MY Central Primary Care
Dr. Nasser Moukaddem M.D. & Dr. Marina Barkov M.D.
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Phone (727) 321-3915 Fax (727) 328-0975

NEW PATIENT PACKET

Dear Patient,

Thank you for choosing My Central Primary Care as your primary care facility. Our physicians and staff look forward to giving you the best medical care possible. Please fill out the following as detailed as possible so we can better assist with your medical needs.

Enclosed in this packet you will find:

- Patient Information Form
- History And Physical Form
- Patient Authorization Form
- Patient Agreement For Opioid Use
- HIPAA Privacy Authorization For Use And Disclosure Of Personal Health Information
- Financial Policy
- Designation Of Health Care Surrogate Form (OPTIONAL)

Please fill out these forms and bring them to your appointment with you. Please remember to inform the office staff immediately of any changes to information provided here.

We look forward to seeing you soon at our office, where we provide care you can count on.

Sincerely,

Physicians and Staff.

PATIENT INFORMATION

Demographics

Last Name: _____ First Name: _____ Middle Initial: _____

Street addresses: _____

City: _____ State: _____ Zip Code: _____

Home Phone : _____ Work Phone: _____ Cell Phone : _____

Sex: ☐Male ☐Female Date of Birth: _____ Social Security : _____

Driver License : _____ Email Address: _____

Race: _____ Primary Language Spoken: _____ Employed : ☐Yes ☐No

Employer: _____ Occupation: _____

Employer Address: _____ City : _____ State: _____ Zip: _____

Marital Status : S☐ M☐ D☐ W☐ Spouse Name: _____

Children: ☐Yes ☐No How Many? _____ Ages: _____

In Case of Emergency Notify: _____ Relationship: _____ Phone : _____

Insurance Information

Person Responsible for Payment: _____ Relationship to Subscriber: _____

Insurance Company: _____ Subscriber Name: _____

Group #: _____ ID#: _____

Insurance Address: _____ Insurance Phone : _____

Medical Information

Today's Chief Complaint: _____ Date symptoms appeared: _____

Have you ever had a blood transfusion: ☐Yes ☐No When and Why: _____

Do you have advanced directives (Living Will, Health Care Surrogate, etc.): ☐Yes ☐No

If not, would you like to discuss this with the physician: ☐Yes ☐No

Pharmacy Information

Pharmacy Name ☐ CVS ☐ Publix ☐ Target

☐ Walgreens ☐ Sweet Bay ☐ Wal-Mart ☐ _____

Pharmacy Address _____

HISTORY AND PHYSICAL *1 of 2*

Patients Name : _____ Date of Birth: _____

CURRENT MEDICATIONS

	Drug Name	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

DRUG ALLERGIES

	Medication	Reaction
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PROCEDURE HISTORY

	Procedure	Date of Last Procedure
1.	*Mammogram*	
2.	*Pap Smear*	
3.	*DEXA-Scan*	
4.	*Colonoscopy*	
5.		

PREVIOUS HOSPITALIZATION

Reason	Date

PREVIOUS SURGERY

Reason	Date

PROVIDER HISTORY

	Name	Phone Number
Previous Primary Care Physician:		

Specialists

	Type	*Name*	*Phone Number*
1.			
2.			
3.			
4.			
5.			

HISTORY AND PHYSICAL *2 of 2*

MEDICAL HISTORY (Check ones that apply)

☐ Diabetes	☐ Bronchitis	☐ Prostate Disease
☐ Anemia	☐ Pneumonia	☐ Incontinence
☐ Headaches	☐ Allergies /Hay Fever	☐ Arthritis
☐ Nervousness	☐ Heartburn	☐ Neck and Back Pain
☐ Depression	☐ Abdominal Pain	☐ Osteoporosis
☐ Dizziness /Fainting	☐ Lactose Intolerance	☐ Gout
☐ Stroke (TIA)	☐ Bowel Irregularity	☐ Chronic Rashes
☐ Heart Palpitations	☐ Gallbladder Disease	☐ Rheumatic Fever
☐ Chest Pain	☐ Hepatitis	☐ _____
☐ Myocardial Infarction	☐ Sexual/ Menstrual Dysfunction	☐ _____
☐ Peripheral Vascular Disease	☐ Sexually Transmitted Disease	☐ _____
☐ Shortness Of Breath	☐ HIV	☐ _____
☐ Asthma	☐ Frequent Infections	

FAMILY HISTORY (Check ones that apply)

	Father	Mother	Fathers Parents	Mothers Parents	Siblings
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer (specify type)	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐

MEN ONLY

It's common for men to occasionally experience erectile difficulties.
Is this something that happens to you? ☐Yes ☐No
How often does it happen to you? ☐Frequently ☐Sometimes ☐Rarely

HABITS (Check ones that apply)

SMOKE

Packs Daily	☐*½ Pack*	☐*1Pack*	☐*1 ½ Pack +*
How Long	☐*>6 months*	☐*1 year*	☐*Year +*
Interested in stopping?	☐*Yes*	☐*No*	

EXERCISE

Routine :
Frequency per week: ☐*1-2* ☐*3-4* ☐*5+*
Other:

CAFFEINE

Type	☐*Coffee*	☐*Soda*	☐*Energy Drinks*
Cups daily	☐*1-3*	☐*3-6*	☐*6+*
Other:			

ALCOHOL

Type	☐*Beer*	☐*Liquor*	☐*Wine*
Frequency	☐*Daily*	☐*Weekly*	☐*Monthly*
Amount	☐*1-3*	☐*4-6*	☐*6+*

DIET

Salt intake	☐*Minimal*	☐*Moderate*	☐*Excessive*
Fat intake	☐*Minimal*	☐*Moderate*	☐*Excessive*
Sugar Intake	☐*Minimal*	☐*Moderate*	☐*Excessive*

Other : _____

SLEEP

Difficulty falling asleep	☐*Yes*	☐*No*
Continuity disturbances	☐*Yes*	☐*No*
Snoring	☐*Yes*	☐*No*
Early morning awakening	☐*Yes*	☐*No*
Day time drowsiness	☐*Yes*	☐*No*

Other: _____

PATIENT AUTHORIZATION FORM

Patient Name _____

[X] Authorization to Release Information

Please accept this document as authorization to physicians, hospitals, medical attendants, employees, record custodians, insurance carriers and my attorney to furnish full and complete medical records, reports and x-rays. Further, this authorization is intended to include my psychiatric, psychological, HIV, drug and alcohol information. Also, confidential patient information may be assessed by employees of other designated providers for the purpose of photocopying the information in response to properly authorized requests for copies of medical records. Designated providers are bounded by the same confidentiality requirements as are the employees of this facility.

[X] Authorization for Treatment

I hereby authorize the medical staff of *Nasser Moukaddem M.D. P.A.* to render medical services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also certify that all insurance information given to *Nasser Moukaddem M.D. P.A.* is correct and complete; I understand that every attempt will be made by this office to verify my insurance benefits. I understand that it is my responsibility to be aware of what services are covered and what my insurance benefits are for the services rendered.

[X] Physician/Supplier Notice to Beneficiary and Agreement to Pay

Medicare will only pay for services that it determines to be "reasonable and necessary" under the section 1862 (a) (1) of the Federal Medicare statutes. If Medicare determines that a particular service, although it would otherwise be covered is "not reasonable and necessary" under the Medicare program standards, then Medicare would deny payment for that service. If Medicare denies payment, I agree to be personally and fully responsible for payment.

[X] Financial Agreement

I understand I am financially responsible for services rendered by physicians employed by *Nasser Moukaddem M.D. P.A.* and their staff. Payment is to be made by insurance assignment, by myself and/or authorized guarantor. I understand and agree, regardless of my insurance, I am ultimately and fully responsible for my account for any professional services rendered. **I also agree to pay all collection, attorney and court fees that may be incurred for the collection of delinquent accounts.**

[ ] Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my Attorney _____ to pay any outstanding bills out of my settlement, and in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for doctor's additional protection and consideration of his awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current basis.

Patient _____ Date_____
(Signature) (Printed Name)

PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amounts, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Some prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. More closely controlled drugs, such as, narcotic pain medications and tranquilizers, require greater responsibility on your part. We will accept **NO** excuses for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or are receiving them from another source. Furthermore, you are required to notify our office if you change drug stores, so that the order at the first store may be canceled.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action. We reserve the right to do random drug testing for anyone taking narcotic medications.

REFILLING MEDICATIONS

When your non-narcotic medications are getting low please contact your pharmacy for a refill. You pharmacy will, in turn, submit a refill request to our office. Make sure you contact the pharmacy in advance so we will have ample time to consult your treating physician regarding this medication and determine whether it requires a follow-up at the office.

Controlled substances cannot be called into the pharmacy; prescriptions should be picked up at your next scheduled appointment.

Failure to follow these policies will force our office to terminate our professional relationship with you and may require us to file a report with the United States Department of Justice Drug Enforcement Administration (DEA) or the local police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

Patient _____ Date_____

(Signature) (Printed Name)

HIPAA PRIVACY AUTHORIZATION
FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively) referred to as "HIPAA".

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Nasser Moukaddem M.D. P.A. will not condition treatment, payment, enrollment in a health plan or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that ***Nasser Moukaddem M.D. P.A.*** may use or disclose protected health information for the purposes(s) of treatment, payment or health care operations.

By signing this authorization you agree that ***Nasser Moukaddem M.D. P.A.*** or its Business Associates may disclose your personal health care information to other medical professionals relating to your treatment, payment, or health care options.

Further by signing this authorization you acknowledge that you have been provided a copy of and have read and understand ***Nasser Moukaddem M.D. P.A.*** HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While ***Nasser Moukaddem M.D. P.A.*** has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from ***Nasser Moukaddem M.D. P.A.*** at 4230 Central Ave Saint Petersburg Florida 33711.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your Personal Health Information (PHI) in the designated record set maintained by ***Nasser Moukaddem M.D. P.A.*** for as long as the Personal Health Information (PHI) is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that ***Nasser Moukaddem M.D. P.A.*** has taken action in reliance on it. A revocation is effective upon receipt by ***Nasser Moukaddem M.D. P.A.*** of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of ***Nasser Moukaddem M.D. P.A.*** or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HPAA. ***Nasser Moukaddem M.D. P.A.*** will provide you with a copy of this signed authorization, if requested.

Acknowledged and agreed to by:

Patient _____
(Signature) (Printed Name)

Date _____ Address _____

Or, On Behalf of Patient:
By _____
(Signature) (Printed Name)

Date _____ Address: _____

FINANCIAL POLICY

I. **PAYMENTS**
   a. Payments are due, for self-pay patients, prior to you seeing the provider.
   b. Co-Payments are due, for patients with insurance, prior to you seeing the provider.

II. INSURANCE
   a. Our office will attempt to verify your insurance prior to your visit. However, you are responsible to inform us of any coverage changes that have taken place.
   b. If your insurance plan requires a designation of primary care physician, you are required to make sure that physician you are seeing is listed as your primary care. If you are seen in this office and we are not your primary care you will be responsible for the charges incurred at your visit.
   c. You are responsible for knowing what your insurance will or will not cover.
      i. If you are unsure, please speak with our billing department prior to services being rendered.
         a) The statements of our billing department will be the most up to date information provided by your insurance company, and will not be a guarantee of payment. Your insurance company will make final coverage determination after the services are rendered

III. MISSED APPOINTMENTS.
   a. New patient's appointments will not be rescheduled if you do not show up to your first scheduled visit. Our office reserves the right to bill you up to $100.00 for this no show.
   b. Established patients will be charged a $25.00 no show fee for
      i. Failure to show up for scheduled appointment.
      ii. Cancelation of an appointment without a 24h notice.

Patient _____ Date_____
(Signature) (Printed Name)

DESIGNATION OF HEALTH CARE SURROGATE

(OPTIONAL)

Name:_____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name _____
Street Address _____
City_____ State _____ Zip_____
Phone _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____
Street Address _____
City_____ State _____ Zip_____
Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____
Name:_____
Signed: _____

Witnesses
1._____
2._____

At least one witness must not be a husband or wife or a blood relative of the principal.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —