Good Health Physicians

217 E Central AVE, Winter Haven FL, P.863-299-2540 F.863-229-1230

Welcome to Good Health Physicians, LLC

In an effort to decrease your waiting time, we ask that you please complete the enclosed questionnaires.

You can bring in the completed questionnaires to your appointment, we ask that you bring the following:

- A list of your current medications with doses and strengths
- Photo ID
- Your Insurance Card(s)
- Any Co-Pay or Cash Payment due at that visit

If you have any questions or need assistance concerning this paperwork, you can call our office and we will be more than happy to assist you.

On behalf of Good Health Physician staff, welcome and we look forward to seeing you soon!

Patient Name: _____ DOB:_____

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Affordable, Quality, and Compassionate Care

Patient Information:

Patient Name: _____ Age: _____
DOB: _____Social Security: _____Marital Status: S M D W
Address: _____
City: _____ State: _____ Zip Code: _____
Contact Number(s): _____ _____
Ins. Company: _____Member ID_____Effective Date_____
Employer: _____ Phone: _____
Employer Address: _____
Emergency Contact: _____ Phone:_____

Assignment of Insurance Benefits:

I hereby authorize direct payment of medical benefits to Good Health Physicians, LLC for services rendered. I understand that I am financially responsible for any balances not covered by insurance.

Authorization to Release Information:

I hereby authorize Good Health Physicians, LLC to release to, and receive from, exchange written or oral communication on any medical or other incidental information that may be necessary for either medical care, claims processing or continuity of care between behavioral or physical health providers.

Medicare Medicaid Medigap:

I certify that the information given by meis true and correct. I authorize the release of all records to collect benefits on my behalf.

Signature:_____Date:_____

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Health History

Patient Name:_____ DOB:_____

Medical History:

Do you have any allergies? Yes or No.
If yes, please explain: _____
List of medications: Yes or No. (List medication on LAST sheet if yes)
List of major injuries/surgeries:
(If needed to add more, please add additional information on back of the page)
Procedure: _____Date: _____
Procedure: _____Date:_____
Ongoing medical problems:
(If needed to add more, please add additional information on back of the page)

1. _____
2. _____
3. _____

Medical History:

- ❑ Anxiety
- ❑ Autism
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Bipolar
- ❑ Cancer
- ❑ Coronary Artery Disease
- ❑ Claustrophobic
- ❑ Diabetes
- ❑ Dialysis
- ❑ Fibromyalgia
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hiatal Hernia OR Reflux Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Leg Disease
- ❑ Osteoporosis
- ❑ Rheumatism
- ❑ Schizophrenia
- ❑ Sickle Cell Anemia

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Family History

Patient Name: _____ DOB:_____

List any conditions or ongoing medical problems that your family may have.

Mother:

1.
2.
3.
4.
5.

Father:

1.
2.
3.
4.
5.

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Email: _____

(This will be used to gain access to your patient portal. You will also receive appointment reminders and updates once your email is provided.)

Race:

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Native Hawaiian or other Pacific Islander
- ❑ Black or African American
- ❑ White

Ethnicity:

- ❑ Hispanic
- ❑ Not Hispanic or Latina

Language:

- ❑ English
- ❑ Spanish
- ❑ Other _____

Sex: M F T

Preferred Pharmacy: _____City_____Zip_____

Patient Name: _____ DOB: _____

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Patient Name: _____DOB: _____

Social History:

Are you a current smoker? YES or NO. If yes, how often:_____

Do you currently drink? YES or NO. If yes, how often:_____

Do you use Tobacco? YES or NO. If yes, how often: _____

Preventive Care:

Are you currently pregnant or may become pregnant?

- ❑ Yes
- ❑ No

Are you currently using birth control?

- ❑ Yes
- ❑ No

Have you had a mammogram in the past year?

- ❑ Yes
- ❑ No

If yes, date of examination: _____

Have you had a pap-smear in the past year?

- ❑ Yes
- ❑ No

If yes, date of examination: _____

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Patient Name: _____DOB: _____

Date of Last Physical: _____

Have you had a colonoscopy?

- ❑ Yes
- ❑ No

If yes, date of examination: _____

Date of Last Fecal/Stool Occult: _____

Date of Last Eye Exam. (If Diabetic):_____

List of Medications

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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Medical Release Consent Form

217 E Central Ave, Winter Haven FL, 33880 **PHONE:**863-229-2540 **FAX:**863-229-1230

I_____ authorize my medical records to be released from the named health care provider below.

Social Security#_____ DOB_____

Previous Provider Name: _____

Phone:_____ Fax:_ _____

Records Authorized to be release:

- ❑ Lab Reports
- ❑ Radiology
- ❑ Last visits Note
- ❑ Substance Abuse
- ❑ Mental Health
- ❑ Other : (specify)_____

The purpose of this request is for continued medical care.

I Understand that the information contained in my medical records may include records pertaining to diagnosis, evaluation or treatment of any mental or emotional condition or disorder including alcoholism and/ or drug addition and may also containing information regarding test results for AIDS/HIV or infection with any probable causative agent of AIDS. I understand the expiration date of this is one year. I understand that i may revoke this authorization at any time by notifying the provider and it will be effective on the date notified expect to the action has already been taken. I understand the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by Federal privacy regulations. I understand by authorization and this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand i have the right to receive a copy of this form after i have signed it. I also understand that in compliance with Florida Law, I may be required to pay a fee for for retrieval and photocopying of records and /or supervising inspection of medical records. This authorization will expire one year from the date of the signature below. I understand that i can revoke this authorization at any time by letting my healthcare provider know but the revoking of this authorization will not affect disclosure made or actions taken before the revocation is revoked.

Signature:_____ Date:_____

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Pain Management Agreement

I understand that I have aright to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Dr. Shoba Sama MD not providing ongoing care for me.

I _____, agree to undergo pain management by Dr. Shoba Sama MD, My diagnosis _____ I agree to the following statements.

I will not accept any narcotic prescriptions from another doctor. I will be responsible for making sure that I do not run out of my medications on weekends and holidays, become abrupt discontinuation of these medications can cause severe withdrawals syndrome.
I understand that I must keep my medications in a safe place.
I understand that Dr. Shoba Sama MD will not supply additional refills for prescriptions of medications that I may lose.
If my medications are stolen, Dr. Shoba Sama MD will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.
I will not give my prescriptions to anyone else.
I will only use one pharmacy.
I will keep my scheduled appointments with Dr. Shoba Sama MD unless I give notice cancellation 24 hours in advance. I agree to refrain from all mind/mood altering/addicting drugs including alcohol unless authorized by Dr. Shoba Sama MD.

Patient Name: _____ Date: _____

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Affordable, Quality & Compassionate Care

Notice of Privacy Practices

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff managers.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Lakeview Internal Medicine. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health.

Other Uses & Disclosures Require your Information: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or under any use of disclosure of information that occured before you notified us of your decision.

Information About Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of you protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Other Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice o your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing, with

24-hours notice. You may obtain a form to request access to your records by contacting the medical records department of Lakeview Internal Medicine.

Requests for Restrictions on Protected Health Information: You have a right to request us to restrict how we use and disclose your protected health information. We are not required by to law to agree with your requested restrictions in certain situations. These situations include emergency treatment, disclosure to the Secretary of the Department of Health and Human Services, and any uses and disclosures described on the front page of the Notice. However, if we decided to grant your request, we are bound by our agreement.

For More Information about HIPAA: Visit the U.S. Department of Health and Human Services HIPAA website. (http://www.hhs.gov/ocr/hippa/)

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do se by sending a letter outlining your concerns. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is:

Good Health Physicians, LLC

I _____ have recieved, read, and understand your Notice of Privacy Practice of complete disclosure of my health information. I understand that this organization has the right to amend or modify Privacy Policies & Practices and may contact Good Health Physicians, LLC, to obtain a current copy if needed.

Name: _____

DOB:_____Date_____