PATIENT INFORMATION SHEET

PAYMENT IS DUE AT THE TIME OF SERVICE. Please print the information below as completely as possible.

DATE

NAME

EMAIL

IF PATIENT IS A MINOR, GUARDIAN

BIRTH DATE

HOME PHONE

CELL PHONE

PERMANENT ADDRESS

STREET

CITY

STATE

ZIP CODE

LOCAL ADDRESS (IF DIFFERENT)

STREET

CITY

STATE

ZIP CODE

IDENTIFICATION

SS#

DRIVER LICENSE #

STATE

MARITAL STATUS ☐ SINGLE

☐ DIVORCED

☐ WIDOWED

☐ MARRIED

SPOUSE'S NAME

EMPLOYER

EMPLOYER

WORK ADDRESS

STREET

CITY

STATE

ZIP CODE

PHONE

SPOUSE'S EMPLOYER

EMPLOYER

SPOUSE'S WORK #

REFERRAL

REFERRED TO THIS OFFICE BY

PHONE

CONTACT IN CASE OF AN EMERGENCY

NAME

PHONE

NEAREST RELATIVE NOT LIVING WITH YOU

NAME

RELATIONSHIP

PHONE

PLEASE LIST ANY ALLERGIES

WHEN THESE FORMS ARE COMPLETED. PLEASE RETURN WITH YOUR:

INSURANCE CARD AND DRIVER LICENSE

THEY WILL BE RETURNED AFTER COPIES HAVE BEEN MADE.

SIGNATURE

DATE

PERSONAL HEALTH HISTORY

DATE _____

NAME _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE OR HAVE HAD:

Anemia/Blood Disease	☐ YES	☐ NO
Sickle Cell Anemia	☐ YES	☐ NO
Bronchitis/ Chronic Cough	☐ YES	☐ NO
Loss of Consciousness/ Dizziness	☐ YES	☐ NO
Hepatitis/ Liver Disease/ Jaundice	☐ YES	☐ NO
Neck/ Back Problem	☐ YES	☐ NO
Cancer/ Tumor/ Leukemia	☐ YES	☐ NO
Arthritis/ Rheumatism	☐ YES	☐ NO
Color Blindness/ Glaucoma	☐ YES	☐ NO
Heart Disease/ Heart Murmur	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Sinus Problems/ Hay Fever	☐ YES	☐ NO
Immune Deficiency Syndrome	☐ YES	☐ NO
Removal of Spleen	☐ YES	☐ NO
Gall Bladder Surgery	☐ YES	☐ NO
Hernia Repair	☐ YES	☐ NO
Rectal/ Bowel Surgery	☐ YES	☐ NO
Major Bone/ Joint Surgery	☐ YES	☐ NO

Prostate Surgery ☐ YES ☐ NO

Pregnancies ☐ YES ☐ NO

Allergies ☐ YES ☐ NO

Tonsils/Adenoids/ Ear Surgery ☐ YES ☐ NO

Asthma/ Emphysema ☐ YES ☐ NO

TB/ History of Positive Skin Test ☐ YES ☐ NO

Seizures/ Epilepsy ☐ YES ☐ NO

Frequent or Severe Headaches ☐ YES ☐ NO

Thyroid Disease/ Goiter ☐ YES ☐ NO

Kidney Disease/ Kidney Stones ☐ YES ☐ NO

Knee or Joint Problems ☐ YES ☐ NO

Stroke/ Paralysis ☐ YES ☐ NO

Deafness/ Hearing Loss/ Ringing in the ears ☐ YES ☐ NO

Ulcer/ Digestive/ Problems Bowel Disease ☐ YES ☐ NO

History of Alcohol/ Drug Problems ☐ YES ☐ NO

Gyn(female) Problems/infections ☐ YES ☐ NO

Hysterectomy/ Gyn(female) Surgery ☐ YES ☐ NO

Ulcers/ Stomach Surgery ☐ YES ☐ NO

Appendectomy ☐ YES ☐ NO

Breast Surgery ☐ YES ☐ NO

Heart/ Lung Surgery ☐ YES ☐ NO

Cataract Surgery ☐ YES ☐ NO

CURRENT MEDICATIONS:

PLEASE LIST ANY OTHER MEDICAL/SURGICAL CONDITION, OR COMMENT ON ANY OF THE ABOVE:

FAMILY HISTORY: MOTHER

CURRENT AGE (or if deceased give date of death)

ILLNESSES

GENERAL HEALTH

FAMILY HISTORY: FATHER

CURRENT AGE (or if deceased give date of death)

ILLNESSES

GENERAL HEALTH

FAMILY HISTORY: SIBLINGS

CURRENT AGE (or if deceased give date of death)

GENDER

ILLNESSES

GENERAL HEALTH

FAMILY HISTORY: SIBLINGS

CURRENT AGE (or if deceased give date of death)

GENDER

ILLNESSES

GENERAL HEALTH

Please include cancer, diabetes, heart attacks, blood pressure, strokes, TB and any important illnesses.

DO YOU SMOKE?

CURRENTLY ☐ YES ☐ NO

HOW MUCH?

NUMBER YEARS?

☐ CIGARETTES ☐ CIGARS ☐ PIPE

DO YOU DRINK ALCOHOLIC BEVERAGES?

CURRENTLY ☐ YES ☐ NO

WHAT KIND? _____

HOW OFTEN? _____

FOR FEMALES ONLY:

ARE YOU PREGNANT? ☐ YES ☐ NO

DATE OF LAST MENSTRUAL CYCLE? _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY

SIGNATURE _____

DATE _____

FAMILY HISTORY

PLEASE LIST ANY OTHER MEDICAL/ SURGICAL CONDITION, OR COMMENT ON ANY OF THE ABOVE:

FAMILY HISTORY

MOTHER: AGE ☐ DECEASED? ☐

ILLNESSES

GENERAL HEALTH

FATHER AGE ☐ DECEASED? ☐

ILLNESSES:

GENERAL HEALTH:

BROTHER(S) AGE(S) DECEASED? ☐
SISTER(S)

ILLNESSES:

GENERAL HEALTH:

PLEASE INCLUDE CANCER, DIABETES, HEART ATTACKS, BLOOD PRESSURE, STROKES, TB AND ANY IMPORTANT ILLNESSES.

DO YOU SMOKE? YES NO HOW MUCH?

NUMBER OF YEARS? CIGARETTES

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO

WHAT KIND? HOW OFTEN?

FOR FEMALES ONLY: ARE YOU PREGNANT? YES NO

DATE OF LAST MESTRUAL CYCLE

SIGNATURE OF PERSON
COPLETING HEALTH HISTORY

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	
SUBSCRIBER:	
SUBSCRIBER'S DATE OF BIRTH:	
SUBSCRIBER'S SOCIAL SECURTY#	
SECONDARY INSURANCE:	
SUBSCRIBER:	
SUBSCRIBER'S DATE OF BIRTH:	
SUBSCRIBER'S SOCIAL SECURITY#	

PHARMACY INFORMATION

NAME

LOCAL PHARMACY

NAME

ADDRESS

PHONE

MAIL ORDER PHARMACY

NAME

ADDRESS

PHONE

FINANCIAL POLICY

Thank you for choosing Kavita Rao. M.D. as your health care provider. I am committed to your care and treatment being mutual being mutually satisfying experience. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my Financial Policy which we require you to read and sign prior to treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE

The doctors are providers for many managed care insurances in this area. You are responsible for your co-pay and / or deductible at the time of your service. My office will be happy to file the insurance claim to any insurance company which I am contracted with. I respectfully request that all minor emergency walk in patients pay at time service is rendered.

If I am not contracted with your insurance company the balance is your responsibility. You will be given the necessary information to be reimbursed for the visit.

The balance is your responsibility whether the insurance company pays or not. Your insurance policy is contracted between you and your insurance company. I am not a party to the contract. If your insurance company does not pay my claim within 45 days, the balance will be transferred to you.

Please be aware your insurance company will only pay for services that it determines to be "reasonable and necessary" under your insurance company's standards. You will be responsible for payment of those services in full and collection agency fees. Late or unpaid balances may be assessed interest charges and collection agency fees.

Unless appointments are canceled 24 hours prior to the scheduled time, you may be billed for an office visit.

Thank you for understanding my **Financial Policy.** If you have any questions, feel free to ask the receptionist of practice manager.

I authorize any holder of medical or other information that is necessary to process this claim to release my medical record to the insurance company listed above. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

GULF COAST INTERNIST, LLC

Kavita Rao, M.D.
4957 38th Ave. N. Suite C
St. Petersburg, FL 33710
Telephone: (727) 525-0900
Fax: (727) 525-9500

Dear Patient:
The completion of information/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant cost especially when multiplied over the large number of patients our practice services. The refusal of insurance companies and requesting agencies to cover the cost requires us to institute a policy of charges for the completion of forms as follows and subject to change at any time:

$10.00:
- Disabled Parking Applications

$25.00:
- Workers Compensation requested Disability and Work Status forms
- Auto Insurance Carrier requests for Work Status and Treatment plans
- Credit card deferment forms
- School Educational Disability or Limitation forms

$35.00:
- Family Medical Leave Act forms

$150.00-$300.00:
- for completion of any dictated letter describing medical care and limitations.

Patient Signature _____

Date _____

Gulf Cost Internist, LLC
Patient Medication Agreement

Please read carefully before signing; you will be held to all aspects of this contract. The physician of Gulf Coast Internist, LLC adhere to policies regarding the prescribing of medications. As a patient of my practice, medication may be prescribed to you ONLY if adhere to the following:

1. Prescription medications are only filled during regular office hours: 9:00am- 5pm. Monday thru Friday. There is at least a 72-hours turn around period for prescription refills that are NOT controlled medications.

2. All medications are to be taken within the parameters prescribed (e.g. Take one tablet every day, NOT one to two tablets every day).

3. Controlled medications are to be prescribed by ONE physician only (Gulf Coast Internist, LLC). Receiving pain management controlled medications from multiple physician's will result in immediate dismissal from our practice.

4. Controlled medications that are "lost" or "stolen" may OR may not be replaced. A police report IS required. This still does NOT guarantee a renewal; it is to the discretion of the doctor.

5. Controlled medications MUST be written and will not be called into a pharmacy. A doctor's visit is required EACH time a controlled medications are written for no more than a 30 -day supply at a time. Patients are responsible for prolonging the use of their controlled medications until the next scheduled appointment.

6. As a patient, you MAY be subject to a random urine and blood screen tests at any time to detect the use of non-prescribed medication.

7. As a patient you are allowing Gulf Coast Internist, LLC to access your external medication history.

Gulf Coast Internist, LLC. Will do their best to provide you with excellent medical care, We expect your best efforts in this mutual relationship.

I have read and understand the above medication agreement and agree to abide by this contract.

Patient Name Printed: _____

Patient Signature: _____ Date _____

Witness Signature: _____ Date _____

GULF COAST INTERNIST, LLC

Kavita Rao, M.D.
(727) 525-0900
4957 38th Avenue North, Suite C
Saint Petersburg, FL 33710

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I _____ Have reviewed a copy of Gulf Coast Internist, LLC Notice of privacy practices.

Signature _____

Date _____

Authorization for Release of Medical Information

This will authorize

To release medical information including psychiatric and / or drug and alcohol abuse information and HIV Results from my medical records to:

Dr. Kavita Rao, MD
4957 38th Avenue North, Suite C
St. Petersburg, FL 33710
Visit: DrKavitaRao.com
Fax:(727) 525 9500

The facility named above is released from all legal liability that may arise from the release of the information requested above.

Print Patients Name:

Date

Guardian Signature

Date

Witness

Date

Signature

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Gulf Coast Internist, LLC we are committed to responsibly treating and protecting your information. This Notice of Health Information Practice describes the personal information we collect, how and when we use or disclose that information. It also describes your rights as they relate to your protected health information (PHI). This Notice is effective April 14, 2003 and applies to all PHI as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit Gulf Coast Internist, LLC a record of your visit is made. Typically this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care or treatment, as indicated. This information often referred to you as your health or medical record. Serves as a :

-Basis for planning your care and treatment
-Means of communication among the many health Professionals who contribute to your care
-Legal document describing the care you received
-Means by which you or a third party payer can verify that services billed were actually provided
-A source of information for public health officials charged with improving the health of this state and the nation
-A source of data for planning better ways to serve you in the future
-A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical/electronic property of Gulf Coast Internist, LLC the information belongs to you. You have the right to:

-Obtain a paper copy of this notice of information practices;
-Inspect and copy (a copying fee may charged) your health record as provided for in 45 CFR 164.524;
-Request in writing an amendment to your health record as provided in 45 CFR 164.528;
-Obtain an accounting of disclosures of your health information by alternative means or at alternative locations;
-Request a restriction on certain uses and disclosures of your information as provided in 45 CFR 164.522;
-Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Gulf Coast Internist, LLC is required to:
-Maintain the privacy of your health information;
-Provide you with this notice as to your legal duties and privacy practices with respect to information we collect and maintain about you;
-Abide by the terms of this notice;
-Notify you if we are unable to agree to a requested restriction; and
-Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the rights to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, you may obtain a copy at any of our facilities. We will not use or disclose your health information without your authorization, except as described in the notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:
If you have any questions and would like additional information, you may contact practice's Privacy Officer Mr. Nat at (727) 525 0900.

If you believe your privacy rights have been violated, you can file a complaint with practice's Privacy Officer or with the Office for Civil Rights, U.S. Dept of Health and Humans Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights (OCR). The addresses for the Privacy Officer and the OCR are listed below:

Gulf Coast Internist, LLC
4957 38th Ave N, Suite C
St Petersburg, FL 33710

Office for Civil Rights
U.S. Dept of Health & Human Services
200 Independence Ave, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLE OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

WE WILL USE YOUR HEALTH INFORMATION FOR TREATMENT:

For example: information obtained by a nurse, physician, or other member of our office staff will be recorded in your health record and used to determine the course of treatment that should work best for you. In that way, the physician will know how you are responding to the treatment.

Copies of various reports may be provided to your private physician(s) or subsequent health care provider(s) to assist him or her in treating you once you are discharged from Gulf Coast Internist, LLC.

WE WILL USE YOUR HEALTH INFORMATION FOR PAYMENT:

For example: a bill may be sent to your insurance or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

WE WILL USE YOUR HEALTH INFORMATION FOR REGULAR HEALTH OPERATIONS:
For example: members of our medical staff or quality improvement team may use information in your medical record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in medical record storage and billing companies. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals using their best judgment may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Access to protected health information:
-Requires you or your legal representative to put your request to view or copy your protected health information (Medical Record) in writing.
-Reserve the right to charge a reasonable fee for copying, mailing, and/or preparing a summary of the protected health information on paper and/or electronic media.

Marketing: We may contact you to provide appointment reminders or information about your treatment alternatives, any questions you may have concerning your care and treatment or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplement products and product defects of post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Employer: If you are being seen for an employment physical and/or test, **Gulf Coast Internist, LLC** may disclose your health information to your employer as determined by you and your employer.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing and controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct to have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or public.

TREATMENT AND FINANCIAL AGREEMENT

NOTE: AS A COURTESY, WE WILL BILL YOUR INSURANCE FOR YOU AFTER YOUR DEDUCTIBLE HAS BEEN MET.
BUT NO INSURANCE WILL BE FILED WITHOUT ALL OF THE ABOVE INFORMATION AND A COPY OF YOUR CARD.

TREATMENT AND FINANCIAL AGREEMENT: PAYMENT IS DUE AT THE TIME OF SERVICE. AN OFFICE VISIT CHARGE MAY BE MADE IF AN APPOINTMENT IS NOT CANCELLED IN A TIMELY FASHION. UNDERSIGNED AGREES AND REQUESTS THAT ALL PAYMENTS MADE BY INSURANCE BE SENT DIRECTLY TO PROVIDER WITH INSURED AND PROVIDER AS JOINT PAYEES. AUTHORIZATION IS HEREBY GIVEN TO RELEASE COPIES OF MEDICAL RECORDS TO CARRIER IF REQUESTED FOR CLAIM PROCESSING. IN CONSIDERATION FOR MEDICAL SERVICES RENDERED BY DR. RAO, THE UNDERSIGNED AGREES THAT REGARDLESS OF INSURANCE STATUS, UNLESS THERE IS A CONTRACTUAL AGREEMENT TO THE CONTRARY (AS IN THE CASE OF MEDICARE OR A PPO), OR IN THE EVENT THAT INSURANCE COVERAGE IS DENIED, THAT HE OR SHE IS PERSONALLY RESPONSIBLE FOR THE PROMPT PAYMENT OF CHARGES FOR ALL MEDICAL SERVICES RENDERED. IT IS FURTHER AGREED THAT ALL DELINQUENT ACCOUNTS, THAT THE COURT SHALL AWARD TO THE PROVIDER PREJUDGEMENT AND POST-JUDGEMENT INTEREST, COURT COSTS AND REASONABLE ATTORNEY FEES, AND THAT UNDERSIGNED SHALL PAY THE FEE CHARGED BY THE COLLECTION AGENCY. I HEREBY ASK AND AUTHORIZE PROVIDER TO COMPLAIN TO THE INSURANCE COMMISSIONER IF NECESSARY.

SIGNATURE OF THE PATIENT OR GUARDIAN

DATE: