

## **Financial Policy**

We consider payment of services to be the responsibility of the patient-physician relationship. Therefore, we would like to share our payment policy expectations with you to ensure understanding and compliance.

We participate with various insurance companies and managed care plans, which we will file on your behalf directly to the insurance carrier for payment, less any co-payments, coinsurance, deductibles and non-covered benefits.

Please make sure that on your commercial managed plans, you choose us as your primary care physicians. If we are not the doctors of choice we will not be able to see in the office. Also, be sure that your insurance is active before making an appointment or you will be charged the full cost of the office visit.

Payment is expected at the time of service.

ON ALL RETURNED CHECKS FOR NON-SUFFICIENT FUNDS, there is a \$25.00 fee charged back to the patient. We will be unable to accept any personal checks until the account balance and associated service fees are paid in full. If this is a repeated offense, we will be unable to accept any further checks.

By signing below, I have read and understood the payment terms and my obligations within the Financial Policy. Please let us know if you have any additional questions or concerns.

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Signature of Patient / Person responsible for Account

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Date

Please let us know your wishes:

Check ALL that apply:

\_\_\_\_\_ I have a living will. (If yes, please provide a copy).

\_\_\_\_\_ I have a document that I signed that allows another person to make healthcare decisions for me. (If yes, please provide a copy).

\_\_\_\_\_ If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me:

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

**If I become so ill that I cannot tell my doctor what I want, and two doctors agree that they cannot make me better, please: (Check ALL that apply)**

\_\_\_\_\_ Keep me clean and free from pain.

\_\_\_\_\_ Do **Not** use tubes for: \_\_\_\_\_ breathing \_\_\_\_\_ feeding \_\_\_\_\_ IV fluids.

\_\_\_\_\_ Let my appointed person decide.

\_\_\_\_\_ If my heart stops, do \_\_\_\_\_ do not \_\_\_\_\_ try to restart it.

\_\_\_\_\_ Do EVERYTHING possible.

\_\_\_\_\_ I do not wish to complete an advanced directive at this time

**Additional instructions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1<sup>st</sup> Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

2<sup>nd</sup> Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures that the surrogate feels are in your best interest and make health care decisions for you that the surrogate believes that you would have made under the circumstances if you were capable of making such decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate persons to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

## **Assignment of Benefits and Privacy Practices Acknowledgement**

\* HMO, PPO, Commercial Insurance, Healthsease and Medicaid

I request that payment of authorized benefits be made on my behalf to the rendering physicians for any services furnished to me. I agree to comply with the terms of my insurance coverage, including payment of my co-payment at the time services are rendered, payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\* Medicare insurance

I request that payment of authorized Medicare benefits be made on my behalf to the rendering physicians for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*All Patients:

I acknowledge receipt or offer to have a copy of the Notice of Privacy Rights and Practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**VALRICO MEDICAL CARE'S**

**MEDICATION REFILL POLICY**

**PATIENT NEEDS TO**

**CALL THE OFFICE**

**TO REQUEST**

**MEDICATION REFILLS**

**DO NOT**

**HAVE THE PHARMACY**

***FAX OR CALL***

**FOR YOUR REFILLS**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**ALL PATIENTS**

**AS A COURTESY**

**THE OFFICE REQUIRES**

**A**

**24 HOUR**

**NOTICE ON ALL CANCELLATION OF**

**APPOINTMENTS**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Valrico Medical Care

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143 N. Oakwood Avenue, Brandon, FL 33510-4629  
Office Phone: 813.685.4617 Fax: 813.685.7105

I authorize the named healthcare provider to release the information or records specified to upon requested in person or by mail to the address / fax number specified at the time of the request.

## Provider

## Patient Info

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Records to:

Patient Name:

Records from:

SSN:

DOB:

Phone / Fax:

- |  |  |
|--|--|
| <input type="checkbox"/> Admission of history and physical | <input type="checkbox"/> Consults      |
| <input type="checkbox"/> Office Notes                      | <input type="checkbox"/> Hospital      |
| <input type="checkbox"/> Lab Reports                       | <input type="checkbox"/> Medication    |
| <input type="checkbox"/> Radiology X-rays                  | <input type="checkbox"/> All the above |

This information to be released for the purpose of:

Continuation of care

Other: \_\_\_\_\_

This authorization will expire one year from the date of signature below. I understand that I can revoke this authorization at anytime by writing to the healthcare provider, but that revoking this authorization will not affect disclosure made or actions taken before the revocation is received. Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information. A copy of this authorization may be utilized with the same effectiveness as original.

Patient:

Date:

## PATIENT'S PERSONAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Your current medical problem:

\_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you had any of the following illness?

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	or Bladder		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart			Nervous		
disease	<input type="checkbox"/>	<input type="checkbox"/>	Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
High Blood			Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Lung			Migraine		
infections	<input type="checkbox"/>	<input type="checkbox"/>	headache	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

**Serious Injuries (Other than the above):**

List and give approximate dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Diagnostic X-Rays/Tests:** List and give approximate dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Operations:** List and indicate approximate year.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Immunizations:** Please give date.

Smallpox \_\_\_\_\_ Polio \_\_\_\_\_

Typhoid \_\_\_\_\_ Tetanus \_\_\_\_\_

Are you allergic to any medications: Yes  No

If yes, please list medications and the reaction you had to them:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Hospitalizations (other than operations):** List reasons and approximate dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY

NAME	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers / Sisters (Circle Sex)				
M    F				
M    F				
M    F				
M    F				
Husband / Wife				
Sons / Daughters (Circle Sex)				
M    F				
M    F				
M    F				
M    F				



**PERSONAL HABITS**

Check if you regularly smoke:

Cigarettes: Number per day \_\_\_\_\_ Pipe  Cigars

How long have you been smoking? \_\_\_\_\_ years

Check if you regularly drink:

Hard Liquor 1-3 oz. per day  Over 3 oz. per day

Beer 1 bottle per day  2 bottles  3 or more

Wine 1 glass per day  2 glasses  3 or more

Do you drink coffee? Yes  No  3 or more

Do you have difficulty sleeping?

Never  Often  Sometimes

Do you wake up very early in the morning without apparent Cause and find it difficult to fall asleep again?

Frequently  Occasionally  Rarely

**MEDICATIONS**

Check the following, if any, you are regularly taking:

Asthma or wheezing medication

Thyroid medicine

Aspirin, Bufferin, Anacin, Tylenol or similar products

Stomach or digestive medication

Blood pressure pills

Blood thinners or Coumadin

Weight reducing pills

Prednisone, steroids

Dilantin

Cough medicine

Water pills, diuretics

Digitalis or heart medicine

Antibiotics

Hormones or birth control pills

Phenobarbital or barbiturates

Insulin or diabetic pills

Vitamins

Iron or medications for blood

Laxatives

Sleeping pills or tranquilizers

Other drugs or injections (List below)

\_\_\_\_\_  
\_\_\_\_\_

**OCCUPATIONAL**

**Yes No**

Are you presently employed?

If yes, do you have more than one job?

Do you work more than 60 hours a week?

Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.?

Do you get along poorly with your fellow employees and / or your supervisor?

Are you retired?

If retired, have you had difficulty adjusting to retirement?

Are you unable to perform any work because of disability?

Are you dissatisfied with your present type of work?

**MARITAL / FAMILY**

Has there been a recent change in your marital status?

Are there any problems with your married life?

Do you have any sex problems?

If a widow or widower, have you had difficulty adjusting to your spouse's death?

Do you have any serious problems with your children?

Is your present home life causing unhappiness?

Have there been any deaths in your family or among close friends in the past year?

Does anyone in your family have a serious illness or disability?

Does anyone in your family have a drug or alcohol problem?

**SOCIAL HISTORY**

Have you recently lived or traveled outside the U.S.?

Did you complete high school education?

Did you attend and/or complete college?

Were you rejected from the Military Service?

Have you even been rejected for life or health insurance or had to pay an extra premium?

Do you eat less than three meals a day?

Do you have special food customs or restrictions?

Have you ever been treated for drinking problem?

Do you exercise less than three times a week?

Are you active in political, community or church activities?

Do you have a hobby or hobbies?

If yes, please identify below:

\_\_\_\_\_

## REVIEW OF SYSTEMS

	Yes	No		Yes	No
<b>A. General</b>			<b>F. Cardiovascular</b>		
Do you worry a lot about your health?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, tightness or pressure in the front or back of your chest?	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually feel tired or worn out?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, is it when walking fast, working Hard, or when excited?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel depressed a lot of the time?	<input type="checkbox"/>	<input type="checkbox"/>	Have you even been told that your Electrocardiogram was abnormal?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently noticed that heat or warm weather bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have swelling of your feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently been drinking more water or fluids?	<input type="checkbox"/>	<input type="checkbox"/>	Does your heart ever beat fast or irregularly?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any unusual weight gain or loss recently?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have cramps in the calf muscles when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Skin</b>			Do you ever awaken at night with severe difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed:			Do your fingers or toes ever get cold, become numb, get very white or bluish?	<input type="checkbox"/>	<input type="checkbox"/>
any change in the color of your skin?	<input type="checkbox"/>	<input type="checkbox"/>	<b>G. Gastrointestinal</b>		
any skin rashes or itching?	<input type="checkbox"/>	<input type="checkbox"/>	Have you recently had any change in your eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
unusual dry skin?	<input type="checkbox"/>	<input type="checkbox"/>	Are there any special foods that cause you to be upset or have stomach pains, nausea, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
any growth on your skin that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	Do you tend to burp a lot?	<input type="checkbox"/>	<input type="checkbox"/>
any sores or wounds that do not heal?	<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noted any trouble swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
any change in color or size of warts?	<input type="checkbox"/>	<input type="checkbox"/>	Are you bothered with constipation?	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Eyes</b>			Do you have frequent loose stools or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had:			Do you pass a lot of gas?	<input type="checkbox"/>	<input type="checkbox"/>
any pain in your eye?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	Do you ever wake up at night with feeling of fullness underneath your breast bone?	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever passed blood from your rectum?	<input type="checkbox"/>	<input type="checkbox"/>
halos around lights?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had black or tarry stools?	<input type="checkbox"/>	<input type="checkbox"/>
change in vision?	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any recent changes in your bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. ENT</b>			Do you take laxatives regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have:			Do you have frequent nausea and / or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
any trouble hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<b>H. Genitourinary</b>		
ringing or buzzing in your ears?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have:		
earaches or discharge from your ears?	<input type="checkbox"/>	<input type="checkbox"/>	anything wrong with your genitals?	<input type="checkbox"/>	<input type="checkbox"/>
a lot of nasal stuffiness?	<input type="checkbox"/>	<input type="checkbox"/>	burning or pain when you urinate?	<input type="checkbox"/>	<input type="checkbox"/>
drainage down the back of your throat?	<input type="checkbox"/>	<input type="checkbox"/>	to pass water frequently?	<input type="checkbox"/>	<input type="checkbox"/>
frequent or severe nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	to pass more water than you used to?	<input type="checkbox"/>	<input type="checkbox"/>
persistent hoarseness?	<input type="checkbox"/>	<input type="checkbox"/>	trouble passing water?	<input type="checkbox"/>	<input type="checkbox"/>
a lump in your throat?	<input type="checkbox"/>	<input type="checkbox"/>	ever blood in your urine?	<input type="checkbox"/>	<input type="checkbox"/>
a sore tongue or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	trouble with loosing urine when you cough or sneeze?	<input type="checkbox"/>	<input type="checkbox"/>
bleeding gums?	<input type="checkbox"/>	<input type="checkbox"/>	a problem dribbling urine?	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Respiratory</b>					
Do you have:					
frequent chest colds?	<input type="checkbox"/>	<input type="checkbox"/>			
a constant or bothersome cough?	<input type="checkbox"/>	<input type="checkbox"/>			
coughing of blood	<input type="checkbox"/>	<input type="checkbox"/>			
sputum or phlegm between colds?	<input type="checkbox"/>	<input type="checkbox"/>			
difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you noticed any wheezing or whistling in your chest?	<input type="checkbox"/>	<input type="checkbox"/>			

- I. Musculoskeletal**
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Do you have a problem with back pain?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have pain in your legs or feet?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Does back pain interfere with your work or activities?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have joint pain or stiffness?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble walking or using your hip or knee joints? | <input type="checkbox"/> | <input type="checkbox"/> |

- J. Central Nervous System**
- |  |                          |                          |
|--|--------------------------|--------------------------|
| Do you have frequent or severe headaches?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you often have spells or dizziness or faintness or lightheadedness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever seen double?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you sometimes lose track of what happens around you for a short time? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you sometimes lose the ability to speak for a few seconds?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you recently fainted, blacked out or lost consciousness?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble remembering recent events?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had convulsions or fits?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have numbness or tingling in your head, arms or legs?             | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you consider yourself a nervous person?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you cry a lot for no reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever thought about committing suicide?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever hear voices or see people when no one is around?             | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever have a feeling that someone is trying to harm you?           | <input type="checkbox"/> | <input type="checkbox"/> |

- H. Genitourinary (cont.)**
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation?) | <input type="checkbox"/> | <input type="checkbox"/> |
| Men, do you have prostate gland trouble?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have to get up at night to urinate?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many times? _____   |                          |                          |

- K. Women only**
- |  |                          |                          |
|--|--------------------------|--------------------------|
| Did your menstrual periods start before you were 10?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your menstrual periods start after you were 15?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your menstrual periods irregular?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your periods less frequent than every four weeks?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your periods more frequent than every four weeks?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use more than 10 pads or have to use a super size pad or tampon for your periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you pass clots with your periods?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you become bloated or gain weight just before your periods?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you passed menopause or change? If yes, at what age? _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have hot flashes?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any lumps in your breasts?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any discharge from your nipples?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever used an intrauterine device (IUD)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you used other birth control measures?  | <input type="checkbox"/> | <input type="checkbox"/> |
| How many pregnancies did you have? _____   |                          |                          |
| How many live births did you have? _____   |                          |                          |
| Did you have any abortions or miscarriages?  | <input type="checkbox"/> | <input type="checkbox"/> |

**ADDITIONAL COMMENTS**

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