Review of Systems

Please complete this questionnaire for your visit today.

APOLLO BEACH FAMILY medical center

Name: _____ **Date of Birth:** _____ **Today's Date:**_____

Do you CURRENTLY have any of the following symptoms? (If **yes**, circle appropriate symptom)

GENERAL: Chills, Fever, Weight Loss, Weakness, Fatigue, Weight Gain

HEAD: Dizziness, Headaches, Pain **EYES**: Blurry Vision, Double Vision, Eye Pain

NOSE: Discharge, Stuffy Nose, Nose Bleeds **EARS:** Hearing Loss, Ringing in Ear, Dizziness, Ear Pain

THROAT/NECK: Lumps, Tenderness

RESPIRATORY: Asthma, Bronchitis, Shortness of Breath, Cough, Wheezing

CARDIOVASCULAR: Chest Pain, Heart Murmur, Palpitations, Swelling of Legs, Varicose Veins, Recent EKG, High Blood Pressure, Short of Breath - Lying flat

GASTROINTESTINAL: Abdominal Pain, Rectal Bleeding, Black tarry stools, Trouble Swallowing, Constipation, Nausea, Vomiting, Diarrhea, Change in Appetite

MUSCULOSKELETAL: Arthritis, Back Problems, Muscle Cramps/Aches, Joint Pain, Muscle/Joint Stiffness

PSYCHIATRIC: Depression, Memory Loss, Nervousness/Anxiety **BREASTS:** Lumps, Tenderness

SKIN: Easy Bruising, Lumps, Rashes **ENDOCRINE:** Cold/Heat Intolerance, Increased Thirst

NEUROLOGICAL: Dizziness, Tingling, Tremors, Numbness, Unsteady Walking

HEME/LYMPH: Anemia, Easy Bruising or Bleeding **ALLERGY:** Runny Nose, Sneezing, Stuffy Nose

GENITOURINARY: Awakening to Urinate, Burning, Increased Frequency/Urgency of Urination, Blood in Urine, Incontinence, Urinary Retention, Prostate Problems, Sexual Problems, Postmenopausal Bleeding

Has There Been Any Change In Your Medications?_____

What specific needs would you like to talk to the doctor about today?

_____

Disclaimer: Additional concerns may require a future appointment.

When was your last colonoscopy?_____

When was your last eye exam?_____

Date of last mammogram?_____

Date of last Bone Density?_____

Diabetes? **YES** or **NO** **Date of last Blood Work:**_____

Do you have: Advance Directive____ LivingWill_____

Surrogate Decision Letter_____Date Discussed_____

OFFICE USE ONLY:

Onset:_____**Location:**_____

How long do sxs last?_____

What makes it better?_____

What makes it worse?_____

Do sx radiate?Yes/No____**Severity:**Mild/Moderate/Severe

Timing: Constant/Intermit/On and Off

Character: Sharp/ Dull/Achy

Staff Initials:_____Time:_____

OFFICE

☐ RRR- Yes
☐ RRR- No

☐ Medicare
☐ Humana ☐ HMO
☐ Humana Gold Plus ☐ PPO
☐ Self Pay
☐ BCBS ☐ Supplement Plan
☐ Freedom
☐ Optimum
☐ Direct Family Care

WT_____HT_____B/P_____

Temp_____

O2 Sat _____ R.R. _____

H.R. _____

Staff Initials _____

Patient Information Form

Last Name	First Name	Middle/Maiden Name	Date of Birth	Sex (Circle): M — F

Mailing Address	Apt/Lot	City	State	How did you hear about us?

Marital status (circle): Married-Single-Divorced-Widowed-Separted	Mother's Name if Minor Patient	Father's Name if Minor Patient

Home Phone ( )	Work Phone ( )	Mobile Phone ( )	Email Address

Race (circle): Black- White-Asian-Hispanic-Other	Ethnicity (circle): Hispanic-Non-Hispanic-Unknown	Preferred Langage

Spouse/Parent Name	Do you have a Living Will or Medical Advance Directive Yes - No
Emergency Contact if different than parent or spouse list below	Emergency contact address City State/Zip
Emergency Contact Phone Number:	Home Phone ( ) Work Phone ( ) Mobile Phone ( )

Insurance Information

Primary Carrier Insurance Company Effective Date	Primary Carrier Insurance Company Effective Date
Insurance Carrier Mailing Address City State/Zip	Insurance Carrier Mailing Address City State/Zip
Policy Holder's Name	Policy Holder's Name
Policy # Group#	Policy # Group#

Responsible Party Information if other than parent/spouse listed above

Head of Household or Parent with custody of minor	Relationship to parent

Mailing Address Apt./Lot City State/Zip	Phone # Home ( ) Work ( ) Mobile ( )

Authorization for Treatment

I authorize Apollo Beach Family Medical Center (ABFMC) to preform procedures and treatment including the administration of medicine & anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information (including the release of HIV/AIDS, Mental Health, Substance Abuse- to include alcohol & drugs and any reportable communicable diseases), which is necessary to process a claim and hereby asking benefits payable to ABFMC in the event of any health insurance becoming primary over my health insurance. To further provide continuity of care. I authorize the release of medical information to specialty physicians under contract with ABFMC. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by ABFMC.

Patient/Legal Guardian Signature **Date**

Patient/Legal Guardian Signature

Health Questionnaire

Patient Name:_____ **DOB:**_____

Please indicate each of your chronic medical problems by marking the appropriate box below:

☐ High blood pressure	☐ Asthma	Please list any other medical problems:
☐ Heart disease	☐ Emphysema/Lung Problems	
☐ Diabetes	☐ Kidney Problems	
☐ Stroke	☐ Anemia	
☐ Cancer	☐ High Cholesterol	
☐ Thyroid	☐ Glaucoma	

Please list All medications that you are now taking, Strength (in milligrams) and how often. Include non- prescription medications, vitamins and herbal supplement.

Are you allergic to any medications? ☐ Yes ☐ No If yes, Please list them and the reaction they causes.

Social History

Tobacco _____ a day Number of years:_____ Year Quit:_____

Alcohol _____ drinks per week Caffeine _____ cups a day

Street Drugs _____ Low fat diet ☐ Yes ☐ No

Exercise _____ type Times a week _____ minutes/session

Water _____ cups a day Marital Status _____

# of Children _____ Occupation_____

Do you have a living will? ☐ Yes ☐ No If yes, have you given us a copy? ☐ Yes ☐ No

Family History

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

☐ Heart Disease	☐ Stroke	☐ Asthma	☐ Glacoma
☐ Diabetes	☐ High Blood Pressure	☐ Emphysema/ Lung Disease	
☐ Thyroid	☐ High Cholesterol	☐ Cancer	

Patient Name:_____

Pleas list any surgeries/hospitalizations (including the year)

Are you under the care of any other doctor for any medical problems?_____

If so, whom and for what medical problem?_____

Year of Last: Tetanus Shot_____ Flu Shot_____ Pneumonia vaccine_____

Women Only: Date of first day of last menstrual period:___/___/___ Contraception Type_____

Number of: Pregnancies_____ Live Births_____

Miscarriages_____ Abortions_____

Date of last: PAP_____(Abnormal?_____) Mammogram_____ (Abnormal?_____)

Date of last: Osteoporosis Scan_____ Flushing/Menopausal Symptoms Yes ☐ No ☐

Have you been a victim of abuse? ☐ Yes ☐ No

Men only:

Date of last: Prostate Exam_____ Last PSA (Prostate Blood Test)_____

Procedures(list year):

Sigmoidoscopy	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)

Please place a checkmark next to any symptoms that you are currently having and indicate the if the occurred in the past.

General	Fever	Night Sweats	Unexplained Weight Loss or Gain	Fatigue	
Skin	Rashes	Cancers	Change in Hair Skin, or Nails		
Eyes	Glasses	Contact Lenses	Changing Vision	Pain	Discharge
Ear Nose Throat	Ear Pain Sore Throat	Change in Hearing Change in Voice	Persistent Runny Nose Sinus Trouble		
Heart	Chest Pain	Swelling in Ankles	Heart Murmur	Palpitations	
Lungs	Cough	Short of Breath	Wheeze		
Gastrointestinal	Nausea Ulcers	Blood in Stool Heartburn	Change in Bowel Movement		
Genitourinary	Blood in Urine Incontinence	Painful or frequent urination Sexually Transmitted Disease	Women: Vaginal Discharge Change in Menstrual Cycle or Sexual Function	Men: Penile Discharge Change in Sexual Function	
Orthopedic	Painful Joints	Muscle Weakness			
Neuro/Psych	Seizures	Tremors	Frequent Headaches	Paralysis	
	Depression	Anxiety			
Allergy	Hives	Hay Fever			
Circulation	Leg Swelling	Blood Clots			

Apollo Beach Family Medical Center

Authorization to Release Confidential Information

I _____, authorize Apollo Beach Family Medical Center and personnel to release information to the following person(s) listed below. The below listed also have my permission to pick up anything related to my medical files, should I not be able to do so.

Patient Name:_____**Date of Birth:** _____

I authorize the following people to access my medical records:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Leaving Messages: Our office policy is to leave generic, innocuous information on answering machines. We would like to accommodate our patients and can do so, by **initialing** next to your preference.

a._____Leave very little information.
b. _____Please call # _____ and leave specific details.

Signature: _____Date:_____

Apollo Beach Family Medical Center

FINANCIAL AGREEMENT

In consideration of the patient receiving services from
Apollo Beach Family Medical Center I agree:

- I am responsible for all expenses for treating the patient
- Payment of charges is due at the time of the appointment.
- If ABFMC files my insurance for me, I agree to pay for non - covered insurance, benefits, co - insurance, copays and deductibles.

Authorization to Release Information & To Pay Benefits

I authorize ABFMC to release any of my medical information, including drug and alcohol and HIV positive test results to my insurance company(s), as needed to process my insurance claim.
I authorize my insurance company to make payments directly to Apollo Beach Family Medical Center (ABFMC) for covered medical and/or surgical services.

_____ _____

Signature of Patient of Authorized Representative Date Signed

_____

Print Name

_____ _____

Print Name of Patient Patient Date of Birth

Cancellations/ No show appointment Policy

Apollo Beach Family Medical Center has an established No - Show Policy. This policy is designed to insure Apollo Beach Family Medical Center can give service to as many patients as possible, and is in no way designed to be punitive to patients who have been, or are, responsible when it comes to scheduling and keeping their appointments.
A charge of $25.00 will be charged to your account for any appointment not cancelled within 24 hours of your scheduled date.

_____ _____

Signature of Patient of Authorized Representative Date Signed

_____

Print Name

_____ _____

Print Name of Patient Patient Date of Birth

APOLLO BEACH FAMILY medical center

FEE FOR FORMS

Please note it will take 24 to 48 hours to process the request. If the request is received at the end of the day allow 72 hours for processing.

An additional fee of $15 will be applied if requested forms need to be completed the same business day.

$25.00 for 1 - 5 Pages
$50.00 for 5 - 10 pages

- FMLA
- Disability
- Workmen's Comp forms
- Sports/ School Form Physicals are already included in the visit fee
- Auto Forms

Entire Medical records included and not limited to labs, diagnostics, results etc. $75.00 for entire medical file.

Handicap Form for the Tax Collectors Office one page Free of charge.

I, _____ have read and understand the contents of this form.
Patient/Guardian Name

Signature_____Relationship to Patient_____Date:_____

Apollo Beach Family Medical Center

Notice of Privacy Practices Acknowledgement Form

ABFMC's Notice of Privacy Practices provides information about how we may use and disclose protected information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician' office or by visiting our Web site at www.apollobeachfamilymed.com

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Apollo Beach Family Medical Center Notice of Privacy Practices.

_____ _____

Signature of Patient of Authorized Representative Date Signed

_____

Print Name

_____ _____

Print Name of Patient Patient Date of Birth

ABFMC USE ONLY

Patient declined signing this acknowledgement form

Reason given:_____

Staff Member Name:_____

Office Location:_____Date:_____

Apollo Beach Family Medical Center (ABFMC)

Authorization for the Use and Disclosure of Protected Health Information (Medical Record)

_____ hereby authorizes the use or disclosures of the individually identifiable health
Print Patient/Legal Representative/ Legal Guardian Name

information of _____as described herein.
Print Patient Name Date of Birth

Person/organization authorized to use/disclose the information :	Person/organization authorized to use/disclose the information :
Name/ Organization_____	Name/ Organization_____
Address:_____	Address:_____
City, State, Zip_____	City, State, Zip_____
Phone:_____Fax_____	Phone:_____Fax_____

For the purpose of: □ Legal Request □ Moving out of Area New Local Physician □ Other (please specify)

_____

Date(s) of Service From:_____ To _____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that ABFMC, DFC, CMC Care may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

_____ Complete Record _____ All diagnostic test results _____ Pathology/Operative Report(s)
Or _____ Consultation/Progress Note(s) _____ Lab only
_____ Abstract of Record _____ Radiology only _____ Other (please Specify)

In addition, place your initials by each specific item: (if applicable)

_____ Mental Health _____ HIV Testing _____ Genetic Counseling/Testing Information
_____ Drug and/or Alcohol _____ AIDS Information

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Required Date of Authorization

_____ _____ _____
Patient Date of Birth Social Security Number (optional) Identification Shown

_____ _____
Translator or Interpreter's Name Telephone Number

_____
Address City State Zip Code

Mini Nutritional Assessment
MNA®

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3kg (6.6lbs)
1 = does not know
2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F Body Mass Index (BMI) = weight in kg / (height in m)^2
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

Assessment

G Lives independently (not in nursing home or hospital)
1 = yes 0 = no

H Takes more than 3 prescription drugs per day
0 = yes 1 = no

I Pressure sores or skin ulcers
0 = yes 1 = no

J How many full meals does the patient eat daily?
0 = 1 meal
1 = 2 meals
2 = 3 meals

K Selected consumption markers for protein intake
- At least one serving of dairy products (milk, cheese, yoghurt) per day — yes no
- Two or more servings of legumes or eggs per week — yes no
- Meat, fish or poultry every day — yes no

0.0 = if 0 or 1 yes
0.5 = if 2 yes
1.0 = if 3 yes

L Consumes two or more servings of fruit or vegetables per day?
0 = no 1 = yes

M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?
0.0 = less than 3 cups
0.5 = 3 to 5 cups
1.0 = more than 5 cups

N Mode of feeding
0 = unable to eat without assistance
1 = self-fed with some difficulty
2 = self-fed without any problem

O Self view of nutritional status
0 = views self as being malnourished
1 = is uncertain of nutritional state
2 = views self as having no nutritional problem

P In comparison with other people of the same age, how does the patient consider his / her health status?
0.0 = not as good
0.5 = does not know
1.0 = as good
2.0 = better

Q Mid-arm circumference (MAC) in cm
0.0 = MAC less than 21
0.5 = MAC 21 to 22
1.0 = MAC greater than 22

R Calf circumference (CC) in cm
0 = CC less than 31
1 = CC 31 or greater

Assessment (max. 16 points)

Screening score

Total Assessment (max. 30 points)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐

Physician notes:_____

_____

Physician Signiature_____Date:_____

CREDIT CARD AUTHORIZATION FORM FAQ

1. **Where will my card be stored? Is it secure?**

   Your credit card information will be stored on a secure server and once your credit card is added, only the last four digits of the card will be visible on the server. No employee will have access to your complete credit card information.

2. **What will my card be used for?**

   To pay account balances after insurance payments have been received. ex: Patient responsibility, Deductibles, Coinsurance, Copays, etc.

3. **How will I be notified of a charge made to my credit card?**

   You will receive a notice via email or phone call of the amount being charged. As well as a statement from ABFMC outlining what the charges are for.

4. **I am a Medicare Advantage patient, why do I need to fill out the credit card authorization form?**

   Your credit card will only be used in a case of no show appointments and records requests. There should be no other reason to run a credit card on your account.

Apollo Beach Family Medical Center

6150 N.US. HWY 41
Apollo Beach, FL 33572
813-641-0007

Credit Card Recurring Payment Authorization Form

At Apollo Beach Family Medical Center we strive to make the best out of our relationships and financial partners. Moving forward, Apollo Beach Family Medical Center will require to have a credit card on file with every individual seeking care. Please complete the form below and hand it back to a member of our staff.

You are authorizing regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged each billing period for the total amount due for that period. A receipt may be emailed to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided if the total payment amount is reflected in this schedule. If new charges are incorporated into this schedule and the total payment amount or date changes, you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize **Apollo Beach Family Medical Center** to charge my card for amounts owed. Apollo Beach Family Medical Center will advise me of my balance via phone several days in advance before charging my card. I acknowledge I will forfeit any discount given should I default on any of the terms of this agreement, including any declined transaction. I understand any failure to pay my balance in full as per the terms of this agreement may result in additional charges from a Collection Agency, Attorney, and/or court costs and that I will only receive advance notice of the charge if the total payment amount or date changes. I authorize the incorporation of new charges into this agreement for anything that is processed in the last 30 days. No show fees will be charged with 7 days of a missed appointment. This card will be retained for future use on this day and moving forward.

Account Name _____

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Account Type: Visa MasterCard Amex Discover

Cardholder Name _____

Account Number _____

Expiration Date ____/_____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.