NEW PATIENT APPOINTMENT

M T W T F

DATE: _____/_____/_____

TIME: _____ AM PM

MedFlorida
Primary Care Medicine

PATIENT REGISTRATION FORM

TODAYS DATE:	DRIVERS LICENSE #:	AGE:	DATE OF BIRTH: / /

PATIENT NAME: (LAST) (FIRST) (MIDDLE)	SOCIAL SECURITY #: - -	GENDER: ☐ MALE ☐ FEMALE

BILLING ADDRESS: (STREET) (CITY) (STATE) (ZIP)

PHYSICAL ADDRESS: (STREET) (CITY) (STATE) (ZIP)

HOME PHONE:	CELL PHONE:	WORK PHONE:	EXT:

EMAIL ADDRESS:	PORTAL ACCESS | WEB ENABLE: ☐ YES | ☐ NO

RACE: ☐ White | ☐ American Indian or Alaska Native ☐ Black/African American | ☐ Hispanic | ☐ Pacific Islander ☐ Other: _____ | ☐ Decline to Report	ETHNICITY: ☐ Hispanic or Latino | ☐ NOT Hispanic or Latino ☐ Decline to Report

PRIMARY LANGUAGE: ☐ ENGLISH | ☐ OTHER: _____ | ☐ REQUIRE ASSISTANCE FOR ENGLISH TRANSLATION

FACILITY INFORMATION (IF APPLICAPLE):	FACILITY PHONE:

FACILITY ADDRESS: (STREET) (CITY) (STATE) (ZIP)	APT/RM #:	ROOM PHONE #:

EMERGENCY CONTACT

EMERGENCY CONTACT NAME:	RELATIONSHIP:	PRIMARY PHONE:

ADDRESS: (STREET) (CITY) (STATE) (ZIP)	SECONDARY PHONE:

POWER OF ATTORNEY NAME:	RELATIONSHIP:	PHONE:

PHARMACY INFORMATION

PHARMACY NAME:

PHARMACY ADDRESS: (STREET) (CITY) (STATE) (ZIP)	PHARMACY PHONE:

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INS NAME:		INS NAME:	
MEMBER ID:		MEMBER ID:	
GROUP #:		GROUP #:	
MEDICAL CLAIMS ADDRESS:		MEDICAL CLAIMS ADDRESS:	
INS PHONE #:		INS PHONE #:	
INSURED NAME:		INSURED NAME:	
RELATIONSHIP:		RELATIONSHIP:	
SSN#:	DOB#:	SSN#:	DOB#:
COPAY:	DEDUCTIBLE:	COPAY:	DEDUCTIBLE:

PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

MedFlorida
Primary Care Medicine

Date: _____

Patient Name: _____ **DOB:** _____ **Gender:** ☐ Male | ☐ Female

Relationship Status: ☐ Single | ☐ Married | ☐ Male Partner | ☐ Female Partner | ☐ Separated | ☐ Divorced | ☐ Widowed

Living Situation: ☐ Alone | ☐ Spouse | ☐ Significant Other | ☐ Family | ☐ Friend | ☐ Nursing/Assisted Living Facility

Employment: ☐ Retired | ☐ Full-Time | ☐ Part-Time | ☐ Unemployed | ☐ Self-Employed | ☐ Military | ☐ Homemaker

Education: ☐ High School | ☐ Undergraduate | ☐ Graduate | ☐ Doctorate | ☐ Other: _____

Occupational Exposure: ☐ None | ☐ Toxic Chemicals | ☐ Noise Exposure | ☐ Infectious Agents | ☐ Repetitive Physical Stress

Travel: ☐ None in last six months | ☐ Traveled/Traveling to: _____ in last/next six months.

PREVIOUS Family Physician / Primary Health Care Provider: _____

City/State/Zip: _____ Phone: _____ Fax: _____

1. PREVIOUS/CURRENT **Specialist**: _____ Specialty: _____

City/State/Zip: _____ Phone: _____ Fax: _____

2. PREVIOUS/CURRENT **Specialist**: _____ Specialty: _____

City/State/Zip: _____ Phone: _____ Fax: _____

3. PREVIOUS/CURRENT **Specialist**: _____ Specialty: _____

City/State/Zip: _____ Phone: _____ Fax: _____

(*Continue On Back Of Form For Additional Providers)*

List any **labs, medical, or diagnostic tests** you have had in the past two years (include dates):

_____ _____ _____

_____ _____ _____

List **hospitalizations** you have had in the past one year (include hospital, dates of visit/admission and reasons for hospitalization):

_____ _____ _____

_____ _____ _____

MEDICATIONS & SUPPLEMENTS

* *Please bring your prescription bottles to appointment or next visit.*

List any **prescription medications** you are currently taking (dose & directions):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any **other-the counter, self-prescribed medications, dietary supplements, or vitamins** you are currently taking:

_____ _____ _____

_____ _____ _____

List any **drug allergies**:

_____ _____ _____

PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

MedFlorida
Primary Care Medicine

Patient Name: _____ **DOB:** _____

FAMILY MEDICAL HISTORY

Father: ☐ Alive - Current age _____ My father's general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**If Poor, reason for poor health:* _____

☐ Deceased - Age at death _____ Cause of death: _____

Mother: ☐ Alive - Current age _____ My mother's general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**If Poor, reason for poor health:* _____

☐ Deceased - Age at death _____ Cause of death: _____

Siblings: Brothers (Age): 1. _____ 2. _____ 3. _____ 4. _____

Sisters (Age): 1. _____ 2. _____ 3. _____ 4. _____

Familial Diseases

Have any of your blood relatives had any of the following? *(include grandparents, aunts and uncles | Do NOT include cousins, relatives by marriage and half-relatives)*

Check those to which the answer is **YES** & List which relative with condition & age. *(leave others blank)*

☐ Heart attacks under age 50 _____

☐ Strokes under age 50 _____

☐ High blood pressure _____

☐ Elevated cholesterol _____

☐ Diabetes _____

☐ Asthma or hay fever _____

☐ Obesity (20 or more pounds overweight) _____

☐ Other _____

☐ Congenital heart disease (existing at birth but not hereditary) _____

☐ Heart operations _____

☐ Glaucoma _____

☐ Leukemia or cancer under age 60 _____

☐ Cancer (What type of cancer?) _____

☐ Mental Disease _____

SOCIAL MEDICAL HISTORY

Smoking: Have you ever smoked cigarettes, cigars or a pipe? ☐ Yes ☐ No *(If no, skip to next section)*

If you did or now smoke cigarettes, how many per day? ☐ Light 1-9/day ☐ Moderate 10-19/day ☐ Heavy 20-39/day

If you did or now smoke cigars, how many per day? _____ Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____

If you did or now chew tobacco, how often per day? _____ Age started _____

If you have stopped smoking, when was it? _____

If you now smoke, how long ago did you start? _____

Alcohol: Do you ever drink alcoholic beverages? ☐ Yes ☐ No

If yes, what is your approximate intake of these beverages?

Beer:	None	Occasional	Often	If often, _____ per week
Wine:	None	Occasional	Often	If often, _____ per week
Hard Liquor:	None	Occasional	Often	If often, _____ per week

At any time in the past, were you a heavy drinker? *(consumption of six ounces of hard liquor per day or more)* ☐ Yes ☐ No

Comments: _____

_____

PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

MedFlorida
Primary Care Medicine

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY

Cancer	**YES**	**NO**	**Musculoskeletal**	**YES**	**NO**	**Rheumatology**	**YES**	**NO**
Diagnosed with Cancer?			Arthritis - Location(s):			Gouty Arthritis		
Type:			Cervical Spine			Fibromyalgia		
Cardiology			H/O compression - Fractures			Lupus Erythematosus		
Angina			Lumbar disc disease			Rheumatoid Arthritis		
Aortic Valve Disorder			Lumbar Spine			SLE		
Atrial Fibrillation			Osteopenia/Osteoporosis			**Skin**		
CHF (Congestive Heart Failure)			Osteoarthritis (generalized)			Basal Cell Carcinoma		
Coronary Artery Disease			Restless Leg Syndrome			Melanoma		
Heart Attack (myocardial infarction)			Rotator cuff syndrome			Psoriasis		
Hypertension			Sciatica			Rosacea		
Mitral Valve Disorder			Spinal Stenosis of:			Squamous Cell Carcinoma		
Pacemaker / Placement Date: _____			**Neurology**			**Urinary / Renal**		
Endocrine			Alzheimer's Disease			Polycystic tic kidney disease		
High Cholesterol			Gail Instability with falls			History of UTI's		
Diabetes Type 1			Migraine Headaches			Nephrolithiasis		
Diabetes Type 2			Multiple Sclerosis			Urinary Incontinence		
Grave's Disease			Parkinson's Disease			**Women Reproductive**		
Hyperthyroidism			Peripheral Neuropathy			Bladder suspension surgery		
Hypothyroidism			Seizures			Fibrocystic breast disease		
Thyroid Nodule			Stroke - Area Affected:			H/O of cervical or endometrial cancer		
Gastrointestinal			TIPS			Hysterectomy		
Acid Reflux			Trigeminal Neuralgia			Polycystic ovarian disease		
Barrett's Esophagus			**Psychiatric**			Uterine Prolapse		
Diverticulosis			Alcoholism			Other:		
H/O Colon Cancer			ADD/ADHD					
Irritable bowel syndrome			Anxiety			**Male Reproductive**		
Peptic Ulcer Disease			Bipolar Disorder			Erectile Dysfunction		
Ulcerative Colitis			Bulimia			H/O of prostate cancer		
Hearing / Eyes / ENT			Depress ion			Hypogonadism		
Glaucoma			Drug Abuse			Prostate Enlargement		
Diabetic Retinopathy			**Respiratory**			Urological implant		
Ear Infections			Asthma			Other:		
Hearing Loss			Chronic Bronchitis					
Macular Degeneration			COPD			**Please Provide Other Not Listed:**		
Sinusitis Chronic			Emphysema					
Hematology			Interstitial lung disease					
B-12 deficiency anemia			Obstructive Sleep Apnea					
Anemia			Pulmonary Embolism					
Iron deficiency anemia			Tuberculosis exposure					
Myelodysplastic Syndrome								

PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

MedFlorida
Primary Care Medicine

Patient Name: _____ **DOB:** _____

SURGICAL HISTORY

General	YES	NO	Joint Replacement	YES	NO
Aortic aneurysm repair			Left Hip		
Aortic Valve Repair			Right Hip		
Appendix removal (Appendectomy)			Left Knee		
Bariatric surgery			Right Knee		
Carpal tunnel release			Left Shoulder		
Cataract surgery: Right Left			Right Shoulder		
Colon resection (Colectomy')			Left Elbow		
Coronary artery - Bypass surgery			Right Elbow		
Fracture repair - Where?			**Biopsy**		
Gallbladder removal (Cholecystectomy)			Bone Marrow		
Gastric Bypass surgery			Liver		
Hemorrhoid removal (Hemorrhoidectomy)			Skin		
Hernia Repair: Femoral Inguinal			Mass Excision - Where?		
Kidney Removal(Nephrectomy): Right Left			**Women**		
Mitral valve replacement			Breast Implants		
Parathyroid removal (Parathyroidectomy')			Breast reduction		
Pacemaker placement			C-Section		
Polyp Removal (Polypectomy)			Endometrial biopsy		
Septum and nose repair			Hysterectomy: Partial Complete		
Spinal surgery - Where?			Lumpectomy: Left / Right Breast		
Type:			Mastectomy: Left / Right Breast		
Thyroid removal (Thyroidectomy')			**Men**		
Tonsillectomy			Prostate Biopsy		
Varicose vein surgery			Prostate Removal		

OTHER HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Have you ever had a **blood transfusion**? ☐ Yes ☐ No

Immunizations and Dates:

☐ Tetanus _____ ☐ Pneumonia _____

☐ Hepatitis _____ ☐ Chickenpox _____

☐ Influenza _____ ☐ MMR Measles, Mumps, Rubella _____

Exercise: ☐ Sedentary (No exercise) ☐ Difficult due to weight ☐ Occasionally

Exercise Frequency: ☐ Weekly ☐ Daily ☐ 1-2 times/week ☐ 2-3 times/week ☐ 4-5 times/week

☐ Less than 30 min./day ☐ 30-60 minutes/day ☐ 1-2 hours/day

☐ Type of Exercise: (i.e. golf, bicycling, walking, running, swim, weights): _____

Diet: # of meals you eat in an average day? _____

☐ Diabetic Diet ☐ Cardiac Diet ☐ Un-Restricted Diet ☐ Low Carbohydrate ☐ Low Fat

☐ Vegetarian ☐ Vegan ☐ Eat out several days a week ☐ Drink high sugar beverages

☐ Low salt Diet ☐ Low Cholesterol Diet ☐ Low Sugar Diet

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day? _____

AUTHORIZATION TO USE OR DISCLOSE MEDICAL RECORDS

TO:

MEDFLORIDA, LLC | YERVANT KHATCHERIAN MD PA
CRITERION CENTRE | 29605 US HWY 19 N, SUITE 170 | CLEARWATER, FL 33761
P: 727-771-8444 | F: 844-473-3116

_____ | _____ | _____
(PATIENT NAME) (DATE OF BIRTH) (LAST 4 OF SS#)

I, the patient, give authorization to the following provider to disclose the specific health/medical information identified below:

REQUEST RECORDS FROM: **OFFICE USE* - *PLEASE LEAVE BLANK**

*PROVIDER: _____ *SPECIALTY: _____

*ADDRESS: _____

*PHONE: _____ *FAX: _____

FOR THE FOLLOWING PURPOSES: CONTINUED MEDICAL CARE

RECORDS REQUESTED: ☐ ENTIRE MEDICAL RECORD | ☐ MOST RECENT ____ YEAR HISTORY

☐ SPECIFIC RECORD: _____

I, the patient, authorize the use and/or disclosure of the following health information and/or medical records. If such information and/or records exist.

The Following Items Must Be **INITIALED** To Be Included In The Use And/Or Disclosure:

**** Authorizing the following items below is NOT an admission of any such record, this is only an authorization of any/all items to be provided in the event of any such discovery.*

_____ General Health Information and/or Records
_____ Mental Health Information and/or Records
_____ Communicable Diseases: (Examples: HBV, TB, HIV/AIDS) related information and/or records
_____ Domestic Violence
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____

I, the patient, understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I, the patient, also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, the patient, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. REFUSAL SIGNATURE & DATE: _____
Finally, I, the patient understand that I may revoke this authorization, in writing, at any time, provided that, I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

PATIENT / REPRESENTATIVE SIGNATURE: _____ DATE: _____

REPRESENTATIVE NAME: _____ RELATIONSHIP: _____
(IF APPLICABLE)

MedFlorida
Primary Care Medicine

HIPAA FORM

STANDING AUTHORIZATION FOR DISCLOSURE OF INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the use or disclosure of Protected Health Information (PHI) other than Treatment, Payment or healthcare Operations (TPO). Others that are permitted to receive disclosure of information by law include: Judicial proceedings, coroners, medical examiners, research purposes, law enforcement, worker's compensation and other areas so designated by law.

Release or disclosure of information to family members, friends, clergy or others involved in a patient's care is NOT included in the General Rule and require specific authorization for disclosure of information.

If you would like us to share your PHI with family members or others, please fill in the information below for each individual, designate if unrestricted or limited release of information. Please note that ABSOLUTELY NO INFORMATION WILL BE DISCLOSED to spouses, children, other family members, care givers or friends if not authorized below. You may rescind or change any authorization by a written request at any time.

I, *(Patient name)* _____**, give MedFlorida, LLC my permission to leave phone messages, send emails or fax anything regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.**

Authorized Individuals:

Name: _____ Relation: _____ Phone: _____
☐ *UNRESTRICTED* ☐ *LIMITED (EMERGENCY ONLY)*

Name: _____ Relation: _____ Phone: _____
☐ *UNRESTRICTED* ☐ *LIMITED (EMERGENCY ONLY)*

Name: _____ Relation: _____ Phone: _____
☐ *UNRESTRICTED* ☐ *LIMITED (EMERGENCY ONLY)*

Authorized Answering Systems:

Cell phone: (_____) _____ - _____

Home answering machine/voice mail: (_____) _____ - _____

Office/work voice mail: (_____) _____ - _____

Email: _____@ _____._____

Fax: (_____) _____ - _____

Patient Name (please print): _____ DOB: _____

Representative Name (please print): _____ *Relationship*: _____

Patient/*Representative* Signature: _____ Date: _____

MedFlorida
Primary Care Medicine

ADVANCED DIRECTIVE

PATIENT SELF DETERMINATION ACT INFORMATION

What are Advance Directives?

A Living Will allows you to document your wishes concerning medical treatments at the end of life.
Before your living will can guide medical decision-making two physicians must certify.

- You are unable to make medical decisions
- You are in the medical condition specified in the state's living will law (such as "terminal illness" or "permanent unconsciousness").
- Other requirements also may apply, depending upon the state.
- A medical power of attorney (or healthcare proxy) allows you to appoint a person you trust as you healthcare agent (or surrogate decision maker), who is authorized to make medical decisions. In addition:
- If a person regains the ability to make decisions, the agent cannot continue to act on the person's behalf.
- Many states have additional requirements that apply only to the decisions about life-sustaining medical treatments.
- For example, before your agent can refuse a life-sustaining treatment on your behalf, a second physician may have to confirm your doctor's assessment that you are incapable of making treatment decisions.

What Else Do I Need to Know?

• Advance directives are legally valid throughout the United States. While you do not need a lawyer to fill out an advance directive, your advance directive becomes legally valid as soon as you sign them in front of the required witnesses. The laws governing advance directives vary from state to state, so it is important to complete and sign advance directives that comply with your state's law. Also, advance directives can have different titles in different states.

• Emergency medical technicians cannot honor living wills or medical powers of attorney. Once emergency personnel have been called, they must do what is necessary to stabilize a person for transfer to a hospital, both from accident sites and from a home or other facility. After a physician fully evaluates the person's condition and determines the underlying conditions, advance directives can be implemented.

• One States advance directive does not always work in another state. Some states do honor advance directives from another states; others will honor out-of-state advance directives as long as they are similar to the state's own law; and some states do not have an answer to this question. The best solution is if you spend a significant amount of time in more than one state, you should complete the advance directives for all the states you spend a significant amount of time in.

• Advance directives do not expire. An advance directive remains in effect until you change it. If you complete a new advance directive, it invalidates the previous one.

• You should review your advance directives periodically to ensure that they still reflect your wishes. If you want to change anything in an advance directive once you completed it, you should complete a whole new document.

Patient Initials:_____

MedFlorida
Primary Care Medicine

ADVANCED DIRECTIVE

(ACP) ADVANCED CARE PLAN / PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please review & answer the following questions:

DECLARATION TO DECLINE LIFE-PROLONGING PROCEDURES:

❑ I **HAVE** MADE SUCH A DECLARATION. (**DNR – FLORIDA DO NOT RESUSITATE ORDER**)

- ❑ *I WILL PROVIDE A COPY OF A PREVIOUSLY COMPLETED DNR or*
- ❑ *I WILL REVIEW WITH THE PROVIDER & COMPLETE A FL STATE DO NOT RESUSITATE ORDER TODAY.*

❑ I **HAVE** MADE SUCH A DECLARATION DOCUMENTED IN A **LIVING WILL**.

- ❑ *I WILL PROVIDE A COPY OF A MY 'LIVING WILL' FOR OFFICE MEDICAL RECORDS.*

❑ I **HAVE NOT** MADE SUCH A DECLARATION. ***(FULL CODE)***

HEALTH CARE SURROGATE:

❑ I **HAVE** DESIGNATED A HEALTH CARE SURROGATE.
(AUTHORIZED MEDICAL DECISION MAKER IN THE EVENT YOU ARE UNABLE TO MAKE MEDICAL DECISIONS ON YOUR OWN BEHALF)

Name: _____Relation: _____Phone: _____

❑ I HAVE **NOT** DESIGNATED A HEALTH CARE SURROGATE.

DURABLE POWER OF ATTORNEY:

❑ I **HAVE** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

Name: _____Relation: _____Phone: _____

❑ I **HAVE NOT** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

Patient Name (please print): _____ DOB: _____

Representative Name (please print): _____ *Relationship*: _____

Patient/*Representative* Signature: _____ Date: _____

Physician's Signature: _____ Date: _____
YERVANT KHATCHERIAN MD PA

❑ *I HAVE BEEN PROVIDED WITH INFORMATION REGARDING THE PATIENT SELF DETERMINATION ACT, HOWEVER ******I DECLINE TO COMPLETE******* THE QUESTIONNAIRE ABOVE.*

MEDFLORIDA, LLC • YERVANT KHATCHERIAN MD PA • INTERNAL MEDICINE & GERIATRICS
29605 US HWY 19 N SUITE 170 • CLEARWATER, FL 33761 • PHONE: 727-771-8444 • FAX: 844-473-3116

MedFlorida
Primary Care Medicine

Office Policies

Thank you for choosing MEDFLORIDA, LLC | YERVANT KHATCHERIAN MD PA as your medical provider. Please review the office information & policies below.

Office Hours: Monday to Thursday from 9:00 AM to 4:00 PM eastern time & Friday from 9:00 AM to 12:00 PM.

Cancellations / Reschedule Requests: Please inform the office staff at least 24 hours before the time of your scheduled appointment. This will assist us in accommodating other patients who may need to be seen by the physician. Failure to comply with this policy may result in a $25.00 missed office visit charge.

Tardiness: If you anticipate being more than 15 minutes late for your appointment, please call our office to see if your appointment may be kept or if it will need to be rescheduled.

Payments: Co-payments are due at the time of service the day of your appointment. Co-payments & Account Balances may be paid by Credit Card, Check, or Cash.

Referral/Authorizations: All routine referral requests require 2-3 business days' notice. For any referral requiring insurance authorization, the request must be received at least 7 business days in advance. We will not be able to issue a referral for any follow up appointments until we receive consult notes & test results from the specialist. We do not issue same day referrals or back dated referrals. Please do not go to your specialist appointment without a prior referral or confirmed authorization.

Prescriptions and Refills: Please give our office a 48-hour notice for all prescription refills to be called in. You will be notified by your pharmacy when your prescription is ready to be picked up.

- The best time to get a prescription refill is at your appointment.
- If you need to call us for medication refills, do not wait until you have run out of medication completely. Most refills require the doctor's approval. If your doctor is out of the office, you may need to wait until the next business day (or following Monday) before your medication can be authorized and sent to the pharmacy.
- Do not go to the pharmacy to wait for your prescription to be called in while you are there. Please call the pharmacy first to see if your medication is ready to be picked up.
- Some prescriptions cannot be called in. The prescription must be printed out or handwritten so you can go to the pharmacy.
- Do not call after hours for prescription refills. We will not be able to help you until regular business hours.

Annual Wellness Visits: Routine lab screening tests and complete annual physical exams are very important for maintenance of good health. However, insurance benefits may vary on coverage for these types of visits and tests. Please learn about your benefits prior to your appointment so you will know beforehand what is covered by your insurance health plan.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

MedFlorida
Primary Care Medicine

NO SHOW / LATE CANCELLATION POLICY

This policy has been established to help us serve all our patients better.

It is necessary for us to make appointments to schedule and see our patients as efficiently as possible. No-shows and late-cancellations cause issues that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

A **'No-Show'** is missing a scheduled appointment without any notification to the office. A **'Late-Cancellation'** is canceling an appointment without notifying the office to cancel 24 hours in advance of an office visit.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept, and adequate notice is not possible. These situations will be considered on a case by case basis.

Methods of payments: Cash, Checks, American Express, MasterCard, Visa, and Discover.
*(*Returned check fee is $25.00)*

***** A charge of $25.00 will be assessed & billed for each 'No-Show' or 'Late-Cancellation' Office Visit Appointment if less than 24 hours' notice is given. *****

☐ I certify that I have read and understand the cancellation policy and agree to All terms and conditions as stated above.

Patient Name (please print): _____ DOB: _____

Representative Name (please print): _____ *Relationship*: _____

Patient/*Representative* Signature: _____ Date: _____

MEDFLORIDA, LLC • YERVANT KHATCHERIAN MD PA • INTERNAL MEDICINE & GERIATRICS
29605 US HWY 19 N SUITE 170 • CLEARWATER, FL 33761 • PHONE: 727-771-8444 • FAX: 844-473-3116

MedFlorida
Primary Care Medicine

CONTROLLED SUBSTANCE MEDICATIONS PATIENT AGREEMENT

I, _____, understand and voluntarily agree to the following statements.
(PATIENT NAME)

Initial each line next to the following statements, must agree to all in order to receive controlled medication RX.

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team, if not I will cancel or reschedule accordingly.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not he replaced until my next appointment and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patents my treatment will be stopped.

_____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____I will sign a release form to allow the doctor to speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all on my medicines. Please list intended pharmacy below, this will be monitored on FL prescription tracking website.

Pharmacy Name: _____ Phone: _____

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

MEDFLORIDA, LLC • YERVANT KHATCHERIAN MD PA • INTERNAL MEDICINE & GERIATRICS
29605 US HWY 19 N SUITE 170 • CLEARWATER, FL 33761 • PHONE: 727-771-8444 • FAX: 844-473-3116

_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that I'll do, my treatment may be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information to reach me, and that any missed tests will be considered positive for drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

PAIN TREATMENT PROGRAM STATEMENT

We here at MEDFLORIDA, LLC are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we must cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we win help you get treatment and get off the medications that are causing you problems safely, without getting sick.

_____	_____	_____
Patient Name Printed	Patient Signature	Date
_____	_____	_____
Provider Name Printed	Provider Signature	Date

MEDFLORIDA, LLC • YERVANT KHATCHERIAN MD PA • INTERNAL MEDICINE & GERIATRICS
29605 US HWY 19 N SUITE 170 • CLEARWATER, FL 33761 • PHONE: 727-771-8444 • FAX: 844-473-3116

MedFlorida
Primary Care Medicine

Notice to our HMO/Managed Care Members:
Referral & Authorization Policy

If you are enrolled in a HMO/Managed Care Insurance Plan, please read the policy and procedures for referrals and authorizations.

If you are requesting a referral for a specialist, you must call the office and make an appointment to see Dr Khatcherian or one of the Nurse Practitioners to discuss the issue first. This is to ensure you are going to the correct physician and receiving the proper care. Please be advised that your insurance plan require that your primary doctor's office provide initial care before referring to a specialist. If Dr Khatcherian has determined a referral is medically necessary the proper documentation will be submitted to your insurance company for approval, according to your plans guidelines. After the approval has been obtained the referral will be sent to a provider that is in network with your insurance company. Prior Authorization is required by the insurance company for all visits and procedures, this process will take 4-14 business days for routine approval. This time frame is strictly determined by your Insurance Plans protocol.

If you require medications and/or are prescribed a new medication by Dr Khatcherian / Nurse Practitioners, your Insurance Company may require Prior Authorization which may take up to 2-3 business days.

If you have any questions of concerns regarding the Referral and Authorizations process, please speak with our office Case Manager/Referral Coordinator for more information.

Please sign and date below stating that you have read and understand the referral and authorizations policy.

Patient Name: _____

Patient Signature: _____

Date: _____

BayCare Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

❑ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

❑ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

_____ _____ _____

Printed Name of Patient/Representative | Signature of Patient/Representative | Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____

BayCare Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX **only**:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. **Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.**
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

MedFlorida
Primary Care Medicine

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____
Street Address _____
City _____ State _____ Phone _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____
Street Address _____
City _____ State _____ Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

_____
_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Name _____

Signed _____ Date _____

Witnesses 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

MedFlorida
Primary Care Medicine

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name:_____ Relationship:_____

Address:_____ Phone: (_____) _____-_____

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____

Signature: _____ Date:_____

Witness _____
Street Address _____
City _____ State _____
Phone: (_____) _____-_____

Witness _____
Street Address _____
City _____ State _____
Phone: (_____) _____-_____

At least one witness must not be a husband or wife or a blood relative of the principal.