MY *Central Primary Care*
Dr. Nasser Moukaddem M.D. & Dr. Marina Barkov M.D.
4226 Central Ave Saint Petersburg Florida, 33711
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
- Prescription Drug Policy
- Financial Policy
- Summary Notice For Privacy Practices
- Acknowledgement Of Receipt Of Summary Notice For Privacy Practices
- 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	☐ High Cholesterol
☐ Myocardial Infarction / Heart Attack	☐ Sexual/ Menstrual Dysfunction	☐ High Blood Pressure
☐ Peripheral Vascular Disease	☐ Sexually Transmitted Disease	☐ COPD
☐ Shortness Of Breath	☐ HIV	☐ Thyroid Disease
☐ Asthma	☐ Blood Clots	☐ Cancer

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				EXERCISE			
Packs Daily	☐*½ Pack*	☐*1Pack*	☐*1 ½ Pack +*	Routine :			
How Long	☐*>6 months*	☐*1 year*	☐*Year +*	Frequency per week:	☐*1-2*	☐*3-4*	☐*5+*
Interested in stopping?	☐*Yes*	☐*No*		Other:			

CAFFEINE				ALCOHOL			
Type	☐*Coffee*	☐*Soda*	☐*Energy Drinks*	Type	☐*Beer*	☐*Liquor*	☐*Wine*
Cups daily	☐*1-3*	☐*3-6*	☐*6+*	Frequency	☐*Daily*	☐*Weekly*	☐*Monthly*
Other:				Amount	☐*1-3*	☐*4-6*	☐*6+*

DIET				SLEEP		
Salt intake	☐*Minimal*	☐*Moderate*	☐*Excessive*	Difficulty falling asleep	☐*Yes*	☐*No*
Fat intake	☐*Minimal*	☐*Moderate*	☐*Excessive*	Continuity disturbances	☐*Yes*	☐*No*
Sugar Intake	☐*Minimal*	☐*Moderate*	☐*Excessive*	Snoring	☐*Yes*	☐*No*
				Early morning awakening	☐*Yes*	☐*No*
Other : ______				Day time drowsiness	☐*Yes*	☐*No*
				Other: ______		

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MY CENTRAL PRIMARY CARE

Patient Authorization Form

[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., d/b/a My Central Primary Care* 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., d/b/a My Central Primary Care.* 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., d/b/a My Central Primary Care.* 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.**

Patient ____ Date____________

(Name) (Signature)

MY CENTRAL PRIMARY CARE

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 Controlled 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 issued 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____________

(Name) (Signature)

MY CENTRAL PRIMARY CARE

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.
c. **Co-payments cannot be waived by My Central Primary Care; it is an agreement through your insurance company and is required by your insurance company.**

II. INSURANCE

a. As a courtesy to the patient, we will file your insurance. Please remember you insurance coverage is a contract between you and your insurance company; therefore you are responsible for full payment of your account when due.
b. 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.
c. 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.
d. 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____________
(Name) (Signature)

Summary Notice Of Privacy Practices

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our pledge to protect your privacy:

My Central Primary Care is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of My Central Primary Care's disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information;
- to request that we communicate with you in a certain way or at a certain location;
- and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run My Central Primary Care and assure that our Patients receive quality care;
- and as required or permitted by law.

There are additional situations where we may disclose medical information about you without your authorization, such as:

- for workers' compensation or similar programs;
- for public health activities (e.g., reporting abuse or reactions to medications);
- to a health oversight agency, such as the Florida Department of Health Services;
- in response to a court or administrative order, subpoena, warrant or similar process;
- to law enforcement officials in certain limited circumstances;
- to a coroner, medical examiner or funeral director; and
- to organizations that handle organ, eye, or tissue procurement or transplantation.

Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices, your rights regarding you medical information, and pertinent contact information.

**Acknowledgement Of Receipt
Of Summary Notice Of Privacy Practices**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at staff@mycentralprimarycare.com.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. My Central Primary Care provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- My Central Primary Care has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- My Central Primary Care reserves the right to change the Notice of Privacy Practices.
- The patient has the right to request restrictions to the uses of their information My Central Primary Care does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and full disclosures will then cease.
- My Central Primary Care may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

Patient ____ Date____________

(Name) (Signature)

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 —