East Lake Medical Center
2595 Tampa Road, Suite K,
Palm Harbor, FL 34684
Vijay Taunk, M.D., Internal Medicine - Board Certified

Patient Information

Name:_____ **DOB:**_____ **SSN:**___-___-____

Marital Status (Circle One): Single Married Divorced Separated Widowed

Spouse's Name:_____ **Referred By:**_____

Address:_____ **City:**_____

State:_____ **Zip Code:**_____ **Email:**_____

Cell Phone:___-___-____ **Home Phone:**___-___-____ **Work Phone:**___-___-____

Okay to leave a message? (Circle all that apply) Cell Phone Home Phone Work Phone

Race (Circle what applies): American Indian or Alaskan Native - Asian – White – Hispanic – Native Hawaiian or Other Pacific – Black or African American – Other

Ethnicity (Circle what applies): Hispanic or Latin – Non-Hispanic or Latin – Declined to Specify

Emergency Contact:_____ **Relation:**_____ **Phone:**___-___-____

Previous Primary Care Physician?_____

Pharmacy Preference:_____ **Location (Cross Street):**_____

Do you have a Living Will? Yes – No
Do you have a Durable Power Of Attorney for healthcare? Yes – No
If yes to either of these, please supply us with a copy for your file!

Employer Name:_____ **Occupation:**_____
Job Description:_____
Employer Address:_____ **City/State:**_____
Zip Code:_____ **Employer Phone:**___-___-____

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Required Signatures

Insurance Statement (All Insurances)

I request that payment of authorized insurance benefits be made on my behalf to East Lake Medical Center for any services provided from this date forward. I authorize any holder of medical information about me be released to the insurance carrier/healthcare finance administration and it's agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary Insurance carrier benefits be made on my behalf to East Lake Medical Center. I understand that I do not need to provide my Medigap/Secondary Insurance carrier with information concerning Medicare claims because by signing this authorization it allows Medicare payment information to cross over automatically.

All Patients (Required)

I understand that as a courtesy, East Lake Medical Center, will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges billed and will pay promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of the date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the Pinellas County Court.

Rx History Consent (Required if you receive any controlled medications)

I hereby give East Lake Medical Center permission to view my prescription information and Rx History from all external sources. By signing this consent form you are agreeing that East Lake Medical Center can request and use your prescription medication history from other healthcare providers and or third party pharmacy benefit payers for all treatment purposes.

Understanding all of the above, I hereby provide informed consent to East Lake Medical Center.

_____

Print Name

_____

Patient Signature/Representative

_____

Date Signed

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Patient Name: _____ **Age:** ____ **Sex:** _____ **Date of Today's Visit:** _____

How did you hear about us? _____

Reason for today's visit? _____

Medication List (Excluding Herbal Supplements)

Name of Medication & Strength	How Many Tablets/Caps	How Many Times A Day	Reason for taking this medication

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Patient Name: _____ **Today's Date:** _____

Past/Present Medical History (Check ALL that apply to you)

(X)		(X)		(X)	
	Amputation of leg		Colitis, Ulcerative		Kidney Failure
	Anemia		Colostomy		Migraines
	Angina		Congestive Heart Failure		Multiple Sclerosis
	Anxiety		COPD		Old MI (Heart Attack)
	Arthritis		Dementia		Osteoarthritis
	Asthma		Depression		Osteoporosis
	Atrial Fibrillation		Diabetes - Type:		Parkinson's Disease
	Attention Deficit Disorder		Deep Vein Thrombosis		Psoriasis
	Back Pain		Fibromyalgia		Pulmonary Embolism
	Barrett's Esophagus		Gastrostomy		Replacement (Hip)
	Bipolar Disorder		Gout		Replacement (Knee)
	Cancer, Bladder		Hepatitis - Type:		Seizure
	Cancer, Breast		Herniated Disc		Skin Tags
	Cancer, Colon		Hypertension		Sleep Apnea
	Cancer, Lung		Hyperthyroidism		Smoking
	Cancer, Ovarian		Hypothyroidism		Smoker's Cough
	Cancer, Prostate		Ileostomy		Stroke
	Cancer, Skin		Insulin Use (Long Term)		Thyroid Nodule
	Colitis, Crohn's		Kidney Stones		Urinary Incontinence

Other medical conditions not listed above: _____

_____

_____

Allergies to Medication (Please list all medications you are allergic to)

Medication	*Reaction Experienced*

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Patient Name: _____ **Today's Date:** _____

Previous Surgeries (Please check ALL that apply to you)

	Appendectomy		Endarterectomy		Prostatectomy
	Back Surgery		Hernia Repair		Shoulder Surgery
	Bariatric Surgery		Hip Replacement (Circle) Left or Right or Both		Stent Placement in Heart
	Cholecystectomy		Hysterectomy		Stent in Leg Artery
	Colostomy		Knee Replacement (Circle) Left or Right or Both		Stent in Carotid Artery
	Coronary Artery Bypass		Mastectomy (Circle) Left or Right or Both		Stent in Kidney
	Defibrillator		Pacemaker		Stent in Gallbladder

Other surgeries not listed above: _____

_____

_____

Previous Hospitalizations

Date	Reason for being hospitalized

Family History – Have any of your blood relatives (not yourself, spouse, or friends) been diagnosed with any of the following? ** **Please state whether it was Paternal or Maternal Side.** **

Disease	Relation	Age when diagnosed
Breast Cancer		
Colon Cancer		
Lung Cancer		
Ovarian Cancer		
Prostate Cancer		
Diabetes		
Heart Disease		
Hypertension		

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Patient Name: _____ **Today's Date:** _____

Social History

1. Do you currently smoke? ___Yes ___No
   *If yes to above, how many cigarettes do you smoke in a day?_____

2. Do you use an Electronic Cigarette? ___Yes ___No

3. Are you a former smoker? ___Yes ___No
   *If yes to above, how long ago did you quit?_____
   *How many cigarettes did you smoke in a day?_____
   *How long did you smoke for before quitting?_____

4. Have you ever chewed tobacco? ___Yes ___No

5. Do you use recreational drugs? ___Yes ___No
   *If yes, please explain_____
_____

6. Do you drink alcohol? ___Yes ___No
   *If yes to above, how many drinks per week?_____

7. Do you drink Caffeine? ___Yes ___No
   *If yes, how many caffeinated drinks per day?_____

8. Does anyone in your home physically abuse you? ___Yes ___No
   *If yes, please explain_____
_____

9. Do you exercise? ___Yes ___No
   * If yes, how many times per week?_____

10. Are you sexually active? ___Yes ___No
    *How many partners have you had?_____

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Patient Name:_____ **Today's Date:**_____

Preventative History (Please list the month and year)

Colonoscopy – Date:_____ **Result:**_____

Eye Exam – Date:_____ **Result:**_____

Bone Density (Dexa) – Date:_____ **Result:**_____

Flu Vaccine – Date:_____

***If not done, please state reason:**_____

Pneumonia 13 Vaccine – Date:_____

***If not done, please state reason:**_____

Pneumonia 23 Vaccine – Date:_____

***If not done, please state reason:**_____

Patients over 50 years old only

*Have you fallen in the past year? ___Yes ___No

*If yes to above, when did you fall?_____

*How many times have you fallen?_____

*With injury or without injury?_____

Females Only

Mammogram – Date:_____ **Result:**_____

Pap Smear – Date:_____ **Result:**_____

Men Only

Prostate Specific Antigen (PSA) – Date:_____ **Result:**_____

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Acknowledgment of Receipt of Privacy Practice Notice

I acknowledge that I was provided with a copy of the Notice of Privacy Practices for East Lake Medical Center.

_____

Patient Name (Printed)

_____

Patient Signature

_____

Today's Date

If completed by a patient's personal representative, please print and sign your name in the space below.

_____

Patient's Personal Representative (Printed)

_____

Personal Representative's Signature

_____

Today's Date

I authorize release of my medical information and records to the following:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

_____

Patient's Signature Today's Date

FOR OFFICE USE ONLY

Complete this section if the form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain the written acknowledgment of receipt of East Lake Medical Center's Notice of Privacy Practices but was unable to for the following reason:

Patient refused to sign - Patient unable to sign - Other

Employee Name:_____ Today's Date:_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Baycare eXchange

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications

Do research, Comply with the law, Respond to organ and tissue donation requests, Work with a medical examiner or funeral director.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Vijay Taunk, M.D., P.A.

HIPAA Compliance Officer: Jacke Salanitri

Phone: 727-789-6551

This Notice of Privacy Practices is effective November 1, 2015

BayCare Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX **only**:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. **Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.**
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

BayCare
Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☐ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

_____ _____ _____

Printed Name of Patient/Representative Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____