-month period, we may charge you the reasonable cost-based expenses incurred to comply with your additional request.

6. **Right to Alternative Communications.** You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail. Such requests must be made in writing.

7. **Right to Receive a Paper Copy of this Notice of Privacy Practices.** You have the right to receive a paper copy of this Notice of Privacy Practices upon request.

If you want to exercise any of these rights, have any questions, or feel that your privacy rights have been violated, please contact us. All requests must be submitted to us in writing and returned to the address below.

GMS Florida West Coast, Inc.
Attn: Privacy Officer
15320 Amberly Drive, Suite B
Tampa, FL 33647

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with our Privacy Officer. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services. Our Privacy Officer can provide you with the address.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient

_____
Printed Name of Parent/Patient's Representative (If Applicable)

_____
Signature of Parent/Patient's Representative (If Applicable)

MEDICARE WELLNESS - Page 1

Date:_____

Name: _____ Date of Birth: _____

Gender (Circle one): Male / Female Race:_____ Ethnicity:_____

Medical Problems:

_____
_____
_____
_____
_____
_____
_____
_____

Treating Physician/Specialist:

_____
_____
_____

Family History:

Mother: _____
Father: _____
Sibling: _____
Other: _____

Screening Questions:

Over the past two weeks, have you felt down, depressed or hopeless Yes_____ No_____
Over the past two weeks, have you felt little interest or pleasure in doing things Yes_____ No_____
How would you rate your current health:
Excellent_____Good_____Fair_____Poor_____

Functional Ability/Safety Screening Questions:

Are you able to perform your daily activities (dressing, feeding, toileting, grooming, bathing, etc.) Yes_____ No_____
Are you able to perform instrumental activities (shopping, housekeeping, cooking, using the telephone, laundry, finances, medications, transportation, etc.) Yes_____ No_____
Do you feel you need assistance performing your daily or instumental activities Yes_____ No_____

Fall Risk Questions:

Does your home have rugs in the hallway Yes_____ No_____
Do you have grab bars in the bathroom Yes_____ No_____
If you have stairs, do you have handrails inside and out Yes_____ No_____
Do you have ample lighting inside and outside your home Yes_____ No_____
Do you feel that you lose balance or get dizzy and have problems walking Yes_____ No_____

End of Life Planning Questions:

Do you have an advanced directive Yes_____ No_____
Do you have a medical power of attorney Yes_____ No_____
Do you have a living will Yes_____ No_____
If yes to any of the above, please provide copies for our records

Nutrition Questions:

Do you eat less than three meals a day Yes_____ No_____
Have you ever been treated for a drinking problem Yes_____ No_____

Cognitive Function Questions:

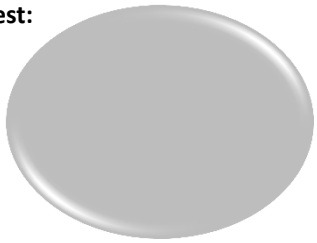
Who is the current President of the United States

_____

What day of the week is it today

_____

Clock Test:



Review Of Systems

Date: _____

Name: _____ Date of Birth: _____

General:	Yes	No
Do you worry a lot about your health?	____	____
Do you usually feel tired and worn out?	____	____
Do you feel depressed a lot of the time?	____	____
Have you recently noticed that heat or warm weather bothers you?	____	____
Have you recently been drinking more water or fluids?	____	____
Has there been any unusual weight gain or loss recently?	____	____

Skin:	Yes	No
Have you noticed:		
any change in your skin color?	____	____
any skin rashes or itching?	____	____
unusually dry skin?	____	____
any bothersome growths on your skin?	____	____
any sores or wounds that do not heal?	____	____
any change in color or size of warts?	____	____

Eyes:	Yes	No
Have you had:		
any pain in your eyes?	____	____
glaucoma?	____	____
blurry vision?	____	____
halos around lights?	____	____
change in vision?	____	____

ENT:	Yes	No
Do you have:		
any trouble hearing?	____	____
ringing or buzzing in your ears?	____	____
earaches or discharge from your ears?	____	____
a lot of nasal stuffiness?	____	____
drainage down the back of your throat?	____	____
frequent or severe nosebleeds?	____	____
persistent hoarseness?	____	____
a lump in your throat?	____	____
a sore tongue or mouth?	____	____
bleeding gums?	____	____

Respiratory:	Yes	No
Do you have:		
frequent chest colds?	____	____
a constant or bothersome cough?	____	____
coughing of blood?	____	____
sputum or phlegm between colds?	____	____
difficulty breathing?	____	____
wheezing/whistling in your chest?	____	____

Cardiovascular:	Yes	No
Do you have pain, tightness or pressure in the front or back of your chest?	____	____
If yes, is it when walking fast, working hard, or when excited?	____	____
Have you ever been told that your EKG was abnormal?	____	____
Do you have swelling in your feet or ankles?	____	____
Does your heart ever beat fast or irregularly?	____	____
Do you get cramps in your calf muscles when you walk?	____	____
Do you ever awaken at night with severe difficulty breathing?	____	____
Do your fingers or toes ever get cold, become numb, or get white or bluish?	____	____

Gastrointestinal:	Yes	No
Have you recently had any changes in your eating habits?	____	____
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc?	____	____
Do you tend to burp a lot?	____	____
Have you recently noted any trouble swallowing?	____	____
Do you have a lot of indigestion or heartburn?	____	____
Have you ever vomited blood?	____	____
Are you bothered with constipation?	____	____
Do you have frequent loose stools or diarrhea?	____	____
Do you pass a lot of gas?	____	____
Do you have a poor appetite?	____	____
Do you ever awake at night with the feeling of fullness under your breast bone?	____	____
Have you ever passed blood from your rectum?	____	____
Have you ever had black or tarry stool?	____	____
Have you noticed any recent changes in your bowel movements?	____	____
Do you take laxatives regularly?	____	____
Do you have frequent nausea and/or vomiting?	____	____

Genitourinary:	Yes	No
Do you have:		
anything wrong with your genitals (privates)?	____	____
burning or pain when urinating?	____	____
to pass water frequently?	____	____
to pass more water than you used to?	____	____
trouble passing water?	____	____
to get up at night to urinate?	____	____
trouble with losing urine when you cough or sneeze?	____	____
a problem dripping urine?	____	____
Have you ever passed blood in your urine?	____	____
Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	____	____
MEN - Do you have prostate gland trouble?	____	____

Review Of Systems

Date: _____

Name: _____ Date of Birth: _____

Musculoskeletal:	Yes	No
Do you have a problem with back pain?	_____	_____
Do you have pain in your legs or feet?	_____	_____
Does back pain interfere with your work or activities?	_____	_____
Do you have joint pain or stiffness?	_____	_____
Do you have trouble walking or using your hip or knee joints?	_____	_____

Central Nervous System:	Yes	No
Do you have frequent or severe headaches?	_____	_____
Do you often have spells of dizziness, faintness or lightheadedness?	_____	_____
Have you seen double?	_____	_____
Do you sometimes lose track of what happens around you for a short time?	_____	_____
Do you sometimes lose the ability to speak for a few seconds?	_____	_____
Have you recently fainted, blacked out or lost consciousness?	_____	_____
Do you have trouble remembering recent events?	_____	_____
Have you ever had convulsions or fits?	_____	_____
Do you have numbness or tingling in your head, arms or legs?	_____	_____
Do you consider yourself a nervous person?	_____	_____
Do you cry a lot for no reason?	_____	_____
Have you ever had an urge to commit suicide?	_____	_____
Do you ever hear voices or see people when no one is around?	_____	_____
Do you ever have a feeling that someone is trying to harm you?	_____	_____

Personal Habits:	Yes	No
Do you regularly smoke:		
Cigarettes:	_____	_____
How many per day?_____		
For how many years?_____		
Pipe, Cigars or use Chewing Tobacco:	_____	_____
For how many years?_____		
Are you a former smoker/tobacco user?	_____	_____
If so, how long ago did you quit?_____		
Do you drink:		
Hard Liquor:	_____	_____
1-3 oz per day_____over 3 oz per day_____		
Beer:	_____	_____
1 bottle a day_____2 bottles_____3 or more_____		
Wine:	_____	_____
1 glass a day_____2 glasses_____3 or more_____		
Do you drink coffee?	_____	_____
Do you drink 3 or more cups a day?	_____	_____
Do you have difficulty sleeping?	_____	_____
If yes, how often?_____		
Do you awaken very early in the morning without an apparent cause and find it difficult to go back to sleep?	_____	_____
If yes, how often?_____		
Do you exercise?	_____	_____
# of days a week_____Minutes a day_____		
If you exercise, how intense is your exercise?		
Light____Moderate____Heavy____Very Heavy____		
Do you wear a seat belt when traveling in a car?	_____	_____
Are you sexually active?	_____	_____
Have you had more than one partner in the past 2 years?	_____	_____
Do you protect against STD's?	_____	_____
Do you use contraception/birth control?	_____	_____

Women Only	Yes	No
Did your menstrual cycle start before you were 10?	_____	_____
Did your menstrual cycle start after your were 15?	_____	_____
Are your menstrual cycles irregular?	_____	_____
Are your periods less frequent than every 4 weeks?	_____	_____
Are your periods more frequent than every 4 weeks?	_____	_____
Do you use more than 10 pads or have to use a super size pad or tampon for your periods?	_____	_____
Do you pass clots with your periods?	_____	_____
Do you become bloated or gain weight just before your periods?	_____	_____
Have you passed the menopause or change?	_____	_____
Do you have hot flashes?	_____	_____
Have you had an abortion or miscarriage?	_____	_____
Have you had lumps in your breast?	_____	_____
Have you had any discharge from your nipples?	_____	_____
Have you used an intrauterine device (IUD)?	_____	_____
Have you used other birth control measures?	_____	_____

GMS Florida West Coast, Inc.

A Physician Group Practice

Preventive/Physical

We applaud your efforts to maintain your health by utilizing your preventive care physical benefits. In today's age of medicine and government involvement, these benefits continue to change, unfortunately covering less and less under preventive care. Your exact benefits are not only determined by what insurance company you have but also what plan you have chosen through your company's individual offerings. Your company may offer multiple different plan choices, each having different preventive care benefits. This makes it impossible for our office to accurately know your benefits.

Medically we feel that an EKG and certain lab tests (CBC, CMP, Lipid Panel, and TSH) are appropriate and have been previously covered under preventive care. However, you are welcome to check your individual benefit package through your employer or insurance company to see what your plan specifically covers under your current preventive care benefits.

Please realize that all insurance companies and Medicare agree that preventive care does not include any procedures or treatments including the writing of prescriptions. Further, many insurances will not cover specialty lab tests such as Testosterone, Vitamin D or hormone levels under preventive care either. We are providing you this information so that you are aware of preventive care coverage issues which currently exist and of your possible financial responsibilities. Please sign below acknowledging that these issues have been brought to your attention.

We thank you for allowing our office to provide your health care and hope to do so in the future.

_____ _____

Patient Signature Date

Northwest Family Medical Center

Michael A. Cromer, M.D.

Stephen P. Meyer, M.D.

PLEASE READ CAREFULLY

DOCTOR PATIENT ARBITRATION AGREEMENT

This agreement is made between Northwest Family Medical Center ("Practice"), all employed physicians, physician assistants, nurse practitioners and other employees, referred to hereinafter as "Provider" and _____ referred to hereinafter as the "Patient" (Practice/Provider and Patient collectively referred to as the Parties). The Parties to this agreement bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving their claims through, or on behalf of, the Parties.

It is further understood that in the event of any controversy or dispute which might arise between Practice/Provider and the Patient, regardless of whether the dispute concerns the medical care rendered, or payment of fees, or any other matter whatsoever, then the Parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration code, Chapter 682, Florida Statutes. This arbitration shall be binding. Each Party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each Party shall be entitled to the discovery provided for under Rules 1.280 – 1.390, Florida rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all Parties, and may be enforced by a court of competent jurisdiction in and for Hillsborough County, Florida. Requests for arbitration by either Party must be made within the time frame set forth in section 95.11 of the Florida Statutes dealing with medical malpractice.

This agreement shall remain in effect for all treatment and/or surgery provided the Patient presently and at any future date.

In witness whereof, I (we) have set our hands this date _____.

Practice/Provider: **Patient:**

By: _____ By: _____

Authorized Agent/Witness Patient Signature

NORTHWEST FAMILY MEDICAL CENTER

Office Hours – We are open Monday – Thursday 8:30am to 7:00pm, Friday 9:00am to 5:00pm, and Saturday 9:00am to 1:00pm. There is an on-call provider available for after hours emergencies only. Please call 813-960-3321 for any after hours emergency need.

Appointments – We do not provide treatment over the phone. Patients are cared for during office visits. We offer appointments between 9:00am and 11:20am Monday – Friday, 1:30pm and 4:20pm Monday thru Friday. After hours are available from 5pm -7pm Monday thru Thursday. We also accept walk-ins Monday thru Thursday from 8:30am to 5:30pm/ 5:00pm on Friday. Walk-ins are seen on a first-come-first-served basis. Walk-ins will be seen in the morning if they arrive by 11:30am and will be seen by the end of the workday if they sign in by 5:30pm/ 5:00pm on Friday. With some exceptions, scheduled appointments will take priority in being seen. You can not specify a provider that you want to see when you come as a walk-in. Walk-ins who come after 5pm on Monday – Thursday and on Saturdays may be subject to an additional after hours charge.

Cancellations – We know there will be times when you are unable to keep your scheduled appointment. We ask that if this occurs, you contact our office at least 24 hours in advance so we can offer your appointment time to another patient. ***If you fail to notify us and do not show up for your scheduled appointment, you will be charged a no show fee on $25.00.***

Prescriptions – Prescriptions will be electronically transmitted during your visit. As a general rule, we do not call in or fax prescriptions for you. Please keep track of all your medication refills and notify the provider during your visit if you need any refills prior to your next scheduled visit. We ask that you bring your prescription bottles, or an accurate medication list, with refills listed to each of your visits. Some of you may have signed up for a pharmacies auto refill plan. We do not acknowledge faxed requests to continue to renew prescriptions after the allotted refills expire. ***To clarify again … an office visit is needed for any prescription or prescription refills.***

Insurance – For your convenience, we have contracts with many insurance companies. Even though we try to know insurance companies general rules, it is the patient's responsibility to know his/her benefits. We only submit your office visit charges to insurance companies we have contracts with. In order for us to appropriately submit your claims, you will be required to provide a valid insurance card with all of the necessary information. If you do not have your insurance card or if your card is missing pertinent information, we will ask that you get on the phone with your insurance company so we can verify/acquire the information needed. If neither of these options is doable, we will require full payment at the time of service and will provide you with the necessary information for you to submit your claim to your insurance company.

Patient Responsibilities – Co-payments, deductibles, and patient responsibility percentages must be paid at the time of service. For your convenience, we accept cash, check, Visa, American Express, and Master Card. Please inform us of any updated personal or insurance information at each visit. We will ask you to fill out a new demographic/insurance information sheet at least once a year.

Referrals – If your insurance company requires you to have a referral/authorization for medical services obtained outside of our office, it is your responsibility to obtain it prior to your appointment date for that service. ***We do not provide referrals without an office visit.*** With some exceptions, such as medical emergencies, referrals are processed in the order they are received. ***Please allow 3-5 business days for all referral processing.*** We ask that you not schedule any appointments until your referral is ready.

Telephone Calls – If you call our office during regular office hours, a member of our staff will answer your call and ask some specific questions. This is necessary so that the providers can give the most accurate answers possible. All questions are routed to the appropriate provider. One of our staff will make every effort to return your call ***within 24 hours.*** If you are calling for prescription refills or with symptoms of an illness for which a provider has not seen you, you will be instructed to make an appointment to be seen. ***We do not practice medicine over the phone.***

After Hours Calls – If you have an emergency, please call 911, or go to the nearest emergency room. Our after hours service is for urgent medical questions that cannot wait until the next business day. Please do not call the after hours service for prescription refills, referrals, or non-urgent problems. After assessing your situation, we may ask that you make an appointment to be seen the next day in our office. Our after hours phone number is 813-960-3321.

Medical Records – If you need your medical records sent to another doctor or facility, you will be required to sign a HIPPA compliant medal release form provided by our office. We will send medical records to another doctor or facility as a professional courtesy. Patients requesting his/her own medical records will be charged $1.00/page for pages 1-25 then $0.25/page for additional pages. Requests are handled in the order received. ***Please allow 7-14 days to process your request.***

Please be advised that our office policies are subject to change at any time. At times, updates are necessary in order to best serve your medical needs.

Hospital Admissions – If you need to be admitted to the hospital, one of the hospital specialists that we use will oversee your care. If you go to an ER or are hospitalized after going through an ER, please inform the doctors that take care of you that Northwest Family Medical Center is your primary care provider. Instruct them to send us a summary of your ER or hospital admission so that we will have it by the time you see us for follow up care.

Northwest Family Medical Center
4278 W. Linebaugh Ave.
Tampa, FL 33624

I have received a copy of Northwest Family Medical Center's office policies and agree to comply with all the guidelines set forth by Northwest Family Meidcal Center. I am aware that current office policies are subject to change without prior notice as deems neccessary to ensure that quality care is provided to all patients.

Signed _____ Date _____

Print Name_____