ALL FLORIDA FAMILY CARE

SREELATHA TIRUPATHI, M.D.

(Please Print)

Today's Date ____/____/____ PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ MEDICARE ❑ MEDICAID ❑ WELLCARE ❑ HUMANA ❑ BC/BS ❑ UNITED HEALTH CARE ❑ AVMED ❑ PHCS ❑ STAYWELL ❑ Other _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

EMAIL ADDRESS _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ALL FLORIDA FAMILY CARE, SREELATHA TIRUPATHI, M.D. or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Patient Responsibility Agreement

I understand that as a patient I have responsibilities to my health care provider. As a CONDITION OF MY TREATMENT by ALL FLORIDA FAMILY CARE I WILL:

1. Expect to be treated with respect by all facility representatives and I, in turn, will treat them respectfully.

2. Provide information regarding any health insurance I may have.

3. Keep my scheduled appointments or provide 24 hours notice if I can't, except in an emergency.(Three no shows will result in discharge and we will notify your insurance company or plan).

4. Provide my health care provider, to the bets of my knowledge, with accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to my health,

5. Follow my health care providers instructions for care and any treatment including filling prescriptions and taking any medications as directed. If I disagree with my treatment plan, it is my responsibility to seek an independent second option.

6. Comply with office rules regarding food or drink, office hours, making appointments, walk-ins or any reasonable request made by the physician or staff.

7. Be responsible for children under my care an supervision while we are on ALL FLORIDA FAMILY CARE premises. ALL FLORIDA FAMILY CARE is not responsible for injuries sustained bt individuals when the injuries are a result of negligence or lack of supervision by the responsible adult.

Good health is partnership between me and ALL FLORIDA FAMILY CARE. I agree to do my part. I understand that if I do not comply with these responsibilities, I may be discharged as a patient.

NAME _____ DATE _____

ALL FLORIDA FAMILY CARE
Sreelatha Tirupathi, MD
3301 66th Street N. St. Petersburg, FL 33710
Phone (727) 344-6200 Fax (727) 344-6222

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you and want you to completely understand our financial policies.

1. payment/co-payment is due at the time services are renderd, unless you're insurance carrier has made arrangements I n advance. Please note if you have no insurance carrier, you are consiered self pay status. First time visits are $125.00 each visit thereafter is $75.00.

2.Please keep in mind that your insurance policy is a contract between you and your incurance company. As a service to you, we will file your insurance claim provided the octor is designated as your primary care physician with your insurance company. By doing so, you agree to have your insurance company pay the doctor directly. If your insurance copmany does not pay the practice within a resonable perio of time, you will be responsible for the payment or balance. If we receive payment at a later date from your insurer, we will gladly refund any over payment made by you.

3.We have prior arrangements with many insurance companies and other health care plans to accept an assignment of benefits. We file a claim and bill them for services rendered. In return, you are required to pay a co payment set forth by your insurance company due at each office viait.

4.If you are insured by a plan that we do not have prior arrangements with. We will prepare and send the claim for you on an unassigned basis. This means the insurance company will sent the payment directly to you. Therefore any charges for your care are due at the time of services.

5.Not all services are cover by your insurance plan. In the event your insurse determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

6. We will bill your insurance company/companies for all services provided in the hospital. You are responsible for any remainder balance due.

7. Please notify our office of any insurance changes so that we may submit claims accordingly. Remember to bring in any new insurance cards so that we mat have them on file.

8. I authorize release of information to process ant and all insurance claims for services rendered and that any payment be made directly to the doctor. I understand and agree, regardless of my insurance, I am ultimately and fully responsible of 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.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also agree and understand that such terms may be updated and amended as needed.

PATIENT SIGNATURE_____DATE_____

PRINT PATIENT NAME_____

ALL FLORIDA FAMILY CARE
SREELATHA TIRUPATHI, M.D.
3301 66th STREET NORTH SUITE A ST PETERSBURG, FL 33710
PH: 727-344-6200 FAX: 727-344-6222

CONSENT TO DISCUSS MEDICAL CONDITION

I _____ authorize **ALL FLORIDA FAMILY CARE** to discuss information contained in my medical records with my:

Daughter_____

Son_____

Husband_____

Wife_____

Others_____

_____
Patient Signature

Patient: DOB: Date:

Original Date: ____/____/____
Dates Revised: ____/____/____
____/____/____
____/____/____
____/____/____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)* ☐ M ☐ F **DOB** ____/____/____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or Referring Doctor: **Date of Last Physical Exam:** ___

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:

☐ Tetanus _____ ☐ Pneumonia _____
☐ Hepatitis _____ ☐ Chickenpox _____
☐ Influenza _____ ☐ MMR _____
Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ..... ☐ Yes ☐ No

Please turn to next page

Patient: DOB: Date:

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting? ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:
Do you currently use recreational or street drugs? ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Patient: DOB: Date:

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:

Are you sexually active? ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ☐ Yes ☐ No
If not trying for a pregnancy list contraceptive or barrier method used? _____
Any discomfort with intercourse? ☐ Yes ☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No

Personal Safety:

Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you have vision or hearing loss? ☐ Yes ☐ No
Do you have an Advance Directive and/or Living Will? ☐ Yes ☐ No
Would you like information on the preparation of these? ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

Patient: DOB: Date:

MENTAL HEALTH

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____/_____/_____
Period every _____ days. Heavy periods, irregularity, spotting, pain or discharge? ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a D&C, hysterectomy or cesarean? ☐ Yes ☐ No
Any urinary tract, bladder or kidney infections within the last year? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Any hot flashes or sweating at night? ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period? ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps or nipple discharge? ☐ Yes ☐ No
Date of last pap and rectal exam? _____/_____/_____

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times _____
Do you feel pain or burning with urination? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Do you feel burning discharge from penis? ☐ Yes ☐ No
Has the force of your urination decreased? ☐ Yes ☐ No
Have you had any kidney, bladder or prostate infections within the last 12 months? ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ☐ Yes ☐ No
Any testicle pain or swelling? ☐ Yes ☐ No
Date of last prostate and rectal exam? _____/_____/_____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin _____
☐ Head/Neck _____
☐ Ears _____
☐ Nose _____
☐ Throat _____
☐ Lungs _____
☐ Chest/Heart _____
☐ Back _____
☐ Intestinal _____
☐ Bladder _____
☐ Bowel _____
☐ Circulation _____

Recent Changes In:

☐ Weight _____
☐ Energy Level _____
☐ Ability to Sleep _____

Other Pain/Discomfort:

_____
_____
_____
_____

ALL FLORIDA FAMILY CARE
Sreelatha Tirupathi, M.D.
3301 66th St. N Suite A St. Petersburg, FL 33710
Phone (727)344-6200 Fax (727)344-66222
allfloriafamily@yahoo.com

Patient Agreement for Narcotic and Controlled Medication Use

I,_____understand that I have a chronic pain condition and narcotics may need to be prescribed as part of my treatment. **Narcotics are highly addictive.** The risks, benefits and alternatives of narcotics will be discussed with me by my physician, including but not limited to, drug dependancy, tolerance, addiction, liver and/or kidney damage, if narcotics are required for a prolonged period of time for my pain control. If prescribing of narcotics becomes necessary to control my pain, I agree to the following conditions regarding narcotic use:

1. I will obtain prescriptions for narcotics and other controlled medications **from only one physician** and I will not request any narcotic prescriptions from any other physician. If any other physician prescribes me narcotics I will notify my physician immediately.

2. I will have my prescriptions **filled at only one pharmacy** if given for long term basis, and will notify my treating physician of the name of pharmacy.

3. I will take the narcotic medication **only as prescribed** and will not increase or change the dose or frequency without first discussing it with my prescribing physician. **If necessary I agree to random urine and blood testing to assess my compliance.**

4. I understand that the goal is to control my pain, and not to have euphoric effect. If narcotic dependancy or rapid escalation of doses occurs, I agree to gradually taper off the medication if recommended by my physician. I also agree to detoxification or rehabilitation program if recommended by my physician.

5. **Prescription for lost or stolen narcotics will not be replaced.** It is my responsibility to safeguard my prescription and medication.

6. Refills may not be given earlier than scheduled time.

7. Physician visit and evaluation will be required for refills.

8. **Narcotic prescriptions will only be given using regular office hours and will not be given or refilled during weekends, holidays, or by telephone.**

9. A Psychological evaluation to assess compliance, addiction and drug dependency may be

require if narcotics are prescribed for long term.

10. If I am non compliant with any of the above guidelines, I understand that I may be terminated as a patient.

I have read the above policy and I agree to abide by the agreement.

Patient Signature_____Date_____

Physician's Signature_____Date_____

ALL FLORIDA FAMILY CARE **SREELATHA TIRUPATHI, M.D.**

3301 66TH STREET N.,SUITE A, ST. PETERSBURG, FL 33710
Phone: 727-344-6200 Fax: 727-344-6222

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize(PREVIOUS PHYSICIAN) _____ to release healthcare information of the patient named above to:

Name: ALL FLORIDA FAMILY CARE INC PHONE # 727-344-6200 FAX # 727-344-6222

Address: 3301 66TH STREET NORTH SUITE A

City: ST. PETERSBURG State: FLORIDA Zip Code: 33710

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to *the person*(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

HIPAA NOTICE OF PRIVACY PRACTICES

All Florida Family care
3301 66th Street North Ste A
ST.PETERSBURG, FL 33710
727.344.6200

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer Kenya Allen at 727.344.6200

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to

Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer at 727.344.6200

You may contact the DHHS at:
The U.S. Department of Health and Human Services,
200 Independence Avenue, S. W.,
Washington, D.C. 20201
Telephone: 202-619-0257,
Toll Free: 1-877-696-6775