Seminole Family Health

10875 Park Blvd. Ste A

Seminole, FL 33772

Name : _____ DOB :_____ SSN _____

Address: _____ City: _____

State: _____ Zipcode: _____ e-mail: _____

Phone# _____ Cell# _____

Emergency Contact: _____ Phone# _____

Privacy Practices Acknowledgement Information

Notice of Privacy Practices of Gay G Holland MD PA can be found in the waiting room. If you would like a copy one can be provided to you. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Please sing below that you read and have been informed.

Signature: _____ Date: _____

Assignment of benefits / Advanced Beneficiary Notice / Financial Policy

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Gary G Holland MD PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I furthermore understand that I am waiving any anti-assignment clauses that are written in to my health care contract. I have requested that the office of Gary G Holland MD PA be my agent in the filing, processing and appealing of claims related specifically to medical treatment rendered by this office. I understand that I have the opportunity to submit my bills directly to my health insurance carrier but have chosen voluntarily to have the claims submitted by and paid directly to the office Gary G Holland MD PA with accompanying explanation of benefits. Authorization to Release Information I hereby authorize Gary G Holland MD PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Gary G Holland MD PA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of the treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: _____

Medical Information

Name: _____ Age:_____ Sex: M F Height: _____ Weight: _____

What is the reason you are here today?

_____

REVIEW OF MEDICAL SYSTEMS – Circle any current problems that you are having

Change of appetite	abdominal pain	back pain	earaches	headaches	shortness of breath
Change in vision	chronic cough	chest pain	nausea	fever	leg swelling
Loss of balance	hearing loss	constipation	numbness	dizziness	fatigue
Loud snoring	heartburn	stressed	wheezing	itchy/rash	fainting
Ringing in ears	allergies	joint pain	incontinence	weakness	muscle pain
Weight change	back pain	bleeding	eye pain	arthritis	cough

PAST MEDICAL HISTORY – Circle any problems you have had in the past .

Hepatitis A/B/C	Lyme disease	Liver disease	Thyroid disease	COPD
Heart Disease	Diabetes	Gout	Bronchitis	Asthma
Carpal Tunnel	Blood Clots	Heart Attach	Sleep Apnea	Anemia
Cancer	Migraines	High Cholesterol	Seizures	Hernia
Gout	CHF	Parkinsons	Diverticulitis	Erectile Dysfunction

HOSPITALIZATIONS/SURGERIES – Date, Diagnosis and Hospital name .

_____
_____
_____
_____
_____

TESTING (x-rays, mri, ct) Please list date, body area and facility where tests were preformed

_____
_____
_____

SPECIALISTS : Please list all specialists you are currently seeing. Name & phone number

_____
_____
_____
_____

PREVNTATIVE CARE & PATIENT HISTORY

Last Eye Exam: _____ Last Mammogram: _____

Last Colonoscopy: _____ Last Pap Test: _____

Last Blood work: _____ Last PCP Visit: _____

Name of last PCP: _____

SOCIAL HISTORY: Do you drink alcohol? Y N If so how much & how often? _____ Beer/wine/liquor

Current Smoker? Y N If so how much per day? _____ How long have you been smoking? _____

Former smoker how long did you smoke?_____ How long since you quit? _____

Do you use: Dip/Cigars/Chew/Pipe? Y N If so for how long? _____

Do you currently use recreational or street drugs? Y N If so what kind how much? _____

Do you follow a specific diet? Y N Diabetic__ Low Cholesterol____ Low Carb____ Other_____

Martial Status_____ Number of Children _____

What type of employment do you have? _____Is it stressful Y N

FAMILY HISTORY: List any diseases that run in your family (blood relatives only)

Relative	Alive	Age now or deceased age	Diseases i.e. (cancer, heart disease, stroke, highblood pressure, diabetes)
Mother	**Y N**		
Father	**Y N**		
Sister	**Y N**		
Brother	**Y N**		
Grandmother	**Y N**		
Grandfather	**Y N**		

CHILDHOOD DISEASES: Circle any problems you had as a child.

Hand, foot mouth mononucleosis chicken pox asthma ADHD allergies rheumatic fever

Reye syndrome scarlet fever roseola polio measles/mumps meningitis

I understand that all of the information that I have provided will become part of my permanent medical record and will be used as part of my medical treatment. I also attest that all of the information is accurate.

Signature: _____ Date: _____

MEDICATION INFORMATION

MEDICATION ALLERGIES? _____

Pharmacy name & phone# _____

Medication List – please list ALL current medications. Please include herbal supplements

Medication (ex: asprin)	Strength & dosage (ex: 81 mg daily)	Reason for taking (headaches)	Prescribing Dr (if applicable)

I understand that all of the information that I have provided will become part of my permanent medical record and will be used as part of my medical treatment. I also attest that all of the information is accurate.

Signature: _____ Date: _____

Controlled Substance Agreement

The Florida Legislature has laws governing the prescription of controlled substances. These drugs include but not limited to all narcotics, sleeping aids, benzodiazepines and ADHD medications. To comply with these laws and prevent misunderstanding, I acknowledge and agree to the following:

1. **I understand that the main treatment goal is to reduce pain and improve my ability to function. In consideration of this goal and the fact that I am being given a potent medication to reach my goal: 1) I agree to use my medication at the rate no greater than prescribed. 2) I will not sell, trade or share my medication. 3) I will not consume alcohol while on controlled substances. 4) I not drive or operate heavy machinery while on controlled substances.**
2. **I understand that prescriptions for controlled substances can only be written for a 30 day supply and requires a face to face doctors visit to obtain refills. Refills must be written not faxed or called in. Refills will only be given at scheduled appointments. Refills will not be given on weekends or holidays.**
3. **It is a crime to obtain controlled substances under false pretenses. This could include getting medications from another doctor, misrepresenting myself to obtain medications, or using them in a manner other than prescribed. If my physician has reason to believe that I have violated this agreement my physician has the right to contact law enforcement and discharge me from the practice.**
4. **I understand that my physician is not responsible for misplaced, lost or stolen medications. Controlled substances cannot be refilled before the 30 day renewal date**
5. **I agree to comply with random urine drug screenings and random pill counts. Any use of illegal substances or absence of my prescribed medication is a direct violation of this agreement and will result in a discharge from the practice.**
6. **I understand that the long term advantages and disadvantages of chronic opioid use has yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long term use of controlled substances.**
7. **I am fully aware of the psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to medications and necessitating a dose increase to achieve the desired effect and doing so may increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for more than several weeks. Therefore, when I need to stop taking the medication, I must comply and slowly taper off under medical supervision or I may have with draw symptoms.**
8. **I understand that if I violate this controlled substance agreement due to non – compliance of medical directions, failure to take medications as prescribed, utilizing other illicit drugs, refusal for urine drug screens or excessive no show appointments I will be discharged from the practice.**

I hold Gary G Holland MD PA physicians harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

Patient/ Guardian Signature _____

Patients Printed name _____

Date: _____

Seminole Family Health - Gary G Holland MD PA

10875 Park Blvd. Ste A

Seminole, FL 33772

Permission to Speak Form

Patient Name: _____Date of Birth: _____

I give permission to Gary G Holland MD PA to VERBALLY discuss the following medical and billing information about me:

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

☐ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan

☐ Lab/test results

☐ Billing and payment information

1) Name: _____ Relationship: _____

Phone # _____

2) Name: _____ Relationship: _____

Phone # _____

3)Name: _____ Relationship: _____

Phone # _____

Signature: _____ Date: _____

I understand that I may cancel this permission at any time by writing Gary G Holland MD PA, but that cancelling it will not affect any information that has already been released. I understand that I do not have list anyone on this form. If so please mark N/A on name line

Seminole Family Health 10875 Park Blvd ste A

Seminole, FL, 33772

Phone (727) 392-2247 Fax (877) 328-1192

RELEASE OF CONFIDENTIAL INFORMATION

1, _____ SSN: _____DOB:_____

Authorize: _____

Phone# _____ Fax# _____

Name of who is to release information (previous doctor/hospital)

To release information from my medical records. Please include all of the following:

- Office notes, lab work, testing & x-rays
- Information of psychological, psychiatric, alcohol or drug related nature
- HIV antibody test results, and AIDS records
- Other: _____

TO : Gary G Holland, M.D., P.A., 10875 Park Blvd., Ste A, Seminole, FL. 33772-5456

This information will be used for the following purpose of Continued Medical Care

I hereby authorize the use or disclosure off my individual identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider the released information may no longer be protected by federal privacy regulations. I understand that this consent shall be valid for a period of I year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization. further understand that the confidentiality of this information may be protected by federal regulations {42CFR, Part1}, prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

Signature: _____ Date: _____