Surgical Associates of Bayonet Point			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Surgical Associates of Bayonet Point

TAMPA BAY SURGICAL GROUP

New Patient Information Packet

Name: _____ Sex at birth: ❑ M ❑ F

Gender Identity (check one) ❑ Female ❑ Male ❑ F→M Trans ❑ M→F Trans ❑ Non-Conforming ❑ Other

Local Address: _____

City: _____ State:_____ Zip:_____

Home Phone:_(___)_____Work Phone:_(___)_____ Cell Phone:_(___)_____

Email: _____

Date of Birth: _____ Age:_____ SS#: _____

Ethnicity:_____ Preferred Language:_____

Race: ❑ American Indian or Alaska Native ❑ Black or African American ❑ Asian

❑ Native Hawaiian or Other Pacific Islander ❑ Unreported/Refused to Report ❑ White

Emergency Contact:_____ Phone: _(___)_____Relationship:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced/Separated ❑ Widowed

Employed: ❑ Full Time ❑ Part-time ❑ Unemployed ❑ Disabled ❑ Retired ❑ Military

Employer: _____ Job Title: _____

Primary Care Provider: _____ Referring Physician Name: _____

Local Pharmacy Name: _____Address/Cross Roads: _____

Preferred Lab Facility:_____

Preferred Treatment Facility: ❑ Trinity Hospital ❑ Bayonet Point Hospital ❑ North Bay Hospital

Insurance Card(s): Please present to receptionist to photocopy for file.

Insurance Information – Primary

Insurance Company Name: _____ Phone Number_(___)_____

Claims Address _____

Policy # _____ Group#_____ Subscriber _____

Subscriber SSN:_____ Subscriber DOB:_____

Subscriber Marital Status:_____ Relationship to Subscriber:_____

Insurance Information – Secondary

Insurance Company Name: _____ Phone Number_(___)_____

Claims Address _____

Policy # _____ Group#_____ Subscriber _____

Subscriber SSN:_____ Subscriber DOB:_____

Subscriber Marital Status:_____ Relationship to Subscriber:_____

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Reason for your visit?_____

Whom may we thank for referring you to us?

❑ Friend/Family ❑ The Beacon local paper ❑ Postcard ❑ Valpak ❑ Consult A Nurse ❑Health Fair
❑ Hospital_____ ❑ Physician referral _____ ❑ Insurance_____
Internet: ❑ Google Plus ❑ Facebook ❑ Vitals ❑ Healthgrades ❑ Yelp

I hereby authorize Surgical Associates of Bayonet Point to release all or part of my medical records to Medicare and/or any other companies, if requested, without any liability to Surgical Associates of Bayonet Point. I hereby authorize Medicare and/or my insurance companies to pay directly to Surgical Associates of Bayonet Point any payments, assignments or benefits due me.

_____ **Date:** _____
Patient Signature

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

Bariatric Surgery:
□Hx of Lap Band □Hx of Sleeve gastrectomy □Hx of Gastric Bypass □Hx of Duodenal Switch
Cardiovascular:
□Arrhythmia □Murmur □ Angina/heart stents □Clots in legs/arms □High cholesterol □High blood pressure
□Heart attack □Congestive Heart Failure
Pulmonary:
□Asthma □Pneumonia □Lung Clots □COPD/Emphysema □Sleep Apnea □CPAP use
Gastrointestinal:
□Cirrhosis □ Hepatitis □Irritable Bowels □Crohn's disease □Heartburn (reflux)
□Gastric Ulcers □Diverticulitis □Rectal bleeding □Colonoscopy
Renal/GU:
□Prostate Enlargement □Kidney stones □Incontinence/loss of bladder control □Urinary Tract Infections
Musculoskeletal:
□Chronic Pain (where?)_____ □Fibromyalgia □Gout □Arthritis □Osteoporosis
Endocrine:
□Diabetes (□Type I or □Type II) □Thyroid problems (□High or □Low)
Neurological:
□Stroke □Dementia □Migraines □Multiple Sclerosis □Parkinson □Neuropathy □Seizures □TIA/ministroke
Allergy/Immunology/Dermatology:
□Allergies □eczema □frequent ear infections □psoriasis □frequent sinus infection
Other:
□Any Cancer (what kind?)_____
□Cataract □Glaucoma □Anemia or blood problems □Psychiatric care

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CURRENT MEDICATIONS

Name of Medication	Strength	Frequency	Purpose

ALLERGIES

Do you have allergies to drugs, food, latex, dye? **YES** **NO**

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

SURGICAL HISTORY

Surgery	Facility/Dates

FAMILY HISTORY

Living	Age	Health Status
Father		
Mother		
Sisters		
Brothers		
Deceased	**Age at Death**	**Cause of Death**
Father		
Mother		
Sisters		
Brothers		

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Social History

Number of Children? _____ Ages _____ Sex _____

Do you smoke/Vape? Yes ___ No ___ How much _____ How Long _____ Year Quit _____

Do you chew tobacco? Yes ___ No ___ How much _____ How Long _____ Year Quit _____

Do you drink alcohol? Yes ___ No ____ how much per week? _____

Review of Symptoms:

Please check all that applies:

Eyesight: ☐ Good ☐ Wears glasses ☐ Blind ☐ Glaucoma ☐ Blurred Vision ☐ Double Vision

Head, Ears, Nose, Throat: ☐ Poor Hearing ☐ Sore Throat ☐ Sinus Problems ☐ Ringing in ears ☐ Changes in smell/taste/hearing ☐Nose bleeds ☐ Oral Ulcers ☐ Trauma

Gastrointestinal: ☐ Swallowing Problems ☐ Indigestion ☐ Bloody stools ☐ Diarrhea ☐ Constipation ☐ Rectal bleeding ☐ Diverticulosis/Diverticulitis ☐ Hemorrhoids

Genitourinary: ☐ Difficulty Urinating ☐ Blood in Urine ☐ Prostate/kidney Problems

Musculoskeletal: ☐ Muscle Pain ☐ Back Pain ☐ Joint pain ☐ Arthritis ☐ Sciatica ☐ Swelling

Integumentary: ☐ Rash ☐ Skin Disorders ☐ Itching ☐ Changes in moles

Neurological/Psychiatry: ☐ Fainting ☐ Depression ☐ Anxiety ☐ Drug Dependence ☐ Dizziness ☐ Loss of Balance ☐ Seizures ☐ Stroke ☐ Recent falls ☐ Headaches

Endocrine: ☐ Thyroid Disease ☐ Diabetes ☐ Hot/Cold Intolerance ☐ Pituitary Disease

Hematologic/Lymphatic: ☐ Anemia ☐ Easy Bruising/Bleeding ☐ Taking Blood Thinners ☐ Taking Aspirin ☐ Coumadin ☐ Xarelto ☐ Elliquis ☐ Brillenta

Allergic/Immunologic: ☐ Sinusitis ☐ Hayfever ☐ Allergies ☐ HIV/AIDS ☐ Chemotherapy/Radiation

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Patient HIPAA Acknowledgment and Consent Form

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Surgical Associates of Bayonet Point			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Patient HIPAA Acknowledgment and Consent Form

Release of Information.

I hereby permit Surgical Associates of Bayonet Point and Tampa Bay Surgical Group and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Surgical Associates of Bayonet Point			
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Surgical Associates of Bayonet Point

TAMPA BAY SURGICAL GROUP

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

Surgical Associates of Bayonet Point			
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Surgical Associates of Bayonet Point

TAMPA BAY SURGICAL GROUP

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. **_____(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** any insurance or other third-party benefits available for health care services provided to me. I understand **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** by the Medicare or Medicaid program.

5. **_____(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **SURGICAL ASSOCIATES OF BAYONET POINT/ Tampa Bay Surgical Group** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **_____(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

Surgical Associates of Bayonet Point			
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Surgical Associates of Bayonet Point

TAMPA BAY SURGICAL GROUP

Authorization for Release of Information

Patient Name:_____ Patient Date of Birth: _____

Patient Social Security Number (last 4): _____

I am Requesting PHI from:_____
(Name, Address, Phone/FAX)

_____

The specific information to be released is:_____

_____

[X] I would like my protected health information to be released to:

Surgical Associates of Bayonet Point
7541 Medical Drive
Hudson, FL 34667
PH: 727.819.9107 FAX: 727.819.9138

Surgical Associates of Bayonet Point or other named facility has permission to release any and all information which the names facility may possess in regard to the patient's examinations and treatments, including but not limited to, alcohol abuses or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment. I understand that I have a right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to the Medical Record Department at Surgical Associates of Bayonet Point. I understand that the disclosure of my protected health information (PHI) carried with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal privacy rules. Surgical Associates of Bayonet Point may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization. The authorization and consent will expire 90 days from the date of authorization.

Signature of Patient: _____ Date Signed: _____

Relationship: [ ] Patient [ ] Natural Guardian/Parent [ ] Legal Guardian [ ] Authorized Representative