NEW PATIENT HISTORY FORM – ST. LUKE'S REGIONAL HEALTHCARE, PLC

Patient Name: _____ **Date:**_____

DOB: _____ **Age:** _____ **Sex:** ___

Reason for this visit: _____

MEDICATIONS: Please list all prescription medications that you are taking currently:

Name	Dosage	# of pills	Frequency	Date Started

Please list all over-the-counter medications: (i.e. vitamins, herbs, supplements, aspirin, CPAP)

_____

_____

ALLERGIES: Please list medication allergies as well as environmental/food allergies:

Medication/Type of Allergy/Reaction	Medication/Type of Allergy/Reaction

PAST MEDICAL HISTORY:

Head:

___Glaucoma
___Allergic Rhinitis (Allergies)
___Sinusitis
___Hearing Deficiency
___Legally Blind
___Epistaxis (nose bleeds)
___Cataracts
___Diabetic Retinopathy
___Macular Degeneration

Abdomen:

___Peptic Disease (stomach ulcers)
___Gastritis
___GERD (heartburn)
___Hepatitis (liver)
___Irritable Bowel (diarrhea)
___Colitis (colon inflammation)
___Constipation
___Hemorrhoids
___Inflammatory Bowel Disease
(Crohn's disease, ulcerative colitis)
___Hiatal Hernia

Patient Name: _____ **DOB**_____

PAST MEDICAL HISTORY: (continued)

Heart:
___Atrial Fibrillation
___Coronary Disease (heart attack)
___Congestive Heart Failure
___Hypertension (high blood pressure)
___Arrhythmia (irregular heartbeat)

Endocrine:
___Hyperthyroidism (overactive)
___Hypothyroidism (underactive)
___Diabetes

Cancer:
Type: _____
_____

Reproductive:
___Endometriosis
___Uterine Fibroids
___Ovarian Cysts
___Urinary Incontinence (leaking)
___Hernia (inguinal)
___Prostate Hypertrophy (enlarged)
___Erectile Dysfunction (impotence)
___Uterine Bleeding

Circulation:
___Peripheral Artery Disease (PAD)
___Carotid Disease (blockage)
___Varicose Veins
___DVT (blood clot)
___PE (clot in the lung)

CNS:
___Cerebrovascular Accident (stroke)
___Seizures (convulsions)
___Migraine Headaches
___Vertigo
___Insomnia

Chest:
___Asthma
___COPD (emphysema)
___Chronic Bronchitis
___Fibrocystic Breast (cyst)

Musculoskeletal:

___Cervical Disc Disease
___Lumbar Disc Disease
___Chronic Back Pain
___Knee Arthritis
___Fibromyalgia

Other:
___Depression
___Anxiety
___Nephrolithiasis (kidney stones)
___Hyperlipidemia (high cholesterol)
___Sleep Apnea

Other: (not listed)
_____
_____
_____
_____

SURGICAL HISTORY: Please specify type of surgery and date.

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____ **DOB:** _____

SOCIAL HISTORY: (Now and in the past. If yes, please list how much and how often.)

Tobacco: ___ _____packs/ day _____how long _____quit how long _____other type(s)	Alcohol: ___ _____type _____how much _____how long	Drugs: ___ _____type _____how much _____how long	Caffeine: ___ _____type _____how much _____how long

Type of work: _____ Full time: ___ Part time: ___

Marital Status: ___Single___ Married ___Divorced ___Widow/Widower ____Domestic Partner
Number of children: (please list ages of each): _____
_____
Lives with (check all that apply): ___Alone ____Spouse/Partner ____Children ____Other Family

FAMILY HISTORY:

Mother: __Alive ___Deceased (Age) Problems:	Father: __Alive __Deceased (Age) Problems:
Maternal Grandmother: __Alive __Deceased Problems:	Maternal Grandfather: __Alive __Deceased Problems:
Paternal Grandmother: __Alive __Deceased Problems:	Paternal Grandfather: __Alive __Deceased Problems:
Sisters: ___How many __Alive __Deceased Problems:	Brothers: __How many __Alive __Deceased Problems:

HEALTH MAINTENANCE/DIAGNOSTIC STUDIES/IMMUNIZATIONS:
(List month/year and any abnormalities)

Eye Exam	TSH	Mammogram	Flu Shot
Colonoscopy	Prostate	Pap/Pelvic	Pneumonia Shot
Cholesterol	PSA	Bone Density	Tetanus
TB Test			Other

WOMEN ONLY: Age of first period_____ Last normal period _____
Problems with periods_____
Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

Section I: Patient Information

Date: _____

Name: First: _____ Middle Initial: _____ Last: _____

I prefer to be called: _____

Date of birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Best time to call: _____ AM _____ PM on my _____Home _____ Work _____ Cell

E-Mail address: _____

Check appropriate:

____ Minor ____ Single ____ Married ____ Widowed ____ Separated ____ Divorced

Employer: _____ Phone: _____

If Student, name of school: _____

City/State: _____ FT _____ PT _____

Spouse/Parent's Name: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____

Phone: _____ Relationship: _____

The following information must be filled out completely.
Failure to do so may result in a denial from your insurance company.

Section II: Responsible Party

Relationship to patient: _____ Self _____ Spouse _____ Parent _____ Other

If self, skip to Section III.

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Employer: _____ Work Phone: _____

Section III: Insurance Information

Name of Primary Insured: _____ DOB: _____

Primary SSN: _____ Relationship to Patient: _____

Name of Primary Employer: _____ Work Phone: _____

Address of Employer: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____

Group #: _____ ID#: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Do you have additional insurance? If YES, please complete the following:

Name of Primary Insured: _____ DOB: _____

Primary SSN: _____ Relationship to Patient: _____

Name of Primary Employer: _____ Work Phone: _____

Address of Employer: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____

Group #: _____ ID#: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

ENCOUNTER NON-COVERED SERVICE WAIVER

I acknowledge that I will be charged, and agree to pay interest (at a rate no higher than the maximum permitted by law), on any overdue amounts until they are paid in full. If my account is referred for collection, I agree to pay for all costs of collection, including reasonable attorneys' fees and court costs. When an account is referred to a collection agency, the agency fee will be added to the outstanding balance. The agency fee is currently 50% of the outstanding balance. A $15 collection fee will be added for all accounts turned over for collections. I understand and agree that any over payments collected by St Luke's Regional Health Care, PLC with regard to any care, treatment, or services provided to me may be applied to any outstanding amounts then due and payable to St Luke's Regional Health Care, PLC for which I am legally responsible.

Patient's Name: _____ DOB: _____
Print

Patients Signature: _____

Date: _____

ST LUKE'S REGIONAL HEALTH CARE
JOSEPH GHALY, M.D.
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing signed by you. However, such revocation shall not affect any disclosures we have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient had the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of his/her information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

_____ _____

Patient or representative's name (please print) Date

_____

Patient or representative's signature

Relationship to patient: _____(If patient is a minor- Example: mother, father, etc)

***** Please list here any person (s) with whom you wish for us to discuss your medical history, appointments and billing matters. *****

_____

Name/Relationship to Patient

_____

Name/Relationship to Patient

St Luke's Regional Health Care, PLC
Joseph Ghaly, MD
6030 S. Florida Avenue, Suite 110 - Lakeland, FL 33813
Phone: 863.644.9800, Fax: 863.644.9822

Dear New Patient;

Welcome to St Luke's Regional Health Care. Our office policies are designed to ensure that we are able to provide the highest quality of care for our patients. The staff is not responsible for these policies nor are they authorized to change or modify them. Please take the time to read, sign & return at your first visit. A copy will also be provided upon request.

Office Policies

Office Hours: Our regular office hours are Monday through Friday 8:00 am to 5:00 PM.

Medical Appointments: Appointments should be made to address any new problem or concern especially if it requires a prescription medication. Appointments are also necessary for periodic follow-up of chronic medical problems, such as high blood pressure, diabetes, high cholesterol, etc. This allows us an opportunity to assess the effectiveness of treatment, evaluate for side effects of medication, & monitor lab work if necessary. New patients need to arrive 30 minutes early for the first appointment, so necessary paperwork can be completed. (All other patients need to arrive prior to scheduled appointment times). Arriving on time helps us to stay on schedule & minimize wait time for you as well as other patients.

Auto Accident Appointments: Appointments made for auto cases are billed to your auto Insurance only. We do not bill your medical insurance for exhausted benefits or deductibles. Therefore, any medical issues not pertaining to the auto accident will not be discussed at these visits. If you would like to discuss other medical issues (high blood pressure, weight loss, diabetes, etc.), you will need to schedule a separate office visit. The medical office visit will be billed through your medical insurance. Therefore, your health insurance copay and deductible will apply. We will do our best to accommodate both visits on the same day.

Weight Loss Appointments: St Luke's Weight Loss program. Patients interested should inquire at the front desk for more information**. Patients enrolled in the weight loss program may only discuss weight loss issues. Any other medical concerns will need to be scheduled a separate office visit due to payment and billing differences.** We will do our best to accommodate both visits on the same day.

Family/Friends: There are sometimes instances when family members and friends accompany patients to an office visit. Please note that if medical concerns are addressed for an accompanying member (e.g. such as medication refills) an office visit will be charged. The applicable copayment and deductible will also apply. Please respect the other patients' and the doctor's time and schedule an appointment.

 Patient Initials: _____

St Luke's Regional Health Care, PLC
Joseph Ghaly, MD
6030 S. Florida Avenue, Suite 110 - Lakeland, FL 33813
Phone: 863.644.9800, Fax: 863.644.9822

Insurance/Payment: Patients who have insurance coverage should provide their insurance card at each visit. If there are any changes to your health care coverage, you must notify us in advance of the appointment so that the insurance may be verified prior to the appointment to minimize wait time. Your failure to update your insurance can result in you being responsible for the charges.

Payment is due at time of service. All copays, deductibles & balances (including family member balances) will be collected at the time of each office visit. Amounts not covered by insurance are the patient's responsibility. We accept Visa, MasterCard, Discover & American Express, cash, and Money Orders**. Due to the increase in returned checks, personal checks will no longer be accepted!**

If you have not met your deductible with your insurance carrier, you will be asked to leave a $125 deposit, ($200 if new patient) to cover your office visit. Adjustments will be made on your account after your insurance company has paid their portion.

Medicare Supplement Insurance: We are a participating provider with Medicare Part B program; and as such, we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the allowable amount) and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductible are your responsibility according to federal law. Annual deductibles are set by Medicare each year.

Nonpayment: Invoices are sent every 30 days. Your prompt payment will assist us in keeping down the cost of healthcare. You acknowledge that you may be charged, and agree that you will pay, interest at a rate no higher than the maximum permitted by law on any overdue amounts until they are paid in full. If your account remains past due, you understand that your account may be referred to a Collection Agency and agree to pay for all costs of collection, including but not limited to, reasonable attorneys' fees and court costs. You understand that any overpayments collected with regard to any care, treatment, or services provided to you may be applied to any outstanding amounts then due and payable for which you are legally responsible. You understand that in the event you (or your family members) have an outstanding balance, you (they) can be discharged from this practice. If this occurs, you understand that you will be notified by regular and/or certified mail that you have 30 days to find alternative care.

Cancellations: We require 24 hours' notice if you are canceling your appointment. If you cancel without 24-hour notice or fail to appear, you may be responsible for a $30 no-show fee. If you were scheduled for an in-house diagnostic such as nerve conduction study, ultrasound, etc., a $150 no-show fee will be added

Form Fees: there will be a fee charged for the completion of forms (disability parking, adoption, FMLA, physical, prescription, etc.). The fee is $25 for the first page & $15 for each additional page. This fee must be paid up front at the time the forms are dropped off.

Lab Forms: Due to the increase of lost lab slips/forms, a $2 fee will be issued for a reprint of a lab form.

Medical Records: All medical record requests must be submitted in writing. After you sign an authorization of release, we will provide any doctor's office with a copy of your records free of charge. If you or your legal representative needs copies of these records, we will provide them for a cost of $1.00 per page for the first 25 pages then $.25 per page thereafter. Please allow 7-10 business days for records processing. Prepayment is required for this service.

 Patient Initials: _____

Prescription refills: Prescription refills can take 48-72 hours to process due to the need to evaluate whether labs or office visits are necessary. Requests must be made before you run out of your medication so we have ample time to approve your refill or notify you that an appointment is needed. Prescription refills will be handled during regular business hours only. Calling after regular office hours will not result in a medication being refilled.

Controlled Substances: Prescriptions for medications with the potential for misuse, abuse, or addiction are carefully monitored. Prescriptions for these medications will not be filled without an office visit first. Patients who lie or are otherwise dishonest about the use of these medications will be dismissed from the practice immediately & the proper authorities will be notified. We must abide by the federal regulations for these medications. Drug screening will be performed on a regular basis. You will be responsible for the charges for this service.

Controlled substances should NOT be obtained from multiple physicians and/or multiple pharmacies. Lost prescriptions will not be refilled early. Stolen prescriptions require a police report.

Referrals: Not all insurance companies require a referral to a specialist. If you do require a referral, please notify the office 48 to 72 hours in advance of the appointment. Failure to do so may result in rescheduling or non-payment by your insurance carrier. We will try our best to complete these in a timely manner, but please remember we are at the mercy of the insurance companies.

Test results: Patients will be asked to schedule an appointment to review test results (labs, x-rays, MRI's etc.) within two (2) weeks of completion. Please schedule an appointment once your test has been completed.

Privacy: We will maintain the privacy of your medical & personal information in accordance with the HIPPA laws established by the federal government. A copy of the HIPPA regulations will be provided to you, upon request. Unless authorized by the patient, family members should not inquire about patient medical information.

_____ _____
Patient and/or Guardian name (please print) Date

_____
Patient and/or Guardian signature

_____ _____
Witness signature Date

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At all**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+