



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

Lindsay K. Summer, ARNP

Melissa James, ARNP

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 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

Signature of Custodian (if applicable)



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Orthopedic History Questionnaire New Patient

Please take a few minutes to complete this form. By doing so you will help us to provide you with the best possible medical care. 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.

Patient Information:

Name: _____

Visit Date: _____

DOB: _____

Age: _____

Gender: Male Female

Dominant hand: Right Left

Who referred you to our office? _____

Chief Complaint:

What is the main reason for your visit today? _____

History of Present Illness:

Date problem began (approximate, if unsure): _____

Location of problem: _____

Have you had a problem like this before? Yes No If yes, please briefly describe: _____

How problem started:

NO INJURY onset was: Gradual Sudden

Please indicate why you think it started: _____

(If **NO INJURY**, skip to **Associated Symptoms**)

INJURY

Please specify where and how it happened: _____

Check all of the following that happened at the time of your injury: Swelling Bruises Numbness Tingling
 Weakness Loss of control bowel or bladder Locking/Catching Giving way/Buckling
 Loss of consciousness Feeling/hearing a tear/pop Joint popping out of place Joint loose/unstable
 Unable to continue activity

Associated symptoms: Check all of the following symptoms that are related to your current problem:

Pain: Severity: On a scale of 0 – 10 (0=No pain, 10=worst possible pain)

Current: ___/10 Best: ___/10 Worst: ___/10 Average: ___/10

Quality: Sharp Dull Stabbing Throbbing Aching Burning

Frequency: Constant Comes and goes (intermittent) Occasional Rare

Swelling Bruises Numbness Tingling Weakness Loss of control bowel or bladder

Locking/Catching Giving way/Buckling Grinding/Grating Stiffness

Since my problem started, it is: Getting better Getting worse Unchanged

Name: _____ DOB: _____

What makes your symptoms worse? Standing Walking Running/jogging Sitting Lifting
 Exercise Twisting Lying down Bending forward Bending backward Squatting Kneeling
 Stairs Coughing Sneezing Driving Typing/using computer
 Other: _____

What make your symptoms better? Rest Elevation Ice Heat Lying down Standing Walking
 Sitting Massage Manipulation Physical therapy Pain pills Muscle relaxants Aspirin/NSAIDs
 Nothing Other: _____

Prior evaluation/treatment of your problem: Please check all that apply.
 X-Rays MRI CAT Scan Bone Scan Ultrasound Nerve Test Myelogram Arthrogram
 Blood work Prescription medication OTC medication Herbal/Natural Remedies Brace/Splint
 Cane/Crutch Cast

<input type="checkbox"/> Emergency Room	Where?	Date:
<input type="checkbox"/> Physician's Office	Provider's Name:	Date:
<input type="checkbox"/> Physical Therapy	Where?	# of weeks:
<input type="checkbox"/> Injections	Location?	# of injections:
<input type="checkbox"/> Chiropractic Treatment	Provider's Name:	# of weeks:
<input type="checkbox"/> Massage Therapy	Where?	# of treatments:
<input type="checkbox"/> Acupuncture	Where?	# of treatments:
<input type="checkbox"/> Surgery:	Procedure:	Surgeon: Date:
	Procedure:	Surgeon: Date:

Other: _____

Functional Activities: Using the list below, indicate how your current problem has affected your life. Circle the number next to each activity that best describes both your current and previous (before you began having this problem) ability to function.

1 = No problem 2 = Can do with some difficulty 3 = Can do with great difficulty 4 = Not able to do

Activity	Current	Previous	Activity	Current	Previous
Sitting	1 2 3 4	1 2 3 4	Eating	1 2 3 4	1 2 3 4
Standing	1 2 3 4	1 2 3 4	Cooking	1 2 3 4	1 2 3 4
Walking	1 2 3 4	1 2 3 4	Using phone	1 2 3 4	1 2 3 4
Changing Positions	1 2 3 4	1 2 3 4	Shopping	1 2 3 4	1 2 3 4
Squatting	1 2 3 4	1 2 3 4	Housework	1 2 3 4	1 2 3 4
Kneeling	1 2 3 4	1 2 3 4	Yard work	1 2 3 4	1 2 3 4
Climbing Stairs	1 2 3 4	1 2 3 4	Speaking	1 2 3 4	1 2 3 4
Lying down	1 2 3 4	1 2 3 4	Typing	1 2 3 4	1 2 3 4
Lifting/Carrying	1 2 3 4	1 2 3 4	Reading	1 2 3 4	1 2 3 4
Coordination	1 2 3 4	1 2 3 4	Writing	1 2 3 4	1 2 3 4
Reaching	1 2 3 4	1 2 3 4	Memory	1 2 3 4	1 2 3 4
Gripping	1 2 3 4	1 2 3 4	Sleeping at night	1 2 3 4	1 2 3 4
Bathing	1 2 3 4	1 2 3 4	Driving	1 2 3 4	1 2 3 4
Dressing	1 2 3 4	1 2 3 4	Traveling	1 2 3 4	1 2 3 4
Grooming	1 2 3 4	1 2 3 4	Sports	1 2 3 4	1 2 3 4
Controlling bowel/bladder	1 2 3 4	1 2 3 4	Social Activities	1 2 3 4	1 2 3 4
Toileting	1 2 3 4	1 2 3 4	Working	1 2 3 4	1 2 3 4

Name: _____ DOB: _____

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

Drug Allergies: _____

Food/Environmental Allergies: _____

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

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

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

Name: _____ DOB: _____

Family Medical History:

Relative	Age	Health (List significant illnesses)	Age at Death (if deceased)	Cause of Death (if deceased)
Mother				
Father				
Sisters/Brothers				
Children				

Social History:

Birthplace: _____ Education (highest level completed): _____

Occupation/Job Duties: _____

Are you currently working? Yes No

If yes, please specify: Hours/week: _____ Full Time Part Time Full Duty Restricted Duty

If no, please specify: Last day worked: _____ Retired Temporarily Disabled Permanently Disabled

Nature of Disability (if disabled): _____

Do you have any activity limitations/restrictions? Yes No

If yes, please list: _____

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

Did you smoke in the past? Yes No If yes, when did you quit? _____

Type/Amount smoked per day? _____ How long? _____

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 are your hobbies/interests? _____

Exercise History:

Activity Level: Sedentary Mildly Active Moderately Active Very Active

Exercise Regimen: None Type(s): _____

Hours/week: _____

Name: _____ DOB: _____

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

General

- Excessive fatigue
- Recent weight gain
- Unusual weakness
- Night sweats
- Fever/chills

Eyes

- Loss of vision
- Spots before your eyes
- Double or blurry vision
- Eye pain
- Red eye
- Itchy, watery eyes
- Glasses/contact lenses

Ears, Nose & Throat

- Loss of hearing
- Ringing in the ears
- Ear pain
- Hay fever/allergies
- Frequent colds
- Loss of smell
- Loss of voice
- Frequent sore throat
- Bleeding gums or nose
- Post-nasal drainage

Endocrine

- Excessive thirst
- Excessive urination
- Excessive hunger
- Heat intolerance
- Cold intolerance

Respiratory

- Chronic cough
- Coughing up blood
- Shortness of breath
- Wheezing
- Shortness of breath with laying flat

Cardiovascular

- Chest pain or discomfort
- Swollen ankles/feet
- Fainting spells
- Fast or irregular heart beat
- Exercise intolerance
- Leg/calf pain with walking
- Cold, pale feet

Gastrointestinal

- Difficulty swallowing
- Recurring stomach pain
- Nausea/vomiting
- Vomiting blood
- Bloody or black stools
- Diarrhea
- Constipation
- Loss of appetite
- Frequent heartburn
- Change in appearance of stool

Genitourinary

- Pain with urination
- Blood in urine
- Leakage of urine
- Urinary dribbling
- Frequent need to urinate
- Decreased force of urine stream
- Waking up to urinate at night

Musculoskeletal

- Painful joints
- Back pain
- Frequent muscle cramps
- Joint swelling
- Red, hot, tender joints
- Frequent muscle pain
- Sprain/strain

Neurologic

- Paralysis
- Memory loss
- Numbness
- Weakness
- Dizziness/vertigo
- Loss of balance
- Seizures/convulsions
- Frequent headaches
- Frequent falls
- Inability to walk without help
- Tremors

Psychiatric

- Anxiety
- Depression
- Panic attacks
- Manic depression
- Thoughts of suicide
- Feelings of hopelessness
- Emotional stress
- Difficulty sleeping
- Sleeping too much

Skin

- Rash
- Decreased pigmentation
- Increased pigmentation
- Itching
- Dry skin
- Excessive sweating
- Excessive hair growth
- Loss of hair
- Oily skin
- Changing/new moles
- Nail changes

Hematologic/Oncologic

- Unusual bleeding
- Increased bruising
- Difficulty stopping bleeding
- Enlarged lymph nodes/glands
- Unusual lump/mass
- Breast lump/pain/discharge

Female Only

- Painful intercourse
- Bleeding after intercourse
- Frequent periods
- Infrequent periods
- Bleeding between periods
- Painful periods
- Excessive flow with periods
- Vaginal discharge/itching
- Pelvic pain
- Nursing
- Currently using birth control
- Currently pregnant
- Currently breastfeeding
- Menopausal

Male Only

- Difficulty with erections
- Lump on testicle
- Painful erections
- Penile discharge

Carillon Sports and Family Medicine Office Policies (updated 12/20/2010)

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. The following details our office policies and allows us to provide excellent health care to all of our patients in an office atmosphere based on mutual respect. Please review and initial next to each office policy summary acknowledging that you have read and understand the policy. **Our office does not honor or recognize any patient deletions, additions or notations to these policies. Please refer to both sides of this page.**

_____ (initial) 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.

_____ (initial) **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 estimated 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.

_____ (initial) **Any outstanding balance 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.**

_____ (initial) Our physicians and nurse practitioners 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 coverage for labs, imaging and procedures.

_____ (initial) 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 plan. 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 a 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.

_____ (initial) 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.

_____ (initial) 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 such as an immunization or antibiotic, you will be invoiced the difference between the amount paid by the insurance company and our cost for the product.

_____ (initial) 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 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.

_____ (initial) 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. A late cancellation fee will be assessed.

_____ (initial) 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 that day. 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 \$25 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 48 hours prior to your appointment. However, it is your responsibility to know your appointment day and time.

_____ (initial) Our office opens at 7:15 am each morning for blood draws. We see patients on Monday, Tuesday and Wednesday from 8:00 am - 7:00 pm, Thursday from 8:00 am - 5:00 pm and Friday from 8:00 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 our provider will return your call. Patients in need of after hours care may visit the Bardmoor Emergency Department. Hospital coverage at Morton Plant Hospital is provided by 24 on Physicians Hospitalist Group. Hospital coverage for our patients at St. Anthony's Hospital, Bayfront Hospital and Ed White Hospital is provided by West Coast Hospitalists.

_____ (initial) 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.

_____ (initial) Many insurance companies require authorization for imaging studies such as MRI and CT scans. Carillon Sports and Family Medicine has a partnership agreement with St. Anthony's One Call and St. Pete MRI 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.

_____ (initial) 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.

_____ (initial) **Please note that there is a \$25 minimum charge for the completion of all paperwork,** including FMLA paperwork and short term and long term disability paperwork. Payment will be collected at the time paperwork is received in our office. Paperwork will be completed as quickly as possible, and our office will call you when it is completed.

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

Print Name

Signature

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
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

\$25 for each form:

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

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

Race:

- | | | |
|--------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Native Hawaiian/Other Pacific Island |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Other |
| | | <input type="checkbox"/> Decline |

Ethnic Group:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Andalusian | <input type="checkbox"/> Argentinean | <input type="checkbox"/> Asturian |
| <input type="checkbox"/> Belearic Islander | <input type="checkbox"/> Bolivian | <input type="checkbox"/> Canal Zone | <input type="checkbox"/> Canarian |
| <input type="checkbox"/> Central American Indian | <input type="checkbox"/> Central American | <input type="checkbox"/> Chicano | <input type="checkbox"/> Chilean |
| <input type="checkbox"/> Columbian | <input type="checkbox"/> Criollo | <input type="checkbox"/> Cuban | <input type="checkbox"/> Dominican |
| <input type="checkbox"/> Ecuadorian | <input type="checkbox"/> Gallego | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Honduran |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> La Raza | <input type="checkbox"/> Latin American | <input type="checkbox"/> Mexican |
| <input type="checkbox"/> Mexican American Indian | <input type="checkbox"/> Mexican American | <input type="checkbox"/> Mexicano | <input type="checkbox"/> Nicaraguan |
| <input type="checkbox"/> Panamanian | <input type="checkbox"/> Paraguayan | <input type="checkbox"/> Peruvian | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> South American Indian | <input type="checkbox"/> South American | <input type="checkbox"/> Salvadoran | <input type="checkbox"/> Spaniard |
| <input type="checkbox"/> Spanish Basque | <input type="checkbox"/> Uruguan | <input type="checkbox"/> Valencian | <input type="checkbox"/> Venezuelan |
| <input type="checkbox"/> Decline | | | |

Preferred Language:

- | | | | | |
|-----------------------------------|---------------------------------|----------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other | <input type="checkbox"/> Russian | <input type="checkbox"/> Spanish | <input type="checkbox"/> 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

Lindsay Summer, ARNP

Melissa James, ARNP

Carillon Sports and Family Medicine Patient Portal

We are pleased to announce the implementation of the Patient Portal component of our electronic health record (EHR) system. The Carillon Sports and Family Medicine Patient Portal is a secure web portal for the exclusive use of our established patients. This secure online portal functions much like your bank's secure online website. It utilizes individual user names and passwords via a secure website to allow you to have 24 hour online access to your private health information contained in our EHR system.

The Patient Portal will enable

- Secure email interaction with providers and staff
- Access to your complete health history including immunizations, medications and drug allergies
- Access to downloadable x-ray and laboratory results
- Requests for medication refills
- Requests for referrals
- Direct appointment scheduling
- Prompt medical alerts such as health maintenance reminders, drug recalls or announcements regarding available services

The Patient Portal is not intended to provide internet based medical services. The following limitations apply:

- No internet based triage or treatment requests. Diagnosis of medical issues can only be made and treatment rendered after a patient is physically examined by a provider.
- Do not use the portal to communicate if there is an emergency.
- Do not use the portal to request narcotic pain medication or other controlled substances.
- Do not use the portal to request a new prescription for a condition for which you are NOT currently being treated by your provider.

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.

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

Carillon Sports and Family Medicine

Policies and Procedures

Patient Portal

- Current Functionality of Patient Portal
 - Schedule, confirm, cancel or reschedule appointments
 - Receive laboratory and imaging results with provider interpretation
 - Request medication refills...Ensure that you include your pharmacy name, address and telephone number
 - Request referrals
 - Communicate securely with our office
 - View and print your continuity of care health record
 - View and update health information
 - More functionalities coming soon!
- Requests for updates to your health records, medication list and medical problem history will be sent to our medical staff for review prior to entry into your personal health record
- Do not use email to communicate if there is an emergency or urgent need for communication; Call 911 in the event of an emergency.
- Proper subject matter
 - As described above in Functionality of Patient Portal
 - HIV results cannot be provided via the Patient Portal
 - We are unable to refill controlled substances via the Patient Portal. Please contact the office to schedule an appointment for evaluation of your medical problem in order to obtain a medication refill
- Be concise
- Because your log-in is tied directly to your Electronic Health Record in our office, you do not need to enter information such as your name, telephone number or address, unless you need to update them with our office
- All portal communication will be maintained as permanent communication in your patient record
- Our system will automatically generate a read receipt upon viewing of the message by the patient. It is not necessary for you to confirm receipt of our message
- Privacy
 - All messages we send will be encrypted – see informed consent for explanation
 - Emails from you to any staff member should be sent through this portal or they are not considered secure
 - We will keep all email addresses confidential and will not share with other parties
- Response Time
 - After you agree to these “Policies and Procedures” and sign the “Informed Consent to Use Patient Portal” we will send a welcome message to you. This will provide a link to log in.
 - We will generally respond to non-urgent email inquiries within 24 hours but no later than 3 business days.

All Policies and Procedures are subject to change without notice.

How to Use the Patient Portal

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.** This email will include a URL link and your assigned log-in and password. Click on the link to enter the information provided.
4. Once you are logged into the portal, you should select "My Account" on the top right of the page. Here you will need to change your user name and password to something that you will remember.

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 through December 2012. Portal access must be renewed annually. Access to this secure web portal is an optional service. 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:

Signature _____

Date _____