



26750 US Hwy 19 N, Suite 100, Clearwater, FL 33761 PH: 727-726-1460  
 1001 37th St. N., Suite D, St. Petersburg, FL 33713 PH: 727-914-9130  
 667 W. Lumsden Rd., Brandon, FL 33511 PH: 813-867-7323

**NEW PATIENT INTAKE**

**Patient Name (Print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Social Security:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Sex:**  M  F **Marital Status:**  M  D  W  S

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Cell Phone:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Email Address:** \_\_\_\_\_

*The listed information will be used to supply patient health information. Emails from staff are not encrypted.*

**Primary Care Physician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Name of Persons (s) you want to have access to your medical information. Due to HIPAA regulations, we will not be able to release information to those not listed:**

**Name & Relationship** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Name & Relationship** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**\*HEALTH INSURANCE INFORMATION:**  N/A

**Insurance Carrier:** \_\_\_\_\_ **Plan Name:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_ **DOB of Insured:** \_\_\_\_\_

**Relationship to Insured:**  Self  Spouse  Parent **Other** \_\_\_\_\_

**\*ACCIDENT INFORMATION:**  N/A

**What were you involved in?**  Auto Accident  Slip & Fall  Worker's Comp  Other \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_ **Auto Insurance Carrier:** \_\_\_\_\_

**Claim #:** \_\_\_\_\_

**If this is a Work Injury: Company Name:** \_\_\_\_\_ **Phone:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**If this is a Slip & Fall: Where did the incident happen?** \_\_\_\_\_

**Did the Accident occur in Florida?**  YES  NO **\*If NO, where did it occur?** \_\_\_\_\_

**Is there an Attorney involved?**  YES  NO

**If YES, Attorney/Law Firm Name:** \_\_\_\_\_

**Did you go to the Hospital/Urgent Care?**  YES  NO

**Hospital/UrgentCareName/Location:** \_\_\_\_\_

*By signing below, I attest that all information supplied today is true and valid to the best of my knowledge. I have been given a copy of Total Vitality Medical Group's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Total Vitality Medical Group LLC has the right to change this Notice at any time. I may obtain a current copy by contacting the office.*

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Review of Systems: Do you currently have or have had a problem with: Please Circle if YES**

<p><b><u>Constitutional:</u></b>          Difficulty Sleeping          Excessive Fatigue          Fever          History of Falls          Weight Gain          Weight Loss</p> <p><b><u>Eyes:</u></b>          Wear Glasses          Cataracts          Double/Blurry Vision          Glaucoma          Infections          Injuries</p> <p><b><u>Ear, Nose, Throat &amp; Mouth:</u></b>          Wear Hearing Aids          Ear Pain/Infection          Hearing Loss          Ringing in Ears          Nasal Congestion/Drainage          Nose Bleeds          Sinus Pain</p> <p><b><u>Cardiovascular:</u></b>          Chest Pain or Angina          Heart Murmur          High Blood Pressure          High Cholesterol          Irregular Pulse          Leg Pain While Walking          Swelling in Hands/Feet</p>	<p><b><u>Respiratory:</u></b>          Asthma          Bloody Sputum          Emphysema          Pneumonia          Shortness of Breath</p> <p><b><u>Gastrointestinal:</u></b>          Abdominal Pain          Change in Bowel Habits          Diarrhea/Constipation          Jaundice          Nausea          Ulcers or Gastritis          Vomiting</p> <p><b><u>Endocrine:</u></b>          Diabetes          Excessive Thirst          Excessive Urination          Thyroid Disease</p> <p><b><u>Genitourinary:</u></b>          Blood in Urine          Difficulty Starting/Stopping Stream          Incontinence          Kidney Stones          Painful Urination</p> <p><b><u>Integumentary:</u></b>          Skin Disease or Cancer</p> <p><b><u>Psychiatric:</u></b>          Anxiety          Depression</p>	<p><b><u>Neurological:</u></b>          Difficulty with Balance          Difficulty with Speech          Dizziness/Disorientation          Fainting Spells/Blackouts          Headaches          Inability to Concentrate          Loss of Sensation/Numbness          Memory Loss          Seizures</p> <p><b><u>Hematologic/Lymphatic:</u></b>          Anemia          Bleeding Tendencies          Blood Transfusions          Hemophilia          HIV          Swollen Glands/Lymph Nodes</p> <p><b><u>Allergic/Immunologic:</u></b>          Autoimmune Disease          Food or Nasal Allergies</p> <p><b><u>Musculoskeletal:</u></b>          Pain in the Neck or Back          Pain in the Arm or Leg          Arthritis          Joint Pain/Swelling          Numbness/Tingling in Arms or Legs          Shoulder Pain Left or Right          Weakness in Arms or Legs</p>
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The Information of the Patient Review of Systems Form is Correct to the Best of My Knowledge.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician / Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## New Patient Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason you are here: \_\_\_\_\_

**Personal Medical History:** Have you ever had any of the following conditions? (Check if yes)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Crohn's Disease    | <input type="checkbox"/> HIV / AIDS            |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Depression         | <input type="checkbox"/> Hypertension          |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Chemical Dependency      | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Peptic Ulcer Disease  |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> GERD               | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Clotting Disorder        | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Ulcerative Colitis    |

**Personal Surgical History:** Have you ever had any of the following surgeries? (Check if yes) **Add the date of the surgery.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Adrenal Gland Surgery _____ | <input type="checkbox"/> Colon Surgery _____          | <input type="checkbox"/> Kidney Surgery _____          |
| <input type="checkbox"/> Appendectomy _____          | <input type="checkbox"/> Coronary Artery Bypass _____ | <input type="checkbox"/> Neck Surgery _____            |
| <input type="checkbox"/> Bariatric Surgery _____     | <input type="checkbox"/> Esophagus Surgery _____      | <input type="checkbox"/> Prostate Surgery _____        |
| <input type="checkbox"/> Bladder Surgery _____       | <input type="checkbox"/> Gastric Bypass Surgery _____ | <input type="checkbox"/> Small Intestine Surgery _____ |
| <input type="checkbox"/> Breast Surgery _____        | <input type="checkbox"/> Hemorrhoid Surgery _____     | <input type="checkbox"/> Spine Surgery _____           |
| <input type="checkbox"/> Cesarean Section _____      | <input type="checkbox"/> Hernia Repair Surgery _____  | <input type="checkbox"/> Stomach Surgery _____         |
| <input type="checkbox"/> Cholecystectomy _____       | <input type="checkbox"/> Hysterectomy _____           | <input type="checkbox"/> Thyroid Surgery _____         |

Other surgeries and date(s): \_\_\_\_\_

List all **medications** and dosages you are currently taking: (including HRT) \_\_\_\_\_

List all **supplements** and dosages you are currently taking: \_\_\_\_\_

List any **allergies**: (Food, medications, environmental): \_\_\_\_\_

**Family History:** Has anyone in your family had any of the following conditions? (**Check if yes, and indicate relationship to you.**)

- Cancer / Polyps \_\_\_\_\_ (Circle all that apply) Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma, Other \_\_\_\_\_
- Anemia: \_\_\_\_\_  Diabetes: \_\_\_\_\_  Blood Clots: \_\_\_\_\_  Heart Disease: \_\_\_\_\_  Stroke: \_\_\_\_\_
- High Blood Pressure: \_\_\_\_\_  Anesthesia Reaction: \_\_\_\_\_  Bleeding Problems: \_\_\_\_\_
- Hepatitis: \_\_\_\_\_ Other: \_\_\_\_\_

# PAIN DRAWING

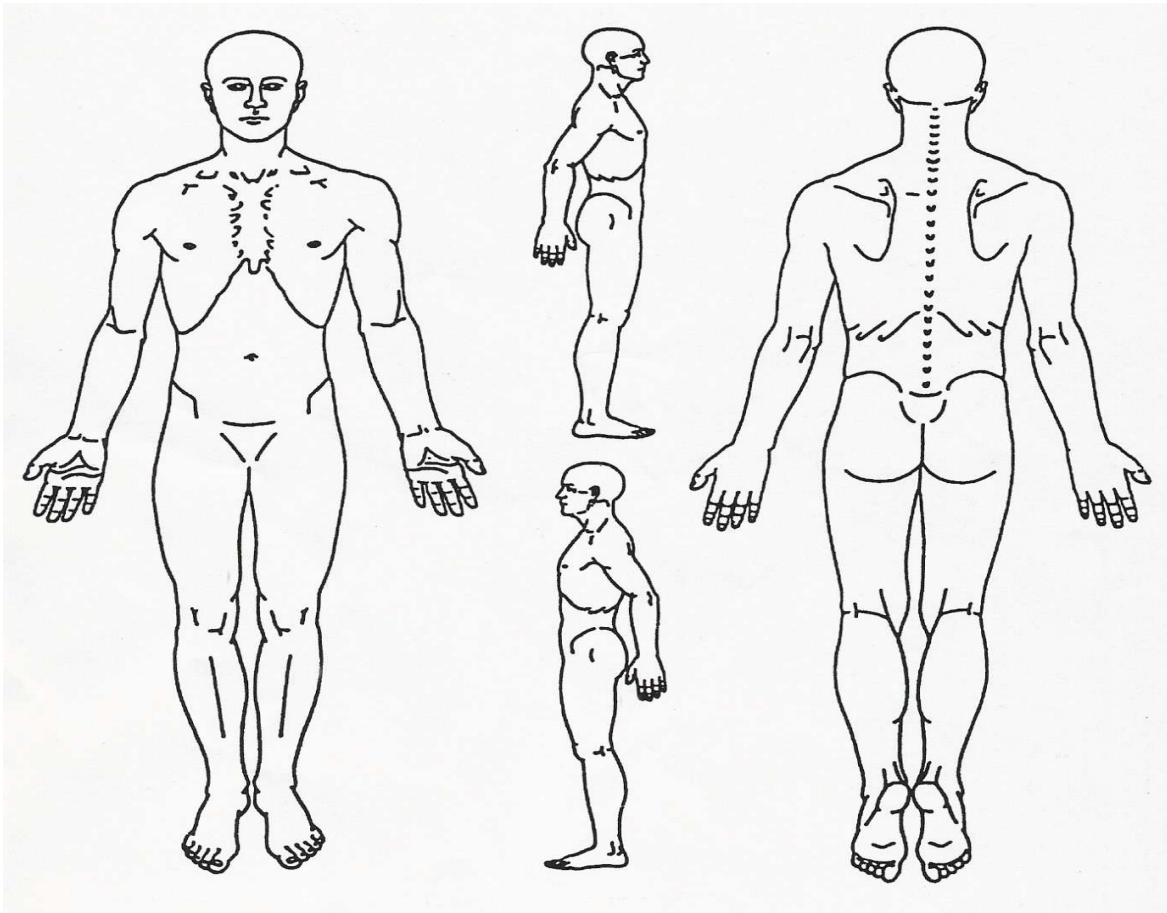
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please mark the figures below with the letters that best describe the sensation or pain you are feeling, AND areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain.

(Include all affected areas – you may draw in the face as well.)

A = Ache      B = Burning      R = Radiating Pain      D = Dull Pain

N = Numbness      S = Stabbing      P = Pins & Needles      O = Other



Please indicate how you would rate your pain (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

- a) Right Now      (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
- b) Average Pain      (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
- c) At Best      (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
- d) At Worst      (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)



**MULTI-DISCIPLINARY TREATMENT CENTERS**

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**Authorization to Administer Treatment:**

I hereby give permission to the Providers and staff at Total Vitality Medical Group, LLC to administer treatment, prescribe medication and/or testing procedures indicated by the provider he/she may deem necessary to diagnose and/or treat my condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Communication Consent**

I authorize Total Vitality Medical Group, LLC to contact me regarding my care (appointments, treatment, billing) via phone, voicemail, text (SMS), email, and fax (if applicable). I understand these communications may include protected health information (PHI), and that email/text may carry some security risk. Standard messaging rates may apply. I may opt out of any communication method at any time by notifying the practice in writing. I am responsible for keeping my contact information current. This consent does not replace the need for direct medical care or emergency services.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Pregnancy Release for X-rays:**

I, \_\_\_\_\_, hereby state to the best of my knowledge that I am not pregnant and give my full consent to Total Vitality Medical Group LLC, their associates, and x-ray technicians to x-ray me. My last menstruation cycle began on \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Minor Consent (if applicable):**

I hereby request and authorize Total Vitality Medical Group, LLC to render treatment to my minor child \_\_\_\_\_. This authorization is extended to all affiliated doctors and staff members and is intended for the performance of diagnostic tests, chiropractic adjustments, physical therapy, radiographic examination (at the doctor's discretion) as well as other treatment necessary for the minor child's care. As of this date, \_\_\_\_\_, I have the legal right to select and authorize health care services for the minor child named above. (If applicable), under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize care to my child should be revoked or modified in any way, I will notify this office immediately.

\_\_\_\_\_  
Parent or Guardian (Print) Signature Date

**RELEASE / WAIVER / DISCLOSURE OF OWNERSHIP**

**RELEASE FORM**

I accept full responsibility for my use of any and all equipment owned by Total Vitality Medical Group, LLC, its shareholders, directors, employees, representatives or agents. I hold them harmless for any and all loss, claim, injury, damage or liability sustained or incurred by me resulting there from.

**WAIVER FORM**

I fully understand and agree that I am engaging in physical exercise and the use of exercise equipment owned by Total Vitality Medical Group, LLC which could cause injury. I am voluntarily participating in these activities and assume all risks that might result. I hereby agree to waive any claim or rights I might otherwise have to sue the facility, its employees or agents for injury on account of these activities. I have carefully read this waiver/release and fully understand it is a release of liability.

I understand that I have the right, at any time, to freely choose my provider and the facility in which they practice. Please contact our office for a list of providers/ownership.

\_\_\_\_\_  
Name (Print) Signature Date

\_\_\_\_\_  
Witness (Print) Witness Signature Date



## Office/Financial Policy

Thank you for choosing **Total Vitality Medical Group (TVMG)** for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Except as indicated below, payment is required at the time services are provided unless other arrangements have been made in advance. We accept cash, VISA, MasterCard, Discover, American Express and Care Credit cards. Personal checks are not accepted.

### **OFFICE HOURS:** (By Appointment Only):

Each location has different hours, please contact the office to verify the specific days/hours of operation.

The office doesn't schedule patients between 12pm and 2pm.

As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. We do not have after-hours or weekend providers available.

### **INSURANCE:**

We participate in many insurance networks and will bill your insurance plan accordingly. If we do not participate with your insurance network, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan.

- **Proof of Insurance:** All patients must complete and/or update our Patient Information Form at the beginning of each year, and if when you change personal information. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.
- **Co-payments and deductibles:** All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible and non-covered services.
- **Claim submission:** We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Florida insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. Referrals: If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to referral. We require a 72 hour notice to facilitate a referral request and cannot issue retroactive referrals.

**OUT-OF-NETWORK CARE / SELF PAY:** Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, it is your responsibility to seek reimbursement through your insurance company. We will only send your claims for out-of-network care to your insurance if requested in advance. We will charge a self-pay rate. Please contact the front office for current Self-Pay Pricing.

**ADMINISTRATIVE SERVICES, CHARGES AND PATIENT RESPONSIBILITIES:** Due to the continued decline in reimbursements from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

\*Missed appointments. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require **24-hour notice of cancellation to avoid a \$95 cancellation** fee for all appointments. It is your responsibility to remember your appointment.



- Prescription refills. New prescriptions will not be issued without first seeing your Physician. Prescriptions for acute care or chronic conditions are written with an appropriate number of refills to complete the course of treatment or to last until your next scheduled appointment. You will be charged **\$75** for any additional refills issued without seeing the Physician or to replace a lost prescription, as long as it's a medication in which we are able to do so. All prescription requests are taken only during regular office hours and filled within 48 hours.
- Prescription Prior- authorizations. We will honor prior authorization requests from the patient, but the patient is responsible for contacting their insurance company to have them forward the prior authorization form to our office. A **\$25** fee may be assessed for time to complete the prior authorization form. Any request for a forced change in your medication by your insurance company will require an office visit. The patient will need to ask their insurance plan what "alternative medications" are covered and provide a list to their Physician.
- Letters / Form completion. At the discretion of the Physician, letters and forms requiring medical review and Physician signature are subject to a **\$50.** fee.
- Telephone Consultations: Telephone consultations calls for medical advice/treatment may be subject to a **\$195.** fee that is billed directly to you.
- Requests for medical records. In accordance with Florida law, TVMG requires written requests for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on current Florida law and is dependent on the number of pages requested. Please take this into consideration when requesting copies of your medical records.

**Personal Injury Cases**

- This office will bill for any auto accident or other liability or lawsuit related cases as a courtesy to you. It is your responsibility to provide us with the car insurance carrier name, claim number and any corresponding information prior to your visit in order to obtain proper authorization.

**Workers Compensation**

- If your injury is work related, it is your responsibility to provide us with the case number and carrier name prior to your visit in order to obtain proper authorization. We will be happy to bill your worker's compensation insurance company as a courtesy to you.

**Assignment of Insurance Benefits (Health Insurance)**

Patients with insurance please read and sign below that you understand and agree with the following statement. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, or services provided by Total Vitality Medical Group LLC, to Total Vitality Medical Group, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges which remain unpaid by insurance. I hereby authorize said assignee to release information necessary to secure payment.

I have read, understand, and agree to comply with the terms of your Office / Financial Policy for payment of professional fees.

_____	_____	_____
Name (Print)	Signature	Date
_____	_____	_____
Witness (print name)	Witness Signature	Date



## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Phone Number	E-mail

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.  
 I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information	
Phone Number	Fax Number

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information	
Phone Number	Fax Number

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. The following health information that relates to service beginning from \_\_\_\_\_ to \_\_\_\_\_, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories
- Office Notes (except psychotherapy notes)
- Test Results
- Radiology Studies
- Films
- Referrals
- Consults
- Billing Records
- Insurance Records
- Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis • HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

- |   |  |
|---|--|
| <input type="checkbox"/> Change of Doctor<br><input type="checkbox"/> Individual Request<br><input type="checkbox"/> Specialist Referral<br><input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Insurance Purposes<br><input type="checkbox"/> Continued Treatment<br><input type="checkbox"/> Legal Investigation<br><input type="checkbox"/> Other: _____ |
|---|--|

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority:
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## **LAB SERVICES DISCLAIMER**

**It is advised that every patient check with their insurance company prior to having labs drawn to determine coverage.**

**Why? Some insurance policies only cover preventative labs such as screening for diseases and/or an annual physical, while others only cover diagnostic labs for treatment of a specific issue.**

**It is also possible that your insurance policy has different deductibles for medical services. You may have a large deductible that is not yet met for the year, making your out-of-pocket expense greater.**

**While we make every effort to supply genuine and appropriate billing codes, we are unable to determine if your insurance coverage will pay for any labs ordered for you. Lab orders will not be altered by our providers to change coverage.**

**We do not accept any liability if your labs are not covered by your insurance.**

**Total Vitality Medical Group offers a cash lab option for those patients who are uninsured or underinsured, available by appointment only.**

**By signing below, I have read and understand the Lab Policy at Total Vitality Medical Group.**

**Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

