FamilyMedicalDoctors

5234 Little Road
New Port Richey, FL 34655
727-807-6900 Fax: 727-807-6901

Patient_____
Last Name First Name Middle Initial

DOB _____ Social Security #_____

Address _____

City _____ State _____ Zip _____

Phone # _____Cell# _____Work#_____

Email Address_____

Marital Status _____ Do you live alone: YES NO

Emergency Contact (not living with you) _____ Phone # _____
Name

Pharmacy Name _____ Phone # _____
Mail Away Pharmacy _____ Phone # _____

Please provide the receptionist with your current insurance card(s), and photo ID.

Please list which phone(s) number we can leave messages at:
_____

Any additional information you would like to provide.

_____

_____

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by Family Medical Doctors, Bharat Desai, M.D., Nilesh Desai, M.D., Yamitza Cordero-Ferrer,M.D. deemed advisable and necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination in the office.

Signature _____ Date_____

AUTHORIZATION AND ASSIGNMENT

I authorize that payment of Authorized Medicare/Insurance Benefits be made directly to Family Medical Doctors for any services furnished by Bharat Desai, M.D. and or Nilesh Desai, M.D., and or Yamitza Cordero-Ferrer, M.D. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize Family Medical Doctors, Bharat Desai, M.D. and or Nilesh Desai, M.D., and or Yamitza Cordero-Ferrer, M.D. to furnish information to medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payment directly to Family Medical Doctors, Bharat Desai, M.D. and or Nilesh Desai, M.D. and or Yamitza Cordero-Ferrer, M.D. for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of any insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to the collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.
I certify that the information I have given is true and correct to the best of my knowledge. I will also notify you of any change in my status or changes in the above information.

Signature _____ Date _____

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations, and in case of emergency) with following family members or significant others.

Name_____Relationship_____Phone#_____

name_____Relationship_____Phone#_____

PRIVACY NOTICE

I have received a copy of Family Medical Doctors, Bharat Desai, M.D. and Nilesh Desai, M.D. and Yamitza Cordero-Ferrer,M.D office privacy notice as required by HIPAA.

Signature _____Date_____

Patient Name (print) _____

FamilyMedicalDoctors

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date _____

Patient Name _____**Age**_____**Sex**_____

Ethnicity _____**Language** _____**Race**_____
Chief Complaints _____

Past History (have you ever had or do you currently have) **Please circle below:**

Asthma	Enlarged Heart	Bipolar
Bronchitis	Diabetes	Anxiety
COPD/Emphysema	Thyroid Problems	Depression
Pneumonia	Osteoporosis	Glaucoma
Tuberculosis	Peptic Ulcer	Cataracts
Sleep Apnea	Acid Reflux/GERD	Stroke
High Blood Pressure	Liver Problems/Hepatitis	Mini Stroke
Heart Attack	Gallstones	Seizure/Epilepsy
Congestive Heart Failure	Diverticulitis	Enlarged Prostate
Atrial Fibrillation	C. Diff Diarrhea	Hay Fever/Allergies
High Cholesterol	Osteoarthritis	HIV/AIDS
Pacemaker/AICD	Rheumatoid Arthritis	Cancer: _____
Kidney Problems	Gout	Bleeding Disorders
Varicose Veins	Lupus	Anemia

Any prior surgeries

_____

_____

Any prior hospitalizations

_____

_____

Allergies to medications

_____

_____

Are you currently suffering from: (please circle)

GASTROINTESTINAL
Indigestion/Heartburn
Ulcer
Nausea/Vomiting
Stomach Pain
Poor Appetite
Vomiting Blood
Bleeding From Rectum
Constipation
Hemorrhoids
Jaundice
Difficulty Swallowing

GENITOURINARY

Difficult Urination
Poor Stream/Dribbling
Increased Frequency of Urination
Burning/Pain on Urination
Blood in Urine

FEMALE
Breast Lump/Surgery
Discharge from Nipple
Hormone Treatment
Hot Flashes
Vaginal Bleeding

MALE
Penile Discharge
Scrotal Swelling/Pain

ENDOCRINE

Excessive Thirst
Dry mouth

RESPIRATORY

Daily Phlegm
Color of Phlegm _____
Persistent Cough

NEUROLOGY
Headaches
Dizziness/Lightheaded
Syncope/Passing Out
Tingling/Numbness

PSYCHIATRIC

Nervousness/Anxiety
Suicidal
Mood Swings

MUSCULOSKELETAL

Back Pain
Loss of Height
Joint Pain

HEMATOLOGY/ONCOLOGY

Excessive Bleeding
Skin Bruising

SKIN

Itching
Rash/Hives
Psoriasis

FAMILY HISTORY

RELATION
Tuberculosis _____
Asthma_____

Shortness of Breath
Wheezing
Coughing up Blood
Blood clot in legs
Blood clot in lung
Loud Snoring
Excessive Daytime Sleepiness
Fatigue
On Home Oxygen

CARDIOVASCULAR

High Blood Pressure
Chest Pain
Swollen Feet
Leg Pain
Leg Cramps
Heart Murmur
Palpitations

EYE

Eye pain
Double Vision
Macular Degeneration

EAR/NOSE/THROAT

Nasal Congestion
Stuffiness
Nasal Polyps
Sinus Problems
Post Nasal Drip
Hoarseness
Ear Pain
Ear Ringing
Deafness

Emphysema_____
Bronchitis_____
Cancer_____
Leukemia_____
Hypertention_____
Stroke_____
Heart Disease_____

Father: Alive Deceased Age_____
Cause of Death_____

Mother: Alive Deceased Age_____
Cause of Death_____

Siblings: How many Brothers:_____
How many Sisters: _____

Children: How many Sons: _____
How many Daughters: _____

SMOKING HISTORY
Current or Quit Total years smoked_____
How many packs a day _____
If Quit, When: _____

ALCOHOL
Current or Past Alcoholic: Yes or No
How much a day_____

PETS
Yes or No Kind & Amount_____
_____

OCCUPATION
Retired or Working

CHEMICAL EXPOSURE

Asbestos: Yes No Other:_____

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Date of last eye exam _____
Doctor _____
Place_____

Date of last colonoscopy _____
Doctor _____
Place _____

Date of last mammogram _____
Place _____

Any additional information that you think might be helpful to the doctor in your care:

_____
_____
_____
_____

PATIENT CONSENT FORM FOR OPIOID AND/OR CONTROLLED SUBSTANCE USE

I, _____, agree to the following conditions regarding opioid and/or controlled substance use:

1) I understand that if I am taking opioids, I have a chronic pain problem that requires the prescription of an opioid pain medication for pain relief and to improve my functional ability. I am aware that the risks include, but are not limited to, drug dependency, addiction, respiratory depression, liver and/or kidney damage, death, ect. The physician has discussed the risks, benefits and alternatives of medications with me prior to treatment.

2) I will obtain prescriptions for opioid and other controlled medication(s) from only ONE physician, i.e. Family Medical Doctors as long as my treating physician believes that it is appropriate to use indicated therapy.

3) I will have my prescriptions filled at only ONE pharmacy and will notify my treating physician of the name of that pharmacy.

4) I give Dr. Bharat Desai and Dr. Nilesh Desai permission to contact other physicians and pharmacies to confirm compliance.

5) I am not currently using any illegal street drug(s) and will NOT do so while being treated at this facility. Failure to comply with this rule could be cause for my immediate termination from this practice.

6) I will take the medication only as prescribed. I agree to **random urine and or blood tests** to assess my compliance, and to make sure there is no illegal drug use.

7) Lost, stolen or misplaced opioids or other controlled substances **WILL NOT BE REPLACED**. Refills will NOT be given early for any reason. PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS OR EVENINGS. **No** narcotics can be given over the telephone. If the prescription or the medication(s) are lost or stolen, a police report will be required for replacement.

8) I understand that even though I might have been prescribed narcotics by another physician prior to establishing with Family Medical Doctors, that does **NOT** mean that I will continue on them. The doctors will assess the need for continued use of narcotics or other controlled substances and discuss the ultimate goal of weaning off of them.

9) I understand that any display of irresponsible, erratic or irrational behavior regarding the use of narcotics or demanding behavior will **NOT** be tolerated. This includes the overuse and abuse of these medications.

10) If narcotics and/or other controlled substances are not tolerated by the patient, the bottle with all unused tablets/pills/capsules must be brought back to our office for proper disposal.

11) When refills are due, empty bottles must be brought into our office to exchange for a refill prescription. This is mandatory and a refill prescription will not be given unless the bottle is presented. Refill prescriptions will only be filled for 1 month at a time. No exceptions.

12) I understand that the eventual goal is to taper off the narcotic medication(s) as tolerated. I agree to meet regularly with my physician to assess my progress

13) If the medication(s) loses its effectiveness in increasing my functional ability, I understand that the physician may taper off or discontinue the narcotic.

14) A psychological evaluation regarding addiction and drug dependency may be necessary at any time the treating physician sees fit.

15) If I deviate from the above guidelines in any way, my treating physician has the right to terminate me from their practice.

My signature at the bottom of this page indicates my understanding and agreement with the above guidelines.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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New Port Richey, FL 34655
727-807-6900 Fax: 727-807-6901

RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB_____
(please print)

SS# _____-_____-_____

I hereby authorize_____

To release my medical information to (address listed above)

Family Medical Doctors, LLC.
Bharat Desai, M.D.
Nilesh Desai, M.D.
Yamitza Cordero-Ferrer, M.D.

These records are to be used for continuing care of the patient above.

Acknowledgement of understanding

* I understand the expiration date of this authorization is one year from the date of signature.
* I understand that I may revoke this authorization at any time, by notifying us in writing.
* I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
* I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
* I understand that Family Medical Doctors may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
* I understand a photocopy or fax of this form is the same as the original.

_____ Date _____
Signature of patient, or guardian/representative

For PCP physicians: Last 3 visits, EKG,ECHO,CXR,MAMMO,LABS,IMMUNIZATIONS,COLONOSCOPY
Specialist: Last 3 visits

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your healthcare provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests. A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct. A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider

A patient is responsible for reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Family Medical Doctors

We would like to thank you for choosing us as your medical provider. Written below is a list of our current office policies and procedures.

Office Hours: Our office is open Monday - Friday, 8:00am - 5:00 pm. There are times when we will be closed for lunch, so it's best to call ahead if you plan on coming by at that time.

Appointments: We see patients by appointment only. Same day appointments are usually available for urgent or sudden illness. Our doctors ***require you to bring all medications*** *you are currently taking, in their bottles to every appointment. Please also include a list of any over the counter medications and/or vitamins/supplements you are taking.*

Cancellations & No-Show: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to offer that time slot to another patient. If you do not call, or show up, there is a fee of $25.00, which will be collected before your next appointment.

Walk outs: For any reason other than an emergency, will still be charged to you, (not your insurance), this will be considered "an abandoned appointment" a fee of $50 will be charged to you at that time.

Running on time: We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 15 minutes so we can double check to see if you have been properly checked in. Remember that we are running several different schedules. If someone who arrived after you is called before you, they might be seeing a different provider.

Lab work: We are able to do certain "point of care" lab testing in the office including… glucose (fbs), urinalysis (ua) and protime (inr). Most of the time we will give you a lab slip to take to an outside lab, i.e., Quest, Labcorp, Vista, Granite, or another lab of preference. There will also be times where blood will need to be drawn at the time of your appointment depending on the problem being worked up.

Complete physical exams: We believe that routine, annual wellness visits, and complete physical exams with screening lab tests are very important to maintain good health. Some insurance benefits will vary. Some policies cover "wellness" and others cover visits only when you have a complaint. Please learn about your benefits prior to your appointment so you will know what will be covered by your insurance and what needs to be covered by you.

Test results:: If you have diagnostic testing, ie., lab, x-ray, echo, ultrasound, sleep study, please make sure you schedule a follow-up appointment within 7-10 days to go over the results with your physician.

Prescriptions and Refills: Get all prescription refills at your appointment. If you need to call for refills, understand that you should not wait until you run out of your prescription. All prescriptions need doctors approval. If you call in the morning for your prescription, it will not be done until that afternoon due to the time needed for it to be approved. We have no control of how long it takes your pharmacy to fill your prescription, this is between you and the pharmacy.

Narcotics: You must sign a contract outlining your requirements in order to receive any narcotics from us. All prescriptions of this kind have to be written and handed to the patient. If you are not able to pick up the prescription, please let our office staff know who will be picking up the prescription for you as they will need to provide identification.

Samples: The doctors sometimes provide samples so that you may try out a medication before you purchase it. Please keep in mind that this is just a sample and you will have to pay for said medication if you and the doctor agree that such medication will work for you. Please do not rely on samples for long term usage.

Referrals: Some insurances require referrals/authorizations to see other physicians or to have other tests. Please make sure you know the rules of your insurance company before your first visit, so there are no surprises. It is your responsibility to ensure the specialist you are going to see is on your insurance plan. Referrals/authorizations do take time, so if you need one for any reason, please give advance notice of at least one week before your appointment. Please do not expect it to be done the same day.

FMLA, Parking Permits, Insurance forms, etc: There will be a charge of $25.00 for the completion of medical forms. Payment is due at the time of pick up. Please allow 7-10 days for completion. Parking permits are $10.00, same rules apply.

Medical Records: You will need to sign a medical release form for us to send you records anywhere.

Return checks: There will be a charge of $30.00 for any returned checks.

Insurance: We are contracted with several insurance companies. It is your responsibility to make sure that our physician is on your plan. It is also your responsibility to know your insurance benefits. As a courtesy to all our patients we do file all insurances for you. You need to notify us of any changes to your insurance policy/policies. We will also need a copy of any new cards issued to you for our files.

Payments: We accept cash, checks and all major credit/debit cards. Copays and deductibles are due at the time of service. If you are unable to pay your bill in full, please ask to talk to our billing staff to arrange a payment plan.

*Service Animals: Only **dogs**, and no other kind of animal, are considered service animals under the 2008 Americans with Disabilities Amendment Act (ADAA). The ADA requires that the disabled individual maintains control and responsibility for the animal. The dog can be ejected if its master does not have control and has demonstrated that by being unable to restrain it from barking or interfering with other patients. The dog **must** be housebroken. If another patient is allergic we will make reasonable accommodations.*

Acknowledgement

I acknowledge that I have read and received a copy of the Family Medical Doctors Office policies.

_____

Signature/Patient or Guardian *Date*

FamilyMedicalDoctors

Patient Feedback

How did you hear about us:_____

Was it hard to find us:_____

Was the staff on the phone helpful and nice:_____

Were you able to get an appointment when you wanted: _____

Was the receptionist friendly:_____

Was the office clean and inviting:_____

Do you have any suggestions:_____