SURGICAL ASSC. OF TAMPA BAY

Patient Information Form

Please Print Clearly **Today's Date**_____

Patient Name:_____Home Phone_____Cell:_____

Last First M

Mailing Address:_____Email:_____

City_____St___ Zip_____D.O.B:_____Age:_____Sex:____

Race:_____Language:_____Ethnicity:_____

SS#_____How Many Children_____Employed:☐Yes ☐No

Employer:_____Work phone_____Ext.____

Work Address:_____City_____St____ Zip____

Spouse or Parent Name:_____Employer:_____

Work Address:_____City_____St__ Zip_____

Phone#_____Ext._____Emergency Contact_____Phone_____

Name of Person who is responsible for this bill._____(Not Insurance Company)

I will be paying by: Cash___ Check___ Debit Card__ MC Visa__ Discover_____

Referred By _____Phone#_____ Primary Care Dr._____

Primary Ins. Name: _____ Policy#_____ Grp#_____

Address:_____ City _____St_____Zip Phone:_____

Policy Holders Name:_____ D.O.B:_____S.S#_____

Secondary Ins.Name: _____ Policy#_____ Grp#_____

Address:_____ City_____St_____Zip_____ Phone:_____

Card Holder's Name:_____D.O.B_____

Is this work related: Yes No Date of Accident:_____Name of Ins.Co._____

Address:_____City:_____St_____Zip_____

Phone#_____Who should we speak with_____

Pharmacy's Name: ---------- Address:_____Phone:_____

I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signed_____Date_____

We will make a copy of your Driver's License or Picture ID card & Primary Insurance Card.
For Medicare Patients, we will need Primary & Secondary Insurance Cards.

SURGICAL ASSOCIATES OF

TAMPA BAY

205 S.Moon **Ave, Suite** 102,
Brandon, FL 33511.
Phone:813-681-4644
Fax:813-654-4486

CONSENT FOR TREATMENT

Patient Name:_____

I, **the undersigned,** for myself or on **behalf** of the patient, **hereby authorize** Physicians **of Surgical** Associates of Tampa **Bay** to administer **such** medical/surgical care as **may be** indicated for the **diagnosis** and treatment **of** the **patient.**

Notice of Part Ownership

Drs. Narasimha/Chavda/Thakkar has a minority ownership in the Brandon Surgery Center located at 205 S. Moon Ave, Brandon, FL 33511. **You** as the patient have **the right** to choose any other **surgical** facility and or another surgeon of your **choice.**

Please direct any questions you **may have** to

Drs.Narasimha/Chavda/Thakkar or Staff.

_____ _____

Signature **of patient** or responsible **party** Date

SURGICAL ASSOCIATES OF TAMPA BAY

Insurance, Payment Authorization and Privacy Policies

1. This office will file your primary insurance only (with the exception of Medicare patients) for any services rendered by our Physicians, if we are a participating provider with your insurance plan. If you do not have any insurance, or we are not a participating provider with your plan you will be responsible for payment in Full at the time service is rendered. Your Initial_____

2. If your insurance requires a co-payment this will be collected in Full at the time services are rendered. It is your responsibility to bring a valid referral from your primary care physician. If you have Medicare and no secondary coverage, or a plan we are not participating with, you will be responsible for the 20% after Medicare has paid their portion. Your Initial_____

3. This is to certify that I fully understand the office policy as outlined above and accept any responsibility in full that should pertain to me. Your Initial____

4. I authorize payment directly to any of the above physicians for any medical care rendered on my behalf. I understand that I am responsible for any balance that is due after filing my insurance as outlined in insurance policy. Your Initial____

5. I give my permission for any of the above Physicians and their office staff to give and to get information regarding my medical status and reports to my referring Physician, Hospital, Surgi Center and Diagnostic Centers. I also give permission to share my medical & billing information with my insurance company. Your Initial____

6. I give consent for confidential messages to be left on my home, work, cell, answering message voice mails. I am fully aware that cell phone is not a private and a secure line. Your Initial____

7. The following person (s) has my permission to give and to receive confidential medical information about me.

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

[redacted]
F.M.L.A, Disability, Cancer Policy & Misc.Letters. [redacted]
These forms will be completed after surgery. It will take five (5-7) working days to complete once you submit the forms. The forms pickup days are Fridays from 1:00PM-3:00PM Your Initial____

9. I also acknowledge that I have received Surgical Associates of Tampa Bay's Notice of Privacy Practices and I have no further questions regarding the same. Your Initial____

_____ _____

Signature of patient or responsible party Date

If signature of acknowledgement could not be obtained from the patient, the reason MUST be documented below.

_____

SURGICAL **ASSOCIATES OF** TAMPA BAY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY **BE** USEDAND DISCLOSED AND HOW YOU CAN **GET ACCESS TO THIS** INFORMATION.

PLEASE REVIEW IT CAREFULLY.
Uses and Disclosures

Treatment. Your health information may be **used by staff** members or disclosed to other health care 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 **members.**

Payment. Your health information may **be** used to **seek** payment from your **health** plan, from other sources of coverage such as an 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 SURGICAL ASSOCIATES OF TAMPA BAY. **For** example, information on the **services** you received may **be** used to support **budgeting** and **financial** reporting, and activities to evaluated 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 **department.**

Other uses and disclosures require your authorization. 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 a 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 undo any use or disclosure **of** information that **occurred before** you notified us of your decision.

Additional Uses of information. Appointment reminders. Your health information will be used **by** our staff to send you reminders. 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 your 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

Surgical Associates of Tampa Bay Duties ·

We are required by law to maintain **the** privacy of your protectedhealth information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and **practices** that are outlined in this notice.

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 on your next office visit The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to **request** access to your records by contacting our Privacy Official.

Complaints.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:
If you believe that your privacy rights have been violated, you should call the matter to our attention by **sending** a letter describing the cause of your concern to the same address.
You will not be penalized or otherwise retaliated against for filing a complaint.

PRN ACY OFFICER
SURGICAL ASSOCIATES OF TAMPA BAY
205 S.Moon Ave, Suite 102
Brandon, FL 33511
813-681-4644

Effective Date

This notice is effective on or after
April 14, 2003

New Patient History - Page 1 of 2

Pt. Name _____ (LAST) _____ (FIRST) **M/ F DOB** __ / __ / __ **Age** __ **Date** ___/___/____

Doctor(s) who sent you: _____ List all Doctors you see: _____

I. Reason for Your Visit: _____

II. History of Present Illness or Injury

Is this illness/injury employment related? ☐ Yes ☐ No

Please answer all questions. If one does not apply to you, please write NIA (not applicable).

1) **Location:** _____ *(Where on the body symptom occurs)*

2) **Severity:** _____ *(Severe, worse, slightly Symptom/pain scale 1-10)*

3) **Timing:** _____ *(When symptoms occur... after meals or exercise, etc.)*

4) **Modifying Factors:** _____ *(Things to make symptoms bet/er or worse)*

5) **Duration:** _____ *(How long have you've ,had symptom/pain? How long does it last?)*

6) **Quality:** _____ *(Character of symptoms/pain.... burning, gnawing, stabbing. etc.)*

7) **Context:** _____ *(Situation associated with symptom)*

8) **Associated Signs/Symptoms:** _____ *(Other things that happen when this symptom occurs)*

III. Past History

Occupation _____ ☐ Retired at Age____

1. Medical History: *(Please circle **Yes** if you have any of the following medical problems. Circle **No if you** don't have the problem.)*

Please circle which one you have

High Blood Pressure	Yes	No	Tuberculosis	Yes	No	Diabetes	Yes	No	High Cholesterol	Yes	No
> Asthma/COPD/Bronchitis	Yes	No	Cancer	Yes	No	Stroke	Yes	No	Heart Bypass	Yes	No
Bleeding After Surgery	Yes	No	Hepatitis	Yes	No	Heart Attack	Yes	No	Dialysis	Yes	No
Anesthesia Complications	Yes	No	HIV/AIDS	Yes	No	Date of attack	_____		Blood Transfusion	Yes	No

Drug Allergies: _____

Current Medications: _____ _____

include Rx, over the counter and Nutritional Supplements _____

Are you on Coumadin? Aspirin? Plavix? Yes No; Insulin? Yes No; Thyroid? Yes No; Birth Control/Hormone Pills? Yes No

List all Hospitalizations / Surgeries/ Injuries and Date _____

_____ _____

_____ _____

_____ _____

2. Family History: *(Please list any known medical problems in your relatives)*

Father: ☐ Alive ☐ Deceased; Age __ Reason:_____ **Mother:** ☐ Alive ☐ Deceased; Age __ Reason:_____

Brother(s): ☐ Alive ☐ Deceased; Age____ Reason:_____ **Sister(s):** ☐ Alive ☐ Deceased; Age__ Reason:_____

3. Social History

Marital Status? _____ (single/married/widowed)

Tobacco Use? ☐ Yes ☐ No ; if yes, since when and frequency: _____

Alcohol Use? ☐ Yes ☐ No ; if yes, frequency: _____

Drug Use? ☐ Yes ☐ No ; if yes, since when and frequency: _____

Pt. Name_____
LAST FIRST M

IV. Review of Systems

Please circle Yes or No as appropriate: Answer all questions

1) Constitutional

Good General Health	Yes	No
Recent Weight Gain	Yes	No
Recent Weight Loss	Yes	No
Night Sweats/Fever	Yes	No
Fatigue	Yes	No

2) Ears/Nose/Neck/Throat

Hearing Loss R L	Yes	No
Swollen Glands R L	Yes	No
Nose Bleeds	Yes	No
Thyroid Lump R L	Yes	No
Difficulty Swallowing	Yes	No

3) Eyes

Wear Glasses or Contacts	Yes	No
Blurred/Double Vision	Yes	No
Eye Disease or Injury	Yes	No
Glaucoma R L	Yes	No
Cataract Surgery R L	Yes	No

4) Heart

Chest Pain/Angina	Yes	No
Mitra! Valve Prolapse	Yes	No
Irregular Heartbeat	Yes	No
Heart Failure	Yes	No
Pacemaker	Yes	No

5) Respiratory

Shortness of Breath	Yes	No
Coughw/yellowSputum	Yes	No
Cancer, Lung R L	Yes	No
Coughing up Blood	Yes	No
Home Oxygen	Yes	No

Neurological

Headaches/Migraines	Yes	No
Paralysis or Tremors	Yes	No
Convulsions/Seizures	Yes	No
Numbness/Tingling	Yes	No
Parkinson's Disease	Yes	No

7) Gastrointestinal

Nausea/Vomiting	Yes	No
Peptic Ulcer	Yes	No
Rectal Bleeding	Yes	No
Hiatal Hernia	Yes	No
Crohn's Disease	Yes	No
Colon Cancer	Yes	No
Irritable Bowel	Yes	No
Ulcerative Colitis	Yes	No

8) Musculoskeletal

Muscle Pain or Cramps	Yes	No
Stiffness/Swelling Joints	Yes	No
Joint Pain/Arthritis	Yes	No
Back Pain	Yes	No
Prosthetic Joint R L	Yes	No
Disc Operation	Yes	No

9) Integumentary (Skin/Breast)

Skin Cancer/Melanoma	Yes	No
Eczema/Psoriasis	Yes	No
Breast Lump	Yes	No
Breast Pain /Discharge	Yes	No
Breast Implants	Yes	No

10) Endocrine

Feeling Hot/Cold	Yes	No
Goiter	Yes	No
Hormone Problem	Yes	No
Pituitary Problems	Yes	No

11) Hematologic/ Lymphatic

Bruise Easily	Yes	No
Bleeds More Than Usual	Yes	No
Enlarged Glands	Yes	No
Platelet Problems	Yes	No

12) Allergic/ Immunologic

Rheumatoid Arthritis	Yes	No
Systemic Lupus	Yes	No
Fibromyalgia	Yes	No

13) Genitourinary-Male & Female

Blood in Urine	Yes	No
Difficulty Urinating	Yes	No
Urine Leakage	Yes	No
Kidney Stones	Yes	No
Sexual Problems	Yes	No

Female Only

Hysterectomy	Yes	No
Tubal Ligation	Yes	No
Menstrual Problems	Yes	No
Date of Last Period_ _ _ _ _ _		
Are You Pregnant	Yes	No

14) Psychiatric

Insomnia	Yes	No
Confusion/Memory Loss	Yes	No
Depression	Yes	No
Anxiety	Yes	No

15) Peripheral Vascular

Dizziness	Yes	No
Passing Out	Yes	No
Calf Pain on Walking R L	Yes	No
Pain in Feet/Toes R L	Yes	No
Weakness Ann/Leg R L	Yes	No
Vision Loss R L	Yes	No
Pain at Night R L	Yes	No
Amputation R L	Yes	No
Varicose Veins-Legs R L	Yes	No
Blood Clots-Legs R L	Yes	No
Venacaval Filter	Yes	No

16) Exposure

Chemicals/Asbestos	Yes	No
Radiation to Neck	Yes	No

17) Pt. Self Exam

Checking Breasts	Yes	No
Checking Testicles	Yes	No
Checking Skin	Yes	No

Patient Statement

To the best of my knowledge, the above information is accurate and complete.

Signed:_____ **Date:** _____

Physician Statement

I have reviewed the questionnaire with the patient. Comments: _ _ _ _ _ _ _ _ _ _ _

Signed _____ Date: _____

For Office Use Only — to score 3. Review of Systems ☐ *Extended = 2-9 systems* ☐ Complete = 10+ systems

For Office Use Only — to score level of History, check appropriate boxes for each of the three history components. Use the lowest level checked.

Type of History	Expanded Problem Focused	Detailed	Comprehensive
1. Chief complaint/Hx of present illness 2. Past, Family & Social History 3. Review of Systems	☐ Brief 1-3 elements ☐ Problem Pertinent (1 system)	☐ 1-2 History areas ☐ Extended 2-9 system	☐ Extended 4+ ☐ 3 History Areas ☐ Complete 10+ systems

Form of Consent:
Media Usage on Social Media

This form gives consent to Tampa Bay Surgical Associates to obtain and utilize media taken from clinic procedures on their social media or for educational purposes. This is including, but not limited to, Instagram, Facebook, poster presentations, case reports, etc. This media will be localized to the physical area of the procedure and will not include my face (unless required by procedure), name, or any other private information. If I choose to alter my decision, I must contact the office and notify them of my change in preference in order to remove any existing media.

- ○ Yes, I give my consent.
- ○ No, I do not give my consent.

Print Name: _____ Date: _____

Signature: _____

Last edited: 11/17/21