NEW PATIENT PACKET

DEMOGRAPHIC INFORMATION:
We will need your driver's license and a front and back side copy of your insurance card.

Name: _____ SSN: _____

DOB: _____/_____/_____ Sex:

ETHNICITY: _____ RACE: _____

ADDRESS:_____

_____

_____ZIP_____

E-MAIL ADDRESS: _____

Home Phone: _____

Mobile Phone: _____

MARITAL STATUS: Single, Married, Divorced, Widowed

OCCUPATION_____

SPOUSES NAME: _____

Phone #_____

INSURANCE Information

Insurance Company Name: _____

Medical Claims Address:

_____

Policy Number: _____

Group Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Relationship to Policyholder: _____

Co-Pay: _____

Other insurance: Yes, No

Emergency contact _____

Phone #_____

Pharmacy Name and Address_____

_____

Trinity Medical Associates Patient Portal Authorization Form

To use the **Trinity Medical Associates Patient Portal**, you must obtain a username and password. You must have a permanent email address that you check consistently. Please contact Trinity Medical Associates and we will assign you a username and a temporary password. You may submit a request to change your password at any time by contacting our Medical Records Department at (727)271-0887.

Important Information Regarding the Trinity Medical Associates Patient Portal:
• Use is limited to **non-emergency** communication and requests.
• The Portal facilitates communication between appointments. However, the Portal **does not replace** your scheduled office visits.
• It is not checked on the weekends.
• Please allow up to **72 hours** to respond to communications and requests.
• TRINITY MEDICAL ASSOCIATES **will not** send any private health information to your email.
• TRINITY MEDICAL ASSOCIATES **will** send you an email only when necessary, to request that you access the secure Patient Portal to review private healthcare information that we have posted on your Patient Portal.

Trinity Medical Associates Patient Portal Terms & Conditions:
Take steps to keep communications private and confidential including:
• Do not store messages on your employer provided computer; otherwise personal information can be
Accessible or owned by your employer.
• Use a screen saver or close your messages so that any passerby cannot read them
• Keep your username and password safe and private.
• Do not allow other individuals or other third parties to access the computer(s) upon which you store
Medical communications.

Communication Etiquette:
• Confirm that your name and other personal information in the message is correct.
• Review the message before sending it to make sure that it is clear and that all relevant information is
included.
• Update your contact information online as soon as it changes including your regularly used e-mail
address.
• TRINITY MEDICAL ASSOCIATES will not use your e‑mail account to send private health care communication due to lack of security.
• TRINITY MEDICAL ASSOCIATES will send a notification to your e‑mail address when a message has been sent to you in your Patient Portal.

Agreements & Procedures Relevant to Online Communications:

• Trinity Medical Associates will keep a copy of all medically important Patient Portal communications in your electronic medical record. This means that appropriate members of the staff will have access to these communications as part of our medical records keeping, treatment, and billing.
• You should print or securely store a copy of all Patient Portal communications that are important to you.
• TRINITY MEDICAL ASSOCIATES will not forward Patient Portal communications to third parties except as authorized or required by law.
• As a Portal user, you agree to follow the procedures that TRINITY MEDICAL ASSOCIATES implements to verify your identity in connection with Patient Portal communications and acknowledge that failure to comply with these procedures may terminate Patient Portal communications.
• Patient Portal communications will be used only for limited purposes. Patient Portal communications
can not be used for emergencies or time-sensitive matters. It should be used with caution.
• TRINITY MEDICAL ASSOCIATES will make every attempt to respond within the timeframe we have designated. However, there may be times when this is not feasible, and you understand and agree to accept variations in response times and use other forms of communications with our office if Patient Portal responses are not satisfactory to you. **Please note that Patient Portal communications should never be used for emergency communications or urgent requests.** These should occur via telephone or using existing emergency communications tools.
• While TRINITY MEDICAL ASSOCIATES will take reasonable precautions to protect your information, we are not liable for improper disclosure of confidential information unless it was caused by our intentional misconduct.
• Follow‑up is solely your responsibility. You are responsible for scheduling any necessary appointments
and for determining if an unanswered online communication was not received or responded to in a timely fashion.
• You are responsible for taking steps to protect yourself from unauthorized use of Patient Portal
communications, such as keeping your password confidential. TRINITY MEDICAL ASSOCIATES is not responsible for breaches of confidentiality caused by you or an independent third party.

Access & Use of Online Communications:
• Online communications does not decrease or diminish any of the other ways in which you can
communicate with our physician and staff. It is an additional option and not a replacement. You are
encouraged to contact our office via telephone, mail or in person, as always, if you have any questions or needs.
• In addition to online communication, you may be directed to contact us via telephone or in person at any time.
• We may stop providing online communications with you or change the services we provide online at any time without prior notification to you.

Risks of Using Online Patient Portal Communications:
All medical communications carry some level of risk. While the likelihood of risks associated with the use of online Patient Portal communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that you consider these risks each time you plan to communicate with us and communicate in such a fashion as to mitigate the potential for any of these risks. These risks include, but are not limited to:
• Online communications may travel much further than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
• Online communication is easier to falsify than handwritten or signed hard copies. A dishonest person
could attempt to impersonate you to try to get your medical records.
• It is harder to get rid of online communication. Backup copies may exist on a computer or in
cyberspace, even after you have deleted your copies.
• Online communication is not private simply because it relates to your own medical information. We use a secure network for the Patient Portal and avoid using standard e-mail or e-mail systems provided by employers to transmit private health care information. Employers and online services have a right to
inspect and keep online communications transmitted through their system.
• Online communications are also admissible as evidence in court.
• Online communications may disrupt or damage your computer if a computer virus is attached

Patient Acknowledgement and Agreement

By using the "Trinity Medical Associates Patient Portal" you acknowledge that you have read and fully understand the Terms & Conditions as described. You understand the procedures and risks associated with online communications with your healthcare team and you consent to the conditions described.

_____
Patient Name

_____
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 to Trinity Medical Associates to access my pharmacy benefits data electronically through RxHub. This consent will enable TRINITY MEDICAL ASSOCIATES to:

1. Determine the pharmacy benefits and drug co pays for a patient's health plan.
2. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
3. Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
4. Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
5. 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 Rx Hub.

By signing below, you agree and give us permission.

_____ DOB _____/_____/_____
Patient Name

_____
Signature

_____
Date

Authorization to Bill Insurance Company and Acknowledgment of Billing Policies

If you have medical insurance, our goal is to help you achieve the maximum benefits due you. In order to achieve this goal, we need your assistance and understanding regarding our payment policy. PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, Visa and MasterCard. If your insurance is one with which we participate, we will file your insurance for you. You are, however, expected to pay your percentage due, co-payment, or any deductible you have not met, at the time of service. We will try to answer any questions regarding your insurance but **understanding that your own insurance benefits are your responsibility**. **As medical providers our relationship is with you, not your insurance company and all charges are YOUR responsibility.**
I have received and understood the billing policy, I understand that payment is my responsibility. I have also reviewed the past due accounts policy and understand it.

For **Medicare Patients**: I request that payment of authorized Medicare benefits be made to me on my behalf, or to Trinity Medical Associates, LLC for any services furnished. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents, any information needed to determine these benefits of these benefits of these benefits payable for relate services. I also request that payment for authorized Medigap benefits be made on my behalf to Trinity Medical Associates, LLC for services provided. I authorize any holder of medical information about me to release it to my Medigap insurer and any information needed to determine these benefits. I understand that I do not need to provide my authorization will cause Medicare payment information to cross over automatically.

Medicare Beneficiary

_____
Signature

_____
Date

For **Non-Medicare Patients**: I authorize release of any medical information necessary to process this claim and related claims. I request that payment of authorized benefits be made either to me or on my behalf to Trinity Medical Associates, LLC for any services furnished to me.

Commercially insured

_____
Signature

Date _____

All Patients: I agree to pay all charges for myself and members of my family, as applicable promptly upon presentation of. Charges as shown by statements are agreed to be correct unless protested in writing within 30 days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

_____
Signature

_____
Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

FROM (Previous Provider): _____

PHONE: _____

FAX: _____

I hereby authorize and request you to release any and all information which you may possess relating to examinations and treatments, including psychiatric and/or psychological, alcohol or drug abuse, or communicable disease information which may be a part of my medical records.

TO: Trinity Medical Associates
Dr. Jeffrey S. Vasta MD,
Julia Vasta MS ARNP, Pam Maxie PA-C
3633 Little Road Suite 101
Trinity, FL 34655

Phone: 727-375-2222 Fax: 866-244-2335

Patients Name (print) _____

Date of Birth _____/_____/_____ SSN_____

_____
Signature

_____
Date

_____
Witness Signature

_____
Date

HIPPA Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you consent, the office is permitted by federal privacy laws to make use and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected Health Information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A nurse obtains information about you and records it in your medical record.
- During the course of your treatment, the physician determines that he will need to consult with another specialist in the area. He will share the information with such specialists and obtain his or her input.

Examples of use of your health information for payment purposes:

- We submit requests for payment to your insurance company. The insurance company or business associate helping us obtain payment requests information from us regarding your medical care. We will provide information to them about you and the care that was given.

Example of use of your health information for Healthcare Operations:

- We may obtain services from business associates such as credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Doctors/Practice. You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office.

2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by submitting a request at our office.

3. Right to inspect and copy your health record and billing record. You may exercise this right by submitting a request in writing by using a form that we provide to you upon your request. You have the right to appeal a denial of a request for access to your Protected Health Information except in certain circumstances.

4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.

5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form provided by this office upon your request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you at your request or disclosures made to family members at your request during the course of providing care.
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form that we provide upon your request.

If you want to exercise any of the above rights, please contact our Privacy Officer at (727)375-2222, in person, or in writing, during normal business hours. They will provide you with assistance and the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and healthcare operations purposes.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information with you
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and requesting a copy in person.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Privacy Officer at (727)375-2222, or in person during normal business hours.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written request.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment at this office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

- **Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule**

Patient Contact:
We may contact you to provide you with appointment reminders, with information about treatment alternatives, or information about health-related benefits and services that may be of interest to you.

Notification – Opportunity to Agree or Object:
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, general condition, or death.

Communication with family:
Using our best judgment, we may disclose to a family member, other relative, close friend, or any other person that you identify, health information relevant to that person's involvement in your care or in payment of such care if you do not object or in an emergency.

Opportunity to object or agree is Not Required

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

Child Abuse and Neglect
We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.

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

Victims of Abuse, Neglect, or Domestic Violence
We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

Oversight Agencies
Federal law allows us to relate your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations, inspections, licenses or disciplinary actions, and for similar reasons related to the administration of healthcare.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting certain types of wounds or other physical injury.

Coroners, Medical Examiners, And Funeral Directors
We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Threat to Health and Safety
To avert a serious threat to health and safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution or it's agents the protected health information necessary for your health and the health and safety of other individuals.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures

- Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website

- We maintain a website that provides information about our practice. This notice will also be published on that website.

I *have read the HIPPA policy posted online, or in writing at the office, and understand and agree to the notice of privacy practices as required by law.*
I understand that I may ask for a copy of the policy at any time or find it online at trinitymedicalassociates.com.

_____
Signature

_____
Date

Alternative Communication Release

Please check your preference (you may check more than one box)

I authorize Trinity Medical Associates, LLC, in regard to my protected health information, (example but not limited to lab results, x-rays, diagnostic tests, communications with the doctor) to release information by:

_____ Call my cell phone #_____-_____-_____

_____ Call me at home phone # _____-_____-_____

_____ Call me at work phone # _____-_____-_____

_____ **Leave a message on the following phones:**

Circle all that apply: Cell Home Work No Messages

_____ Speak only with me.

_____ Speak with my Immediate Family.

_____ Speak with myself or _____only.

_____

_____

I authorize Trinity Medical Associates, LLC, in regards to my protected health information based on the following alternative communications I have listed above.

_____
Signature

_____
Date

PATIENT NAME:

DATE OF BIRTH:

Current Medical Problems:

_____

_____

_____

_____

_____

Past Medical History / Family / Social History

Social History:

Who do you live with? _____

What is your occupation? _____

How many Children? _____

Medical Problems:

Females only: GYN History:

Age of Menarche? _____ Current birth control method _____

Age of Menopause? _____

Pregnancies _____

Miscarriages _____

Live Births _____

Abortions _____

Any Abnormal Mammograms _____

Patients Medical History:

System	Disease	Date Diagnosed	Details
Cardiovascular			
(Heart problem)			
Cancers			
Pulmonary			
(Lung Problem)			
Gastrointestinal			
(Stomach)			
(gallbladder)			
Urinary Tract			
(Urinary tract,			
Prostate)			
Endocrine			
(Blood sugar			
Lipids: Blood fat			
Diabetes)			
Blood Disorder			
(Hemophilia,			
Sickle Cell)			
Muscles			
(myopathy, myalgia)			
Dermatology			
(Skin, rashes,			
Eczema,)			
Psychiatric			
(Anxiety,			
Depression)			
Other			

HOSPITALIZATION:

Diagnosis	Date Diagnosed	Hospitalization	Emergency Room Visits	Complications

Surgical History

Surgery	Date	Reason for surgery	Complications	Other

Testing: Provide dates of exams below if applicable

EKG
Dental exam
Vision exam
Podiatry exam
Colonoscopy
CT SCAN
MRI
Chest X-ray
Other Xray

MEDICATIONS:

Drug Allergies:

_____

_____

_____

Medications, Prescriptions and Over the counter

Medication	Dose	Frequency	Date Prescribed	Reason Taking

Additional Medication Information:

_____

_____

_____

Any Current use of Recreational Drugs?

_____

_____

Any Past Use of Recreational Drugs?
If yes please provide additional information

_____

_____

Alcohol use:

Amount and Frequency:_____

Smoking:

Current: (Y /N)

How many packs per day _____

How many years _____/_____

Past Smoking: When did you quit? _____ How many packs/for how many years?

Family Medical History: Unremarkable

System	Disease	Family Member	Comments	Age of Death
Cardiovascular				
(Heart problem)				
Cancers				
Pulmonary				
(Lung Problem)				
Gastrointestinal				
(Stomach)				
(gallbladder)				
Urinary Tract				
(Urinary tract,				
Prostate)				
Endocrine				
(Blood sugar				
Lipids: Blood fat				
Diabetes)				
Blood Disorder				
(Hemophilia,				
Sickle Cell)				
Muscles				
(myopathy, myalgia)				
Dermatology				
(Skin, rashes,				
Eczema,)				
Psychiatric				
(Anxiety,				
Depression)				
Other				

Review of Systems

Circle if currently experiencing:

Constitutional: Chills Fever Weight Change Night Sweats Fatigue

Eyes: blurred vision, eye pain, sensitivity to light, change in vision

Ears: Change in hearing, Pain in ears, hearing problems, drainage
Nose: pain, congestion, runny nose, clear drainage, green drainage
Throat: soreness, hoarseness, dental problems

Cardiovascular: Chest pain, palpitations, rapid heart rate, irregular heartbeat, Fluttering in chest, skipped heart beats.

Respiratory: Cough, Shortness of breath, bringing up sputum

Gastrointestinal: Abdominal pain, heartburn, constipation, diarrhea, stool change, Blood in stool

Genitourinary: Painful urination, genital lesions, blood in urine, sexual difficulties, Frequent urination, changes in urine stream.

Female: Last Menstrual Period_____, Painful periods, irregular period.

Neurological: Dizziness, headaches, fainting spells, migraine headache

Hematologic/Lymphatic: Easy bruising, easy bleeding, swollen lymph nodes

Endocrine: Hair loss, heat or cold intolerance, frequent hunger, frequent thirst, Weight gain Weight loss.

Allergic/Immunologic: allergies, frequent illness, HIV exposure, itchy skin.

Psychiatric: Anxiety, Depression, Sleep disturbances. Victim Domestic Violence

Any other Problems or Comments Which you would like to discuss with us??

_____

_____

_____

_____

_____