

Theodore R. Small, MD, FACS

www.WestFloridaWeightLoss.com



1840 Mease Drive, Ste 301
 Safety Harbor, Florida 33695
 (727) 712-3233, Phone
 (727) 712-1853, Fax

PATIENT INFORMATION FORM

** All information is kept confidential. Please answer honestly to assure the best possible treatment for you. Please complete all pages. **

(Please Print)

Today's Date: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____

Social Security Number: _____ Sex: Male Female

Driver License Number: _____ Education Level: _____

Employer: _____ Occupation: _____

Approximate Income: _____ Are you currently employed? _____

State the level of activity your job involves: Little (sedentary job) Moderately active Very active

Marital Status Single Married Divorced Separated Widowed

SPOUSE/GUARDIAN INFORMATION:

Spouse's Name or Guardian's Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____

EMERGENCY CONTACT INFORMATION:

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone number and do not update our office.

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Physician's Initials _____

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PATIENT INFORMATION FORM

PATIENT NAME: _____ **SSN # :** _____ **TODAY'S DATE** _____

REFERRAL INFORMATION:

Referring Physician: _____ Phone #: _____

Date of Referral: _____ Fax #: _____

Address: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Cardiologist: _____ Phone #: _____

Psychologist: _____ Phone #: _____

Psychiatrist: _____ Phone #: _____

Pulmonologist: _____ Phone #: _____

Endocrinologist: _____ Phone #: _____

Orthopedic Surgeon: _____ Phone #: _____

Other: _____ Phone #: _____

HOW DID YOU LEARN ABOUT WEST FLORIDA WEIGHT LOSS?

- Referring Physician
- Newspaper
- Web Site (www.WestFloridaWeightLoss.com)
- Dr. Small
- Friend or relative
- Morton Plant Mease Healthcare System
- Other _____

Physician's Initials _____

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INSURANCE INFORMATION

*** Even though we will copy your insurance cards, please complete all of the information requested below. ***

PRIMARY INSURANCE:

Primary Insurance Carrier: _____ Phone #: _____
 PPO POS HMO Other _____
 Subscriber's Name: _____ Subscriber's Date of Birth: _____
 Subscriber's Social Security Number: _____ Subscriber's ID Number _____
 Relationship to Subscriber: _____
 Subscriber's Employer: _____ Work Phone: _____

SECONDARY INSURANCE:

Secondary Insurance Carrier: _____ Phone #: _____
 PPO POS HMO Other _____
 Subscriber's Name: _____ Subscriber's Date of Birth: _____
 Subscriber's Social Security Number: _____ Subscriber's ID Number _____
 Relationship to Subscriber: _____
 Subscriber's Employer: _____ Work Phone: _____

WORKER'S COMPENSATION:

Is this a work related injury? Yes No (If yes, please provide the following information)
 Claim Adjuster's Name: _____ Phone #: _____
 Date of Injury: _____
 Claim Number: _____
 Contact at Employer: _____ Phone #: _____

FINANCIAL AGREEMENT:

I authorize Surgical Associates of West Florida to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Surgical Associates of West Florida to release medical information for insurance purposes. I authorize payment to be made directly to Surgical Associates of West Florida if an assignment is indicated by my insurance company. As a courtesy, Surgical Associates of West Florida will contact insurance companies for authorization for services required. Surgical Associates of West Florida is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

 Patient / Guardian (Please Print Name)

 Patient / Guardian (Signature)

 Date

Physician's Initials _____



CLINICAL HISTORY FORM

PATIENT NAME: _____ **SSN # :** _____ **TODAY'S DATE** _____

REASON FOR YOUR VISIT

What is the reason for this visit? _____

CURRENT MEDICATIONS *(List all medications / herbal / dietary supplements / alternative medications and treatments you are currently taking)*

<i>Medication</i>	<i>Dosage</i>	<i># Per Day / Frequency</i>	<i>Reason for Taking</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***** Please list any other current medications on the other side of this sheet. *****

MEDICATION ALLERGIES *(Are you allergic to any medications?)*

<i>Medication</i>	<i>Reaction</i>
_____	_____
_____	_____
_____	_____

Do you have any problems with anesthesia? Yes No

Have you had an allergic reaction to tape? Yes No

Do you have an allergy to any latex products? Yes No

PAST SURGICAL HISTORY

<i>Check all that apply</i>	<i>Year</i>	<i>Check all that apply</i>	<i>Year</i>	<i>Check all that apply</i>	<i>Year</i>
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Hernia, Inguinal	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Breast Biopsy	_____	<input type="checkbox"/> Hernia, Ventral	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Chest Surgery	_____	<input type="checkbox"/> Mastectomy	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Coronary Artery Bypass	_____	<input type="checkbox"/> Prostate	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Gall Bladder	_____	<input type="checkbox"/> Vascular Surgery	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hysterectomy, Abdominal	_____	<input type="checkbox"/> Tonsillectomy	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hysterectomy, Vaginal	_____	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	_____

Physician's Initials _____



CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN #:** _____ **TODAY'S DATE** _____

PAST MEDICAL HISTORY (Please list all major medical problems)

- | | | |
|---|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Stones / Disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Juvenile Onset Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Heart Attack / Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Elevated Cholesterol/Triglycerides | <input type="checkbox"/> Lung Disorders |
| <input type="checkbox"/> Vein Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

FAMILY HISTORY

<i>Family Member</i>	<i>Alive/Deceased</i>	<i>Age</i>	<i>Health Problems (i.e. cancer, heart disease, etc)</i>
Father	_____	_____	_____
Mother	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Children	_____	_____	_____

SOCIAL HISTORY

Tobacco None Currently smoke ___ packs/day and have done so for ___ years
 Previously smoked ___ packs/day for ___ years. Stopped in _____
 Smokeless Tobacco

Alcohol None Minimal Moderate Heavy Previously Heavy

Caffeine None 1-3 Servings Daily 3-4 Servings Daily More than 6 servings Daily

Drug Use _____ _____

PERSONAL HISTORY OF CANCER

Type of cancer _____ Not applicable

When was your cancer treated? _____

What type of cancer treatment did you receive? Chemo Therapy Radiation Therapy Surgery

Physician's Initials _____



CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN #:** _____ **TODAY'S DATE** _____

SYSTEMS REVIEW (Please place a check next to yes or no for each line item)

	Yes	No		Yes	No		Yes	No
GENERAL			CARDIO / HEART			SKIN		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Skips	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Non Healing Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	History of Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Cardiac Testing within the last year (i.e. EKG)	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Episodic Blindness	<input type="checkbox"/>	<input type="checkbox"/>	GI / DIGESTIVE			Transient Loss of Function	<input type="checkbox"/>	<input type="checkbox"/>
Cataract (s)	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Nausea	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL		
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or GERD	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Mild Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
NOSE/THROAT			Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Under Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC		
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	GENITO-URINARY			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Sores in Mouth of Lips	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Holding Urine	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination at Night	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY / LUNGS			Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Men: Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Men: Discharge from Penis	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or COPD	<input type="checkbox"/>	<input type="checkbox"/>	Women: Menopause	<input type="checkbox"/>	<input type="checkbox"/>	Deep Venous Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Women: Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
TB or positive skin test	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL			BREAST		
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Joints	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolus	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Muscles	<input type="checkbox"/>	<input type="checkbox"/>	Cysts	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
INFECTIONS			Chronic Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Family History	<input type="checkbox"/>	<input type="checkbox"/>
History of Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>			
Staph Infections	<input type="checkbox"/>	<input type="checkbox"/>						



CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ SSN # : _____ TODAY'S DATE _____

SLEEP APNEA HISTORY

Sleep apnea is a life threatening sleep disorder, which frequently causes you to stop breathing. It can happen hundreds of times per night, while you sleep and you may not even be aware it is happening.

Have you been diagnosed with Sleep Apnea? Yes No

Sleep Study Done? (If yes above) Yes No

Where was the sleep study completed? _____

When was the sleep study completed? _____

C-Pap: _____ Bi-Pap: _____

Please mark, which symptoms apply:

- | | | |
|--|------------------------------|-----------------------------|
| Snorting or gasping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loud snoring | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breathing stops, choke, or struggle for breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent awakenings | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tossing, turning, or trashing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty falling asleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Morning headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Night sweats | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| More than three pillows used under the head | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Falling asleep when at work or school | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Falling asleep when driving | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive sleepiness during the day | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Awaken feeling paralyzed, unable to move for short periods | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How well rested do you feel after a full nights sleep?

Not at all Somewhat Well rested

Do you feel more comfortable sleeping in an upright position? Yes No



CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ SSN # : _____ TODAY'S DATE _____

GERD (Gastroesophageal Reflux Disease)

Diagnosed with GERD? Yes No

How often do you have reflux during the day?

Every day Most days Most weeks Occasionally

Do you suffer heart burn/indigestion during the night? Yes No

How often do you have reflux during the night?

Every day Most days Most weeks Occasionally

Does food or fluid reflux in the mouth? Yes No

Details: _____

Do you vomit with reflux? Yes No

Details: _____

OB/GYN

Do you have regular periods (Every 26 to 33 days)? Yes No

Do you have problems with excessively heavy periods? Yes No

Do you have excessively painful periods? Yes No

Have you had difficulty in conceiving in the past? Yes No

Do you currently have problems with infertility? Yes No

Have you suffered from excess body hair or acne? Yes No

Have you ever been told by a doctor that you have polycystic ovaries? Yes No

Have you ever had problems with pregnancy and or children? Yes No

If so, in what way? _____

Have you had a caesarean section? Yes No

If so, why? _____

Physician's Initials _____



CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN # :** _____ **TODAY'S DATE** _____

WEIGHT HISTORY & WEIGHT LOSS ATTEMPTS:

This section is to be completed by the Medical Technician.

Height: _____ Feet _____ Inches Frame: Small Medium Large

BMI: _____ Ideal Weight: _____ Lbs. Overweight: _____

Age of obesity onset: _____ years

How many years have you been at your present weight? _____ years

Greatest single weight loss: _____ pounds

Weight loss was sustained for: _____ months

DIET HISTORY (Non-Physician Supervised Weight Loss Programs):

Answer yes or no to the following and fill in the pounds lost and the time spent in each program.

Name of Diet Program	Yes	No	Pounds Lost	Number of Months
American Heart Association				
Radar Institute				
Duke University Programs				
Structure House				
Inpatient Psychiatric Programs				
Outpatient Psychiatric Programs				
Optifast				
Carefast				
Medifast				
Meridia				
Zenical				
Fastin				
Ionamin				
Phenteramine/Fenfluramine				
Redux				
Other: _____				

Physician's Initials _____

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN # :** _____ **TODAY'S DATE** _____

DIET HISTORY (Physician Supervised Weight Loss Programs):

Name of Diet Program	Yes	No	Pounds Lost	Number of Months
American Heart Association				
Radar Institute				
Duke University Programs				
Structure House				
Inpatient Psychiatric Programs				
Outpatient Psychiatric Programs				
Optifast				
Carefast				
Medifast				
Meridia				
Zenical				
Fastin				
Ionamin				
Phenteramine/Fenfluramine				
Redux				
Other: _____				

Please detail any other weight loss measures (including surgical):

Were there any particular events that lead to the significant weight gain?

Physician's Initials _____

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PATIENT INFORMATION FORM

PATIENT NAME: _____ SSN # : _____ TODAY'S DATE _____

OTHER INFORMATION *(Please write below any other information not covered in this Clinical History Form that you feel the doctor or surgical staff should know about)*

PATIENT'S SIGNATURE

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: _____

Today's Date: _____

Thank you for choosing Surgical Associates of West Florida to provide your surgical care.

Visit Our Web Site at www.WestFloridaWeightLoss.com

Physician's Initials _____



GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

CONFIDENTIALITY:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

Date: _____

ARBITRATION:

The patient understands that he or she is not required to use treating physician or any physician employed by or under the direction of this facility or practice for general healthcare and or surgery. The patient understands medicine is not an exact science and there is risk involved in any medical procedure. The patient understands he or she is being treated at their own risk. It is further understood that in the event of any controversy or dispute which might arise between the patient and the physician, regardless of whether the disputes concerns the medical care rendered by the treating physician, or any manner whatsoever, then the patient agrees that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration code, chapter 682 & 684, Florida Statutes. This arbitration shall be binding and shall be in lieu of the and instead of any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators should choose a third arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280 – 1.390, Florida Rules of Civil Procedure. The panel or arbitrator shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

Date: _____

FAILURE TO FOLLOW PHYSICIAN ORDERS:

“Physician Orders” are meant to improve and/or resolve the patient’s medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient’s failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

Date: _____

FORM COMPLETION POLICY

The ever increasing time and cost burden required to complete the multitude of forms being requested by our patients requires **Surgical Associates of West Florida** to implement the following charge policy for all forms.

- **Completion of one (1) form page = \$25**
- **Completion of two (2) or more form pages = \$50 (maximum charge)**

Forms that will be accessed a form completion fee include FMLA (Family & Medical Leave Act) forms, Disability forms, Back-To-Work forms, and miscellaneous forms.

When your forms are completed, Surgical Associates of West Florida will contact you to let you know that your forms are complete. Prior to the completed forms being distributed to patients, Surgical Associates of West Florida will collect the related fee via cash, money order, personal check, credit card, or debit card (MasterCard or Visa logo).

Patient/Guardian Initials: _____

Date: _____



NOTICE OF PRIVACY PRACTICES

** This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. **

At **Surgical Associates of West Florida**, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on April 14, 2003.

Acknowledgement: I have received a copy of **Surgical Associates of West Florida's** Notice of Privacy Practice.

Patient / Guardian (Please Print Name)

Patient / Guardian (Signature)

Date



ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

(Page 1 of 2)

Please read carefully.

This agreement is made between Surgical Associates of West Florida - SAWF and their physicians extenders, agents, employees, or any of the foregoing referred to hereinafter as “doctors” and _____ hereinafter referred to as “patient”.

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any other legal claimant.

Disputes and Consideration: In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences; (c) avoid lengthy drawn out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses and attorney’s fees. Therefore, the parties voluntarily agree to the following pursuant to their constitutional right to contract:

It is understood by the patient that he or she has voluntarily selected and he or she is neither required to use SAWF, nor any of the doctors involved in their treatment and that there are other competent physicians in Florida who may act as the patient’s treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever related to personal injury, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes.

I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and these two individual selected arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under the Florida Rules of Civil Procedure and agree to be governed by the Florida Evidence Code and Chapters, 766 & 768, Florida Statutes, in any matter subject to this arbitration agreement. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Prior to commencing any action under this Doctor-Patient Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes.

Limitation of Damages: Patient agrees that in the event of any dispute with the Doctor, for any reason whatsoever, including any negligence claim relating to the diagnosis, treatment, or care of the Patient or any other personal injury claim, Patient’s non-economic damages (including, but not limited to, damages for pain and suffering) shall be limited to a maximum of \$250,000 per incident and shall be calculated on a percentage basis with respect to capacity to enjoy life, pursuant to the formula contained in Florida Statutes, Section 766.207. For example, if the Patient’s injuries resulted in a 50% reduction in his or her capacity to enjoy life, this would warrant an award of not more than \$125, 000 in non-economic damages. This limit applies regardless of the number of claimants or defendants in the arbitration proceeding. This limitation of damages provision does not limit or restrict in any way the Patient’s right to seek all economic damages actually incurred by the Patient, including any medical expenses and lost wages.

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Please read carefully.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement (“non-party”), it is the parties’ intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient’s physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient’s physician against said claim(s) up to the amount the chief arbitrator deems reasonable under the circumstances.

Severability Clause: If any provision of this Agreement shall be held invalid under any applicable laws, such invalidity shall not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

By signing below, the patient confirms that:

- The Patient has had an opportunity to read this Doctor-Patient Agreement, or to have it read to him or her if necessary.
- The Patient indicates that they understand English or has had the Doctor-Patient Agreement translated for him or her by _____.
- The Patient has had an opportunity to ask questions about this Doctor-Patient Agreement.
- The Patient understands this Doctor-Patient Agreement and has no unanswered questions.
- The Patient has not been coerced or compelled to sign this Doctor-Patient Agreement, and does so if his or her own free will.
- The Patient is also aware that they may consult with an attorney before signing this Doctor-Patient Agreement.

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date.

BY SIGNING THIS DOCTOR-PATIENT AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____

Date: _____

Parent, Guardian or Legal Representative Signature: _____



***AUTHORIZATION FOR RELEASE OF
MEDICAL INFORMATION***

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby consent to the release and disclosure of my personal health information to:

Name (Individual or Organization): _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the use or disclosure of the above named individual's health information as described below. Surgical Associates of West Florida is authorized to make this disclosure for the purpose of :

- | | |
|--|---|
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Information for Insurance Co. | <input type="checkbox"/> Information for Attorney |
| <input type="checkbox"/> Other (please specify) _____ | |

This authorization for release includes my personal health information consisting of:

- | | | |
|---|---|---|
| <input type="checkbox"/> Initial Evaluation | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Medical Status |
| <input type="checkbox"/> Progress/Office Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Work Status |
| <input type="checkbox"/> Diagnostic Imaging Reports | <input type="checkbox"/> Laboratory Reports | |
| <input type="checkbox"/> Other (please specify) _____ | | |

_____(initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. I understand that the disclosure of my personal health information as provided for herein will now constitute an authorized use or disclosure of my personal health information (PHI) pursuant to 45 C.F.R. § 164. I also understand, upon disclosure to the above recipient, my PHI will no longer be protected by the federal regulations governing the privacy of individual identifiable health information and that Surgical Associates of West Florida will not be able to restrict the disclosure of the my PHI by the intended recipient who is not affiliated with Surgical Associates of West Florida.

This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

Signature of Patient, Guardian, or Personal Representative

Date

Social Security Number: _____

Date of Birth: _____