WELCOME!

Supreme Medical Group PLLC Infectious Diseases Care

Patient Registration Form. Please take a moment to completely fill out this form.

SECTION 1. PATIENT INFORMATION DATE_____

Patient name: _____ I prefer to be called _____

Address: _____City_____ State _____ Zip _____

Permanent Address (if different): _____

Home telephone #: (___) _____ Cell Phone#: (____) _____ Work phone#: (____) _____

Best time to contact is ☐ A.M ☐ P.M on my ☐Home phone ☐ Work phone ☐Cell phone

Date of Birth: _____ Social Security Number _____

E-mail: _____

Sex: ☐M ☐ F Check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Race: _____ Ethnicity: _____

if minor, Parent/Guardian Name _____ Phone (____) _____

if Student, Name of School: _____ City/State _____ ☐FT ☐ PT

Emergency Contact/Relationship _____ Phone (____) _____

Do you provide consent to contact the person above when deemed required: ☐Yes ☐ No

SECTION 2. REFERRAL INFORMATION

Whom may we thank for referring you? _____ Phone # (____) _____

Primary care Physician_____ PCP phone # (____) _____

SECTION 3. RESPONSIBLE PARTY

RELATIONSHIP to patient: ☐ Self (skip to section 4) ☐ Spouse ☐ Parent ☐ Other

Name _____ Date of birth _____

Address _____ City_____ State _____ Zip_____

Phone (_____) _____

SECTION 4. INSURANCE INFORMATION

Primary insurance Company _____Member ID#_____ Group #_____

Insurance Co. Address _____ Insurance Co. Phone (___) _____

Policy Holder [as listed on card] _____

Patient's relationship to Policy Holder ☐Self ☐ Spouse ☐ Child ☐ Other

Policy holder's Date of Birth_____ Social Security #_____

Employer name _____Work Phone (___) _____ Exten:_____

If you have Secondary or Supplemental Insurance:

Secondary insurance Company _____ Member ID#_____ Group #_____

Insurance Co. Address _____ Insurance co Phone (____) _____

Policy Holder [as listed on card] _____

Patient's relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy holder's Date of Birth_____ Social Security #_____

Employer name _____Work Phone (____) _____ Exten:_____

Supreme Medical Group PLLC Infectious Diseases Care

AUTHORIZATION FOR BILLING, COPAYMENT AND FINANCIAL AGREEMENT

I hereby authorize Supreme Medical group PLLC to bill my medical insurance carrier, or other third party specifically designated by me, for services rendered and I give permission to provide the diagnosis, type of service and dates of the service which are required to obtain payment from insurance providers and their reviewers.

Copayment are due at the time of service and are payable by Check, Credit Card or Cash.

I agree that there is a $25.00 charge for all returned checks. I agree that if my insurance company requires a referral from my Primary Care Provider, I will bring the referral with me or instruct my Physician to contact Supreme Medical Group ID care office with the referral.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Supreme Medical group PLLC for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Supreme Medical group PLLC files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Florida.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Supreme Medical group PLLC Physicians, Practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____

PATIENT FULL NAME PATIENT SIGNATURE

_____ _____

DATE WITNESS SIGNATURE

Supreme Medical Group PLLC Infectious Diseases Care

PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ Date _____
Age _____ Date of Birth _____ Sex □ Male □ female
What is the reason for this visit? _____
Are you a hospital Follow up □ Yes □ No Which hospital? _____When _____
Who is your primary care Physician? _____--

1.HEALTH HISTORY: (check only those conditions which apply)

□ AIDS/HIV	□ Cataracts	□ Gout/Thyroid Tumor	□ Mononucleosis	□ Scarlet Fever
□ Alcoholism	□ Chemical Dependency	□ Heart Disease	□ MRSA	□ Sciatic Pain
□ Allergies	□ CHF	□ Hepatitis	□ MS	□ Stroke
□ Anemia	□ Chicken Pox	□ Hernia	□ Mumps	□ Thyroid Problems
□ Anorexia	□ COPD	□ Herniated Disc	□ Osteoporosis	□ Tonsillitis
□ Appendicitis	□ Depression	□ High Cholesterol	□ Pacemaker	□ Tuberculosis
□ Arthritis	□ Diabetes	□ Kidney Disease	□Parkinson's Disease	□ Tumors/Growths
□ Asthma	□ Dizzy Spells	□ Liver Disease	□ Pinched Nerve	□ Typhoid Fever
□ Bleeding Disorders	□ Emphysema	□ Lupus	□ Pneumonia	□ Ulcer
□ Breast Lump	□ Epilepsy	□ Lymph edema	□ Polio	Urinary Incontinence
□ Bronchitis	□ Fractures	□ Measles	□ Prostrate Problems	□ Vaginal Infection
□ Bulimia	□ Glaucoma	□ Migraines	□ Psychiatric Care	□ Whooping Cough
□ Cancer	□ Goiter/ Thyroid Disease	□ Miscarriage	□ Rheumatic Fever	□ Other _____

If yes, when were you diagnosed?

Condition	Diagnosis date
_____	_____
_____	_____
_____	_____

Major Surgeries and hospitalizations:

Surgery/Hospitalization	Approximate Dates	Where treated?
_____	_____	_____
_____	_____	_____
_____	_____	_____

2.. STD HISTORY: Have you had any of the following? If so, when were you treated?
□ None □ Syphilis _____ □ Herpes simplex _____
□ Gonorrhea _____ □ PID _____
□ Chlamydia _____ □ Genital warts_____

Have you had these vaccinations?

Vaccine	Date	Vaccine	Date
Pneumovax	_____	Hepatitis A	_____
Influenza	_____	Hepatitis B	_____
Tetanus (TDAP)	_____	Chickenpox or Shingles	_____

Supreme Medical Group PLLC Infectious Diseases Care

3. FAMILY HISTORY

Relationship	Condition(s) (cancer, heart problems, diabetes, etc.)	Alive (age)	Deceased (age)
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling(s)	_____	_____	_____
Other	_____	_____	_____

4. **REVIEW OF SYSTEMS**—Are you currently experiencing any of the following?

General Condition:

□ No □ Yes Weight Loss - if yes, how much in what time period? _____
□ No □ Yes Weight Gain - if yes, how much in what time period? _____
□ No □ Yes Fever or Chills - if yes, when was the onset? _____
□ No □ Yes Night sweats - if yes, when was the onset? _____
□ No □ Yes Problems with wound healing - if yes, when was the onset? _____
□ No □ Yes Increasing weakness, fatigue - if yes, when was the onset? _____
□ No □ Yes Dizziness - if yes, when was the onset? _____
□ No □ Yes Intolerance to heat or cold - if yes, when was the onset? _____
□ No □ Yes Poor appetite - if yes when was the onset? _____

Respiratory Condition:

□ No □ Yes Cough - if yes, when was the onset? _____
□ No □ Yes Wheezing/ asthma - if yes, when was the onset? _____
□ No □ Yes Sputum production - if yes, when was the onset? _____
□ No □ Yes Shortness of Breath- if yes, when was the onset? _____
□ No □ Yes History of exposure to tuberculosis - if yes, when was the onset? _____

Gastrointestinal Condition:

□ No □ Yes Nausea/vomiting - if yes, when was the onset? _____
□ No □ Yes Vomiting blood - if yes, when was the onset? _____
□ No □ Yes Blood in stools - if yes, when was the onset? _____
□ No □ Yes Black/tarry stools - if yes, when was the onset? _____
□ No □ Yes Difficulty swallowing - if yes, when was the onset? _____
□ No □ Yes Indigestion/heartburn - if yes, when was the onset? _____
□ No □ Yes Abdominal pain- if yes, when was the onset? _____
□ No □ Yes Diarrhea - if yes, when was the onset? _____
□ No □ Yes Constipation- if yes, when was the onset? _____
□ No □ Yes Hemorrhoids - if yes, when was the onset? _____
□ No □ Yes History of Hepatitis- if yes, when was the onset? _____

Musculoskeletal/Skin Condition:

□ No □ Yes Joint pain/swelling - if yes, when was the onset? _____
□ No □ Yes Body ache/muscle cramps - if yes, when was the onset? _____
□ No □ Yes Morning stiffness - if yes, when was the onset? _____
□ No □ Yes Itching - if yes, when was the onset? _____
□ No □ Yes Rash - if yes, when was the onset? _____
□ No □ Yes Skin problems - if yes, when was the onset? _____
□ No □ Yes Easy bleeding- if yes, when was the onset? _____
□ No □ Yes Nail problems - if yes, when was the onset? _____

Supreme Medical Group PLLC Infectious Diseases Care

Review of Systems (Continued)—Are you currently experiencing any of the following?

Neurological Condition:

□ No □ Yes Seizures- if yes, when was the onset? _____
□ No □ Yes Headache - if yes, when was the onset? _____
□ No □ Yes Tingling/numbness- if yes, when was the onset? _____
□ No □ Yes Weakness on one side- if yes, when was the onset? _____
□ No □ Yes Vertigo/balance problems- if yes, when was the onset? _____
□ No □ Yes Sleep disturbances- if yes, when was the onset? _____

ENT Condition:

□ No □ Yes Blurred or bad vision - if yes, how much in what time period? _____
□ No □ Yes Spots before eyes - if yes, how much in what time period? _____
□ No □ Yes Eye pain - if yes, when was the onset? _____
□ No □ Yes Hoarseness - if yes, when was the onset? _____
□ No □ Yes Thrush - if yes, when was the onset? _____
□ No □ Yes Mouth sores - if yes, when was the onset? _____
□ No □ Yes Difficulty hearing - if yes, when was the onset? _____
□ No □ Yes Frequent nose bleeds - if yes, when was the onset? _____
□ No □ Yes Frequent sinus problems - if yes when was the onset? _____

Cardiovascular Condition:

□ No □ Yes Chest pain/discomfort - if yes, when was the onset? _____
□ No □ Yes Irregular heartbeat - if yes, when was the onset? _____
□ No □ Yes Fainting spell - if yes, when was the onset? _____
□ No □ Yes Swelling of feet/legs- if yes, when was the onset? _____
□ No □ Yes High blood pressure - if yes, when was the onset? _____
□ No □ Yes High cholesterol - if yes, when was the onset? _____
□ No □ Yes Rheumatic heart disease- if yes, when was the onset? _____
□ No □ Yes Heart murmur - if yes, when was the onset? _____

Genitourinary Condition:

□ No □ Yes Frequent urination - if yes, when was the onset? _____
□ No □ Yes Painful urination - if yes, when was the onset? _____
□ No □ Yes Difficulty holding urine - if yes, when was the onset? _____
□ No □ Yes Blood in urine - if yes, when was the onset? _____
□ No □ Yes Penile/virginal discharge - if yes, when was the onset? _____
□ No □ Yes Frequent vaginal yeast - if yes, when was the onset? _____
□ No □ Yes Sores/lesions on genitals- if yes, when was the onset? _____
□ No □ Yes Pain/ masses in breasts - if yes, when was the onset? _____
□ No □ Yes Nipple discharge- if yes, when was the onset? _____

Endocrine Condition:

□ No □ Yes Thyroid problems - if yes, when was the onset? _____
□ No □ Yes Diabetes - if yes, when was the onset? _____
□ No □ Yes Excessive thirst - if yes, when was the onset? _____
□ No □ Yes Change in breast size - if yes, when was the onset? _____
□ No □ Yes Change in body hair - if yes, when was the onset? _____
□ No □ Yes Decreased interest in sex - if yes, when was the onset? _____
□ No □ Yes Problems with erection- if yes, when was the onset? _____

Supreme Medical Group PLLC Infectious Diseases Care

Review of Systems (Continued)

Psychiatric Condition:

□ No □ Yes Depression- if yes, when was the onset? _____

□ No □ Yes Anxiety - if yes, when was the onset? _____

□ No □ Yes Spontaneous crying- if yes, when was the onset? _____

□ No □ Yes Less interest in usual activities- if yes, when was the onset? _____

□ No □ Yes Feelings of lack of self-worth- if yes, when was the onset? _____

MEDICATIONS—Please include vitamins, herbs & over-the –counter pills

(please use back of page if additional space is needed, or you can give a copy of your current medications)

Medication Name	Dose	Form	Route	Frequency	Date Started
(i.e. Zyrtec	10 mg	Tablet	by mouth	once per day	10/24/2008)

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Name of the drug **Type of reaction** (i.e.—Hives, Rash, throat /tongue swelling, etc.…)

_____ _____

_____ _____

_____ _____

DAILY HABITS

Exercise: □ Yes □ No Type: _____ Frequency: _____

Personal Habits: Tobacco □ Yes Packs/Week _____ □ No If you ever did smoke, when did you quit? _____

Alcohol □ Never □ No longer use, quit _____ □ Yes Drinks/Week _____

Any drugs - □Marijuana □ Cocaine □ Heroin □ Crystal Meth □ Never □ No longer use, quit _____□ Yes How often? _____any other illicit drugs _____

Have you ever injected IV drugs? □ Yes □ No

Do you consider yourself? □ Heterosexual □ Homosexual □ Bisexual □ Transsexual

Marital status □ single □ married

Do you have a sexual partner □Yes □No.

Do you use condoms? □ Never □ Sometimes □Always

Do you have children □ Yes □ No

Is there anything else we need to know?

_____

_____

_____

Supreme Medical Group PLLC Infectious Diseases Care

CANCELLATION AND NO SHOW POLICY

In order to be respectful to the medical needs of the community, please be courteous and call our office promptly if you are unable to attend an appointment. We require at least a 24-hour notice so that your appointment time can be reallocated to someone else.

Patients who fail to provide 24-hour notice of cancellation or who do not show up for an appointment will be charged a **$25 no show/ cancellation fee**. This fee is not covered by your insurance company.

I have read and understand the cancellation and no show policies of the practice and agree to the terms.

_____ _____

Printed Name Signature

_____

Date

Supreme Medical Group PLLC Infectious Diseases Care

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of birth: _____
Social security #_____ Phone Number (_____) _____
Address: _____
I hereby authorize Supreme Medical Group Infectious Diseases care to
☐ Obtain my medical Reports from _____
☐ Release my reports to: Name of Facility _____
Address: _____
Attention: _____ Fax # (_____) _____

To Release Medical records to **Supreme Medical Group ID Care**, please fax to: **407-286-2860**

☐ ADMISSION NOTE ☐ FOLLOW--UP VISIT ☐ DISCHARGE SUMMARY ☐ LABORATORY RESULTS
☐ IMAGING STUDIES (X--rays, CT, MRI etc.) ☐ CULTURE RESULTS (Blood, Urine, Sputum etc.)
☐ SEROLOGY STUDIES (Elisa, IgG IgM, Western Blot) ☐ OPERATIVE REPORTS ☐ PATH REPORT (Biopsy, Cytology etc.)
☐CARDIOVASCULAR STUDIES (Echo, stress test, EKG, Cath, PTCA etc.) **or** ☐ **SEND ALL AVAILABLE RECORDS**

Other Entity to receive information. Check each that apply	Description of Information to be released. Check each that apply.
☐Spouse ☐ Parent ☐ Authorized Agent ☐ Voice Mail ☐ Other: Name_____ Relationship_____	☐ Account Information ☐ Appointment information ☐ Medical information

- The PHI [Protected health Information] to be disclosed is relevant medical records and reports relating to my medical treatment, consultation and/or examination.
- I understand the information disclosed based on this authorization may include sensitive information related to mental health treatment, drugs and alcohol (including records of a program that provides alcohol or drug abuse, diagnosis, treatment or referral, that is protected by federal regulation at 42 C.F.R part 2), records and information regarding HIV/AIDS status, treatment and/or testing, other communicable diseases and genetic testing.
- I understand that I have the right to refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility of benefits will not be affected.
- I understand that I have the right to revoke the authorization in writing. I understand that such revocation will not have any effect on any information already used/disclosed by Supreme Medical group ID care prior to our office receiving written notice of revocation. I also understand that the information disclosed under this release is subject to re-disclosure by the recipient and is no longer subject to protections of HIPPA. Treatment or payment for treatment cannot be conditioned on this authorization, except as allowed in the Privacy rule.
- I understand that this authorization is in effect until revoked by the patient.
- My signature below indicates that I have read and understand the authorization and its terms.

Signature of Patient or Authorized Agent_____ Date: _____
_____Description of Authorized agent's relationship [attach necessary Documentation)

Signature of Witness _____ Date _____

Supreme Medical Group PLLC Infectious Diseases Care

PRIVACY PRACTICE SUMMARY

This summary of our privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully and sign below.

Notice of Privacy Practices:

We understand that your medical information is personal to you, and we are committed to protecting this information. As our patient, we create medical records about your health care for you and the services and /or items we provide to you as our patient. By law, we are required to make sure that your protected health information [PHI] is kept private. How we will use or disclose your information?

Here are some examples:

- For Medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient call reminders
- Monitoring Public Health Risk and safety
- For Worker's compensation program
- In response to certain requests arising out of lawsuits or other disputes.

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the secretary of the Department of Health and Human services.

To file a complaint with the practice, contact the office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to access /copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications
- Please contact us if you have questions or concerns about this policy.

I_____ have read this notice of Privacy Practices.

(Print your name here)

_____ _____

(Signature) (Date)