TRINITY DOCTORS GROUP, PA

Medical History Form

Name: _____ Age: _____ Height: _____ Weight: _____

Pharmacy Name: _____ Location: _____ Phone: _____

List Any Allergies to Medications/Food: ☐ **No Known Drug Allergies**

☐ Aspirin ☐ Sulfa ☐ Penicillin ☐ NSAIDS ☐ Codeine ☐ Other: _____

_____

List Current Medications Including Over the Counter Medications ☐ **No Current Medications**

Name Strength/Dosage Directions/Frequency

_____

_____

_____

Past Medical History: Do you have any medical problems listed below? ☐ **None**

☐ Anemia	☐ Constipation	☐ Goiter	☐ Osteoporosis
☐ Angina/Chest Pain	☐ Coronary Artery Disease	☐ Heart Attack	☐ Rash
☐ Arthritis/Joint Pain	☐ Depression/Anxiety	☐ Hepatitis	☐ Seizure Disorder
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Stomach Issues/Acid Reflux
☐ Blood Clots	☐ Diarrhea	☐ High Cholesterol	☐ Stroke, CVA/TIA
☐ Cancer: _____	☐ Diverticulitis/Diverticulosis	☐ Kidney Disease	☐ Thyroid Disease
☐ Constipation	☐ Enlarged Prostate	☐ Kidney Stones	
☐ COPD (Emphysema)	☐ Gallbladder Disease	☐ Migraine/Headaches	

Past Surgical History: Have you ever had any surgeries? What year did they occur? ☐ **None**

☐ Appendix Removal	☐ Fibroid Removal	☐ Hip Replacement – RIGHT/LEFT
☐ Back Surgery	☐ Gallbladder Removal	☐ Knee Replacement – RIGHT/LEFT
☐ Carpal Tunnel Release	☐ Heart Bypass	☐ Pacemaker
☐ Cataract Surgery	☐ Heart Stent	☐ Prostate Removal/Seeds
☐ Colon Resection	☐ Hernia Repair	☐ Tonsil/Adenoid Removal

☐ Other: _____

Female Only:

Still menstruating? YES NO ☐ Date of Last Period: _____

☐ Menopause/Menopausal Symptoms ☐ C-Section ☐ Hysterectomy

☐ Breast Biopsy/Surgery ☐ Breast Augmentation

☐ Are you Pregnant? ☐ Are you nursing?

☐ Date of Last Mammogram: _____ ☐ Date of Last PAP: _____

Continued on Back →

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Do you use tobacco? YES NO

☐ Do you consume Alcohol? YES NO

-How often? Daily Weekly Monthly Rarely

-How many? 1-2 drinks 3-4 drinks 4-5 drinks 6+ drinks

☐ Use Marijuana? YES NO

☐ Do you have children? How Many? _____

☐ Occupation? _____

☐ Retired? What was your past profession? _____

Family Medical History **☐ Adopted/Unknown**

	If Living Age	Medical Conditions	**If Deceased:** Age at Death	Cause of Death/Medical Condition
Father:				
Mother:				
Brother(s):				
Sister(s):				

Preventive Care/Services: *Please provide approximate dates of your last screening services:*

☐ PSA (Prostate) _____ (Male Only)

☐ Cholesterol _____

☐ Colonoscopy_____

☐ Eye Exam _____

Vaccines (What date did you receive them?) **☐ NONE**

☐ FLU _____ ☐ Pneumonia _____

☐ Shingles _____ ☐ Tetanus _____

Patient Signature: _____ Date: _____

TRINITY
DOCTORS GROUP, PA
Caring For Adolescents To Adults

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently we have developed an appointment system that sets asides ample time for a patient.

"No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, that time that has been allotted for you cannot be used to treat another patient and is time lost to our office. In effort to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office a 24- hour notice in the event you need to reschedule your appointment. Our phone number is 727-372-3750.

2. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a **$50.00** no-show fee with be assessed to you. This applies to late cancellations and "no-shows."

3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

4. Our office makes reminder calls for appointments. If you are registered for the patient portal, you will receive e-mail reminders as well. However, the cancellation policy remains in effect regardless if a reminder message was received. It is ultimately the patient's responsibility to remember their scheduled appointments.

If you have any questions regarding this policy, please contact the office and we will be glad to clarify any concerns you may have.

We thank you for trusting Trinity Doctors Group, P.A. with your medical care.

I have read and understand the Medical Appointment Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

_____

Printed Name

8133 State Road 54 – New Port Richey, FL 34655 – Ph: 727-372-3750 – Fx: 727-372-3754

TRINITY
DOCTORS GROUP, PA

Patient Last Name _____ First Name_____M.I. _____

Primary Address: _____City _____ State & Zip _____

Secondary Address: _____City _____ State & Zip _____

Home Phone (____) _____ Cell Phone (____) _____Work Phone (___) _____

Social Security_____-_____-_____ DOB: _____/_____/_____ Age_____ Gender: M ( ) F ( )

Employer _____ Marital status _____ Race _____ Ethnicity _____

Emergency Contact Name & Phone Number _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Would you like access to the Patient Portal? If yes, provide E-Mail Address_____

PRIMARY INSURANCE INFORMATION *(This information is required)*

Relationship to Patient ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other _____

Insurance Company _____ Name of Insured _____

Insured's DOB _____/_____/_____ SSN _____-_____-_____ Sex M ( ) F ( )

Insured's ID Number _____ Group Number_____

Insured's Address (if different from patient's) _____ Phone (_____) _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Name of Insured _____

Insured's DOB _____/_____/_____ SSN _____-_____-_____ Insured's ID Number _____

Address _____ Effective Date _____/___/_____

ASSIGNMENT OF BENEFITS

I hereby authorize any insurance or other third party benefits to make medical benefits payments, otherwise payable to me for services rendered by John D. Ibrahim, M.D. and his staff payable to and mailed directly to: ***Trinity Doctors Group, P.A., 8133 State Road 54, New Port Richey, FL 34655***. Furthermore, I hereby IRREVOCABLY ASSIGN to Trinity Doctors Group, P.A. the rights and benefits under any polity of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and/or changes, provided by Trinity Doctors Group, P.A. Furthermore, the undersigned allows Trinity Doctors Group, P.A. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements.

_____

Patient Name (Patient or Legal Guardian) **Signature** **Date**

_____

Print Witness Name **Signature** **Date**

Patient Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. Please read carefully the financial policies as described below.

PAYMENT OF SERVICES: Payment for services rendered is ultimately the patient's responsibility. Your insurance is a contract between you and your insurance company. It is YOUR responsibility to provide us with correct information about your insurance plan. If your plan requires authorization it is your responsibility to provide this failure to provide this will warrant you responsible for any costs incurred. If you cannot provide a current medical insurance card, full payment must be made at the time of service. For your convenience we accept cash, personal checks, most major credit and debit cards.

CO-PAYMENT OF SERVICES: Your insurance company requires you to pay your co-payment at the time of service. Failure to pay is a violation of your contract with your insurance company. Please do not ask us to bill you for your co-pay. Procedures (ex: treatments, injections, etc.) are considered "procedures" and the fees for theses services may require separate deductibles or copays as determined by your insurance policy. Any co-payments are required to be paid at the time of service or upon notification. We cannot waive co-payments, deductibles, co-insurance responsibilities or non-covered service amounts that are determined to be the patient's responsibility per contractual obligation. We make every effort to follow the guidelines set by the various insurance companies. If you do not inform us of any special requirements your plan has and we subsequently perform a service that is denied, we have no choice except to bill you directly for those charges. If payment is not received from your insurance company within 45 days from the date of service, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. Non- emergency treatment will be denied unless non-covered charges and co-payments have been paid and insurance billing is approved under the insured's policy.

COLLECTIONS POLICY: If you have an outstanding balance, we will mail you a statement monthly. A prompt response is expected. Failure to pay your portion of insurance allowable is a violation of your insurance contract and could result in insurance cancellation. If you default on your promised payment, our policy is to refer to a collection agency. The balance will accrue a monthly interest fee and an additional fee for the expense related to collections this fee is $30.00. Checks returned to our office for non-sufficient funds (NSF) will incur a $40.00 service charge.

CANCELLATION/MISSED APPOINTMENTS: Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. Appointments that are not cancelled 24 hours in advance will be charged $25.00. Patients who miss their appointments and fail to call will be charged $25.00.

LABORATORY FEES: We try to utilize contracted laboratories for all of our patients, however there are times that we send specimens out and the laboratory will send it on to pathology or another provider, in the event this occurs we can not be responsible for any charges that might be incurred.

MISCELLANEOUS POLICIES: Unaccompanied minors must have a signed consent by a parent or guardian and be sent with a method of payment for their co-pay. The parent or guardian who signs the consent and authorization form is responsible for any balance on the account. Should you request copies of your medical records, there is a fee charged as allowed by current Florida statues. There is also a cost associated with your request for physician narrative reports and or letters not related to insurance claims. These fees would be based on the complexity and amount of time involved.

I have read and understand the terms of this financial policy. I understand and agree that such terms may be amended from time to time by practice. I agree and assign insurance Benefits to **Trinity Doctors Group** authorize the release of medical information to any consultants/ medical facilities if needed and as necessary to process insurance claims, insurance applications and prescriptions.

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X_____ X_____

Signature of patient or Responsible party Date

TRINITY
DOCTORS GROUP, PA

NARCOTICS CONSENT FORM

The administration of any controlled substance or narcotic medication is strictly decided by the physician. If in the instance a narcotic is prescribed the following guidelines must be followed and understood by all patients.

The risks of taking a controlled substance include, but are not limited to, drug dependency, addiction, respiratory problems, depression, liver and/or kidney damage, death, etc.

Patients agree to take medications only as prescribed and also agree to notify the physician if the patient does not comply. By agreeing to take the medications as directed, patient is agreeing to random urine and/or blood test to assess compliance.

Patient understands that random urine drug screens may be performed at any given office visit to monitor prescribed medication. Patient must understand that the insurance company may not cover a drug screen and that they will be responsible for the full amount that is not covered at the time of the office visit.

Patients understand that the test results and interpretation will become part of the medical record. Patient's insurance company may discover the results of this test by obtaining a copy of patient's medical records.

Lost, stolen, or misplaced prescriptions will **NOT BE REPLACED**. If a patient needs a refill on a controlled substance they **MUST** schedule an office visit. The physician will **NOT** refill narcotic medication over the phone or without seeing the patient in the office.

Patients agree that if they deviate from the above guidelines that the physician owns the right to taper off or discontinue the narcotic. Failure to comply with the guidelines also could result in immediate termination from this practice.

By signing this, patient is expressing his/her understanding and agreement with these guidelines.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

8133 State Road 54, New Port Richey, FL 34655- Ph: 727-372-3750, Fax: 727-372-3754

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320D, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

Trinity Doctors Group, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose medical information for the purpose(s) of continuity of care and billing.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to intended recipients.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at the office or by sending a written request with return address to 8215 State Road 54, New Port Richey, FL 34655.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy you PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, expected to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide a copy of this signed authorization when requested.

Trinity Doctors Group, P.A. may release my Protected Health Information to:

Name/Relationship/Phone: _____/_____/_____

Name/Relationship/Phone: _____/_____/_____

☐ Trinity Doctors Group, P.A. may call my home or cell and leave a message on voicemail or in person in reference to any item that assist the clinic in carrying out healthcare operations, appointment reminders, insurance information and calls pertaining to clinical care, such as laboratory results.

Acknowledged and agreed to by:

_____

Patient (or Legal Guardian) Signature Date

TRINITY
DOCTORS GROUP, PA

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Patient Signature Date

_____ _____

Witness Signature Date

8133 State Road 54, New Port Richey, FL 34655- Ph: 727-372-3750, Fax: 727-372-3754

TRINITY DOCTORS GROUP, PA
Caring For Adolescents To Adults

J.D. Ibrahim, M.D.
Jeaninne Oliver, PA-C
8133 State Road 54
New Port Richey, FL 34655
P: 727-372-3750 Fx: 727-372-3754

Authorization to Release Health Care Information

Patient Name: _____

Date of Birth: _____ Patient Phone: _____

Address: _____ City _____ ST, ZIP _____

I authorize and/or request Trinity Doctors Group, P.A. to:

☐ Release my information to:
☐ Obtain health care information from:

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

You are authorized to disclose or receive the following:

☐ History & Physical ☐ Consultations ☐ Discharge Summary ☐ Operative Notes ☐ Labs, Imaging ☐ Office Notes

☐ Other: _____

Specify dates of records needed: _____

I DO ☐ I DO NOT ☐ authorize the release of information relating to the diagnosis of treatment of alcohol or drug abuse. If I authorize release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

I DO ☐ I DO NOT☐ authorize the release of information relating to the diagnosis or treatment of mental health. If I authorize the release of this information, I DO ☐ I DO NOT ☐ want to review this information before it is released. I understand that my review must be supervised. I understand that release of information may be necessary for reimbursement and that I may decide to pay for services myself rather than allow release of my information.

I DO ☐ I DO NOT ☐ authorize the release of information relating to the diagnosis or treatment of HIV, ARC, or AIDS.

☐ This authorization is effective for 1 year from the date below and I authorize future disclosures to the same individuals and or entities during this time period.
I understand that:
I can revoke all or part of this authorization at any time by notifying Trinity Doctors Group, P.A., as provided for in our Notice of Privacy Practices, subject to the rights of anyone who received disclosed information prior to receiving my revocation.
I can refuse to disclose all or some of the information in my health care records.
A refusal to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for your health benefits and other adverse consequences.
The information released may be subject to re-disclosure unless otherwise protected by law. I may cross out any words on this form with which I disagree.

Signed: _____ Date: _____
(Patient or his/her legally appointed representative)