Family Practice of Suntree and Viera, P.A.

Frank G. Ditz, M.D.
2 Suntree Place Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

Patient demographic information

DATE: _____

LAST NAME: _____ FIRST: _____ MI: _____

DOB: _____/_____/_____ SOC SECURITY #: _____-_____-_____ SEX: MALE / FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: HOME: _____ CELL: _____
Number you prefer for us to contact you: _____ Home or _____ Cell

EMAIL: _____

ETHNICITY/RACE:
____ Caucasian
____ African American
____ Hispanic/Latino
____ Asian
____ Native American
____ Pacific Islander
____ Middle Easterner
____ Other

RETIRED / DISABLED / EMPLOYED: EMPLOYER: _____

OCCUPATION: _____ MARITAL STATUS: S / M / D / W / OTHER

EMERGENCY CONTACT: _____RELATION: _____ PHONE: _____

EMERGENCY CONTACT: _____RELATION: _____ PHONE: _____

PREFERRED PHARMACY(S): _____ CITY/PHONE: _____

PREFERRED PHARMACY(S): _____ CITY/PHONE: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Insurance Authorization/Financial Responsibility and patient notice

I hearby authorize payment directly to Family Practice of Suntree and Viera, P.A for services rendered and remain in effect until revoked in writing. I understand that my insurance policy is a contact between myself and my insurance provider and I agree to be financially responsible for non-covered services. I understand that I am ultimately responsible for ALL charges whether or not covered by my insurance company or policy and any co-payments, co-insurance or deductibles amounts not covered by my insurance is my financial responsibility. My insurance claim is billed by Family Practice of Suntree and Viera, P.A. as a courtesy and any of my financial responsibility is **due at the time of service.**

I understand that it is my responsibility to know and understand my benefits, coverage, participating labs, hospitals, diagnostic centers and pharmacies. I hereby authorize Family Practice of Suntree and Viera, P.A to release any information/medical records regarding my treatment to my insurance company to secure payment for services rendered. I have provided current and accurate information.

Signature: _____ Date: _____
(Patient, parent or legal guardian if minor)
Relationship to patient if signed by personal representative: _____

Family Practice of Suntree and Viera, P.A.

Frank G. Ditz, M.D
2 Suntree Place Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

HIPPA PRIVACY PRACTICES AND AUTHORIZATION FOR DISCLOSURE

I, _____ have been
(Please Print)

provided access to a copy of **Family Practice of Suntree and Viera, PA** for review. I give authorization and consent for the physician and staff of Family Practice of Suntree and Viera, PA to:

A. Discuss my medical conditions, health care;
B. Pick up prescriptions, medical procedure orders or x-rays;
C. Payment/insurance information ;
D. All of the above

with the following family members or friends. **Write N/A on 1st line if you not choose any person**

****PLEASE PICK A, B, C or D****

FULL NAME	**RELATION**	**A,B,C, or D**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further understand this authorization will remain in effect unless terminated with a personal dated signature.
My signature below indicates that I have read and agree to abide by the terms of this agreement.

_____ _____
Signature of patient or responsible party if minor Date

_____ _____
Signature of office staff/witness Date

Insurance and Payment Responsibility

I also authorize the release of information/medical records regarding my treatment and medical conditions to my insurance company to help secure payment for services rendered and to my health care providers. I understand that any **CO-PAYMENTS, CO-INSURANCE** and/or **DEDUCTIBLE** not covered by insurance will be due at the time of service. If no insurance provided, I am responsible for full payment for treatment.

_____ _____
Signature of patient or responsible party if minor Date

Family Practice of Suntree and Viera, P.A.
Frank G. Ditz, M.D
2 Suntree Place Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

CONTROLLED MEDICATION POLICY

_____ _____
Print Name Date of Birth

Prescription history is required and requested with our electronic medical records. The history is pulled from outside pharmacies, healthcare and/or insurance plans and the State of Florida prescription drug monitoring program. If you are taking a controlled medication, you have agreed to receive the treatment for this chronic ailment and you will be provided with enough medication on a monthly basis. Controlled medications cannot be "**called in**" and require a monthly scheduled appointment for refills. The state of Florida changed the rules and laws pertaining to controlled medications to prevent "Pill Mills", **Florida Rule 64B8-9.013**

By signing below, you acknowledge and agree that:

(1) I have read and fully understand the Physician/Patient Informed Consent and Agreement for long-term controlled medication therapy for treatment;

(2) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits;

(3) I knowingly accept and agree to assume the risks of the proposed treatment as presented;

(4) I agree to submit to scheduled or random urine and/or blood testing to monitor the levels of my medication or other drugs in my system. I also understand that other doctors and law enforcement may be notified of these results.

(5) The controlled medication prescribed to me may be discontinued immediately and I may be discharged from the practice for: **A.** my prescribed medication not being identified or traced in my testing, **B.** medication abuse, and/or obtaining and using **C.** street drugs that will be checked in my urine and/or blood testing.

(6) If/After testing positive for non-prescribed medications, testing negative for my prescribed medications or positive for street drugs by urine, I will have **(1) One** opportunity to go to an outside laboratory (Quest, Labcorp, Wuesthoff,etc) within 24 hours to obtain a blood/urine drug test to confirm or deny drug abuse. If the test is positive for abuse, we reserve the right to you discharge you from the practice immediately or continue to treat you for medical/health maintenance or sick visits. Controlled medications will no longer be prescribed.

(7) I agree to abide by the terms of this agreement.

_____ _____

Signature of patient or responsible party if minor Date

Office Staff Witness Signature Date

Family Practice of Suntree and Viera, P.A.
Frank G. Ditz, M.D
2 Suntree Place Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

APPOINTMENT and CANCELLATION POLICY

Appointments are reserved especially for you. The **Physician Assistant** makes every effort to schedule times that accommodate your needs. Any changes in the schedule greatly affect our patients and maybe preventing another patient from getting the much needed medical treatment. Because we want to offer appointments to all of our patients who need them, patients that fail to provide **24 hours' notice** before canceling their appointment, you will be charged a fee of **$25.00 that is not covered by your insurance.** If you are over 15 minutes late for your scheduled appointment, we will have to reschedule your appointment.

My signature below indicates that I have read and agree to abide by the terms of this agreement.

Signature of patient or responsible party if minor Date

MEDICATION POLICY

Family Practice of Suntree and Viera request 24 hours notice for **ALL** prescription refills and any refill request is subject to the provider's approval. Under **NO** circumstances will prescriptions be refilled on weekends and/or holidays and will be filled the next business day.

** **Prescription history is required** and requested with our electronic medical records. The history is pulled from outside pharmacies, healthcare and/or insurance plans and the State of Florida prescription drug monitoring program.
If you are taking a controlled medication, you have agreed to receive the treatment for this chronic ailment and you will be provided with enough medication on a monthly basis. Controlled medications cannot be "called in" and require a scheduled appointment for refills. By signing below, you acknowledge and agree that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for long-term controlled medication therapy for treatment; (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement.

Signature of patient or responsible party if minor Date

Family Practice of Suntree and Viera, P.A.

Health History Questionnaire

NAME: _____ **D.O.B.** _____ **DATE:** _____

Medical History:

Please list all **P** for Past and **C** for current medical problems.

___ Anemia
___ Anxiety
___ Asthma
___ Blood transfusion
___ Enlarged Prostate
___ Borderline diabetic
___ Coronary Artery disease
___ Cataracts
___ Congestive heart failure
___ Neuropathy
___ Atrial Fib/Arrhythmia
___ Cancer: type _____

___ COPD
___ CVA/Stroke
___ Depression
___ Emphysema
___ Gallstones
___ Glaucoma
___ Gout
___ Heart disease
___ Heart attack
___ Shortness of breath
___ Blood clot/DVT

___ Liver Disorders (Hepatitis)
___ Hypothyroid
___ HIV
___ High cholesterol
___ High blood pressure
___ Kidney stones
___ Leukemia
___ Migraine headaches
___ Diabetes:non-insulin dependent
___ Diabetes: insulin dependent
___ Reflux/GERD
___ Diverticulosis

___ Arthritis
___ Osteoporosis
___ Stomach ulcers
___ Pneumonia
___ Kidney failure
___ Seizure disorder
___ Memory loss
___ Thyroid disorder
___ Low testosterone
___ Tobacco abuse
___ Back pain
___ Dizziness

Allergies: _____

Previous Surgeries:	**Year**	**Hospitalizations/Reason:**	**Year**
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Family History:

Father: Living / Deceased DOB: _____ History: _____

Mother: Living / Deceased DOB: _____ History: _____

Any one in your family with a history of high blood pressure, diabetes, heart disease, stroke, seizures or Cancer? (example:sister/high blood pressure, mother/stroke, maternal grandma/cancer) _____

_____

_____

Social History:

Alcohol:

Do you drink alcohol? Yes or No

Drinks per day:

Beer _____ Wine _____ Hard Liquor _____

Occupation: _____

Smoking or Tobacco Use:

Have you ever smoked? Yes or No

Are you still smoking? Yes or No

Packs per day _____

How many years? _____

Quit in what year? _____

Year of last tetanus shot? _____ Last Flu shot? _____ Last pneumonia shot? _____

Review of systems: Please check off any recent or new problems that apply to your health

General Health:
___ Fatigue
___ Poor appetite
___ Fevers or chills
___ night sweats

Head & Neck
___ Headaches
___ Dizziness
___ Lightheaded
___ Trauma
___ Blacking out

Ear, Nose & Throat
___ eye pain
___ blurred/double vision
___ sore throat
___ sinus/throat pain
___ hearing loss
___ ringing in ears
___ excess ear wax

Skin
___ rash
___ lesions/sores
___ easy bruising
___ dry skin

Endocrine/Hormones
___ hot flashes
___ hair loss
___ sexual dysfunction
___ heat/cold intolerance

Cardiac/Heart
___ chest pain
___ shortness of breath
___ palpitations
___ fatigue w/exercise
___ general swelling

Pulmonary/Lungs
___ shortness of breath
___ cough
___ wheezing
___ bloody sputum

Digestive/Abdomen
___ heartburn
___ nausea/vomiting
___ diarrhea
___ constipation
___ bloody stools
___ black tarry stools
___ abdominal pain

Urinary/Genital
___ painful urination
___ blood in urine
___ discharge or lesion
___ urinary frequency
___ incontinence
___ STD exposure

Joints/Muscle
___ back pain
___ joint pain
___ muscle pain
___ swelling/edema
___ muscle spasms
___ numbness/tingling

Neurological
___ neuropathy
___ loss of consciousness
___ seizures
___ muscle weakness
___ dizziness
___ focal deficits
___ loss of balance
___ slurred speech

Medications: Please list all medications, vitamins and supplements that you are currently taking.

Name:	**Dose (mg)**	**Reason for taking**

Women only:
Last Menstrual Period: _____ Might you be pregnant? Yes____ No____ Unsure____
Contraceptive Method: None___ Pills ___ Condoms ___ Surgical ___ Menopause ___ Other ___
Number of times pregnant: _____ # of Deliveries: _____ # of Children _____
Last Pap Smear: _____ Performed by Dr: _____ Results: _____

Prior abnormal Pap? Yes / No When? _____
Action taken for abnormal pap? Repeat exam _____ Cryotherapy _____ Cone _____ LEEP _____ Other
Last Mammo:_____ Results: _____ Last bone density: _____ Results: _____

Family Practice of Suntree and Viera, P.A.

Frank G. Ditz, MD
2 Suntree Place, Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

Social Security #:_____ TELEPHONE #: _____

Purpose of Release: __PCP Follow-up Care / Relocation_____

****

I hereby authorize **Family Practice of Suntree and Viera PA**, to (**XXX**) Obtain From:

_____ (___) Specialist or (___) Former PCP
NAME OF PHYSICIAN OR FACILTY

_____ PHONE: _____
ADDRESS

_____
CITY, STATE, ZIP

_____
FAX

Any information, including diagnosis, lab results, x-rays results, EKG's, treatment and/or any other testing rendered to me during the following period.

(___) Most recent office note and test results

I understand this is to include or disclosure of my individually, identifiable health information. And to include any Federal or stated protected information under Florida Statute 394.459, Psychiatric information, Florida stature 397.501 and FAC I0D-93.064 Humane Immunodeficiency Virus test results (HIV testing, AIDS and/or related conditions).

- I understand and direct that this authorization remains in effect until I revoke the authorization in writing, except to the extent that the action has already been taken.
- I understand that the information used or disclosed is pursuant to the authorization maybe subject to re-disclosure by the recipient and no longer be protected by HIPPA.
- I hereby release Family Practice of Suntree and Viera PA and the employees from any and all liability that may arise from the release of this information as I have directed.
- I understand that there is a fee associated with copying of my medical records and agree to pay said charges as provisioned by Florida statue 458.309

Signature: _____ Date: _____
(Patient, parent or legal guardian if minor)
Relationship to patient if signed by personal representative: _____

Witness: _____ Date: _____
(Staff signature)

Name _____ Birthdate_____ Doctor _____ Today's Date _____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ❒ Yes ❒ No

Little interest or pleasure in doing things? ❒ Yes ❒ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, how often have you been bothered by of the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

For Office Use Only: Total Score

Activities of daily living (ADL) Questions CPT:1170

	Independent	Needs Help	Dependent	Does not do
Bathing				
Dressing				
Grooming				
Transferring				
Shopping				
Cooking				
Managing Medications				
Driving				
Managing finances				
Housework				

Fall Risk and Balance Assessment: 0518F. 1100F-fall w/injury 1yr, 1101F-no falls, 3288F

Circle the answer for each question

1. Have you fallen in the past year? No Yes
2. Do you feel weaker than you used to or less strength in your arms or legs? No Yes
3. Have you stopped doing daily activities because you are afraid of falling? No Yes
4. Do you feel unsteady, stagger or shuffle when you walk? No Yes
5. Do you get dizzy, faint or have seizures? No Yes
6. Have you had a recent loss or decrease in your vision? No Yes
7. Do you have numbness or tingling in your legs or feet? No Yes

8. Have you experienced hearing loss? No Yes

9. Do you experience any incontinence? No Yes

Do you have any occasional memory loss or forgetfulness? No Yes

Have you had a colon cancer screening? No Yes-when:_____

Have you had your yearly glaucoma screening? No Yes-when:_____

Have you had an EKG or Chest x-ray in the last year? No Yes-when:_____

Family Practice of Suntree and Viera, P.A.

Frank G. Ditz, M.D
2 Suntree Place Melbourne, FL 32940
Phone (321)253-3944, Fax (321)253-4990

DR. DITZ APPOINTMENT and CANCELLATION POLICY

Appointments with **Dr. Ditz in his concierge practice** are reserved especially for you and are for a minimum of 45 minutes long. Dr. Ditz makes every effort to schedule times that accommodate your needs. Any changes in the schedule greatly affect our patients and may be preventing another patient from getting their much-needed medical treatment. Because we want to offer appointments to all of our patients who need them, patients that have an appointment with **Dr. Ditz** and fail to provide a **24 hours' notice** before canceling their appointment or "No Showing" with **Dr. Ditz** , you will be charged a fee of **$214.00 that is not covered by your insurance for appointments in his concierge practice.** If you are over 15 minutes late for your scheduled appointment, we will have to reschedule your appointment.

My signature below indicates that I have read and agree to abide by the terms of this agreement.

_____ _____

Signature of patient or responsible party if minor Date

Print Name

Staff Witness

Health Assessment for Men

Name: Date:

Mail:

SYMPTOMS (Please Check Box)	Never	Mild	Moderate	Severe
1) Fatigue	☐	☐	☐	☐
2) Mood Changes: Irritability Anxiety / Nervousness Depression	☐	☐	☐	☐
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus	☐	☐	☐	☐
4) Excessive Sweating	☐	☐	☐	☐
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight	☐	☐	☐	☐
6) Decreased Sex Drive: No Morning Erections	☐	☐	☐	☐
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep	☐	☐	☐	☐
8) Decreased Muscle Strength	☐	☐	☐	☐
9) Hair loss / Breakage	☐	☐	☐	☐
10) Joint Pain / Muscle Aches	☐	☐	☐	☐

FAMILY HISTORY (Please Check Box)	No	Yes
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Prostate Cancer	☐	☐

Health Assessment for Women

Name: Date:

Mail:

SYMPTOMS (Please Check Box)	Never	Mild	Moderate	Severe
1) Fatigue				
2) Mood Changes: Irritability Anxiety / Nervousness Depression				
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus				
4) Hot Flashes / Night Sweats				
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight				
6) Decreased Sex Drive: Vaginal Dryness				
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep				
8) Cold Hands & Feet / Always Cold				
9) Hair loss / Breakage				
10) Dry Wrinkled Skin				

FAMILY HISTORY (Please Check Box)	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		