DR. R. L. DASO
SUNCOAST FAMILY MEDICAL ASSOCIATES
12020 SEMINOLE BLVD.
LARGO, FL. 33778

NAME_____ DATE_____

Name you prefer to be called_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate conditions experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervous
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headache	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Have you ever had a metal implant? ☐Yes ☐No Ever been gunshot? ☐Yes ☐No
Do you have a pace maker or defibulator ? ☐Yes ☐No

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1._____

2._____

3._____

4._____

5._____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑CONSISTENT

WHEN AND HOW
OCCURRED?_____

_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT
❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET
DATE OCCURRED:_____
SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S)
___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

HAVE YOU EXPERIENCED THESE SYMPTOMS IN THE PAST 6 MONTHS:
❑NO ❑YES WHEN?_____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE ? Y / N WHEN ? _____
ARE YOU APPREHENSIVE ABOUT YOUR VISIT TODAY ? Y / N
IF YES, EXPLAIN: _____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

_____

ARE YOU TAKING ANY NUTRITIONAL PRODUCTS? ❑NO ❑YES
WHAT KIND?_____
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES
WHAT KIND?_____
ARE YOU PREGNANT ❑NO ❑YES
DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Patient's Signature:_____ DATE _____

Patient Name_____

Suncoast Family Medical Associates
Registration Form

Date _____ Social Security Number _____

Patient Name _____ Date of Birth _____ Age ____

Sex _____ Single Married Divorced Widowed Primary Language _____
Circle One

Home Address _____ Apt/Lot #____

City _____ State _____ Zip Code _____

Home phone _____ Cell Phone _____

Referred by _____ E-mail address _____

If other family members are patients, please give their names: _____

Employed by _____ Employer Phone _____

Business Address _____ Occupation _____

IMPORTANT: In case of emergency, who would we contact? _____

Relationship _____ Contact number _____

Primary Health Insurance Company: _____ Policy # _____

Group # _____ Name of insured if other than patient _____

Relationship to insured _____ Date of Birth of Insured _____

Social Security number of insured _____

Secondary Health Insurance company _____ Policy # _____

Group # _____ Name of insured if other than patient _____

Relationship to insured _____ Date of Birth of Insured _____

Social Security Number of Insured _____

SUNCOAST FAMILY MEDICAL ASSOCIATES
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____
  _____

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a voice/text message on your mobile device.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email may be an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to authorize in writing the transmission of your healthcare information to you by unsecured email.**

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):_____

_____ _____ _____
Signature | Print name of person signing if other than patient | Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____ Date: _____

Insurance Authorization, Assignment and Guarantee of Payment

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Suncoast Family Medical Associates for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 11288 of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information).

I request that payment under the Medicare or other medical insurance program(s) be made to Suncoast Family Medical Associates for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by Suncoast Family Medical Associates from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Suncoast Family Medical Associates for services rendered.

I understand that I am responsible for payment of all charges and fees to Suncoast Family Medical Associates that they are entitled to collect that are not paid for by Medicare or other insurance.

Signature of Patient/Guardian_____ Date _____

Consent for Diagnostic and/or Therapeutic Procedures

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunizations(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient/Guardian _____ Date _____

Suncoast Family Medical Associates

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Suncoast Family Medical
(Print Name)

Associate's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Suncoast Family Medical Associates
Authorization for the Release of Information

I hereby give my permission to (list physician/facility name and address):

_____

_____

To release a copy of my medical records to:

- ☐ Jeffrey S. Grove, D.O.
- ☐ Ty L. Tvedten, D.O.
- ☐ N. Nicholas Engelman, D.O.
- ☐ Krista M. Keith, D.O.
- ☐ R.L. DaSo, D.C.

a physician with Suncoast Family Medical Associates. Please forward records to the following location:

12020 Seminole Blvd.
Largo, FL 33778
(727) 588-9572
(727) 559-7181 fax

The undersigned is a patient of Suncoast Family Medical Associates or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment, unless specified below, which may be a part of the medical records.

Print Patient Name: _____ SS#: _____

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

Relationship: _____

Signature of Witness: _____ Date: _____

SUNCOAST FAMILY MEDICAL ASSOCIATES
Notice of Patient Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 3/2013)

Understanding your health record/information:
What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

Your Health Information Rights:
Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

Our Responsibilities, we are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

To Report a Problem
If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Treatment, Payment and Health Operations:

Treatment: Information obtained by a member of our healthcare team will be recorded in your record. It will also be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information maybe used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

Communication with family: Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care, as governed by federal/state law.

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may use or disclose your PHI as required by law or required by a court ordered subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Authorization: We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.

Suncoast Family Medical Associates

12020 Seminole Blvd, Largo Fl. 33778

Health Considerations

Please inform us at time of scheduling of any health conditions, allergies, special needs or concerns you have. Your safety is important to us and some services may not be appropriate for certain conditions.

Sick Policy

In an effort to maintain a healthy environment, we ask that if you are sick (which includes cold, fever, the flu, etc.) or have the onset of symptoms of an illness that you reschedule your appointment. This is for your well-being as well as the health of our employees, therapist and other patients.

For our massage patients,

Receiving a massage when you are sick is not advised. While in the early and acute stages of a cold, the flu or other illness, a massage can accelerate the onset of the infection and intensify its severity (via additional circulation of blood and lymph). If you get a massage after the infection has peaked, you may experience a relapse of symptoms and feel sick again. Please wait until you have been well for at least a week before getting your massage. If you do need to cancel your appointment, please call us as soon as possible and we will be happy to reschedule your appointment for a time when you are feeling better.

Fragrance – Free Policy

Recognizing that some of our staff, therapist, and patients have sensitivities and/or allergic reactions to various synthetic fragrances, we have a Fragrance-Free Policy. In an effort to create the healthiest environment possible for everyone, we request that you refrain from wearing perfume, scented lotions, body sprays or other similar products while at our office.

Cell Phone Usage

In our efforts to maintain a relaxing atmosphere for our patient, we ask that all cell phones and pagers be silenced or turned off upon entering our office. Cell phone use is not permitted beyond the reception area.