www.midwaycare.org

Howard A Grossman, MD
2500 NE 15th Avenue
Wilton Manors, FL 33305
Phone: 954-530-8357
Fax: 954-533-7469

Date: _____

Legal Name: Last: _____ First _____ Middle_____

Preferred Name: _[ ] x if same as above_____

Home Address: Street: _____

City _____ State: ____ Zip Code: _____
Date of Birth: _____ SSN: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Email: _____ Can we leave you a confidential message at these phone numbers? Y N

Emergency Contact: _____ My preferred language is:

Relationship: _____ English Other: _____

Phone Number: _____ Spanish Decline to answer

What type of insurance(s)/coverage(s) do you have? **PLEASE NOTE: We treat everyone regardless of ability to pay.**

_____

For Billing Purpose if you have insurance, what gender do they have on record for you? M F

Name listed on your insurance card: _____

Subscriber ID Number: _____ Group Number: _____

If you do not have insurance: How many people in the household? _____

What is your annual income? _____ (bring proof of income (W-2, tax return, or last 2 pay stubs)

I am Hispanic/Latino: Yes No
My race is:

Native American and/or Alaskan Native
Black/African American
White/Caucasian
Native Hawaiian
Asian
Other Pacific Islander
More than one race
Other: _____

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Date: _____
Name: _____ Birth date: _____

Check all that apply:

My gender identity is:
Female
Male
Transgender (MTF)
Transgender (FTM)
Other: _____
Decline

My marital status is:
Single
Married
Divorced
Domestic Partner
Decline
Widowed
Unmarried Partner
Legally separated
Other: _____

My sexual orientation is:
Bisexual
Heterosexual
Queer
Not Sure
Gay
Lesbian
Other:_____

My Pronoun is:
She/Her
He/Him
They/Them/Their
Other: _____

I live (please check all that apply):
Live alone
Live with roommates
Other: _____
Live with spouse
Live with parents/family

My sex assigned at birth is:
Female
Male
Intersex
Other: _____
Decline

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Date: _____
Name: _____ Birth date: _____

This form lets us get to know you and how we can help. Not every question is important to everyone, but the more you can answer, the more we can help. If there is a question that makes you uncomfortable, skip it and discuss it during your visit. Thank you.

_____

Do you need help with this form? Yes No
If you answered yes, please stop filling out the form and speak with the front desk staff member.
Person filling out this form (if not the patient): _____
Name Relationship to Patient

Reason for your visit: _____

What medical problems do you have now or have you had in the past? None

Diabetes	Depression or anxiety
High blood Pressure/hypertension	Thyroid problems
High cholesterol	Migraines
Hepatitis A	Blood clots
Hepatitis B	Breast Disease
Hepatitis C	Allergies
Other liver problems	Asthma
Pancreatitis	COPD or Emphysema
Kidney failure	Tuberculosis (TB)
Cancer	HIV or AIDS

Addiction to: _____
Other: _____

What surgeries have you had in the past? None

_____	_____
_____	_____
_____	_____

Has anyone in your family had any of the following? None

Diabetes	Thyroid problems	Blood clots/diseases
High cholesterol	Osteoporosis	Breast cancer
High blood pressure	Parkinson's disease	Colon cancer
Heart attack	Alzheimer's disease	Ovarian cancer
Heart surgery	Mental illness	Prostate cancer
Stroke	Alcohol/drug addiction	Other: _____

Do you have any allergies:

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Date: _____
Name: _____ Birth date: _____

What medicines (prescription and over-the-counter), vitamins, supplements and/or herbs do you take regularly (if you need more space continue on back of form)?

Name	Dose	When do you take it?	What is it for?

Do you often have trouble remembering to take medicines? Yes No

When was your last:	**Date**	**Result**
HIV test		
STD(Sexually transmitted disease)test		
Hepatitis C test		
Bone Density test		
Cholesterol test		

Thinking of the last two weeks:
Have you been feeling down, depressed or hopeless? Yes No
Have you had little interest or pleasure in doing things? Yes No

How often is the past year have you had an alcoholic beverage?
Daily or almost daily Less than monthly
Weekly Never
Monthly

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Date: _____
Name: _____ Birth date: _____

When was the last time you had sex with another person? _____
Do you have sex with (circle one)? Men Women Both
In the past year, how many different sexual partner(s) have you had? _____
Currently, how many sexual partner(s) do you have? _____
If you have only one partner, do you only have sex with each other? YES NO
Are you using condoms when you have intercourse? Never Sometimes Always
Do you think you or your sexual partner(s) may have a sexually transmitted infection right now? _____
Are you having any difficulties with your sex life? YES NO
Do you want to discuss this today? YES NO

What Sexually transmitted diseases have you had in the past?

Gonorrhea	Oral Herpes
Chlamydia	Genital herpes
Pelvic inflammatory disease	Herpes through a blood test
Syphilis	Genital warts
Trichomonas	Other: _____

Have you ever been non-consensually hit, slapped, kicked, or otherwise physically hurt by an intimate partner? YES NO
If yes, how long ago? _____
Do you want to discuss this today? YES NO

Have you ever been forced to have sexual activity against your will? YES NO
If yes, when did this happen? _____
Do you want to discuss this today?

MIDWAY
SPECIALTY CARE CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date Signed: _____

OFFICIAL USE ONLY

I attempted to obtain the patient's signature acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Initial: _____ Date: _____

Reason: _____

MIDWAY
SPECIALTY CARE CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain regarding health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practiced to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such

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PATIENT RIGHTS

Access: We have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.

(You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, if in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative mean(s) or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Anand Sukhram

Telephone: (772)464-9746 FAX: (772)464-9750

Address: 356 E Midway Road
Fort Pierce, FL 34982