Stoev & Stoev M.D. P.A.
Internal Medicine Associates
(941)-907-8700
(941)-907-8703
7305 Professional Parkway East
Sarasota, Florida 34240

WELCOME !

Thank you for choosing STOEV & STOEV M.D. P.A. for your health needs. You have been asked to show 45 minutes early to fill out your paperwork. If you are not able to complete your paperwork within the **45-minute time frame**, please let someone at the desk know so we may **reschedule** you, or if possible, block off the appointment following yours. We are asking you to do this because we strongly believe in giving new patients at least one (1) hour with the doctor.

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REGISTRATION FORM – PLEASE PRINT CLEARLY

DATE: _____ DATE OF BIRTH: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

PATIENT COMPLETE NAME: _____

Primary: STREET_____CITY_____STATE_____ZIP_____

Secondary: STREET_____CITY_____STATE_____ZIP_____

RESPONSIBLE PARTY IF A MINOR: _____

PATIENT SOCIAL SECURITY #: _____ SPOUSE'S SOCIAL SECURITY #: _____

_____ FEMALE _____ MALE _____SINGLE _____MARRIED _____DIVORCED _____WIDOWED

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

PATIENT OCCUPATION: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP _____

DO YOU HAVE: _____ MEDICARE CLAIM ID #: _____

DO YOU HAVE MEDICAL INSURANCE: YES NO

IF YES, NAME OF PRIMARY INSURANCE: _____

NAME OF SECONDARY INSURANCE, IF ANY: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED: _____

PHONE #: _____ RELATIONSHIP: _____

HOW DID YOU LEARN OF OUR PRACTICE: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____&_____ and assign directly to STOEV & STOEV M.D. P.A. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions.

_____ _____

SIGNATURE OF INSURED OR GUARDIAN DATE

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to STOEV & STOEV M.D. P.A. for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

SIGNATURE OF INSURED OR GUARDIAN DATE

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PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

ADDRESS: _____

TELEPHONE NUMBER: HOME _____ WORK _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MALE _____ FEMALE

SOCIAL SECURITY NUMBER: _____

LIST ALLERGIES TO MEDICATIONS AND/OR SUBSTANCES AND THE REACTION

MEDICATIONS / SUBSTANCES	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND ALL MEDICATIONS THAT YOU HAVE TAKEN STOPPED TAKING WITHIN THE LAST SIX (6) MONTHS. PLEASE INCLUDE ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS.

MEDICATION NAME	DOSAGE	TIMES TAKEN PER DAY	DATE LAST TAKEN
Ex: TYLENOL	***Ex: 500 MG***	***Ex: 3x A DAY***	***Ex: 10-24-2005***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ADULT IMMUNIZATIONS:

DATE OF LAST TETNUS: _____ DATE OF LAST PNEUMONIA SHOT: _____

DATE OF LAST FLU SHOT: _____ DATE OF HEPATITIS SERIES: _____

LIST ALL MEDICAL PROBLEMS YOU HAVE HAD IN THE PAST:

_____

_____

_____

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LIST ALL PHYSICIANS YOU HAVE SEEN IN THE PAST OR ARE CURRENTLY SEEING AND LIST THEIR SPECIALTY AND ADDRESS AND TELEPHONE NUMBER:

DOCTOR	SPECIALTY	STREET ADDRESS & STATE	TELEPHONE NUMBER

LIST ALL SURGICAL PROCEDURES:

SURGERY	DATE

LIST ALL HOSPITALIZATIONS:

REASON FOR HOSPITALIZATION	DATE

DATE OF LAST PREVENTIVE HEALTH PROCEDURE:

COLONOSCOPY:_____CHOLESTEROL:_____VISIONSCREEN:_____

HEMOCCULT:_____ FLEX SIG:_____ BONE DENSITY:_____

DATE OF LAST PHYSICAL:_____

FOR WOMEN ONLY:

DATE OF LAST MENSTRUATION: _____ DATE OF LAST MAMMOGRAM: _____

DATE OF LAST PAP SMEAR: _____ AGE OF MENOPAUSE: _____

OF PREGNANCIES: _____ # OF ABORTIONS/MISCARRIAGES: _____

DATE OF LAST BREAST EXAM:_____

FOR MEN ONLY:

DATE OF LAST PROSTATE EXAM: _____ PSA: _____

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PERSONAL AND FAMILY HISTORY:

DO YOU OR ANYONE IN YOUR FAMILY HAVE OR EVER HAD ANY OF THE FOLLOWING:

STROKE	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
HEART TROUBLE	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
HIGH BLOOD PRESSURE	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
HIGH CHOLESTEROL	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
DIABETES	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
GOUT	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
ARTHRITIS	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
OBESITY	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
SEIZURES	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
MENTAL ILLNESS	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
MIGRAINES	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
KIDNEY DISEASE	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
CANCER	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
BLEEDING DISORDER	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
BLOOD CLOTS	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
ALCOHOLISM	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
TUBERCULOSIS	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
ASTHMA	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
ANEMIA	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
LIVER DISEASE	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
THYROID DISORDER	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS
ALLERGIES	___ SELF	___ MOTHER	___ FATHER	___ SIBLINGS	___GRANDPARENTS

OTHER: _____

_____

_____

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SOCIAL HISTORY

1) MARITAL STATUS: _____MARRIED ____SINGLE ____DIVORCED ____WIDOWED

2) NUMBER OF CHILDREN: _____ AGE OF CHILDREN: _____

3) DO YOU LIVE ALONE: ____YES ____NO

- IF NO, WHO RESIDES WITH YOU: _____

4) CURRENT OCCUPATION: _____ PREVIOUS OCCUPATION: _____

5) HAVE YOU EVER HAD OCCUPATIONAL EXPOSURE TO TOXIC CHEMICALS? ____YES ____NO

- IF YES, PLEASE EXPLAIN: _____

6) HOBBIES: _____

7) DO YOU EXERCISE:____YES ____NO

- IF YES, HOW MANY TIMES PER WEEK: _____

8) DO YOU USE TOBACCO: ____YES ____NO ____PREVIOUS SMOKER BUT HAVE QUIT

- IF YES, LIST # OF PACKS PER DAY: _____ # OF YEARS _____

- IF A PREVIOUS SMOKER, LIST DATE QUIT: _____

9) DO YOU USE ALCOHOL: ____YES ____NO

- IF YES, LIST TYPE AND AMOUNT: _____

10) DO YOU USE ILLICIT DRUGS: ____YES ____NO

- IF YES, PLEASE LIST: _____

11) DO YOU HAVE ANY RISK FACTORS FOR HIV INFECTION: _____ YES _____ NO

- IF YES, PLEASE EXPL.AIN: _____

12) HAVE YOU EVER HAD A BLOOD TRANSFUSION: ____YES ____NO

- IF YES, LIST DATE: _____

THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE HEALTHCARE STAFF TO PERFORM THE NECESSARY HEALTHCARE SERVICES I MAY NEED.

_____ _____

PATIENT SIGNATURE DATE

THIS IMPORTANT INFORMATION IS CONFIDENTIAL. NO ONE OTHER THAN STOEV & STOEV, M.D. P.A. WILL HAVE ACCESS OR KNOWLEDGE OF THIS INFORMATION WITHOUT YOUR EXPRESS WRITTEN CONSENT. THANK YOU VERY MUCH FOR TAKING THE TIME TO FILL OUT THIS LENGTHY FORM. COMPLETION OF THIS HISTORY ALLOWS US TO PROVIDE YOU THE MOST COMPLETE MEDICAL CARE POSSIBLE. THIS FORM WILL BE REVIEWED WITH YOU DURING YOUR VISIT.

AUTHORIZATION TO RELEASE MEDICAL RECORDS / INFORMATION

I, _____, understand that the information contained in my
Patient's Name
medical record is confidential. However, I hereby authorize a copy of my medical records be

Released From:

_____

Doctor's Name Address Telephone Number

AND

Forwarded To:

Stoev & Stoev M.D. P.A.
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By initialing the spaces below, I authorize the release of the following records, if such exist:

_____ Complete Medical Record

_____ Treatment Reports

_____ Operative Reports

_____ Diagnostic Imaging Reports

_____ Pathology Reports

_____ Physical/Occupational Therapy Reports

_____ Mental Health Records

_____ Physician Office Reports

_____ Consult Reports

_____ Discharge Summary

_____ Laboratory Reports

_____ HIV/AIDS Reports

_____ Drug/Alcohol Reports

I understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it shall remain in force for 1 (one) year. A copy and/or a faxed copy of this release authorization shall be valid as an original. Also, I understand that the entire record may be large and I agree to pay all reasonable copying charges.

_____ _____ _____ _____
Patient's Signature Date DOB SS#
Or
Legal Representative/Guardian

_____ _____
Witness Date

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Office Policy and Procedures

1. Patients will be responsible for knowing the terms, conditions and benefits of their insurance. Notifying your insurance company of the change in Personal Care Provider (PCP) is strongly recommended. Some insurance require you to do so before seeing the doctor.

2. All self-pay patients are required to submit a $170.00 deposit on each visit before seeing the doctor.
*There are no payment plans. Payment is due at the time of service.

3. All billing services are handled outside the office by OptiMed Billing Solutions. For all inquire please contact them directly at 941-870-2112.

4. If you are not able to keep your scheduled appointment please contact the office 24 hours prior.
**Missing an appointment* without contacting the office will result in a *$35.00 fee*.

5. New patients may only cancel an appointment once. If a new patient cancels for a second time he / she will not be given the opportunity to reschedule.

6. Established patients will be discharged if they fail to contact the office to cancel an appointment 3 consecutive times.

7. ALL REFILLS ON MEDICATIONS MAY TAKE 24 TO 72 HOURS. PLEASE CALL YOUR PHARMACY AT LEAST 3 DAYS PRIOR TO RUNNING OUT OF MEDICATION.

I _____, have read the above statement and fully understand Stoev & Stoev's policies and procedures.

X_____ _____
Signature Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS / INFORMATION

I, _____, give **STOEV & STOEV, M.D., P.A.** permission to release a copy of my medical records/information to any healthcare provider I am referred to for the continuity of my care.

***STOEV & STOEV M.D. P.A. will not charge patients for copying or faxing medical records to referring physicians.**

I understand that this authorization, except for action already taken, may be voided by me at any time. A copy and/or a faxed copy of this release authorization shall be valid as an original. Also, I understand that if I request my records to be sent to anyone other than the physicians I am referred to I agree to pay all reasonable copying charges.

Pleas initial one of the following:

_____ 1) **I give permission** to leave any sensitive information on an answering machine including but not limited to test results, changes in medication, medical instructions, etc.

_____ 2) **I do not give permission** to leave sensitive information on an answering machine.

_____ _____
Patient's Signature Date
Or
Legal Representative/Guardian

_____ _____
Witness Date

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NOTICE OF PRIVACY PRACTICES

UNDER FEDERAL LAW YOUR PATIENT HEALTH INFORMATION (PHI) IS PROTECTED AND CONFIDENTIAL. PHI INCLUDES INFORMATION ABOUT YOUR SYMPTOMS, TEST RESULTS, DIAGNOSIS, TREATMENT, AND RELATED MEDICAL INFORMATION. PHI ALSO INCLUDES PAYMENT, BILLING, AND INSURANCE INFORMATION.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO EXPLAINS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY AND SIGN AND DATE IN THE APPROPRIATE SPACE.

Uses and Disclosures: We may use and disclose elements of your protected health information (PHI) in the following ways:

1. To refer you to another physician or specialist for evaluation. We will forward the necessary medical records.
2. To refer you for laboratory work. We will forward the necessary medical records.
3. To refer you for radiological assessment. We will forward the necessary medical records.
4. To obtain payment for your care we will disclose the necessary information to our billing company and to your health plan.
5. When we send your specimens to a laboratory for processing, we will forward the necessary billing information.
6. To contact you about appointment reminders we will leave a message on your answering machine or leave a message with a family member. The only information that will be given is the date and time of the appointment. The other way we contact you about appointment reminders is with a postcard. The postcard is addressed to you and only indicates for you to call and schedule an appointment. There will be a code in the bottom left corner of the postcard you will need to provide to us when you call so we will know how to schedule your appointment.
7. When release is required by law, including in judicial settings and to health oversight regulatory agencies and law enforcement. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant or complying with health oversight authorities, such as audits, investigations and inspection, necessary to ensure compliance with government regulations and civil right laws.
8. We may also disclose your PHI to public health or legal authorities charged with preventing and controlling disease, injury, or disability.

NOTICE OF PRIVACY PRACTICES **(Cont.)**

9. In emergency situations or to avert serious health/safety situations when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.
10. To medical examiners, coroners, or funeral directors to aid in identifying you or to help them in performing their duties.
11. To organ, tissue and other donation organizations, upon or proximate to your death, if we have a positive indication about your donation references and if we have no indication on hand about your donation preferences.
12. To workers compensation.
13. To transcription services.
14. Unless you object, we may disclose to a family member or a close personal friend your PHI that is relevant to that person's involvement in your care or payment related to your care. We may notify these persons of your location and your general condition.
15. All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

1. To request restricted access to all or part of your PHI. To do this, you must put your request in writing and submit your request to this office. We are not required to grant your request. We will respond to your request within thirty (30) days of receipt.
2. To receive correspondence of confidential information by alternate means or locations. To do this, you must put your request in writing and submit your request to this office.
3. To inspect or receive copies of your PHI. To do this, you must put your request in writing and submit your request to this office. We will respond to your request within thirty (30) days of receipt. We may charge a reasonable fee for copying and assembling costs associated with your request.
4. To request changes be made to your PHI. To do this, you must put your request in writing and submit your request to this office. We are not required to grant your request. We will respond to your request within thirty (30) days of receipt.
5. To receive an accounting of the disclosures by us of your PHI. To do this, you must put your request in writing and submit your request to this office. We will respond to your request within thirty (30) days of receipt.
6. To get updates or reissue of this notice. To do this, you must put your request in writing and submit your request to this office. We will respond to your request within thirty (30) days of receipt.

NOTICE OF PRIVACY PRACTICES **(Cont.)**

7. To complain to us if you feel your privacy rights have been violated. To do this, you must put your complaint in writing and submit it to this office. We will respond to your request within thirty (30) days of receipt. To complain to the U.S. Department of Health and Human Services if you feel your privacy rights have been violated, you must contact them directly. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: For more information about our privacy practices, please contact our office Privacy Officer.

Effective date: This notice is effective April 14, 2003.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BY SIGNING BELOW, I ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY

PRACTICES FROM STOEV & STOEV M.D., P.A.

_____
PRINTED NAME

_____ _____
SIGNATURE **DATE**

I AUTHORIZE STOEV & STOEV M.D., P.A. TO SPEAK TO THE FOLLOWING PERSON(S) ABOUT MY HEALTHCARE:

_____ _____
Name/Relationship Name/Relationship

_____ _____
Name/Relationship Name/Relationship