PROACTIVE PRIMARY CARE **11041 Countryway Blvd, Tampa, FL 33626 ** Ph: 813-749-0844 * Fax: 813-749-0846

**SHORTENED HISTORY FOR PATIENTS WITH INFO ENTERED VIA KIOSK/PORTAL **

PATIENT NAME _____ **DOB:** _____

Address: _____

Cell Phone # _____ Work Ph # _____

Email Address**:** _____

Emergency Contact Name: _____ Phone # _____ Relation: _____

Who was your previous primary care physician (PCP) : □ **NONE** - I have NOT seen primary care doctor in several years.

Previous PCP doctor: _____ Ph#_____Fax#_____

Name of current Specialist(s):_____

□ I usually only see my Gynecologist for medical care : Dr. _____

How did you hear about our office ?// Who kindly referred you to our clinic ? _____

□ Internet □ Insurance Directory □ WOW magazine □ Tampa Bay News & Lifestyles Magazine □ Other: _____

Preferred Pharmacy: Name:_____ **Ph#**_____

Address: _____

MEDICATION LIST: (Please **LIST ALL** medications that you are currently taking, **including over-the-counter vitamins, herbs, supplements)**

□□ **NONE - NOT on any meds** ☐ SEE ATTACHED LIST

Drug name	Strength	Frequency taken	Drug name	Strength	Frequency taken

ALLERGIES: **List ANYTHING you may be allergic to and what type of reaction you had: -** → □ **NO KNOWN DRUG ALLERGIES**

Drug / Substance:	**Reaction:**
_____	□ Rash / hives / itching □ _____
_____	Rash / hives / itching □ _____
_____	□Rash / hives / itching □ _____

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PAST SURGICAL HISTORY : □ **NONE , no history of any surgeries**

□ Appendix
□Gallbladder
□ Tonsils / Adenoids
□ Breast Implants
□Breast Reduction
□ C-section
□ Hysterectomy
with □ Ovaries still present
with □ Ovaries removed
□ Kidney stone removed
□ Vasectomy
□ Cataract surgery

Other Surgeries: _____

_____

_____

X _____ _____

Patient / Guardian's Signature **Date**

(Above PMHx was reviewed by provider with the patient and any additions/corrections/clarifications were noted).

Reviewed by: □ **Dr. Bich-Ngoc Pham, MD** □ **Leilani Phelan, PA-C** □ **Christian Neller, PA-C**

_____ _____

Provider's Signature Date

PROACTIVE PRIMARY CARE
Family Practice
B. Ngoc Pham, MD
Leilani Phelan, PA-C
Christian Neller, PA-C
11041 Countryway Blvd, Tampa, FL 33626
Ph: 813 -749 - 0844
Fax: 813 - 749 - 0846

MEDICAL RECORDS REQUEST FORM

Patient Name: _____ DOB: _____/_____/_____

Patient Phone #: _____

I hereby authorize ProActive Primary Care (PPC) and its affiliated providers to contact, request and obtain medical records pertaining to my medical, social and psychological health. This pertains to information from PAST doctors/providers/hospitals/clinics as deemed appropriate in maintaining continuity of my medical care.

I also consent to any exchange of medical information between ProActive Primary Care and any specialist/hospital/clinic that I may be referred to in the future for medical evaluation.

I understand that I have the right to retract this consent at any time with written and signed notice in the future.

Patient Signature: _____ Date: _____

****

TO WHOM IT MAY CONCERN: _____

PLEASE SEND/FAX THE FOLLOWING: LAST 2 YEARS OF CONSULT NOTES, LABS, AND IMAGING REPORTS, as well as any pertinent information you feel would help with patient care.

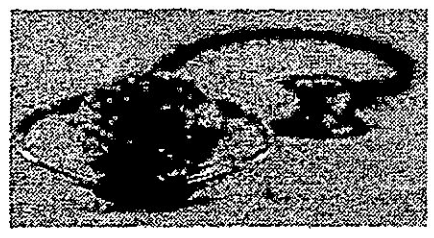
Thank you,

Dr. B. Ngoc Pham, MD
Leilani Phelan, PA-C
Christian Neller, PA-C

**This release of medical records is for the continuation of care as we are the patient's primary care provider. **

COMMENTS:

_____
_____
_____
_____
_____
_____



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LIVING WILL (ADVANCE DIRECTIVE) ACKNOWLEDGEMENT

Name: _____ **DOB:** _____

What is an <u>Advanced Directive</u> ? It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make any anatomical donation after death.
Some patients make advance directives when they arer diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.
What is a <u>Living Will</u> ? It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living.

If you are considering an advance directive or living will, please ask our staff for more written information on the process/forms.

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Federal and state regulations **require** contracted providers/physicians with certain insurance plans to document whether or not members 18yrs and older have an **<u>advance directive</u>**. A "yes" or "no " response is required to be recorded and easily accessible in the medical records.

Please read and **INITIAL** the following three statements.

1. _____ I have been informed of my rights to formulate living wills.
2. _____ I understand that I am not required to have a living will in order to receive medical treatment at this healthcare facility.
3. _____ I understand that the terms of any living will that I have executed will be followed by my healthcare facility and and my caregivers to the extent permitted by law.

PLEASE CHECK **ONE** OF THE FOLLOWING STATEMENTS:

_____ I have **<u>NOT</u>** executed a living will.

_____ I have executed a living will.

<u>X</u> _____ _____
Patient Signature Date

_____ _____
Patient's Guardian/Representative's Signature Date

_____ _____
Witness Signature Date

Proactive Primary Care

Dr. B. Ngoc Pham, MD ** Leilani Phelan, PA-C ** Christian Neller, PA-C
11041 Countryway Blvd, Tampa, FL 33626
Ph: 813-749-0844 Fax: 813-749-0846

CREDIT CARD ON FILE AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Our office requires a credit card to be kept on file for all patients.

The undersigned agrees and authorizes our medical practice to save the credit card indicated below on file.

Medical Practice: **Proactive Primary Care**

Information to be completed by Cardholder:

Name as it appears on the Credit Card: □ Same name as patient or _____

Type of Credit Card: □ Visa □ Mastercard □ Discover □ AMEX □ Other: _____

Credit Card to be On File – please present your valid credit card you wish to put on file to the Receptionist to be entered/scanned.

I, the undersigned cardholder, authorize Proactive Primary Care to process the above credit card as "Card on File" for the following reasons:

The Card on File will be charged for the following payments:

$75 Fee for any NO SHOW or Late Cancellation appt (<24 hour notice) for NEW patients.

$25 Fee for any NO SHOW appointments or Late Cancellation (<24 hour notice) for established patients

- **The Card on File will be charged for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance for all in office and telemedicine visit fees after the appointment.**
- **All outstanding balances greater than 90 days will automatically be charged to the card on file.**

I understand this authorization will remain in effect as long as I am a patient here at the medical practice. If the credit card is expired, I am to provide a valid, updated card to be on file.

_____ _____

Cardholder's Signature Date

BICH-NGOC T. PHAM, MD, FAMILY PRACTICE
11011 Countryway Blvd. Tampa, FL 33626

Patient Name: _____ **DOB:** _____

RENEWAL OF AUTHORIZATION SIGNATURES

AUTHORIZATION AND RELEASE

Authorization is hereby granted to release to the respective insurance company (companies) and when applicable to the Social Security Administration and Health Care Financing Administrator or its intermediaries or carrier, (or to the billing agent or supplier), and such information as may be necessary for the completion of insurance claims/billing purposes. I permit a copy of this authorization to be used in place of the original.
I hereby authorize the respective insurance company (companies) to pay directly to the clinic, under **Bich-Ngoc T. Pham, MD, LLC,** all medical benefits under my insurance policy (policies) including major medical benefits.

By signing below, I authorize Dr. Bich-Ngoc Pham, MD to share/release my medical information with other physicians/providers or institutions that I may be referred to see or have seen that are also actively involved in my medical care.

_____ X _____
Date **Patient/ Parent's Signature**

Patient's Financial Responsibility Notice:
Insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. In most instances, a contractual arrangement exists between the physician/providers noted above and an insurance company. I, the patient, am aware that I have a contractual agreement with my insurance company and I am responsible for understanding the terms and financial responsibility set forth under my insurance plan. I understand that not all services or procedures rendered may be covered under my insurance coverage, and any non-covered services will be the responsibility of the patient. Any balance upon the Clinic bill which is not expected to be reimbursed by insurance shall be payable by me. I am responsible for any deductible amount, coinsurance, or other balance that is set forth by my insurance coverage/plan.
If patient is a self pay patient with no insurance coverage, all fees are due and payable at the time services are rendered, unless prior arrangements have been made with our Billing Dept.
By signing below, I understand that I AM RESPONSIBLE FOR PAYMENTS OF SERVICES PROVIDED. If for any reason I am delinquent in my payments, I will be responsible for the Collection Fee of 30% and the outstanding balance on my account, plus any possible attorney fees. I acknowledge the understanding of this financial policy and am aware that a copy shall remain in my chart.

_____ X _____
Date **Patient Signature**

(HIPAA) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, NOTICE OF PRIVACY PRACTICES.

Patient's Acknowledgement of Receipt of HIPAA: I hereby acknowledge that I have been provided with a copy of the HIPAA-NOTICE OF PRIVACY PRACTICES. I have been given an opportunity to read and review it. If I wish to terminate this authorization of HIPAA privacy act at any time in the future, I will submit the request in writing.

_____ X _____
Date **Patient/ Guardian Signature**

Medical Confidentiality and Privacy Notice/ RELEASE AUTHORIZATION: It is the policy of Dr. Bich-Ngoc Pham, MD office that **ALL** medical information/notes pertaining to you is completely private and confidential according to HIPAA regulations. Dr. Pham cannot discuss anything relevant to your medical care/condition with anyone including your spouse/significant other without your signed consent. **I do authorize the release of any/all information pertaining to my medical chart/history to the following family members/friends/person (s) listed below:**

☐ **None**

Name _____ Relationship: _____ Phone Number: _____
Name _____ Relationship: _____ Phone Number: _____
Name _____ Relationship: _____ Phone Number: _____

_____ X _____
Date **Patient's /Guardian's Signature**