Patient form

Patient Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Today's Date: _____

ICD Code	Chronic Medical Problem List	Date	Past Surgical Histor	Date

Medications	dose	Hospitalizations	Date

Today's Chief Complaint: _____

Drug Allergies/ Sensitivities: _____

Family History of

	Yes	No	Family Member
Alzheimer's Dz	○	○	
Breast Ca	○	○	
CAD	○	○	
Cerebrovas. Dz	○	○	
Cervical Cancer	○	○	
Colon CA	○	○	
Depression	○	○	
DM	○	○	
Fe Storage	○	○	
Glaucoma	○	○	
Hyperchol	○	○	
HTN	○	○	
Ovarian CA	○	○	
Prostate CA	○	○	
Skin CA	○	○	
Thyroid Dz	○	○	

History of Chief Complaint

When did this start: _____

	Yes	No
Have you had this before	◯	◯
SMOKE cigarettes	◯	◯
Alcohol	◯	◯
Use street drugs	◯	◯

HIPAA

By signing below you give us permission to contact you by phone/text/voice mail

Social History

◯ Married ◯ Single ◯ Civil Union ◯ Divorced

◯ Widow(er) ◯ Lives Alone ◯ Separated

Sexual Preference:

◯ Male ◯ Female ◯ Both

Occupation: _____ Religious Preference: _____

Advance Directive?

◯ Yes ◯ No

Educ.:

◯ JHS ◯ HS ◯ College ◯ Other

Signature: _____ Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

◯ Yes ◯ No

May we leave a message on your answering machine at home or on your cell phone?

◯ Yes ◯ No

NO May we discuss your medical condition with any member of your family?

◯ Yes ◯ No

YES, please name the members allowed:

This consent was signed by: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

HIPAA & Demographics Annual Update

Authorization to Disclose Health Information

Pt Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Number

◯ Home ◯ Work ◯ Cell

Phone Number

◯ I authorize I:argo Clinic/l)r K"s Med Spa to send Ine texts and respond to replies

◯ I authorized Largo Clinic/l)r K 's Med Spa to leave messages on phone.

Email: _____

◯ I authorized Largo Clinic/l)r K 's Med Spa to leave messages on phone.

Health Insurance:

Carrier: _____ ID: _____

Group#: _____

Largo clinic only accepts limited insurance carriers. I lowever, we do refer patients for services beyond the clinic. Your insurance information on file will help us with coordination of' benefits referrals, laboratory request, radiology request, etc.)

I, the Patient, hereby authorized Largo Clinic (the Doctor and Staff), to release medical information (appointments, lab, x-rays, results, diagnoses, treatments, medications, surgeries, etc.)via postal mail, telephone, fax or email to the following designated persons:

Name	Relationship

You May request a copy of our clinics Notice of Privacy Practices

☐ I would like a copy of the clinics NPP

☐ I do not want a copy of the clinics NPP

☐ I also authorized Largo Clinic/Dr K 's Med Spa to send me via phone/text/emails notifications regarding sales specials, specials on services, and discounted services.

Patient Signature: _____

Informed Consent

Largo Clinic is a "point of contact" practice. Our focus is on your acute medical or surgical problem at the time you present to this office. It is our intent to provide you with the best medical care possible within the scope of our experience and the physical facilities available in this office.

A medical membership at Largo Clinic is prepaid medical, not surgical care with us and does not represent insurance of any kind or access to any specialist or ancillary services.

Frequently medical diagnosis or surgical procedures require ancillary modalities such as laboratory tests or x-rays to provide you with appropriate care and treatment. Both x-rays and lab testing are available to this practice but are performed outside this facility. Any charges for those tests are your direct and immediate responsibility. Tests typically require a minimum 48 hour turnaround time before they are made available to our office. Based on our experience it is often appropriate to initiate treatment before performing blood tests or x rays. If such tests are ordered and you chose not to follow up in the office or obtain requested studies or testing, our ability to assist you with your health care needs may be severely limited. If your decision not to pursue testing is based on financial issues, please be aware that local hospital emergency departments will see you without any financial caveats.

Medicare Non-Provider Status

Dr George Kamajian has opted out of Medicare as of 2007. This office will continue to see all patients who present for treatment regardless of their insurance status. You, the patient, agrees to accept full responsibility for payment of our office charges. You understand that Medicare limiting charges do not apply to our office fees. You understand that neither you nor this office should submit a claim to Medicare. You understand that Medicare payments will not be made for items or services that otherwise would to have been covered by Medicare if no private contract existed. You understand you have the right to obtain Medicare covered items and services from participating Medicare physicians.

This practice is not open on nights or weekends or every day of the business week and we do not admit or see patients in the hospital. We will try to return calls promptly during office hours. This is a solo practice and there is no physician coverage for emergencies when this office is closed, and we do not always respond to after hour phone calls. Please proceed to the nearest emergency department or call 911 after our regular office hours.

Authorization and Agreement for Treatment

Consent to treatment: I hereby grant my authorization and consent to such treatment and procedures, including but not limited to trigger point injections, and certify that no guarantee or assurance has been made to me by Dr Kamajian or his staff as to the results or success obtained.

Complications: I understand that it is my responsibility to return to the Clinic or report any change in my condition to the clinic. If the clinic or Dr Kamajian is not available, I understand I must precede to the nearest emergency department or hospital.

Privacy notice: I acknowledge that I have received and/or read the HIPAA privacy notice. The undersigned certifies that he/she has read the above and is the patient, guarantor or the patient's representative duly authorized to execute this agreement and accept its terms.

By signing below you acknowledge that you have read the information above and agree to treatment under these guidelines.

Signature: _____ Date: _____

Financial Policy

Insurance: This office accepts most Florida Blue insurance plans and some forms of Cigna PPO. As a courtesy, we will submit an insurance claim to Florida Blue and Cigna on your behalf. You are agreeing to assume responsibility for any charges not paid for by your health care insurer. If you have a different insurance plan we can provide you with an insurance reimbursement form for services rendered to submit to your insurance company.

Charges, Fees and Collection Procedures: All fees and charges for new and follow-up office visits are due in full upon check-in and before being seen by the doctor. There is a fee for every office visit, please plan accordingly. We accept cash, credit cards, and debit cards. We do not accept checks as a form of payment. You will be billed for any unpaid balance and after 30 days of non-payment, you will be referred to a collection agency.

Care Credit: Care Credit is accepted in this office as an outside financing resource. Your Care Credit card and valid photo ID are required to use this method of payment.

Outstanding Balances: Any patient receiving controlled substances must pay each visit in full and cannot have any outstanding balance. Any patient with an outstanding balance must pay at least 10% of the outstanding balance in addition to present charges before any further office visits or services will be rendered. Failure to pay any outstanding balance will result in patient discharge.

Credit Card Payments: If paying by credit card, you must present your credit card with your name on it, along with your valid driver's license, passport, state or military ID. If another person is paying for your visit, they must fax this office a copy of their valid credit card, valid ID, and written permission to charge their card for services rendered to you. This is required in order to avoid fraud.

Debit Card Payments: Debit card payments are gladly accepted. If you do not know your pin, the payment will be processed as a credit card.

Letters of Protection (LOP): This office does not accept Letters of Protection.

Missed Appointments: At least 24 hour notice must be given to cancel or re-schedule an appointment. Failure to cancel or re-schedule your appointment 24 hours in advance will result in a $25.00 flee. Failure to pay this fee may result in patient discharge.

I have and understood this Financial Policy and I agree to the terms and conditions above.

Patient Signature: _____ Date: _____

Staff member Signature: _____ Date: _____