

Physician Group of Florida, Inc.

Gregory A. Berland, M.D.
 Dipali Patel, M.D.
 Bobbie Bullian, PA-C
 Julie Aull, PA-C



PATIENT INFORMATION (All fields required to be seen)			
Date:	Last Name (Legal)	First Name (Legal)	Middle Initial:
Address:		City:	State: Zip:
Gender: M / F	Date of Birth:	Social Security Number:	Home Phone:
Email Address:		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Cell Phone:
Ethnicity: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Mixed <input type="checkbox"/> Native American <input type="checkbox"/> Unknown (for demographical purposes only)			
Occupation:		Employer	Work Phone:
Employer Address:		City:	State: Zip:

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)			
Insurance Company Name:	Policy Holder Name:	Policy Holder Date of Birth / /	Patient Relationship to Insured Self Spouse Child Other
Policy Holder's SS#:	Policy ID #:	Group #:	Co-pay Amount \$
Insurance Company Address:			Insurance Phone Number:
Secondary Insurance Name:	Policy Holder Name:	Policy Holder Date of Birth:	Patient Relationship to Insured Self Spouse Child Other
Policy Holder's SS#:	Policy ID #:	Group #:	Co-pay Amount \$
Insurance Company Address:			Insurance Phone Number:

EMERGENCY CONTACT INFORMATION***		
Emergency Contact (Full name):	Relationship to Patient:	Contact Phone Number:

REFERRAL SOURCE (How did you hear about us?)
Newspaper__ Radio__ TV__ Yellow Pages__ Magazine__ Mailer Ad__ Internet__ Billboard__ Physician__ PGF Physician__ Family/Friend__ Another Patient__ Seminar__ Hospital__ Insurance Plan__ Other__

REQUIRED RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS
I authorize the release of medical information necessary to process my claim. As a courtesy to our patients we will file the claim with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company is responsible for payment of this account.
Signature of Patient (or responsible party): X _____ Date: X _____
Printed Name: X _____

CONSENT TO TREATMENT
I consent to care at this Physician Group of Florida, Inc. locations, allowing all routine diagnostic procedures, examinations, and medical treatment to be performed. I authorize my insurance carrier to pay Physician Group of Florida, Inc. all benefits due.
I understand and acknowledge this statement.
Patient signature: X _____ Date: X _____

FINANCE CHARGES AND BILLING PROCEDURES

The finance charge is an annual percentage rate of 18% applied to the 90day balance after deducting payments and credits.

Patient is responsible to notify us in case of Errors or Questions regarding your bill:

If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write or phone us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. **You can telephone us, however you must speak with a member of the business office, leaving a message will not preserve your rights.** After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount NOT in question, including finance charges. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay parts of your bill that are not in question. If we find that we made a billing error on your account, you will not have to pay any finance charges related to the questioned amount. IF WE FIND YOUR ACCOUNT CHARGES TO BE CORRECT, YOU MAY HAVE TO PAY FINANCE CHARGES, AND YOU WILL HAVE TO MAKE UP ANY MISSED PAYMENTS ON THE QUESTIONED AMOUNT.

MANAGED CARE/COMMERCIAL INSURANCE

PATIENTS ARE RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES OR NON COVERED SERVICES AS DICTATED BY THEIR MANAGED CARE PLAN. IT IS THE PATIENT'S RESPONSIBILITY BEFORE MAKING AN APPOINTMENT TO CONFIRM WITH THEIR INSURANCE COMPANY WHETHER THE PHYSICIAN IS COVERED AS AN IN-NETWORK PROVIDER FOR THEIR PLAN. THE PATIENT IS RESPONSIBLE FOR SERVICES REDERED BY PHYSICIAN GROUP OF FLORIDA,INC, PHYSICIANS THAT ARE NOT PROVIDERS, OR IN-NETWORK PROVIDERS FOR THEIR PLAN.

I declare that the above answers and statements are true and correct to the best of my knowledge and belief. I hereby acknowledge that I have read this entire document, and agree to all of the terms herein.

Patient Signature: X _____ Date: X _____

Patient's Printed Name: X _____

PAYMENT ARRANGEMENTS

Services are payable upon date performed or upon receipt of monthly statement. If extended terms are required on balances, The Office Manager of this office will need to be contacted to establish a payment schedule. For your convenience we accept VISA, MASTERCARD, American Express, and Discover Card.

Acknowledgment of Notice of Privacy Practice and HIPAA Notice of Privacy Practice

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive at this practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice, whether made by practice personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. By signing this document, I acknowledge that I have read and understand the Notice of Privacy Practices and the HIPAA Privacy Act practices. If you have any questions about this notice, please contact the Privacy Officer.

X _____

Signature

X _____

Date

Acknowledgment of Receipt of Office Guidelines

I acknowledge that I have received a copy of the guidelines, read them and have full understanding of guidelines.

X _____

Signature

X _____

Date

MEDICAL HISTORY FORM

PATIENT NAME: _____

Patient's Date of Birth: _____ **Today's Date:** _____

Problem to address: _____

Previous Hospitalizations / Surgeries (circle): yes / no, if yes, please list including dates of occurrence

Medical History: (Circle items applying to you)

- | | | | | |
|----------------|----------------------|-----------------|---------------------|------------------------|
| Allergies | Cholesterol Disorder | Heart Murmur | Prostate Disorder | Stroke |
| Anemia | Depression | HIV/Hepatitis | Seizures | Thyroid Problem |
| Asthma | Diabetes | Hypertension | Skin Cancer | Vision Problems |
| Back problems | Hearing Problems | Lung Disease | Skin Problems | Cancer: (specify type) |
| Blood Disorder | Heart Disease | Kidney Disorder | Digestive disorders | _____ |

Other/Additional Information _____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Alcohol use: Never Rarely Moderate Daily

Tobacco use: Never Quit Currently smoke _____ packs/day Year began smoking _____

Drug use: Never Type/Frequency _____

Excessive exposure at work/home to: Fumes Dust Solvent Noise Air-born particles

Occupation/Location: _____

Family History:

Father: Age _____ Living/Deceased -cause of death/medical problems _____

Mother: Age _____ Living/Deceased -cause of death/medical problems _____

Bro/Sis Age _____ Living/Deceased -cause of death/medical problems _____

Bro/Sis Age _____ Living/Deceased -cause of death/medical problems _____

Bro/Sis Age _____ Living/Deceased -cause of death/medical problems _____

Bro/Sis Age _____ Living/Deceased -cause of death/medical problems _____

Medication Allergies:

Any other physicians involved in your care? _____

SYSTEM REVIEW: Check the items in each category that you presently cause you problems or discomfort:

General	Gastrointestinal	Endocrine	Integumentary (Skin/Breast)
Recent weight change	Loss of appetite	Glandular/hormone problem	Rash or itching
Fever	Change in bowel habits	Thyroid disease	Change in skin color
Fatigue	Nausea or vomiting	Diabetic	Change in hair or nails
Headache	Rectal bleeding/blood in stool	Excessive thirst/urination	Varicose veins
Eyes	Abdominal pain / heartburn	Heat / cold intolerance	Breast Pain / Lump / Discharge
Blurred/Double vision	Peptic ulcer	Dry Skin	History of Breast Cancer
Eye disease / injury / Glaucoma		Change in hat or glove size	History of cysts
Glasses/Contact lenses			Last Mammogram _____

Genitourinary	Hematological/Lymphatic	Ears/Nose/Throat/Mouth	Cardiovascular	Musculoskeletal
Frequent urination	Slow healing after cuts	Earaches/drainage	Heart trouble/murmur	Muscle pain/weakness
Painful urination	Bleeding or bruising	Chronic sinus problems	Chest Pain	Joint stiffness / pain
Blood in urine	Anemia	Nose or gum bleeding	Palpitation	Back Pain
Force/strain in urination	Phlebitis	Mouth sores	Heart trouble or murmur	Difficulty walking
Incontinence/dribbling	Past Transfusion	Bad breath / bad taste	Shortness of breath	Cold extremities
Sexual Difficulty	Enlarged glands	Sore throat	Swelling /feet/ankles/hands	
Kidney Stones	Hepatitis A B C/HIV	Swollen glands in neck		

FEMALE:

Pain with periods	Neurological	Respiratory	LIST ALL MEDICATIONS AND VITAMINS _____ _____ _____ _____
Vaginal Discharge	Frequent Headaches	Chronic/frequent cough	
Irregular Periods	History of Concussion	Spitting up blood	
# of pregnancies _____	Light headed/dizzy	Shortness of breath	
# of deliveries _____	Seizures/Tremors	Asthma or Wheezing	

Last PAP Smear _____

Method of birth control: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO OUTSIDE PARTIES

This document authorizes Patients First Family Medicine (PFFM) to speak with a family member or friend regarding your medical information. You can designate how much information each person is allowed to obtain. This form is optional.

*****Unless this form is signed, NO information will be given, not even to a spouse.*****

Patient Name: _____ Date of Birth: _____

I authorize Patients First Family Medicine to share my health information to the following person(s) as described below:

Name of individual Patients First Family Medicine is authorized to share the health care information with:

Person #1 _____

The type and amount of information to be used or disclosed is as follows (include dates where appropriate): ALL

- | | | | |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> problem list | <input type="checkbox"/> medication list | <input type="checkbox"/> list or allergies | <input type="checkbox"/> immunization record |
| <input type="checkbox"/> most recent history & physical | <input type="checkbox"/> most recent discharge summary | <input type="checkbox"/> laboratory results | <input type="checkbox"/> appointment schedule |
| <input type="checkbox"/> radiology reports | <input type="checkbox"/> billing | <input type="checkbox"/> treatment for alcohol / drug abuse | |
| <input type="checkbox"/> records pertaining to sexually transmitted diseases/AIDS/HIV | <input type="checkbox"/> records pertaining to behavioral or mental health services | | |
| <input type="checkbox"/> consultation reports from: _____ | <input type="checkbox"/> other _____ | | |

Name of individual Patients First Family Medicine is authorized to share the health care information with:

Person #2 _____

The type and amount of information to be used or disclosed is as follows (include dates where appropriate): ALL

- | | | | |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> problem list | <input type="checkbox"/> medication list | <input type="checkbox"/> list or allergies | <input type="checkbox"/> immunization record |
| <input type="checkbox"/> most recent history & physical | <input type="checkbox"/> most recent discharge summary | <input type="checkbox"/> laboratory results | <input type="checkbox"/> appointment schedule |
| <input type="checkbox"/> radiology reports | <input type="checkbox"/> billing | <input type="checkbox"/> treatment for alcohol / drug abuse | |
| <input type="checkbox"/> records pertaining to sexually transmitted diseases/AIDS/HIV | <input type="checkbox"/> records pertaining to behavioral or mental health services | | |
| <input type="checkbox"/> consultation reports from: _____ | <input type="checkbox"/> other _____ | | |

I understand that this authorization is valid until I revoke it. I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Patients First Family Medicine, Attn: Office Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Office Manager at Patients First Family Medicine. A copy of this authorization will be maintained in the Patient's medical record.

[] YES, I desire a signed copy of this authorization.

X _____
Signature of Patient or Legal Representative *Relationship to Patient*

If Signed by Legal Representative, Signature of Witness *Date*

A photo copy of this Authorization will be considered as an original.



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11663 Countryway Boulevard
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813.891.6889 Fax
www.patients-first.com

Office Guidelines

You will be asked to sign a form acknowledging that you read these policies.

Dr. Gregory A. Berland, Dr. Dipali Patel, Julie Aull, PA-C, and Bobbie Bullian, PA-C, would first like to thank you for your patronage. We are very aware that you could go anywhere for your healthcare, and we will do everything we can to ensure that you have the best possible experience in our office. One of the foundations of our practice is our desire to be available to our patients, and we take pride in providing this accessibility. In keeping with this emphasis, there are some guidelines to assure that we can continue to serve you in this manner. At night and on weekends, we are often on call at two hospitals for inpatient medicine. *We ask that you phone us during after hour times only for serious medical issues.* We are also concerned that when dealing with life-threatening issues, that you call the proper medical service for the quickest response. For these reasons, here are guidelines to assist you when our office is closed:

- If there is an emergency, such as **chest pain or stroke** symptoms, please call 9-1-1 or go to the Emergency Room. If we receive a call for an emergency reason, we will advise you to go immediately, as we do not want you to waste precious minutes getting you or your loved one to the Emergency Room.
- If there are other serious medical questions that need immediate attention, please call us! Serious medical questions may involve: fevers exceeding 100.5 degrees, diarrhea or vomiting for more than 24 hours, seizures, or other health issues that concern you.
- It is illegal for us to refill narcotics (i.e. codeine) over the phone. Please contact the office during regular business hours.
- We are unable to schedule appointments after hours.

Office hours are Monday through Friday from 8:00 am to 5:00 pm. We are closed daily for lunch from 12:00 to 1:00. If you need to reach a healthcare provider during non-business hours, please call 813-891-6310 and you will be assisted by our answering service.

- We will not discuss lab or diagnostic test results over the phone. We do this in person, to answer any other questions that may relate to other aspects of your health care. Additionally, while we have well-trained staff, they are not qualified to accurately interpret some tests in relation to your medical condition. Please schedule a follow up appointment a few days after your tests are completed.
- All prescription requests are addressed during normal business hours. We are able to address these requests very quickly if they come from the pharmacy--please contact them with refill requests, and we will respond as quickly as possible. **Please allow up to 48 hours for refills to be processed.** If we have not filled a specific prescription for you before, you will have to see one of the health care providers at Patients First to have that issue addressed first.
- Please allow four business days to obtain authorizations and referrals for specialist office visits. Contact the office right after you schedule your appointment with the specialist so that we may obtain the insurance company authorization or referral for you.
- Due to federal privacy laws, no information can be given to anyone except the patient, without their prior authorization; this includes spouses. If you are calling about a friend or loved one over the age of 18, we must have written permission from the patient to speak with you about their condition or their appointment times. No exceptions are made since this is a federally mandated law! **An authorization form must be signed to authorize person(s) eligible to obtain medical information.**
- As a courtesy to others, we ask that you cancel an appointment at least 24 hours before the scheduled time. This will allow us to schedule that appointment for someone else who needs it. *There is a \$25 fee assessed for appointments cancelled the same day or "no shows".* Cancellation messages may be left with our answering service after hours.
- There will be a minimum \$25 fee for healthcare provider to complete forms such as disability and attending physician forms. Please allow at least 48 hours for them to be completed.



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PAYMENT POLICY

Thank you for choosing Patients First Family Medicine as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and what services are or are not covered is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 3. Non-covered services.** Please be aware that some – and perhaps -- all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
- 4. Proof of Insurance.** All patients must complete our patient information form before seeing a healthcare provider. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be advised that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 6. Coverage change.** If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days after submission, the balance will automatically be billed to you.
- 7. Nonpayment.** Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our healthcare providers will only treat you on an emergency basis.
- 8. Missed appointments.** Our policy is to charge for missed appointments not canceled within 24 hours prior to the appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve your health care needs better by keeping your regularly scheduled appointment.
- 9. Refund policy:** Patients who have a credit on their account of less than \$50, and are currently being treated or have pending claims, will not receive a credit refund, but it will be applied to their account for future balances. Patients who are no longer patients of the practice will receive a refund check, as appropriate, in the mail for amounts over \$10.
- 10. Late Policy.** Patients who arrive 15 minutes or later for their appointment may be asked to reschedule at the provider's discretion.