Carillon Sports and Family Medicine

12225 28th Street North, Suite B
Saint Petersburg, FL 33716
Telephone: (727) 561-4303 Facsimile: (727) 561-9299

Dear Patient:

Thank you for choosing Carillon Sports and Family Medicine for your health care needs. We recognize that you have a choice in health care providers, and we appreciate the trust that you have placed in us. Your appointment with _____ is scheduled for _____, _____ at _____ am / pm. Please complete the attached patient registration paperwork and bring it with you to your appointment. You will also need to bring your photo identification, your insurance card and a form of payment for your copayment, coinsurance or deductible. **If you are unable to complete this patient registration packet prior to your appointment, it will be necessary for you to arrive 30 minutes prior to your scheduled appointment time in order to complete this paperwork or your appointment may need to be rescheduled.**

In the event that you are unable to keep your scheduled appointment, we ask that you provide 24 hours notice so that we are able to accommodate another patient who may need your time slot.

We look forward to meeting you and working with you to meet your health care needs.

Yours in good health,

Adam A. Brunson, MD Matt Vermeer, MD

01/21/2019

NOTICE OF PRIVACY PRACTICES

Carillon Sports and Family Medicine
Adam A. Brunson, MD
12225 28th St North, Suite B
St. Petersburg, FL 33716

Privacy Officer: Practice Administrator (727) 561-4303 x 5

Effective Date: 1/21/2019

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay

for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Roosevelt Freeman, Regional Manager
Office for Civil Rights, Region IV
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (800) 368-1019
FAX (404) 562-7881
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Carillon Sports and Family Medicine Patient Registration
Patient Information

Last Name | First Name | Middle Name

Date of Birth | Gender | Social Security Number | Marital Status

(Area Code) Home Number | (Area Code) Work Number | (Area Code) Cellular Number

Home Mailing Address | City, State, Zip Code | Email Address

Employer Name | Mailing Address | City, State, Zip Code

It is okay to leave lab results, imaging results and confidential personal health information on the following telephone numbers:

☐ home ☐ work ☐ cell ☐ none

Preferred appointment confirmation method

❑ voice message on home phone ❑ voice message on cell phone ❑ voice message on work phone

Guarantor Information

(This is the person responsible for payment…Not your insurance company)

❑ **Check here if same as above**

Last Name | First Name | Middle Name

Date of Birth | Gender | Social Security Number | Marital Status

(Area Code) Home Number | (Area Code) Work Number | (Area Code) Cellular Number

Home Mailing Address | City, State, Zip Code | Email Address

Primary Insurance Information

(This section must be completed. Obtain this information from your insurance card.)

Insurance Company Name | Insurance Telephone Number

Claims Mailing Address | City, State, Zip Code

Policy Holder | ID# | Group #

Address if different from address above | City, State Zip Code

Policy Holder Date of Birth | Policy Holder Social Security Number | Relationship to Patient | Employer

Secondary Insurance Information

(This section must be completed, if applicable. Obtain this information from your insurance card.)

❑ The patient has NO secondary insurance (please check if appropriate)

Insurance Company Name _____ Insurance Telephone Number _____

Claims Mailing Address _____ City, State, Zip Code _____

Policy Holder _____ ID# _____ Group # _____

Policy Holder Date of Birth _____ Policy Holder Social Security Number _____ Relationship to Patient _____ Employer _____

Pharmacy Information

Name _____ (Area Code) Phone Number _____ ❑ Local ❑ Mail Order

Name _____ (Area Code) Phone Number _____ ❑ Local ❑ Mail Order

Emergency Contact/Others Authorized to Discuss Medical Records (HIPAA)

Name _____ (Area Code) Contact Phone Number _____ Relationship _____
The person above is authorized to receive information regarding my medical records (Check one) ❑ Yes ❑ No

Name _____ (Area Code) Contact Phone Number _____ Relationship _____
The person above is authorized to receive information regarding my medical records (Check one) ❑ Yes ❑ No

Complete ONLY if Related to an Automobile Accident

Insurance Company Name _____ Claims Mailing Address _____ City, State, Zip Code _____

Claim Representative _____ Insurance Telephone Number _____ Date of Accident _____

Policy Holder _____ Relationship _____ Policy Number _____ Claim Number _____

Patient's Complaint _____

Patient acknowledges that CSFM will file auto claim to health insurance **ONLY AFTER** auto benefits have been exhausted. _____ Initials

Patient Name (Print legibly) : _____

Financial Responsibility

I understand that I am responsible for the payment of this account and hereby assume and guarantee prompt payment of all expenses incurred. I understand that, as a courtesy, Carillon Sports and Family Medicine will directly bill my insurance company and that I am ultimately responsible for payment of my account.

Payment of Benefits

I direct payment to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for services as described but not to exceed the reasonable and customary charge for those services

Release of Information

I hereby authorize Physician to release any information acquired in the course of examination or treatment to my insurance company in order to process payment or other health care provider for referral purposes.

Notice of Privacy Practices

I acknowledge that I have been provided with Carillon Sports and Family Medicine's Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that CSFM reserves the right to change its Notice of Privacy Practices that will be effective for health information CSFM already has about me, as well as any it receives in the future. CSFM will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request.

I acknowledge that I have read and understand all of the above information.

_____ _____

Signature of Insured or Custodian Date

Carillon Sports and Family Medicine

12225 28th Street North, Suite B
Saint Petersburg, FL 33716
Telephone: (727) 561-4303 Facsimile: (727) 561-9299

New Patient Health History Questionnaire

Name: _____ **Date:** _____
DOB: _____ **Age:** _____

Please Note: This is a confidential record of your medical history and will be kept in this office. The information contained here will not be released to any person except when you have authorized us to do so.

Drug Allergies:
Food/Environmental Allergies:

Medications: List all medications you take regularly (including over the counter/herbal/natural remedies)

Medication name, strength and frequency taken	Medication name, strength and frequency taken

Medical History: Have you ever had or been diagnosed to have: *Check all that apply below*

☐ Cataracts	☐ Heart Attack/Disease	☐ Bleeding Disorder	☐ Enlarged Prostate
☐ Glaucoma	☐ Angina	☐ Blood Transfusion	☐ Kidney Disease
☐ Allergies	☐ Heart Murmur	☐ Thyroid Disease	☐ Kidney Stones
☐ Asthma	☐ High Blood Pressure	☐ Diabetes	☐ Arthritis
☐ COPD	☐ Heart Failure	☐ Pre-diabetes	☐ Osteoporosis
☐ Lung Disease	☐ High Cholesterol	☐ Liver Disease	☐ Osteopenia
☐ Stroke	☐ Arrhythmia	☐ Jaundice	☐ Low Immune System
☐ TIA	☐ Atrial Fibrillation	☐ Digestive Disorder	☐ Anxiety
☐ Seizures/Epilepsy	☐ Blocked Arteries	☐ Ulcers	☐ Depression
☐ Migraines	☐ Headaches	☐ Anemia	
☐ Hepatitis Type: _____		☐ Cancer Type: _____	

List any other medical problems (not previously listed) below:

Operations: List any surgeries below	**Date**	**Hospitalizations:** Other than for surgery	**Date**

List any other medical providers you see:

Name	Specialty

Family Medical History:

Relative	Age	Health (List significant illnesses)	Age at Death (if deceased)	Cause of Death (if deceased)
Father				
Mother				
Brothers				
Sisters				
Children				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

Social History:

Birthplace: Education (highest level completed):
Occupation: ☐Full Time ☐Part Time ☐Retired ☐Disabled
Nature of Disability (if disabled):
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Number of Children: Number of Persons Living in Home: Pets:
Home Type (house, apt., etc.): Year Built: ☐Rent ☐Own
Do you currently smoke? ☐Yes ☐No Type/Amount smoked per day? How long?
Did you smoke in the past? ☐Yes ☐No If yes, when did you quit?
Do you consume caffeine? ☐Yes ☐No If yes, type? How much?
Do you drink alcohol? ☐Yes ☐No If yes, Type/Amount per week?
Do you use street drugs? ☐Yes ☐No If yes, Type?
Have you ever used drugs? ☐Yes ☐No If yes, Type?
Family history of drug or alcohol addiction? ☐Yes ☐No ☐Unknown
How many hours do you usually sleep at night?
What do you do to relieve stress?

Exercise History:

Activity Level: ☐ Sedentary ☐ Mildly Active ☐ Moderately Active ☐ Very Active
Exercise Regimen: ☐ None Type(s): Hours/week:
Do you have any activity limitations/restrictions? ☐ Yes ☐ No If yes, please list:

Health Maintenance: Check all procedures that you have had done and list date last done

Test	Date	Test	Date	Immunization	Date
☐Mammogram		☐Eye Exam		☐Flu shot	
☐Bone Density Test		☐EKG		☐Tetanus Booster	
☐Pap Smear		☐Chest X-ray		☐Pneumonia Vaccine	
☐Colonoscopy		☐TB Skin Test		☐Hepatitis A Vaccine	
☐Stool Cards		☐Cholesterol Level		☐Hepatitis B Vaccine	
☐PSA		☐Blood Sugar Level		☐MMR	
☐Hearing Test		☐Physical Exam		☐Chicken Pox Vaccine	

Patient Name: _____ Date of Birth: _____

Review of Body Systems: Check all symptoms/problems that you are currently experiencing

Constitutional
- ☐ Chills
- ☐ Excessive fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain (unintentional)
- ☐ Weight gain (intentional)

Eyes
- ☐ Loss of vision
- ☐ Blurry vision
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Red eye
- ☐ Itchy eyes
- ☐ Spots before your eyes
- ☐ Glasses/contact lenses

Ears, Nose & Throat
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Ear pain
- ☐ Frequent runny nose
- ☐ Frequent nose bleeds
- ☐ Nasal congestion
- ☐ Bleeding gums
- ☐ Loss of smell
- ☐ Loss of voice
- ☐ Sore throat
- ☐ Sore tongue
- ☐ Tooth pain
- ☐ Dentures
- ☐ Hearing aids

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Swollen ankles/feet
- ☐ Fainting spells
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Leg/calf pain with walking
- ☐ Dizziness
- ☐ Shortness of breath when lying flat
- ☐ Varicose veins

Respiratory
- ☐ Recent cough
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Exposure to TB

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Stomach/abdomen pain
- ☐ Loss of appetite
- ☐ Bloating
- ☐ Constipation

Gastrointestinal (continued)
- ☐ Diarrhea
- ☐ Frequent heartburn/acid reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Change in appearance of stool

Genitourinary
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Leakage of urine
- ☐ Waking up to urinate at night
- ☐ Frequent need to urinate
- ☐ Change in urine stream
- ☐ Genital sores/rashes
- ☐ Pelvic pain
- ☐ Frequent urinary infections

Male Only
- ☐ Difficulty with erections
- ☐ Lump on testicle
- ☐ Painful erections
- ☐ Penile discharge

Female Only
- ☐ Painful intercourse
- ☐ Bleeding after intercourse
- ☐ PMS (premenstrual tension)
- ☐ Heavy periods
- ☐ Frequent periods
- ☐ Infrequent periods
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Menopausal
- ☐ Currently using birth control
- ☐ Currently/possibly pregnant
- ☐ Currently breastfeeding

Musculoskeletal
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Joint swelling
- ☐ Red, hot, tender joints
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle pain

Skin/Breast
- ☐ Acne
- ☐ Changing/new moles
- ☐ Dry skin
- ☐ Nail changes
- ☐ Jaundice

Skin/Breast (continued)
- ☐ Itching
- ☐ Rash
- ☐ Warts
- ☐ Breast lump
- ☐ Breast skin changes
- ☐ Breast tenderness
- ☐ Nipple discharge

Neurologic
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Seizures/convulsions
- ☐ Tremors
- ☐ Vertigo
- ☐ Weakness

Hematologic/Lymphatic
- ☐ Excessive bleeding
- ☐ Increased bleeding
- ☐ History of blood transfusion
- ☐ Enlarged lymph nodes/glands

Endocrine
- ☐ Enlarging hands/feet
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive hair growth
- ☐ Hot flashes
- ☐ Increased skin pigmentation
- ☐ Infertility
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hunger

Allergic/Immunologic
- ☐ Allergies/hayfever
- ☐ Hives
- ☐ Frequent colds/sinus infections
- ☐ Immune system disorder

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Crying spells
- ☐ Mood swings
- ☐ Feeling stressed
- ☐ Loss of interest in pleasurable activities
- ☐ Sadness
- ☐ Poor concentration
- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ Thoughts of suicide

Patient Name: _____ Date of Birth: _____

Review of Body Systems: Check all symptoms/problems that you are currently experiencing

Carillon Sports and Family Medicine Office Policies

Thank you for choosing Carillon Sports and Family Medicine for your health care needs. We recognize that you have a choice in healthcare providers, and we appreciate the trust that you have placed in us. The following details our office policies and allows us to provide excellent health care to each of our patients in an office atmosphere based on mutual respect. Please review and sign on the next page acknowledging that you have read and understand the policies. **Our office does not honor or recognize any patient deletions, additions or notations to these policies. Please refer to both sides of this page**.

Your first visit, or any visit in which you will provide our office with an insurance update, will require you to arrive 15 minutes prior to your appointment time in order to complete the new patient registration process or update your insurance information. We will obtain a photocopy of your current insurance card and picture identification. Demographic updates will be obtained yearly.

Your copayment, coinsurance and/or deductible will be collected on the day of your visit. Our computer system is linked to insurance carriers' fee schedules, so we are able to determine patient responsibility on the day of your visit. Our office accepts cash, check, American Express, Discover, MasterCard or Visa. **In the event that you do not have payment on the day of your visit, your appointment may need to be rescheduled. If approval is given for our office to invoice you for payment, a $10.00 billing fee will be added to your account.** For your convenience, you may choose to leave a credit card on file with our office.

Any outstanding balances on your account will be collected prior to your visit with our provider. Our office considers spouses and dependents to be a guarantor unit. **Any outstanding balances on spouse or dependent accounts will be collected as well.**

You may be asked to schedule another appointment should issues arise other than the reason for your original appointment.

Not all services are a covered benefit of all insurance plans. Our providers order laboratory studies, imaging studies or procedures that are necessary to make a medical diagnosis or to appropriately manage a medical condition. We do not order unnecessary tests. It is your responsibility to understand your insurance policy, benefits and coverage.

Our providers assign diagnostic and procedure codes to each patient's visit in accordance with their medical findings. Depending on the type of benefits offered under each insurance plan, the codes used for a particular service may not necessarily be covered by your insurance company. We strive to be in compliance with the prevailing federal and state laws and insurance regulations. For this reason, we cannot change diagnosis codes once a claim has been filed. We encourage you to be informed about your insurance benefits. Please do not ask us to change your codes in an attempt to have an office visit or lab work paid by your insurance company. To do so places us at risk of being charged with fraudulent practices and exposes us to civil and criminal prosecution.

Any charges considered "non-covered" by your insurance are your responsibility. In the event that your insurance company does not adequately compensate our office for the cost of an injectable or product such as an immunization, antibiotic or implantable medication, you will be invoiced the difference between the amount paid by the insurance company and our cost for the product.

It is our office policy to file your claim with your primary insurance company, unless you are a Medicare patient, in which case we will file with Medicare and a secondary insurance company. We will make one attempt to correct any claims that are denied, and we will refile the claim for you. If the claim is denied a second time, the claim will be placed to patient responsibility and payment will be collected from the patient. You will be given an itemized receipt and you may submit it to your insurance company for reimbursement.

We respect your time. We try our very best to stay on schedule, but occasionally a patient requires more time than allotted due to an urgent or complicated medical problem. Thank you for understanding that we will provide this same level of attention to you in the event that you have a complicated problem.

If you are more than 10 minutes late for a scheduled appointment, it may be necessary to reschedule your appointment. We will make every effort to see you on the day of your appointment. If, however, the wait time will exceed your availability, we will be happy to reschedule the appointment for you.

In order to better accommodate our patients' medical needs, we offer same day appointments for acute illnesses or injuries. In the event that you have an urgent health care problem that requires immediate attention, we will see you in the office for a same day appointment. In order to accommodate patients in this manner, our office requires **24 hours notice** for cancellations. Appointments not cancelled with 24 hours notice will be considered late cancellations. **Late cancellations or missed appointments will result in a $30 charge being assessed to your account**. A fourth late cancellation may result in dismissal from our practice. If you need to cancel an appointment after our office has closed, please leave a message on our voicemail, still providing 24 hours notice. As a courtesy, we do provide appointment confirmation calls 2 days prior to your appointment. **However, it is your responsibility to know your appointment day and time.**

Our office opens at 7:15 am each morning for blood draws. We see patients on Monday, Tuesday and Wednesdays from 7:30 am – 7:00pm, Thursday from 7:30 am – 5:00 pm and Friday from 7:30 am – 4:00 pm. We provide after hours and weekend call coverage in the event of emergencies only. Please call our office and you will be directed to our provider voicemail. Please leave a detailed message and the on-call provider will return your call. Patients in need of afterhours care may visit the Bardmoor Emergency Department. Hospital coverage at area hospitals is provided by hospitalist physicians.

Routine prescription refills will be given during office hours. Please contact your pharmacy to have a refill request faxed to our office. Please allow 72 hours (not including weekends) for your requests to be refilled. Please note that **NO antibiotics** or **controlled substance** requests can be filled during nights or weekends.

Many insurance companies require authorization for imaging studies such as MRI and CT scans. Carillon Sports and Family Medicine has a partnership agreement with select area imaging facilities to obtain these authorizations for our patients. Patients requiring authorization for imaging studies must use one of these facilities in order to have the necessary authorization completed through our office. If you choose to use another facility, you MUST ensure that the facility is able to obtain the necessary authorization directly through your insurance company. Our office will be unable to obtain authorizations for imaging studies for you.

Patients will find it necessary to leave messages for physicians and staff members. **Our providers utilize their medical assistants to communicate with patients outside of patient appointments.** Our office staff members will respond to all urgent messages daily. It may be necessary for us to respond to your message during evening hours due to heavy office volume. Non urgent messages will be responded to the following day.

Please note that there is a $30 minimum charge for the completion of all paperwork, including FMLA paperwork, short term disability forms and long term disability forms. Payment will be collected at the time paperwork is received in our office. Paperwork will be completed within seven days, and our office will contact you when it is completed.

Due to recent changes in legislation, our office will be unable to prescribe narcotic medication for the management of chronic pain. It will be necessary for our office to refer these cases to a pain management physician.

I have read, understand and agree to abide by the office policies described above.

_____ _____

Print Name Signature

Carillon Sports and Family Medicine
Form Fee Agreement

Please note: The completion of informational/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 the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, particularly when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover these costs requires us to institute a policy of charges for the completion of forms as follows:

No charge:

- Disabled Parking Applications

$30 for each form:

- Family Medical Leave Act (FMLA) forms
- Credit Card Deferment forms
- Short Term Disability forms
- Long Term Disability forms
- Prior Authorization forms

$150 to $500

- For completion of any dictated letter describing medical care and limitations
- For any narrative report detailing diagnosis, treatment and future medical care including work capacity statement.

Medical Records

- Copying medical records…$1.00 per page for the first 25 pages; $.25 per page after that

I have read and understand the above. By signing I agree to comply with the Form Fee policy of CSFM. I understand that pre-payment will be collected prior to the completion of my form. I also understand that fees are subject to change without notice. **I understand that failure to agree to these charges will result in our office being unable to complete any of the above on my behalf.**

_____ _____

Patient Signature Date

_____ _____

Patient Name Printed Date of Birth

Dear Patient:

As our federal government continues to identify the use of electronic health records (EHR) as a priority for medical practices, it has also created an initiative to ensure "meaningful use" of these EHR. The ultimate goal of an EHR that exemplifies meaningful use is to enable significant and measurable improvements in public health through a transformed healthcare delivery system, according to the Meaningful Use Work Group of the Health IT Policy Committee. One of the many components of meaningful use is to record all of the following demographics: (a) preferred language; (b) gender; (c) race; (d) ethnicity; and (e) date of birth.

In an effort to help us meet this component requirement, please complete the following:

*****************PLEASE CHECK ONE IN EACH CATEGORY*****************

Print Name: _____ **Date of Birth:** _____

Race:

❑ White ❑ American Indian/Alaska Native ❑ Native Hawaiian/Other Pacific Island
❑ Asian ❑ Black/African American ❑ Other ❑ Decline

Ethnic Group:

❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Decline

Preferred Language:

❑ English ❑ Arabic ❑ Chinese ❑ French ❑ German
❑ Japanese ❑ Other ❑ Russian ❑ Spanish ❑ Vietnamese

This information will be recorded in your chart and will be provided in required governmental reporting. The information will not be used in determining, authorizing or denying medical treatment.

Thank you for your assistance in helping our office meet these compliance requirements.

Warmest regards,

Adam A. Brunson, MD Matt Vermeer, MD

Authorization to Release Medical Records

Date: _____

I authorize: **Carillon Sports and Family Medicine**
12225 28th St. North, Suite B
St. Petersburg, FL 33716
(727) 561-4303 (727) 561-9299

❑ **To Obtain Records From**
❑ **To Send Records To**

_____
(Medical Facility/Medical Provider)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone Number) (Fax Number)

_____ _____ _____
Patient's Full Name Date of Birth Social Security Number

For the purpose of review/examination, I authorize you to provide the following information:
_____ Complete copy of medical record
_____ Specific information _____

I give permission to release any information related to:
_____ Substance abuse
_____ Psychiatric/mental health information
_____ HIV/AIDS information

Reason for Transfer Request
❑ Continuity of care ❑ Moved from the area ❑ Insurance issues ❑ Problem with staff/physician
❑ Other _____

This authorization will expire one year from the date signed. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer covered by HIPAA.

Patient or Legal Guardian Signature: _____

Relationship to the Patient: _____

Name at time of treatment if other than above: _____

Date of Treatment(s): _____

Carillon Sports and Family Medicine
Patient Portal

IMPORTANT NOTE: While this is an **optional** service provided for our patients, **portal communication is strongly encouraged** and will serve as our **main method of communication** with our patients.

Save a telephone call…Avoid voice mail and playing phone tag…
Use the patient portal!

Did you know…

- You will use **individual user names and passwords** for **24 hour online access** to your private health information contained in our EHR system.
- You can **communicate directly** with **our providers** via the portal. They will respond the same day, usually within the half day!
- You can **communicate directly** with **staff members** regarding demographic updates and billing questions.
- We will provide **laboratory and imaging study results with provider instructions** to you directly via the portal.
- We will send a **visit summary** to you following your office visit.
- You can **request medication refills** via the portal.
- You can **request referrals** via the portal
- You can **review and update your medical history**, including immunizations, medications and drug allergies, via the portal.
- You will receive **appointment reminders**, **health maintenance reminders** and **other important announcements.**

You must **add csportsandfamily@tampabay.rr.com** as a contact to avoid registration email being directed to your spam folder.

Access to the Patient Portal is available through our website at csportsandfamily.com using INTERNET EXPLORER. The Portal does not work properly with other web browsers.

Please note that information communicated via the patient portal becomes a **PERMANENT part of YOUR medical record**. Please do not use your portal account to communicate with our office about another patient.

Please direct any questions or concerns to one of our staff members.

How to Use the Patient Portal
**********Keep this information for future reference**********

1. Request access from Carillon Sports and Family Medicine via our website or at your next office visit.
2. Review, sign and agree to the "Policies and Procedures" and complete the "Informed Consent to Use Patient Portal" form that you will receive.
3. After these items are complete, you can expect to receive a welcome email. **You must add csportsandfamily@tampabay.rr.com as a contact to avoid this email being directed to your spam folder.** Click on the link to create user name and password.
4. Remember, information communicated via the patient portal becomes a PERMANENT part of YOUR medical record. Please do not use your portal account to communicate with our office about another patient.

Available Components

Messages

This allows you to send and receive secure email to and from our staff. This may include attachments, pictures or other information. Use of this is very similar to standard email. Here you can also ask billing questions or make suggestions on how we can improve the site.

Health Summary

Here you can view information entered into various parts of your electronic health record. These are available for you to review for accuracy as well as print for other providers or keep for your records. This information is updated regularly from ongoing office visits with our office and consultation notes we receive from other providers. Here you can also make suggestions or comments for information to be added to your medical record, but it will not be a permanent part of your chart until approved by our staff.

Laboratory and Other Diagnostic Test Results

Here you can receive copies of labs or other tests ordered by our providers and any explanations or comments regarding the testing from your provider. This is a read-only area but if you have questions, you can email us in the Messages section. Please note that communication via the portal will not substitute for an office visit with a provider in the event one is needed.

Medications

Here you can see current and past medications prescribed by one of our providers or entered into your chart by one of our staff members. You can also request medication refills here. Please ensure that we have your accurate pharmacy information. Again, medication refills for narcotics or controlled substances will require an office visit.

Appointments

In this section you can schedule, confirm, cancel or reschedule an appointment. You may also view all upcoming appointments. Appointments must be canceled or rescheduled with a minimum of 48 hours notice. You may also add an appointment request to our waiting list.

Please visit our practice web site at www.csportsandfamily.com to access the Patient Portal and for more general information about our clinic and the services we offer.

Informed Consent to Use Patient Portal

Patient Information:

Name _____ Date of Birth_____

Address _____

Email Address _____

Purpose of this form:
Carillon Sports and Family Medicine offers secure online viewing and communication as a service to patients who wish to view their medical records and communicate with our staff. Secure messaging can be a valuable communication tool but it has certain risks. In order to manage these risks we need to require conditions for participation. This form is intended to affirm that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the secure Patient Portal works:
A secure web portal is a kind of web page that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site.

How to participate in our Patient Portal:
You can compose, retrieve and reply to secure messages or view information sent to you through a website hosted by our electronic health records system provider. Once this form is signed, we will send you an email notification that tells you how to register for the first time. This notification will give you the URL of the website where you can log in. By clicking on the URL you will activate your Internet browser, which will open the website. You will then be able to log in using the user name and password provided. Next you will be able to look in your "mesbox" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the website uses "secure socket layer" technique, you can read or view information on your computer but it is still encrypted in transmission between the website and your computer.

You can view more clinic-specific information or access the portal through **www.csportsandfamily.com**.

Protecting your private health information and risks:
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address and only the correct individual (or someone authorized by that individual) is able to get access to it.

CONTINUED ON NEXT PAGE...

Only you can ensure that these two factors are present. We need you to make certain that we have your correct email address and are advised if it changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you retrieve secure messages from a website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly visit the website to change it.

We understand the importance of privacy with regard to your healthcare and will continue to strive to make all information confidential and will never sell or give away any private information, including email addresses, without your written consent.

Conditions of Participation for the Patient Portal:
The Patient Portal is being provided as a courtesy to our valued patients free of charge. If abuse or negligent usage of the Patient Portal occurs, we reserve the right to suspend or terminate the Patient Portal offering at any time for any reason, suspend user access or modify services offered through the portal.

You acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care you receive. You agree to not hold Carillon Sports and Family Medicine or any of its staff liable for network infractions beyond their control.

Prior to receiving this form, we provided you with our "Policies and Procedures" for using our Patient Portal. You are required to understand and agree to comply with these policies and procedures. By signing below you acknowledge that you understand all policies and procedures and that you agree to comply with them. If you do not understand, or do not agree to comply with our Policies and Procedures, do not sign the form. If you have any questions we will gladly provide additional information.

Patient Acknowledgement:

❑ Great! Sign me up for the Patient Portal! I want to save time, avoid voicemail and skip the game of phone tag! I understand that this will be the **primary method** of communication between CSFM and me

❑ No thanks! I decline the Patient Portal at this time.

Signature_____ Date _____