MINIMALLY INVASIVE INSTITUTE OF SURGERY

TAMPA BAY SURGICAL GROUP

Date: _____

_____

Last Name **First Name** **Middle Initial** **Gender**

_____

Address **City** **State** **Zip**

_____ _____ _____

Email address **Date of Birth** **Social Security Number**

(_____)_____ (_____)_____

Home Phone **Cell Phone**

_____ _____ (_____)_____

Emergency Contact **Relationship** **Phone**

Employer Name: _____**Employer Phone**_____

How did you hear about us? □ Website □ Newspaper □ Magazine □ Physician Referral
□ Friend/Family □ ER/Hospital □ Insurance Plan □ Worker's Comp Adjustor

Do you have a Seasonal Address?

_____

_____

What is your preferred communication?
□ Phone □ E-mail □ Postal Mail □ Fax □ Patient Portal □ Decline

What is your Ethnicity? □ Hispanic or Latino □ Not Hispanic or Latino □ Decline

What is your race? □ American Indian □ Alaskan Native □ Asian □ National Hawaiian
□ Pacific Islander □ White □ Black (African American) □ Other □ Decline

_____ _____

Occupation/Former Occupation **Age at last birthday**

Primary Care Physician_____ **Referring Physician**_____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Consent to request medication history □ Yes □ No

Reason For Today's Visit: _____

Was this related to an Auto Accident? □ Yes □ No **Worker's Comp accident?** □ Yes □ No

If so, what was the date of your injury? _____In what State did your accident occur? ____

INSURANCE INFORMATION (Please present your insurance cards to be scanned.)
Primary Insurance: _____Secondary Insurance: _____

Other Insurance Coverage: _____

CURRENT ILLNESS

Describe in your own words your medical illness. Please include the date of onset, symptoms, previous similar occurrences, names of other physicians already consulted, any tests or medications prescribed.

Past Medical History

Condition	Yes	No	Condition	Yes	No
Allergies	____	____	High Cholesterol	____	____
Anemia	____	____	HIV infection	____	____
Arthritis	____	____	Kidney disease	____	____
Asthma	____	____	Lymphedema	____	____
Blood Clots *specify below	____	____	Lymphoma	____	____
Cancer *indicate type below	____	____	**Neuro/muscular disease *specify below**		
Depression, anxiety	____	____	Phlebitis	____	____
Diabetes I or II (circle)	____	____	Seizures	____	____
Emphysema	____	____	Sleep Apnea	____	____
Heart disease			Stroke	____	____
Hepatitis *indicate type below	____	____	T.B.	____	____
High blood pressure	____	____	Thyroid Problems	____	____

***What type of Cancer? _____ *Blood Clots WHERE? _____**

***Neuro/muscular specify type_____ *What type of Hepatitis? □B □C**

Past Surgical History List any major operations, hospitalizations:

Surgery	Date	Name of Hospital/location
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Have you had any adverse reactions to anesthesia? Yes ___ No ___ If yes, explain:
_____

Do you have any bleeding tendency or clotting disorder? Yes ___ No ___ If yes, explain:
_____

List all ALLERGIES to medicines, latex, adhesives, metals etc.: No Known Allergies □

1._____ 4. _____ 7. _____
2._____ 5. _____ 8._____
3._____ 6. _____ 9. _____

List all MEDICATIONS, SUPPLEMENTS, HERBS and OVER THE COUNTER MEDS such as Aspirin, Advil, Ibuprofen, etc. List the DOSE, FREQUENCY and REASON for use:

Medicine	**Dose & how often**	**Reason for use**
Example: Xanax	*0.5 mg once daily*	*Anxiety*
1._____		
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Family History

Please indicate if anyone in your immediate family has had cancer below:

	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	_____	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____	_____	_____
Age of diagnosis?	_____	_____	_____	_____	_____	_____

Is there any other cancer in your family? Yes □ No □
If yes, what type of cancer? _____
What relative (Aunt/Uncle/Cousin, etc.): _____
Age of diagnosis: _____

Social History

Do you use tobacco products? Yes_____No_____How much_____
Former ____ Start Date _____Stop Date _____

Do you drink caffeinated coffee, tea, soda? Yes_____No_____How often/Much _____

Do you do any recreational drugs? Yes_____No_____What? _____

Do you drink alcohol? Yes _____No _____ If yes, how many times in the past year have you had 5 (for men under the age of 65yrs) or 4 (for women & all adults over 65yrs) or more Alcoholic drinks in a day? _____

Have you ever had a pneumonia vaccine?	Yes □ No □	Date: _____
Have you had a Mammogram with the past 27 months?	Yes □ No □	Date: _____
Have you had a Colonoscopy within the past 9 Years?	Yes □ No □	Date: _____
Have you had a Flu Shot within 12 months?	Yes □ No □	Date: _____

REVIEW OF SYSTEMS:

Do you currently have any of the following symptoms (check all that apply)?

CONSTITUTIONAL SYMPTOMS

____ Fever ____ Infection ____ Night sweats
____ Fatigue ____ Other general problems _____

EYES

____ Blindness ____ Glaucoma ____ Retinal problems
____ Cataracts ____ Other eye problems _____

EARS, NOSE, MOUTH, AND THROAT

____ Earaches ____ Ringing in the ear ____ Sensation of spinning
____ Ear problems ____ Nose bleed ____ Sinus problems
____ Sore tongue ____ Dental problems ____ Bleeding gums
____ Sore throat ____ Painful swallowing ____ Difficulty swallowing
____ Change in voice ____ Other head or neck problems _____

BREAST (women only)

_____ Breast lumps _____ Nipple discharge _____ Breast pain

GYNECOLOGY (women only)

_____Abnormal Pap smear _____Endometriosis _____ Abnormal vaginal bleeding
Last Gynecological Exam/Date: _____ Age of menstruation: _____ Age of menopause: _____
Have you had a hysterectomy? ____ Yes ____ No Are your ovaries removed? ____ Yes ____ No

CARDIOVASCULAR

____ Heart disease ____ High blood pressure ____ Shortness of breath
____ Chest pain ____ Ankle swelling ____ Leg pain when walking
____ Rheumatic fever ____ Fast heart beats ____ Irregular heart beats
____ Heart murmur ____ Congestive heart failure ____ Myocardial infarctions
____ Pulmonary Embolism ____ Thrombophlebitis ____ Venous or Arterial Thrombosis
____ Other heart problems_____

RESPIRATORY

____ Asthma ____ Chronic cough ____ Coughing up blood
____ Emphysema ____ Tuberculosis ____ Shortness of breath

GASTROINTESTINAL

____ Weight loss ____ Decreased appetite ____ Difficulty swallowing
____ Weight gain ____ Hiatal hernia ____ Peptic ulcers
____ Esophagitis ____ Nausea/vomiting ____ Vomiting blood
____ Gastritis ____ Liver disease ____ Hepatitis
____ Gallstones ____ Crohn's disease ____ Cirrhosis
____ Ulcerative colitis ____ Black stools ____ Bloody stools
____ Hemorrhoids ____ Anal problems ____ Diverticulitis

____ Other stomach or intestinal problems_____

GENITOURINARY

_____ Kidney stones _____ Frequent urination _____ Painful urination
_____ Blood in urine _____ Slow starting of urine _____ Passing urine at night
_____ Kidney infection _____ Bladder infection _____ Enlarged prostate
_____ Leaking/Incontinence _____ Other kidney/bladder problems_____

SKIN

_____ Psoriasis _____ Skin cancer _____ Previous biopsies

_____ Melanoma _____ Other skin problems _____

NEUROLOGICAL

____ Headaches _____ Slurred speech _____ Weakness on one side
____ Seizures _____ Stroke _____ Temporary eye blindness
____ Migraines _____ Other brain or nerve problems_____

MUSCULOSKELETAL

_____ Arthritis _____ Osteoporosis _____ Neck pain
_____ Back pain _____ Artificial joints _____ Disc problems
_____ Other muscle or bone problems_____

ENDOCRINE

____ Diabetes _____ Hypoglycemia _____ Goiter/Thyroid surgery
____ Thyroid medications _____ Heat/Cold intolerance
____ Other endocrine problems _____

PSYCHIATRIC

____ Mental illness _____ Depression _____ Drug/alcohol abuse
____ Other psychiatric problems _____

HEMATOLOGIC/LYMPHATIC

_____ Anemia _____ Sickle cell disease _____ Enlarged lymph nodes
_____ Hemophilia _____ Easy bruising _____ Blood clotting problem
_____ Daily aspirin _____ Other blood or lymph gland problems_____

ALLERGY/IMMUNE SYSTEM

____Immune deficiency _____ Plant/animal allergy ____ AIDS/HIV
____ Other allergy/immune problems_____

Patient Signature: _____ Date: _____

Reviewed by Physician/Provider: _____ Date: _____

MINIMALLY INVASIVE INSTITUTE OF SURGERY

TAMPA BAY SURGICAL GROUP

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you release a complete copy of my medical records to:

Dr. Kevin Huguet | Dr. Mindi Giglio | Dr. Larry Williams

Address: 2191 9th Ave N Suite 270

City: St. Petersburg, FL

Phone: (727) 357-MIIS (6447)

Fax: (727) 356-MIIS (6447)

Direct Secure Address - kevinhuguet@tbsg.allscriptsdirect.net

mindigiglio@tbsg.allscriptsdirect.net

larrywilliams@tbsg.allscriptsdirect.net

Name of Patient: _____

Address of Patient: _____

Date of Birth: _____

Signature of Patient or Representative: _____

Date: _____

Print Name, if not Patient: _____

Records Requested From:

Name of Physician: _____

Address: _____

Phone: _____

Fax: _____

MINIMALLY INVASIVE INSTITUTE OF SURGERY

TAMPA BAY SURGICAL GROUP

PERMISSION FOR VERBAL COMMUNICATIONS

_____ _____

(Print name of patient) (Birth date)

_____ _____

(Street address) (City, state, zip code)

_____

(Phone number)

- Can we leave you a message at home? **Yes / No**
- Can we leave you a message at work? **Yes / No**
- Can we leave you a message on your cell phone? **Yes / No**

I permit Tampa Bay Surgical Group, its' physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care).

Name Phone Number Relationship

1. _____ _____ _____

2. _____ _____ _____

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to _____ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office.

Patient's Signature: _____ Date: _____

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____ _____

INSTRUCTIONS: Please print, sign and return to your surgeon's office.

MINIMALLY INVASIVE INSTITUTE OF SURGERY

TAMPA BAY SURGICAL GROUP

Financial Policy and Assignment of Benefits

Patient Name: _____

Thank you for choosing Dr. Huguet, Dr. Giglio, and Dr. Williams as your health care provider. We are committed to providing you the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our Patient Information Form prior to seeing the physician. Payments for service are due at the time services are rendered. We accept cash, check, Visa, Discover and MasterCard. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits.

However, you must understand that:
1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility -- whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or limit your coverage by design.
3. Fees for these services, along with unpaid deductibles and co-payments, are due before treatment.
4. If you have a high deductible health plan, we will collect your deductible before your surgical procedure is performed.
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.
6. If your insurance company does not pay in full within 60 days, we require you to pay the balance by cash, check, Visa, Discover or MasterCard.
7. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney's fees.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you in the management of your account.

Lifetime Authorization

I hereby assign all medical and surgical benefits allowable and otherwise payable under my current insurance policy for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to Tampa Bay Surgical Group/Dr. Brown. I understand that I am responsible for any amount not covered by insurance, including applicable co-payments, deductibles, non-covered services, and unauthorized services, and agree to pay in a current manner.

I understand that Tampa Bay Surgical Group / Dr. Huguet / Dr. Giglio / Dr. Williams does accept assignment for Medicare and payments will be directed to Tampa Bay Surgical Group.

Should my account be referred for collection procedures, I also agree to pay reasonable attorney's fees and collection expenses.

I certify that I have read and understand the above, and as the patient, guarantor, or patient's responsible party, agree to and accept these terms.

_____ _____

Signature of Patient/Responsible Party **Date**

_____

Print Name/Relationship

MINIMALLY INVASIVE INSTITUTE OF SURGERY

TAMPA BAY SURGICAL GROUP

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES ("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.

How We May Use and Disclose Health Information About You

1. We may use and disclose health information about you to:
a. Provide you with medical treatment or services (such as sharing information with a consulting physician who has been asked to examine your health information). We also may share health information about you with people who may be involved with your medical care. These people include family members (unless you object), home health agencies, nursing homes, or others we use to help provide services that are part of your
ongoing care;
b. Bill and collect payment from you, an insurance company or a third party. For example, we may need to give a health plan information about a procedure performed on you so that they will pay us, or reimburse you, for the cost of the procedure. We also may share health information with our business associates who assist us with billing and collection. Our business associates include billing companies, claims processing and precertification companies, collection agencies, clearinghouses and others that process our health care claims.
c. Assist us with our healthcare operations. For example, we may use health information about you to review our treatment and services and/or to evaluate the performance of our staff. We may also share health information with our business associates that assist us with health care operations and perform other technical and administrative activities on our behalf. This may include e-prescribing gateways, patient safety organizations, health information exchanges, personal health records vendors, and others.
2. We may contact you to remind you that you have an appointment, to follow up on health care services that were provided to you, to tell you about treatment alternatives or to tell you about other health related benefits and services that may be of interest to you.
3. We may share health information about you with family members or friends whom you indicate are involved in your medical care. In certain disasters and related emergency situations, we share health information about you with disaster relief organizations (such as the Red Cross, etc.) so that your family can be notified about your condition, status and location.
4. In certain situations, we may use and share health information about you for research purposes. However, all research projects are subject to a special review and approval process designed, among other things, to ensure the privacy of your health information. We may disclose health information about you to people preparing to conduct research (for example, to help them look for patients with specific medical needs).
5. We may use or disclose health information about you without your permission only as allowed by law. Examples of situations where we may be required to release health information about you include: emergencies, public health, health or safety threats, reporting abuse or neglect, health over sight and audit activities, national security, coroners, medical examiners, funeral directors, organ/tissue donation, and workers' compensation.

We also may be required by law to provide health information about you in response to requests from law enforcement officials in limited circumstances, correctional institutions, or as part of legal proceedings in response to valid judicial or administrative orders and/or other valid legal
authority.

Other Uses of Health Information

Uses or disclosures of your health information that are not covered by this Notice or the law will be made only with your written permission. (This includes those used for marketing purposes other than materials sent to you about health care services or other treatment options). In further support of your right to privacy, we cannot accept your blanket authorization to disclose health information for treatment you have not yet received. If you permit us to use or share health information about you, you may take back that permission, in writing, at any time. If you take back your permission, we will no longer use or share the health information you specified for the reasons you noted in writing. You understand that when you take back your permission, we are unable to retrieve any information we may have already shared with your permission. We also are required to maintain original records of the care that we provide to you.

Your Rights Regarding Health Information About You

1. You have the right to see and receive a copy of health information about you. To do so, you must submit your request in writing. If you request a copy, it must be requested in advance and we may charge a fee for the cost of copies, postage and/or other supplies. In certain situations, we may deny your request. If we deny your request, we will tell you, in writing, why your request was denied and explain to you your right to have the denial reviewed.
2. You have the right to receive a clinical summary of your office visit. To do so, simply request this at the time of your visit. We will try to make this available to you within three business days.
3. You have the right to receive an electronic copy of your health information. If you request an electronic copy, it must be requested in advance and we may charge a fee for the cost of providing you a CD, USB drive, postage and/or other supplies. We may also provide you with access to a Universal Health Record, which allows you to create, maintain and share your health record electronically.
4. If you feel that our record of your health information is incorrect or incomplete, you have the right to request to amend the information. You may do this by sending your request in writing, including your reason for the request. We may deny your request if the information was not created by us, is not part of the health information maintained by us, or if it is determined that the health information is correct. You may appeal our decision by sending a written request to us.
5. You have the right to request a list of all of our disclosures of your health information, except for information disclosed for treatment, payment or health care operations, or for those disclosures you specifically authorized and for certain other activities. To request this list, you must send your request in writing. Your request must tell us a specific time period (beginning after April 14, 2003) of not more than six years. The first disclosure list you request in any 12-month period is free. We may charge a fee for additional lists.
6. You have the right to ask that we limit how we use and disclose health information about you. You may do so by submitting a request in writing, telling us how and what information to limit. We will consider your request but we are not legally required to accept it. We also are not required to agree to your request. If we do agree, we will follow your request unless the information is needed to provide you with emergency treatment.
7. If you pay all of your bill out-of-pocket, you may request that we do not share treatment information with your health plan.
8. You have the right to ask us to send information to you at a different address (for example, sending information to your work address instead of your home address) or in a different way (for example, in an unmarked envelope instead of our regular mailing envelope), or to a third party. You may do so by sending a request in writing, and identifying where to send the information. We have the right to decide whether the request is reasonable. We do not have to comply with an unreasonable request.
9. You have the right to be notified of any breaches to your information.
10. We may share decedent information about you with family members and others involved in your care.
11. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Complaints
If you feel that your privacy rights have been violated, you may file a complaint by calling our office manager at **727-357-6447** or with Tampa Bay Surgical Group's Administrative Office at 606 S. Boulevard, Tampa, FL 33606. You also may file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Changes to this Notice
We reserve the right to change this Notice and our privacy policies at any time. Before we make an important change to our policies, we will promptly revise this Notice and post a new Notice. Any changes will apply to the health information we have on file and health information we create or receive after the effective date of the new Notice. You may request a copy of the current Notice from our office. The effective date of this Notice is: April 1, 2013.

Patient Name (Print): _____ Date of Birth: _____

Signature of Patient/Legal Representative: _____ Today's Date: _____

If Legal Representative, List Relationship to Patient: _____