Patient Demographics

Date_____/_____/__________

Patient Name____

Maiden or Other Name_______________________________________

Email Address____
Required for patient portal registration

Address I Street Number____________________________________

City, State and Zip Code___________________________________

Home Phone____________________ Mobile_________________________ Work______________________

☐ Preferred contact ☐ Preferred contact ☐ Preferred contact

Marital Status (circle one): Single I Married I Separated I Divorced Gender (circle one) Male I Female

Date of Birth_____/_____/__________ Social Security Number_______________________________
Required for identification and insurance purposes Required for identification and insurance purposes

Federal health initiatives require us to collect race, ethnicity and language information
If you prefer not to report, you may choose Refuse to report. Please check one per category that applies.

Race: (check one)

☐ Asian
☐ American Indian or Alaska Native
☐ Black/African American
☐ Middle Eastern
☐ Native American
☐ Other Pacific Islander/Native Hawaiian
☐ White/European
☐ More than one race
☐ Refuse to report
☐ Other________________

Ethnicity: (check one)

☐ Central American
☐ Cuban
☐ Dominican
☐ Hispanic or Latino / Spanish
☐ Latin American / Latin, Latino
☐ Mexican
☐ Not Hispanic or Latino
☐ Puerto Rican
☐ South American
☐ Spaniard
☐ Other_________________________
☐ Refuse to report

Preferred Language: (check one) ☐ English ☐ Spanish ☐ Other_____________________

Local Preferred Pharmacy I Prescriptions (if prescribed) will be electronically sent to the pharmacy of your choice. Mail order pharmacies see below.

Pharmacy Name____

Address I Street Number____________________________________

City, State and Zip Code___________________________________

Pharmacy Phone____________________ Pharmacy Fax____________________

If you are using a **mail order pharmacy** please provide detailed information here:

BIGGERS
FAMILY MEDICINE

Patient Medical History

Name____Date of Birth_____/_____/__________

Medical History:

Please let us know about your past diagnoses and medical history.

- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ COPD
- ☐ Decreased Kidney Function
- ☐ HIV/Aids
- ☐ Active Cancer of any type
- ☐ Treated or undergoing treatment of cancer
- ☐ Current or past smoker. Packs per day _________.
  Year quit_________.

Current Medications:

Please let us know about your current medications:

Medication 1:

Name:__________________________________Dosage:________

Medication 2:

Name:__________________________________Dosage:________

Medication 3:

Name:__________________________________Dosage:________

Medication 4:

Name:__________________________________Dosage:________

Medication 5:

Name:__________________________________Dosage:________

Medication 6:

Name:__________________________________Dosage:________

Medication 7:

Name:__________________________________Dosage:________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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 or 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 are 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

FOR OFFICE CODING __*0*__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these 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**
☐	☐	☐	☐

538 Wilbur St
Brandon Fl 33511
Office 813-655-4646
Fax 855-366-8430

PATIENTS CONSENT TO TREAT AND AUTHORIZATION FOR PAYMENT

Unless I have fully paid for all services, I authorize Biggers Family Medicine to apply for benefits on my behalf for services rendered by Biggers Family Medicine. I request payment from my insurance company be made directly to Biggers Family Medicine. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this, or any related claims. I permit a copy of the authorization to be used in place of the original. The authorization may be revoked at any time by me in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided.

Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for fees for all services rendered. There may be a significant delay in the patient receiving a statement of payments due when insurance carriers are involved. This delay in no way lessens the patients responsibility for full payment of services rendered. The patient and/or the patients insurance carrier may receive a separate bill for laboratory services. These payments are due to the entity performing these services. Biggers Family Medicine has no control over the costs or terms of payment associated with these services.

I consent to all treatments as deemed appropriate by the treating physician, and agree to pay for all such services rendered.

During the course of your treatment with Biggers Family Medicine, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be transferred to a third party for disposal. It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.
By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Biggers Family Medicine to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Patient name, printed ______________________________Guardian, if minor: _________________________

Patient Signature___________________________Guardian signature if minor_________________________

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the release of protected health information that is required to carry out treatment and obtain payment for healthcare services performed on my behalf. Biggers Family Medicine has a detailed document called the “Notice of privacy practices”. This document contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the notice before signing this agreement. Upon request, Biggers Family Medicine will provide the most current Notice of Privacy Practices.

I hereby authorize Biggers Family Medicine to share medical information including, but not limited to; immunization records, health registries, and medication histories with other physicians, pharmacies, and designated representatives. In order to provide the best possible medical care, it is important for the practitioners at Biggers Family Medicine to be aware of my complete medical history including all medications prescribed by all other medical providers including: other primary care providers; providers working at local Emergency Departments; pain management centers; and any other medical provider who has prescribed medications. Medications include those subject to monitoring according to the Controlled Substances Act of 1970. I further acknowledge that Biggers Family Medicine may use electronic means of communication to improve my health care experience. This may include but not limited to: phone calls, via landline or cellular line; both live and automated, messages sent via our website, patient portal, email and text messages.

My signature below indicates that I have been given the chance to review the notice of privacy practices. My signature means that I agree to allow Biggers Family Medicine to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Biggers Family medicine has taken action relying on this consent.

Patient name, printed ______________________________Guardian, if minor: _________________________

Patient Signature___________________________Guardian signature if minor_________________________

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The doctors and staff of Biggers Family Medicine would like to welcome you to our practice; please take a moment to review these policies.

- It is the patients responsibility to inform the office of any address or telephone changes.
- The patients account must be kept current. All self-pay or insurance co-payments, co-insurances, and deductibles will be collected at the time of service or billed to you in accordance with your insurance policy.
- If the patient does not have their payment, the appointment will be rescheduled.
- Due to time allowed for each appointment, patients may be asked to schedule another appointment for issues other than the original reason for the original appointment.
- A returned check will result in a minimum service charge of $25 and checks will not be accepted for future payments. Unpaid returned checks will be turned over to the state attorneys office.
- A request for review of your medical record requires an appointment.
- Prescription refills require three (3) business days notice.
- If your insurance requires a referral or authorization it is your responsibility to get all information to the primary care doctor for processing. All referrals and authorizations require 2 weeks (14 days)to complete. If the correct time is not allowed the patient may need to reschedule appointments.
- An appointment is required to request a referral with a specialist.
- Claims will be submitted, however; we must emphasize that as medical providers, the relationship is with patients, NOT insurance companies. Although we attempt to verify benefits with insurance policies, please be advised this is only an estimate of the coverage based on the information given at the time of inquiry.
- It is the patients responsibility to inform us of any changes in their insurance.
- Not all services are covered benefits with all insurance plans.
- It is the patients responsibility to be aware of the services provided, and their covered benefit under their insurance policy.
- The patient is responsible for any non-covered charges not payable by the insurance policy
- Although filing insurance claims is a courtesy extended to the patient, all charges are always the patients responsibility from the date services are rendered.
- If the patients account is turned over to a collection agency, the patient will be responsible for any costs incurred in collection of the balance, which will include collection agency fees, court costs, and attorney fees.
- In the event that the patient does not meet their financial obligation, the patient will be discharged from the practice.

I,_______________________________________have read or have been read; and understand the financial policies of Biggers Family Medicine and agree to meet all financial obligations.

Patient name, printed _________________________________Guardian, if minor: ___________________________

Patient Signature______________________________Guardian signature if minor___________________________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient______________________________ Date of Birth____________

I hereby authorize medical providers and personnel of Biggers Family Medicine to discuss my protected health information with:

Name ______________________________ Relationship ____________________

Name ______________________________ Relationship ____________________

Name ______________________________ Relationship ____________________

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information.

____ Information regarding the patient's diagnosis and treatment of HIV/Aids
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from_______________until___________ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

____ ____________________

Signature of Patient Date

HOW TO GET TESTING AND IMAGING RESULTS

Portal: www.biggersfamilymedicine.com Our easy to use patient portal is the fastest and most convenient way to obtain your results. Providers post results along with follow-up instructions on abnormal findings. This is the primary way to get your test results.

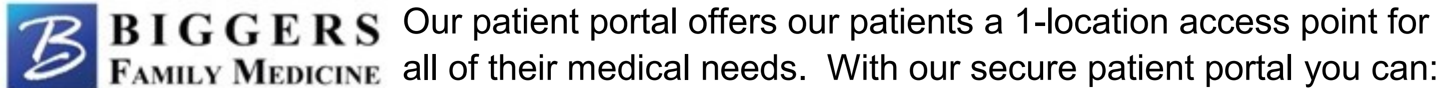
Follow Up Appointment: You can make a follow up appointment with any of our providers to discuss your lab results in detail. Serious or complicated findings will require a follow up appointment.

If you have a chronic condition your labs can be followed up at your next routine visit in most cases.

We will contact you for any clinically significant abnormalities. If we are unable to reach you, a certified letter will be mailed directing you to schedule an appointment to review results.

As always you are welcome to copies of your results at anytime by coming to the office. Explanations of the results may require a follow up appointment.

We do not mail letters or make calls for normal or insignificant findings on labs or imaging.



Our patient portal offers our patients a 1-location access point for all of their medical needs. With our secure patient portal you can:

- **View testing results and any comments from your provider regarding results**
- **Schedule and edit appointments**
- **Send and Receive messages to the Physicians**
- **Request medication refills**
- **View your health records**
- **Request copies of your health records**
- **View and pay any outstanding account balances**
- **Make any demographic updates to your profile**

Patients may access our patient portal by using any of the following web browsers:

Internet Explorer

Google Chrome

Preferred browser

Firefox.

Please type **www.biggersfamilymedicine.com** into your address bar