PLEASE READ AND FILL IN ALL INFORMATION IN ITS ENTIRETY

THIS INFORMATION IS REQUIRED BY YOUR INSURANCE COMPANY

ALL PAGES MUST BE SIGNED AND DATED

APPOINTMENT & REFERRAL POLICIES

24HR CANCELLATION NOTICE IS REQUIRED

OR THERE WILL BE A CHARGE OF $50.00 NO EXCEPTIONS

REFERRALS REQUIRE*48 HOUR NOTICE* – NO EXECPTIONS

PLEASE INITIAL THIS PAGE:_____

FINANCIAL POLICY AND PROCEDURE

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Biljana Baskot for services rendered

In the event of default, I agree to pay all costs of collection 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.

In accordance with Florida State Law, I hereby authorize Dr. Biljana Baskot, to file a formal written complaint on my behalf to my insurance company and to the Florida State Commissioner of other appropriate State insurance Commissioner if payment for services is not received within (30) days from the date of filing.

RESPONSIBILITY FOR PAYMENT:

The patient his or her parent or guardian, or person or agency requesting treatment is fully responsible for all charges incurred. Every effort will be made to verify insurance eligibility and benefit coverage. However, insurance seldom covers the entire fee and the patient is responsible for his/her cost (Co-Pay) at each session.

MISSED APPOINTMENT POLICY:**

Policy for Cancelling your appointment. All appointments must be **cancelled at least 24 business hours prior to the scheduled appointment.** Failure to cancel or attend appointments will result in your being charged **$50.00 for a 15 minute appointment or $75.00 for a 30 minute** appointment. This can NOT be charged to your insurance company.

EMERGENCY SERVICES:

In an emergency you may call 911 or go to the nearest emergency room to be evaluated. If you leave a message for Dr. Biljana Baskot on the answering service, they may not be able to return your call until the office is again open. The patient should make every effort to request prescription refills DURING REGULAR OFFICE HOURS, since they cannot be refilled when the office is closed.

Signature: _____ Date: _____

PATIENT INFORMATION RECORD

PATIENTS LEGAL NAME: DOB:

EMAIL: TODAY'S DATE

CELL PHONE: HOME PHONE:

ADDRESS: CITY ST ZIP

SS# SEX (circle one) FEMALE MALE OTHER

EMERGENCY NAME & PHONE NUMBER:

BELOW CIRCLE ONE IN EACH CATEGORY

MARITAL STATUS:	Married	Single	Divorced	Widowed	Other		
RACE:	Caucasian	Asian	Native Indian	Alaskan	African American	Hawaiian	Decline
RELIGION:	Buddhist	Catholic	Hindu	Islan	Jewish	Protestant	Declined
ETHNCITY:	Hispanic or Latino			Not Hispanic or Latino			
PRIMARY LANGUAGE:	(please note your primary language)						

Pharmacy Name:

ADDRESS / LOCATION / ZIP:

PHARMACY PHONE: **PHARMACY FAX:**

INSURANCE:

(circle one) PPO HMO MEDICARE OTHER

PERSON RESPONSIBLE:

RELATIONSHIP TO INSURED

EMPLOYER:

ALL APPOINTMENT UPDATES WILL BE DIRECTED TO YOUR CELL PHONE

Signature:_____ Date:_____

PATIENT HISTORY FORM **Patient Name:** **Date:**

EYES, EARS, NOSE, MOUTH				***CONSTITUTIONAL SYSTOMS***		
Hearing loss	**No**	**Yes**		Good general health lately	**No**	**Yes**
Hearing ringing	**No**	**Yes**		Recent weight change	**No**	**Yes**
Earaches or Drainage	**No**	**Yes**		Fever	**No**	**Yes**
Chronic sinus problem	**No**	**Yes**		Fatigue	**No**	**Yes**
Chronic sinus rhinitis	**No**	**Yes**		Headaches	**No**	**Yes**
Nose Bleeds	**No**	**Yes**		***INTEGUMENTARY (skin breast)***		
Mouth Sores	**No**	**Yes**		Rash or itching	**No**	**Yes**
Bleeding gums	**No**	**Yes**		Change in skin color	**No**	**Yes**
Voice Change	**No**	**Yes**		Change in hair	**No**	**Yes**
Swollen glands in neck	**No**	**Yes**		Change in nails		
RESPIRATORY				Varicose Veins	**No**	**Yes**
Chronic or frequent coughs	**No**	**Yes**		Breast pain	**No**	**Yes**
Spitting up blood	**No**	**Yes**		Breast Lump	**No**	**Yes**
Shortness of breath	**No**	**Yes**		Breast discharge	**No**	**Yes**
Asthma or Wheezing	**No**	**Yes**		***CARDIOVASCULAR***		
MUSCULOSKELETAL				Heart trouble	**No**	**Yes**
Joint Pain	**No**	**Yes**		Chest pain or angina pectoris	**No**	**Yes**
Joint stiffness or swelling	**No**	**Yes**		Palpitation	**No**	**Yes**
Weakness of muscles or joints	**No**	**Yes**		Shortness of breath with walking	**No**	**Yes**
Muscle Pain or cramps	**No**	**Yes**		Swelling of feet, ankles or hands	**No**	**Yes**
Back Pain	**No**	**Yes**		**NEUROLOGICAL**		
Cold extremities	**No**	**Yes**		Frequent headaches	**No**	**Yes**
Difficulty in walking	**No**	**Yes**		Recurring headaches	**No**	**Yes**
Sports injury	**No**	**Yes**		Light headed or dizzy		
HEMATOLOGIC/LYMPHATIC				Convulsions or seizures	**No**	**Yes**
Slow to heal after cuts	**No**	**Yes**		Numbness or tingling sensations	**No**	**Yes**
Bleeding	**No**	**Yes**		Tremors	**No**	**Yes**
Bruising tendency	**No**	**Yes**		Paralysis	**No**	**Yes**
Anemia	**No**	**Yes**		Stroke	**No**	**Yes**
Phlebitis	**No**	**Yes**		Head injury	**No**	**Yes**
Past transfusion	**No**	**Yes**		***ENDOCRINE***		
Enlarged glands	**No**	**Yes**		Glandular or hormone problem	**No**	**Yes**
GASTROINTESTINAL				Thyroid disease	**No**	**Yes**
Loss of appetite	**No**	**Yes**		Diabetes	**No**	**Yes**
Change in bowel movements	**No**	**Yes**		(Insulin or non insulin -Circle One)	**No**	**Yes**
Nausea or vomiting	**No**	**Yes**		Excessive thirst	**No**	**Yes**
Frequent diarrhea	**No**	**Yes**		Excessive urination	**No**	**Yes**
Constipation	**No**	**Yes**		Heat or cold intolerance	**No**	**Yes**
Rectal bleeding or blood in stool	**No**	**Yes**		Skin becoming dryer	**No**	**Yes**
Abdominal pain	**No**	**Yes**		Change in hat or glove size	**No**	**Yes**
Peptic ulcer (stomach or duodenal)	**No**	**Yes**		***PSYCHIATRIC***		
ALLERGIC/IMMUNOLOGIC				Memory loss	**No**	**Yes**
History of reaction to: ALLERGIES: List Below				Confusion	**No**	**Yes**
				Nervousness	**No**	**Yes**
PATIENTS SIGNATURE:				Depression	**No**	**Yes**
Date:				Insomnia	No	Yes

PATIENT HISTORY FORM	Patient Name:			Date:
GENITOURINARY				**FEMALE**
Frequent urination	**No**	**Yes**		Pain with periods
Burning or painful urination	**No**	**Yes**		Use douche
Blood in urine	**No**	**Yes**		Irregular periods
Incontinence or dribbling	**No**	**Yes**		Vaginal discharge
Kidney Stones	**No**	**Yes**		Age at the onset of menstruation
Sexual difficulty	**No**	**Yes**		Number of days menstruation lasts:
Male - Testicle pain	**No**	**Yes**		Date of last pap smear:
History of Prostate Problems: If YES please explain:	**No**	**Yes**		Date of last menstrual period:
PAST MEDICAL HISTORY:				Miscarriages:

Previous Hospitalizations / Surgeries / Serious injuries: Dates:

MEDICATIONS	**DOSAGE**	**DIRECTIONS**

Patient Social History: CIRCLE ONE						
Use of Alcohol:	RARELY		NEVER	**DAILY**		MODERATRE
Use of Tobacco:	PREVIOUSLY BUT QUITE WHEN:			CURRENT PACKS PER DAY:		
Use of Drugs	NEVER	TYPE/FREQUENCY				
Marital Status:	SINGLE	S/O	MARRIED	DIVORCED	SEPERATED	WIDOWED
Exposure to:	FUMES	AIR-BORNE PARTICLE		SOLVENTS	DUST	NOISE
History of domestic violence:	PHYSICAL	VERBAL	OTHER			

Patient Social History:	AGE	DISEASES	IF DECEASED	CAUSE OF DEATH
FATHER				
MOTHER				
SIBLINGS				
SPOUSE				
CHILDREN				

PHYSICIAN REVIEWED:		DATE:
PATIENT SIGNATURE:		DATE:

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTIES NOTICEHIPAA

I, _____

, hereby acknowledge that I have reviewed and received a copy of this *Notice of Privacy Practices* explaining:

How this office will use and disclose my protected health information. My privacy rights with regard to my protected health Information. This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concern with any concern regarding our privacy and security policies and procedures, Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative:	
Signature:	**Date:**
Name: (please Print)	
Relationship to Patient:	

For office use only:	
We made a good-faith effort to obtain an acknowledgment of Date:	
Receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed	
acknowledgment of receipt for the following reasons *(check all that apply)*:	
☐	Patient refused to sign (date of refusal) **Date: / /**
☐	Communications barriers prohibited obtaining an acknowledgment
☐	An emergency situation prevented us from obtaining an acknowledgment
☐	Other
Attempt was made by:	**Date: / /**

RESULTS FORM

Dear Patient,

When you undergo medical testing or imaging, it is important that you receive the results in a timely manner. **It is your responsibility to learn the results** of any tests or imaging ordered by Dr. Baskot. We recommend that you make a follow up appointment **within one month** of your test or visit to review results with Dr. Baskot. You may also access results through the patient portal.

By signing below, you acknowledge that you have read the statement above and understand your responsibility to learn the results of your medical testing/ imaging.

Name (Print): _____

Signature: _____ Date: _____