BAY AREA INTERNIST, INC.
BHANUPRASAD. J. PATEL, M.D.
5520 DR M.L.K JR STREET NORTH
ST PETERSBURG, FL, 33703
PH:- (727)526-1775 FAX:-(727)526-5764

PATIENT NAME: _____
(LAST FIRST M.I)

D.O.B: ___/___ /_____ S.S.N :_____- _____- _____ GENDER: MALE / FEMALE

ADDRESS:_____
STREET NAME APT#

_____
CITY/STATE/ZIP CODE

LANGUAGE SPOKEN: (PRIMARY):_____(SECONDARY):_____

ETHNICITY (OPTIONAL):_____ RACE(OPTIONAL): _____

RELIGION(OPTIONAL): _____

EMAIL(OPTIONAL): _____

PHONE:(_____) _____-_____ WORK:(_____) _____-_____

HOME: (_____) _____ - _____

EMERGENCY CONTACT:_____

RELATIONSHIP TO PATIENT:_____

PHONE:(_____) _____-_____ WORK:(_____)_____-_____

HOME: (_____) _____ - _____

PHARMACY NAME & LOCATION:_____

ADDRESS:_____

STREET NAME

_____

CITY/STATE/ZIP CODE

PHONE:(_____) _____-_____

GENERAL MEDICAL HISTORY

ALLERGIES TO MEDICATION:_____

_____

FOOD ALLERGIES:_____

_____

CURRENT MEDICATION:_____

_____

PREVIOUS SURGERIES OR HOSPITALIZATION: (INCLUDING MISCARRIAGES OR LIVE BIRTH):

_____

FEMALES ONLY: ARE YOU PREGNANT OR PLANNING A PREGNANCY OR NURSING:

☐ YES ☐NO

DO YOU SMOKE? ☐ YES ☐NO ☐ CIGARETTES ☐PIPE ☐CIGARS
NO. OF YEARS:_____ HOW MUCH:_____

DO YOU REGULARLY DRINK ALCOHOL? ☐ YES ☐NO NO. OF YEARS:_____
HOW MUCH:_____

DO YOU REGULARLY DRINK COFFEE ? ☐ YES ☐NO NO. OF YEARS:_____ HOW MUCH:_____

PERSONAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING.(CHECK ALL THAT APPLY)

- ☐ CHEST PAIN
- ☐ HYPERTENSION
- ☐ HEART ATTACK
- ☐ STROKE
- ☐ HEADACHES
- ☐ GLAUCOMA
- ☐ ECZEMA
- ☐ DEPRESSION
- ☐ BLOOD IN STOOL
- ☐ ASTHMA
- ☐ DIZZY SPELLS
- ☐ CANCER
- ☐ DIABETES
- ☐ ARTHRITIS
- ☐ HEARING LOSS
- ☐ MEMORY LOSS
- ☐ HEMORRHOIDS
- ☐ KIDNEY DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ TB/ LUNG DISORDER
- ☐ ULCERS
- ☐ SKIN DISORDERS
- ☐ HEPATITIS
- ☐ CATARACTS
- ☐ DIGESTIVE PROBLEMS
- ☐ UTI

FAMILY HISTORY

CHECK ALL THAT APPLY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS
HIGH BLOOD PRESSURE				
EPILEPSY				
CANCER				
ECZEMA/ PSORIASIS				
HEART ATTACK/ STROKE				
DIABETES				
ASTHMA				

CONSENT FOR TREATMENT

I HEREBY VOLUNTARILY CONSENT TO CARE ENCOMPASSING ROUTINE DIAGNOSTIC PROCEDURES AND MEDICAL TREATMENT BY DR BHANUPRASAD PATEL AND/OR HIS ASSISTANT(S) AND/OR ASSOCIATE(S).

_____ ROUTINE AND DIAGNOSTIC PROCEDURES
(INITIALS)

_____I AUTHORIZE PERFORMANCE OF THE FOLLOWING TREATMENT(S)/PROCEDURE(S) INCLUDING BUT NOT LIMITED TO LOCAL ANESTHESIA, RADIOLOGY, PATHOLOGY AND AS MANY AS MAY BE ADVISABLE FOR MY WELL BEING.

_____ NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT(S)/PROCEDURE(S). THE NATURE AND PURPOSE OF THE PROCEDURE(S) TO BE PERFORMED, ALTERNATIVE TREATMENT(S), THE RISK INVOLVED, THE POSSIBILITY OF COMPLICATIONS, AND THE EXPECTED OUTCOME HAVE BEEN FULLY EXPLAINED TO ME.

BY SIGNING I AGREE AND UNDERSTAND THAT I HAVE READ AND AGREE TO THE FOREGOING, THE TREATMENT(S) AND/OR THE PROCEDURE(S) HAVE BEEN EXPLAINED TO ME. I HAVE ALL THE INFORMATION THAT I DESIRE AND THEREFORE GIVE MY CONSENT.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTIFICATION AND PHI(PERSONAL HEALTH INFORMATION) RELEASE FORM

I, (FIRST & LAST NAME)_____HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES FOR BAY AREA INTERNIST,INC.

I HEREBY AUTHORIZE BAY AREA INTERNIST ,INC TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING PERSON WITHOUT RESTRICTIONS.

1. _____RELATIONSHIP_____
2. _____RELATIONSHIP_____

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

MANAGED CARE REFERRALS:

MANAGED CARE PROGRAMS COVER MANY OF OUR PATIENT. IF THE DOCTOR DETERMINES THAT YOU REQUIRE SERVICES OUTSIDE OF OUR OFFICE TO A SPECIALIST, YOUR INSURANCE CARRIER MAY REQUIRE YOU TO OBTAIN A REFERRAL FROM OUR OFFICE.

AFTER YOU HAVE MADE YOUR APPOINTMENT, PLEASE CALL US WITH THE PLACE, DATE AND TIME OF YOUR APPOINTMENT; SO THAT, WE CAN MAKE YOUR REFERRAL. IF POSSIBLE WE WILL FAX THE REFERRAL TO THE SPECIALIST FOR YOU. YOU **MUST** NOTIFY OUR OFFICE **AT LEAST 5 DAYS IN ADVANCE,** IN ORDER TO OBTAIN A REFERRAL FROM OUR OFFICE.

IT IS THE **PATIENT'S RESPONSIBILITY** TO KNOW THE PROVISIONS OF THEIR HEALTHCARE POLICY. EACH EMPLOYER DETERMINES THE COVERAGE PROVIDED BY THE INSURANCE CARRIER.THEREFORE, IT IS DIFFICULT FOR OUR OFFICE TO KNOW EXACTLY WHAT SERVICES YOUR PLAN WILL/WILL NOT COVER. BE SURE TO READ YOUR MEMBER SERVICES HANDBOOK.

PRESCRIPTIONS:

IF YOUR MEDICATION(PRESCRIBED BY DR.PATEL) IS RUNNING LOW, PLEASE BE SURE TO NOTIFY YOUR PHARMACY **AT LEAST 48 HOURS** PRIOR TO COMPLETION OF YOU MEDICATION. YOUR PHARMACY WILL CONTACT OUR OFFICE **VIA FAX** WITH YOUR REFILL REQUEST. OUR OFFICE IS CLOSED ON WEEKENDS AND HOLIDAYS; AND THEREFORE, NO REFILLS WILL BE AUTHORIZED DURING THESE TIMES.

APPOINTMENTS:

NOT SHOWING UP FOR APPOINTMENTS CREATES DIFFICULTY IN PROVIDING CARE FOR ALL PATIENTS. A TIME SLOT GIVEN TO YOU FOR WHICH YOU DO NOT KEEP OR CALL US TO CANCEL, DENIES ANOTHER PATIENT OPPORTUNITY TO BE SEEN. PLEASE BE SURE TO CALL AND CANCEL ANY SCHEDULED APPOINTMENT THAT YOU CANNOT KEEP. **CANCELLATIONS ARE TO BE MADE 24 HOURS IN ADVANCE, FAILURE TO NOTIFY AND FOR NO SHOW THERE WILL BE $25 CHARGE APPLIED TO YOUR ACCOUNT.**

I UNDERSTAND AND AGREE TO FOLLOW THE ABOVE MENTIONED OFFICE POLICIES AS OF 1ST JANUARY 2023.

_____ _____

PATIENT NAME (PRINT) DATE

_____

PATIENT/GUARDIAN SIGNATURE

SUMMARY OF FLORIDA PATIENT RIGHTS & RESPONSIBILITIES

- the right to be treated with courtesy and respect
- the right to receive a prompt and reasonable response to questions and requests.
- the right to know who is providing medical services and responsible for his or her care.
- the right to know what patient support services are available
- the right to know what rules and regulations apply to his or her conduct.
- the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- the right to refuse any treatment, except as otherwise provided by law.
- the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained. Florida HEALTH Indian RiverCounty
- the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- the right to know if medical treatment is for purposes of experimental research and to give his or her consent
- the right to express grievances regarding any violation of his or her rights
- A patient is responsible for providing to the health care provider,accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition
- A patient is responsible for reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE