Lake Endocrinology and Diabetes, PLLC
Brian Lake, D.O.
New Patient Intake

Name: ______________________ SS#: ______________

Address: ______________________ Phone: ______________

Primary Care Physician: ______________________ Advance Directive: Y N

Past Medical History:
Do you have a history of:

			Month/Year	Description
Diabetes Mellitus	Yes	No		
Thyroid Disease	Yes	No		
Osteoporosis	Yes	No		
Heart Disease	Yes	No		
Lung Disease	Yes	No		
Stroke	Yes	No		
Kidney Problems	Yes	No		
Eye Problems	Yes	No		
Cancer	Yes	No		
High Blood Pressure	Yes	No		
Circulation Problems	Yes	No		
Other	Yes	No		
Other	Yes	No		

Current Medications (Include all vitamins and over the counter medications)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

Allergies: ______________________

Family History:

Family Member	Current Age	Health Status/Medical Problems
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Surgical History:
List all surgeries you have had and date of surgery.

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Lake Endocrinology and Diabetes, PLLC
Brian Lake, D.O.
New Patient Review of Systems

Name:____________________________________ Date:____

Are you currently having any problems related to the following systems? Check Yes or No

Constitutional Symptoms

Fever	☐ Yes	☐ No
Weight Gain	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Extreme fatigue/tired	☐ Yes	☐ No

Eyes

Blurred Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Bulging eyes	☐ Yes	☐ No
Dry eyes	☐ Yes	☐ No
Loss of peripheral vision	☐ Yes	☐ No

Gastrointestinal

Abdominal Pain	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No
Feeling full early	☐ Yes	☐ No
Constipation/Diarrhea	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Heart racing	☐ Yes	☐ No
Swelling Legs	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Breast

Breast Pain	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No

Heme/Onc

Anemia	☐ Yes	☐ No
History of cancer	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No

Neurological

Headaches	☐ Yes	☐ No
Dizzy spells upon standing	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No

Neck/Thyroid

Thyroid enlargement	☐ Yes	☐ No
Thyroid nodules	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Change in voice	☐ Yes	☐ No

Integumentary (skin)

Skin Rash	☐ Yes	☐ No
Darkening skin pigment	☐ Yes	☐ No
Stretch marks	☐ Yes	☐ No
Skin Tags	☐ Yes	☐ No
Loss of hair	☐ Yes	☐ No

Psychologic

Anxiety	☐ Yes	☐ No
Severe Depression	☐ Yes	☐ No

Genitourinary

Frequent urination	☐ Yes	☐ No
Erectile dysfunction	☐ Yes	☐ No
Prostate enlargement	☐ Yes	☐ No
Poor sex drive	☐ Yes	☐ No

Endocrine

Very thirsty	☐ Yes	☐ No
Very hungry	☐ Yes	☐ No

Musculoskeletal

Muscle weakness	☐ Yes	☐ No
Muscle pains/cramping	☐ Yes	☐ No
Bone pain	☐ Yes	☐ No

Pinellas Internal Medicine Associates AND Lake Endocrinology and Diabetes
Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: ______________________ (last name) ______________________ (first name) ______ (initial)

Date of Birth: __ / __ / __ Social Security #: ____ - ____ - ____ Email: ______________________

Home Phone: (_____) __________________ Work Phone: (_____) __________________ Cell Phone: (_____) __________________

Address: ______________________ Apt. #: ______ City: ______________ State: ____ Zip: __________

SEASONAL PATIENTS BILLING/ MAILING INFORMATION

Mailing Address Summer Dates ______ To _______

Address: ______________________ Apt#: _____ City: ______________ State: ______ Zip: _______

Mailing address Winter Dates _______ To ______

Address: ______________________ Apt. #: ______ City: ______________ State: ____ Zip: __________

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist.

PRIMARY Insurance Name: ______________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: __________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $ _________

SECONDARY Insurance Name: ______________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: __________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $ _________

PATIENT'S REFERRAL INFORMATION

Name: ______________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Phone: (_____) __________________ Fax: (_____) __________________

PHARMACY INFORMATION

Name: ______________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Phone: (_____) __________________ Fax: (_____) __________________

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Home Phone: (_____) __________________ Work Phone: (_____) __________________ Cell Phone: (_____) __________________

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to PIMA AND LAKE ENDOCRINOLOGY AND DIABETES, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ______________ Your Signature: ______________________________

Pinellas Internal Medicine Associates AND Lake Endocrinology and Diabetes
Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)

Patient Name		Date of Birth	Social Security Number	
Address	City		Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record from

Physician/Facility			
Address	City	Zip	Phone

RELEASE TO: [Name of physician or facility receiving information]

Please send my medical record to:

Physician/Facility ***Lake Endocrinology and Diabetes, PLLC or Pinellas Internal Medicine Associates***			***Fax# 727-544-8366***
Address 10707 66th St N, Suite A	City Pinellas Park	Zip 33782	Phone 727-544-8300

RELEASE INFORMATION

Reason: [ ] Change of insurance [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply)

RECENT H&P		LAST THREE VISITS	
LAB REPORTS		X-RAY REPORTS	
HOSPITAL REPORTS		OTHER:	

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

THIS AUTHORIZATION has no expiration. I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric testing, physical abuse, or drug and alcohol abuse. This information is being released, received, and used for the purposes of coordinating my care, evaluating my needs, and/or providing services to me. I understand that I have the right to refuse to sign this authorization and that my treatment is not contingent upon whether or not I sign this authorization. It may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on action previously taken.

	YES	***NO***	***Initials***
I authorize the release of HIV/HTLV/AIDS test results.			
I understand that I may be charged for copies provided.			

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Pinellas Internal Medicine Associates, PA AND Lake Endocrinology and Diabetes, PLLC
Patient's Agreement to Abide By

Office Policies

GENERAL INFORMATION

In order to provide our patients with the best quality of care in the most timely manner, we have established these policies. We welcome your comments, positive and negative, and any suggestion you may have. Our clinic office hours are 8:00 a.m. to 5 p.m. Monday through Thursday, and 8:00 a.m. until noon on Fridays. Doctors' schedules may vary from these hours. Physicians are on call 24 hours a day, seven days a week for emergencies.

OUR POLICIES

- **Payment-** Payment in cash, check, or credit card is expected at the time of service unless other arrangements are made in advance. We accept all major credit cards.

- **Co-Payments-** All insurance and HMO co-payments are due at the time of the office visit prior to seeing the doctor. We are unable to bill for co-payments.

- **Insurance-** We file any insurance with which we have a contract. Please check with us prior to seeing the doctor to make sure we accept your plan. Claims for any other insurance companies with which we are not contracted must be filed by you. After you pay us, we will provide you with the receipt you will need to send to your insurance company. In any case, you are reminded that, regardless of insurance coverage, you are responsible for paying the full balance due in a timely fashion.

- **Delinquent Accounts-** If you fail to pay your bill or the bill of anyone for which you are financially responsible (such as a child or spouse), the following charges also apply:
  - There is a fee of $25 for all checks returned to us due to insufficient funds or other non-payment by your bank.
  - Balances not paid after 3 statements will be referred to a collections agency. You will then be responsible for any costs incurred from that agency in addition to the amount you owe us. Allowing this to happen may affect your personal credit.
  - If we take you to court because of an unpaid balance, you are responsible for any and all costs incurred, including, but not limited to, lawyer's fees and legal filing fees.

- **Office Visits-** Office visits are made by appointment, only. We are not a walk in clinic. The office is extremely busy and we try hard to accommodate everyone. Where possible, please call at least one to two weeks before you would like to see the doctor as we cannot guarantee same-day or next-day appointments. Please call and let us know if you will be unable to make your scheduled visit. In general, we prioritize appointments as follows:
  - Emergencies and urgent care are seen the same day.
  - Semi-urgent problems will be scheduled within three days.
  - Routine physicals and similar types of appointments will be set for one month or more from the time requested.
  - The nature of our practice is to give our patients the best possible care and service. Therefore, you may experience delays in being seen. Please be assured that you will be attended to as promptly as possible and be given the same careful attention as those who came before you.

- **Failure to Keep Appointments-** After three times of failing to notify us that you will be unable to keep your appointment, you will be required to select a different clinic for your medical needs. **There will be a charge of $35 for follow-up appointments broken with less than 24 hours notice and a $75 charge for new patient appointments broken with less than 24 hours notice.**

- **Medical Students-** From time to time, the doctor may have medical residents or students who are in training working with her. If you do not wish to have one of these students or residents see you, please let us know in advance.

- **Phone Calls-** The doctor is quite busy during office hours, therefore he or she cannot be disturbed to answer or return phone calls unless it is an absolute emergency. If you need to speak to the doctor or the nurse, please leave your detailed message and phone number with the receptionist and someone will return your call by the end of the work day. If you need to speak to the doctor after hours for emergencies, only, he or she will be paged and return you call. Patients who abuse this privilege will be asked to find medical services elsewhere.

- **Prescriptions-** If you need a refill, please contact your pharmacy and allow 48 business hours for your request to be completed. The doctors do not call in prescriptions after business hours, or, for health reasons, may not be able to renew your prescription until you have been seen. If you haven't seen the doctor recently, you may need to make an appointment to review your medical history and make any necessary changes before your prescription can be refilled. Some prescriptions require prior authorization from your insurance company and this may take up to a week, so please call well in advance of your needs. Always provide the name of the medication, dosage, and the pharmacy used when calling the office. Due to federal law, this office is no longer able to prescribe chronic narcotics.

- **Referrals-** We try to obtain referrals as soon as possible, however some may take up to five to ten working days. We will send the referral as soon as it is obtained. We appreciate your patience during this time.
  If you are thinking about changing your insurance plan, please make sure the doctors you see (including any specialists that you are seeing) are on that new plan. We cannot get a referral for a doctor that is not included in your insurance.

- **Living wills and Powers of Attorney-** Please inform the receptionist if you have living wills or powers of attorney that pertain to your care. We will need copy to put into your chart.

- **Medical Records-** Your medical records may only be released after you have filled out and signed the appropriate forms'. A copying charge of up to $1.00 per page or a flat fee of $25.00 will be billed to you.

- **May we leave messages on answering machine/voicemail for appointment confirmation?** Yes____ No ___

I have read the above office policies, I understand them, and I agree to them as a condition for being seen by my doctor.

______________________________ ______________________

Patient's Signature Date

Pinellas Internal Medicine Associates AND Lake Endocrinology and Diabetes

Your Financial Responsibility

In an effort to provide you with the highest quality healthcare and still maintain lower prices for our services, we have established this financial policy to assist you in understanding and complying with our clinical practice's service fees.

The patient or patient's guardian is responsible for payment of all services rendered by our physicians/providers.

If you have medical insurance, Pinellas Internal Medicine Associates or Lake Endocrinology and Diabetes will be happy to accurately and efficiently submit all claims to your insurance company. Many of the services provided in this office are covered by insurance companies. However, in cases where a service has not been paid for by your insurance within 60 days, you will be personally responsible for the bill. Your balance payment is due within 30 days upon receipt of your bill.

It is your responsibility to verify all insurance policies regarding co-pays, deductibles and coverage. All patient co-pays are due at the time of visit. If you do not have your co-pay, your appointment will be rescheduled, as it is our responsibility to comply with your insurance policies.

If you have high deductibles, have no insurance or require services not covered by your insurance, Pinellas Internal Medicine Associates or Lake Endocrinology and Diabetes will be happy to provide you with the opportunity to meet with our financial/billing advisors. A financial estimate, possible discounts and agreement form can be set up that allows you to make monthly payments for all of the services rendered.

Payment plans available to our patients include: cash, checks (for existing patients), MasterCard, Discover and Visa (credit/debit). A fee of $25.00 will be assessed on all returned checks.

An outstanding balance of 120 days, with no contact from you will be referred to our collection agency and you will be dismissed from the care of our practice. Should you file bankruptcy, you will also be dismissed.

We are more than happy to meet and work with you on a payment plan, but these arrangements must be made in advance with our financial billing advisors. If you have questions, please feel free to contact our Office Manager at (727) 544-8300.

RELEASE OF INFORMATION: Pinellas Internal Medicine Associates or Lake Endocrinology and Diabetes may disclose all or any part of my medical record and/or financial ledger; including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV to any person or corporation that (1) is or may be under contract to Pinellas Internal Medicine Associates or Lake Endocrinology and diabetes for reimbursement for services rendered, and (2) any health care provider for continued patient care. Pinellas Internal Medicine Associates or Lake Endocrinology and Diabetes may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

____ ____________

Signature of Patient or Authorized Party Date

____

Printed Name of Patient or Authorized Party

Pinellas Internal Medicine Associates AND Lake Endocrinology and Diabetes
10707 66th St N., Suite A
Pinellas Park, FL 33782

2020 HIPAA PRIVACY ACT ACKNOWLEDGEMENT AND CONSENT FORM

Lake Endocrinology and Diabetes, PLLC and Pinellas Internal Medicine Associates, PA are fully compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our manual of Privacy Practices is available for your review in our waiting areas and a copy will be provided to you at your request. By signing this form, you acknowledge that you have been made aware that you have certain rights under HIPAA. Your signature does not waive any of those rights.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not the patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have received our Privacy Notice (Confidentiality of Patient Medical Records) and have the right to review it, to request restrictions, and to revoke consent in writing.

Persons to whom Medical Information may be disclosed to:

___________________________________ ______________________________
Name of person/Family member: Name of person/Family member

___________________________________ _______________________________
Name of person/Family member Name of person/Family member

Print Name:____ Date:______________________________

____
Signature

Pinellas Internal Medicine Associates AND Lake Endocrinology and Diabetes
Patient Portal Authorization Form

Patient Name (please print clearly):________________________________DOB:___________

Personal Email Address (please print clearly):_______________________________________

Note: We suggest you use a personal email.

Purpose of this Form:
The patient portal is designed to enhance secure patient-physician communications and is provided as a courtesy to our valued patients. Please read this form thoroughly before signing.

How the Patient Portal Works:
A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those of whom you are legally responsible.

Via the Patient Portal you will be able to:

– Use the message function to communicate with our staff
– Communication of laboratory & diagnostic results from staff to patient
– View medication list and request refills
– View or print health summary information and send staff requests to update information
– View demographic/insurance information and send staff requests to update information
– Print or save an electronic copy of the health summary
– View or print immunization record
– View upcoming scheduled appointments and in the future schedule new appointments
– e-mail reminder of upcoming scheduled appointments
– Communicate about billing questions

Response time:

– Most non-urgent portal inquiries will be responded to within 2 business days.
– Please give prescription refills 3 business days to be completed.

The Patient Portal is NOT intended for the following:

– **NO** diagnosis or treatment is offered by portal email. Diagnosis can only be made and treatment rendered after the patient schedules and is SEEN (face-to-face encounter) by the physician
– **NO** emergent communications or services. Go to the nearest emergency room or dial 911.
– **NO** request for narcotic pain medication will be accepted.

If there is persistent abuse or negligence with the use of the patient portal, we reserve the right at our own discretion to terminate offering patient portal, suspend user account, or modify services offered through the patient portal.

Protecting Your Private Health Information and Risks:
This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal. By signing this consent, you acknowledge that Pinellas Internal Medicine Associates is not responsible for a breach of information if you are using the portal on a computer workstation or device in a public space or that could be compromised.

We understand the importance of privacy with regard to your health care and will continue to protect the privacy of you medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices.

How to Participate in the Patient Portal:
Once this form is agreed to and signed, you will receive a user name and password via your personal email account. You can log onto the website at: **www.gotomyclinic.com/pima**. You will be able to log in using the username and password provided.

How to end this agreement for Patient Portal:
This authorization MAY BE REVOKED in writing and delivered to Pinellas Internal Medicine Associates, Medical Records Dept, 10707 66th St. N. Suite A,, Pinellas Park, FL 33782 at any time requesting that your account be inactivated. You will receive a notice of cancellation within 10 business days. If you do not receive such notification, it is your responsibility to contact and inform the office of no receipt.

Patient Acknowledgement and Agreement
I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communication between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Pinellas Internal Medicine Associates or Lake Endocrinology and Diabetes should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for the online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity. The authorization stays in effect until cancellation by either you, the patient, or Pinellas Internal Medicine Associates or Lake Endocrinology and Diabetes.

Patient /Guardian Signature:____Date:________________

Formulary Benefits Data Consent Form

Formulary Benefits Data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **Pinellas Internal Medicine Associates** AND **Lake Endocrinology and Diabetes** to access my pharmacy benefits date electronically through RxHub. This consent will enable **Pinellas Internal Medicine Associates and Lake Endocrinology and Diabetes** to**:**

- Determine the pharmacy benefits and drug copays for the patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within drug class for non- formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

____ ____________________
Patient Name (PRINTED) Date of Birth

____ ____________________
Patient/ Guardian Signature Date