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 Anemia Arthritis Asthma Back problems Blood disorder Cholesterol disorder Depression
Diabetes Hearing problems Heart Disease Heart Murmur HIV/Hepatitis Hypertension Lung Disease
Kidney Disorder Prostate disorder Seizures Skin Cancer Skin problems Stomach/Digestive disorders
Stroke Thyroid problem Vision Problems Cancer(specify type)_________________________________
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: **Medication Allergies:**

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 ________________ ________________

Any other physicians involved in your care? ____

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

General
Recent weight change
Fever
Fatigue
Headache

Eyes
Eye disease / injury / Glaucoma
Glasses/Contact lenses
Blurred/double vision

Gastrointestinal
Loss of appetite
Change in bowel habits
Nausea or vomiting
Rectal bleeding/blood in stool
Abdominal pain / heartburn
Peptic ulcer

Endocrine
Glandular/hormone problem
Thyroid disease
Diabetic
Excessive thirst/urination
Heat / cold intolerance
Dry Skin
Change in hat or glove size

Integumentary ___________ (**Skin/Breast**)
Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast Pain / Lump / Discharge
History of Breast Cancer
History of cysts
Last Mammogram_________

Hematological/Lymphatic
Slow healing after cuts
Bleeding or bruising
Anemia
Phlebitis
Past Transfusion
Enlarged glands
Hepatitis A B C/HIV

Ears/Nose/Throat/Mouth
Earaches / drainage
Chronic sinus problems
Nose or gum bleeding
Mouth sores
Bad breath / bad taste
Sore throat or voice change
Swollen glands in neck

Cardiovascular
Heart trouble / murmur
Chest Pain
Palpitation
Heart trouble or murmur
Shortness of breath
Swelling /feet/ankles/hands

Respiratory
Chronic / frequent cough
Spitting up blood
Shortness of breath
Asthma or wheezing

Musculoskeletal
Muscle pain / weakness
Joint stiffness / pain
Back Pain
Back Pain
Difficulty walking
Cold extremities

Genitourinary
Frequent urination
Burning/painful urination
Blood in urine
Force/strain in urination
Incontinence/dribbling
Kidney stones
Last PAP Smear________

Sexual difficulty
Female - pain with periods
Vaginal discharge
Irregular periods
#pregnancies__________
#deliveries__________
miscarriages__________
Method of birth control__________________________

Neurological
Frequent headaches
History of Concussion / Injury
Light headed/dizzy
Seizures / Tremors
Numbness/tingling
Paralysis / Stroke
____
____

LIST ALL MEDICATIONS & VITAMINS
____
____
____
____
____
____

Last Name First Midle Initial

Address Apt # City/State Zip

Home Phone Number Cell Phone Date of Birth Social Security No.

Email Address Employer Name Work number

Emergency Contact Name Phone Number

INSURANCE INFORMATION:

Insurance Company Name

Insurance Policy Holders Name and date of birth Social Security No. Insurance Phone #

ID #

Group # Claim Mailing Address

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.

Signature *Date*

Acknowledgement of Receipt of Office Guidelines

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

Signature *Date*

Release of Medical Information and Authorization for Treatment

I authorize the release of any medical information necessary to process a claim and further authorize payment of insurance benefits directly to Berland MD, P.A. To provide for continuity of care, I authorize the release of medical information to specialty physicians who are participating in my care. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Berland MDS, PA to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I hereby grant permission to Berland MD, P.A. to release any pertinent information to my insurance company upon request, and I also authorize payments to be made on my behalf directly to Berland MD, P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature *Date*

Acknowledgement of Receipt of Payment Policy

I acknowledge that I have received the payment policy, understand the policy and agree to abide by its guidelines

Signature *Date*

Gregory A. Berland, MD

11663 Countryway Boulevard
Tampa, FL 33626
813.891.6310 Office
813.891.6889 Fax
www.patients-first.com

Dr. Berland, Anthony Yarand, 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 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 Mon/Wed/Fri from 8am-5pm, Tu e/Thur from 8am to 8pm. 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! ***A HIPPA 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. 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.

Gregory A. Berland, MD

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813.891.6316 Office
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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.

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.

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.

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.

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.

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.

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.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and 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.

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.

Refund policy: Patients who have a credit on their account of less then $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.

Our practice is committed to providing the best treatment to our patients. Our charges are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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:___________________SS #:____________________________

I authorize Patients First Family Medicine to use or disclose the health information of the above named individual, as described below:

Name of individual PFFM is authorized to share the health care information with: ____

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

- ☐ **problem list**
- ☐ **medication list**
- ☐ **list or allergies**
- ☐ **immunization record**
- ☐ **most recent history & physical**
- ☐ **most recent discharge summary**
- ☐ **laboratory results**
- ☐ **appointment schedule**
- ☐ **radiology reports**
- ☐ **billing**
- ☐ **treatment for alcohol / drug abuse**
- ☐ **records pertaining to sexually transmitted diseases/AIDS/HIV**
- ☐ **records pertaining to behavioral or mental health services**
- ☐ **consultation reports from:____**
- ☐ **other ____**

Name of individual PFFM is authorized to share the health care information with: ____

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

- ☐ **problem list**
- ☐ **medication list**
- ☐ **list or allergies**
- ☐ **immunization record**
- ☐ **most recent history & physical**
- ☐ **most recent discharge summary**
- ☐ **laboratory results**
- ☐ **appointment schedule**
- ☐ **radiology reports**
- ☐ **billing**
- ☐ **treatment for alcohol / drug abuse**
- ☐ **records pertaining to sexually transmitted diseases/AIDS/HIV**
- ☐ **records pertaining to behavioral or mental health services**
- ☐ **consultation reports from:____**
- ☐ **other ____**

Name of individual PFFM is authorized to share the health care information with: ____

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

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- ☐ **billing**
- ☐ **treatment for alcohol / drug abuse**
- ☐ **records pertaining to sexually transmitted diseases/AIDS/HIV**
- ☐ **records pertaining to behavioral or mental health services**
- ☐ **consultation reports from:____**
- ☐ **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 disclose 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.

____ ____________________________________

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.