REGISTRATION FORM

Section I: Patient Information

Date_____

Name:_____
I Prefer to be called: _____
Address:_____
City:_____ State:_____ Zip_____
Phone (_____)_____ Work Phone (_____) _____
Cell Phone (_____)_____
The best time to contact me is: ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____
City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____
Work Phone_____
Whom may we thank for referring you?
_____
Person to contact in case of emergency_____
Phone_____ Relationship_____
Email Address_____

The following information must be filled out completely. Failure to do so may result in a denial from your insurance company.

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____
Relationship to Patient: _____
Address:
_____
City: _____ State: _____ Zip: _____
Phone: (____) _____
Employer_____ Work Phone (____) _____
SSN#_____

Section III Insurance Information

Name of Insured _____DOB_____
Relationship to Patient _____
SSN#:_____ Name of Employer:_____
Work Phone: (____)_____
Address of Employer: _____
City _____State: _____Zip _____
Insurance Company_____ Grp
#_____ID#_____
Ins Co Address: _____
Ins Co. Phone: _____

------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING -------

Name of Insured _____DOB_____
Relationship to Patient _____
SSN#:_____ Name of Employer:_____
Work Phone: (____)_____
Address of Employer: _____
City _____State: _____Zip _____
Insurance Company_____ Grp #_____
ID#_____
Ins Co Address: _____
Ins Co. Phone: _____

ENCOUNTER NON-COVERED SERVICE WAIVER

I acknowledge that I will be charged, and agree that I will pay interest (at a rate no

higher than the maximum permitted by law) on any overdue amounts until they are paid in full. If my account is referred for collection, I agree to pay for all costs of collection, including reasonable attorneys' fees and court costs. When an account is referred to a collection agency the agency fee will be added to the outstanding balance. The agency fee is currently 25% of the outstanding balance. A $10 rebilling fee will be added for all statements after the initial statement. I understand and agree that any overpayments collected by St. Luke's Health Care, PLC with regard to any particular care, treatment, or services provided to me may be applied to any outstanding amounts then due and payable to St. Luke's Health Care, PLC for which I am legally responsible.

Patient Name:_____ DOB:_____
(Print)

Patient Signature:_____

Date:_____

ST. LUKES REGIONAL HEALTHCARE
DR. JOSEPH GHALY, M.D.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains Patient rights section describing your rights under law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:_____
Patient or Representative

Relationship to Patient (if other than patient):_____ DATE:_____

******Please list here any person(s) you wish for us to discuss your medical history with (e.g. spouse, child(ren), caregiver, etc).******

_____
Name/Relationship to Patient

_____
Name/Relationship to Patient

_____
Name/Relationship to Patient

NEW PATIENT HISTORY FORM – ST. LUKE'S REGIONAL HEALTH CARE, PLC

Patient Name_____
DOB:_____ **Age:**_____ **Sex:**_____

Reason for this visit:_____

MEDICATIONS: Please list all medications that you are taking currently:

NAME	DOSAGE	# OF PILLS	FREQUENCY	DATE STARTED

Please list all over-the-counter medications used: (i.e. vitamins, herbs, supplements, aspirin, CPAP)

_____
_____

ALLERGIES: (please list medication allergies as well as environmental allergies)

Medication/Type of Allergy/Reaction	Medication/Type of Allergy/Reaction	Medication/Type of Allergy/Reaction

PAST MEDICAL HISTORY:

Head:
- ☐ Glaucoma
- ☐ Allergic Rhinitis (Allergies)
- ☐ Sinusitis
- ☐ Hearing Deficiency
- ☐ Legally Blind
- ☐ Epistaxis (nose bleeds)
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration

Abdomen:
- ☐ Peptic Disease (stomach ulcers)
- ☐ Gastritis
- ☐ GERD (heartburn)
- ☐ Hepatitis (liver)
- ☐ Irritable Bowel (diarrhea)
- ☐ Colitis (colon inflammation)
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Inflammatory Bowel Disease (Crohn's disease, ulcerative colitis)
- ☐ Hiatal Hernia

Heart:
- ☐ Atrial Fibrillation
- ☐ Coronary Disease (heart attack)
- ☐ Congestive Heart Failure
- ☐ Hypertension (high blood pressure)
- ☐ Arrhythmia (irregular heartbeat)

Endocrine:
- ☐ Hyperthyroidism (overactive)
- ☐ Hypothyroidism (underactive)
- ☐ Diabetes

Cancer
Type_____
_____
_____

Reproductive:
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Ovarian Cysts
- ☐ Urinary Incontinence (leaking)
- ☐ Hernia (inguinal)
- ☐ Prostate Hypertrophy (enlarged)
- ☐ Erectile Dysfunction (impotence)
- ☐ Uterine Bleeding

CNS:
- ☐ Cerebrovascular accident (stroke)
- ☐ Seizures (convulsions)
- ☐ Migraine Headaches
- ☐ Vertigo (dizziness)
- ☐ Dementia (memory problems)
- ☐ Insomnia

Chest:
- ☐ Asthma
- ☐ COPD (emphysema)
- ☐ Chronic Bronchitis
- ☐ Fibrocystic Breast (cyst)

Musculoskeletal:
- ☐ Cervical Disc Disease
- ☐ Lumbar Disc Disease
- ☐ Chronic Back Pain
- ☐ Knee Arthritis
- ☐ Fibromyalgia

Circulation:
- ☐ Peripheral Artery Disease (PAD)
- ☐ Carotid Disease (blockage)
- ☐ Varicose Veins
- ☐ DVT (blood clot)
- ☐ PE (clot in the lung)

Other:
- ☐ Depression
- ☐ Anxiety
- ☐ Nephrolithiasis (kidney stones)
- ☐ Hyperlipidemia (cholesterol)
- ☐ Sleep Apnea

Other: (not listed)
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY:

Surgery	Date	Specify type
Heart Surgery		
Lung Surgery		
Ear Surgery		
Eye Surgery		
Thyroid Surgery		
Breast Surgery		
Lumbar Surgery (back)		
Orthopaedic Surgery (bones, knees, hips, etc)		
Carpal Tunnel Release (left, right, or both)		
Septoplasty (deviated septum)		
Tonsillectomy		
Cholecystectomy (gallbladder)		
Appendectomy		
Colostomy		
Herniorrhaphy (hernia)		
Tubal Ligation (tubes tied)		
Hysterectomy		
Ovary Removal (one or both)		
C-Section		
Bladder Suspension		
Hemorrhoidectomy		

SOCIAL HISTORY: (Now or in the past. If yes, please list how much and how often.)

Tobacco: _____packs a day _____how long _____quit how long	Alcohol:_____ type _____how much _____how long	Drugs:_____type _____how much _____how long	Caffeine:_____type _____how much _____how long

Type of Work (please list full or part time)_____ ☐Disabled
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower
Lives with: ☐ Alone ☐ Spouse ☐ Child/children ☐ Other_____
Number of children: (please list age of each)_____

FAMILY HISTORY:

Mother: ___Alive _____ Deceased (age) Problems:	Father: _____Alive _____Deceased (age) Problems:
Maternal Grandmother: ___Alive ____ Deceased (age) Problems:	Maternal Grandfather: _____Alive _____Deceased (age) Problems:
Paternal Grandmother: ___Alive _____Deceased (age) Problems:	Paternal Grandfather: _____Alive _____Deceased (age) Problems:
Sisters: _____ how many ____Alive _____Deceased Problems:	Brothers: _____how many _____Alive _____Deceased Problems:

HEALTH MAINTENANCE/DIAGNOSTIC STUDIES/IMMUNIZATIONS (List month/year and any abnormalities)

EYE EXAM	TSH	MAMMOGRAM	FLU SHOT
COLONOSCOPY	PROSTATE	PAP/PELVIC	PNEUMOVAX
CHOLESTEROL	PSA	BONE DENSITY	TETANUS
TB TEST			OTHER

WOMEN ONLY: Age of first period_____ Last normal period_____ Problems with periods_____
Birth Control Method_____
Pregnancies_____ Live Births_____ Miscarriages_____ Abortions_____

Patient Name: _____ **DOB:** _____

Reason for visit today: _____

Constitutional	Yes	No
Poor appetite		
Fever (as symptom)		
Chills (as symptom)		
Night sweats		
Recent weight loss/gain (lbs___)		

Skin		
Rash		
Itching		

Head, Ear,Eyes, Nose, Throat	Yes	No
Visual Disturbance		
Sinus problems		
Runny nose		
Headache		
Nasal congestion		
Hearing Loss		
Ringing in the ears		
Earache (left/right)		

Neck	Yes	No
Stiffness		
Swollen glands		

Urinary	Yes	No
Pain during urination		
Increased frequency of urination		
Blood in urine		
Urinating more than 1 time at night		

GI	Yes	No
Abdominal pain		
Change in bowels		
Heartburn		
Indigestion		
Nausea		
Vomiting		
Diarrhea/ulcers		
Blood in stool		

Musculoskeletal	Yes	No
Back pain		
Joint pain		
Cramps		
Neck pain		
Muscle weakness		

Respiratory	Yes	No
Cough (productive or non-productive)		
Shortness of breath		
Wheezing		
Chest Congestion		

Chest/Heart	Yes	No
Chest pain		
Palpitations		
Swollen ankles/legs		
Irregular heartbeat		

Neurology	Yes	No
Dizziness		
Numbness		
Poor Balance/Instability		
Tremors		
Fainting		

Psych	Yes	No
Depression		
Anxiety		

Endocrine/Hematology	Yes	No
Change in Energy Level		
Cold/Heat Intolerance		
Tired/Sluggish		
Easy Bruising		
Excessive bleeding		
Swollen glands		

Gynecological (women only)	Yes	No
Unexplained vaginal bleeding		
Vaginal discharge		
vaginal pain		
vaginal itching or burning		

Surgeries/procedures done since last visit:

_____

_____

New Medications (including herbal, over the counter, and vitamins):

_____

_____

_____

Other symtoms not listed:

_____

_____

_____

_____

St Luke's Regional Health Care, PLC
Joseph Ghaly, MD
145 Horizon Court
Lakeland, FL 33813
Phone 863-644-9800, Fax 863-644-9822

Dear New Patient:

Welcome to St. Luke's Regional Health Care. Our office policies are designed to ensure that we are able to provide the highest quality of care for our patients. The staff is not responsible for these policies nor are they authorized to change or modify them. Please take the time to read it, sign it & return it at your first visit. A copy will also be provided to you.

Office Policies

Office Hours: Our regular office hours are Monday through Friday 9am to 5pm.

Medical Appointments: Appointments should be made to address any new problem or concern, especially if it requires a prescription medication. Appointments are also necessary for periodic follow-up of chronic medical problems such as high blood pressure, diabetes, high cholesterol, etc. This allows us an opportunity to assess the effectiveness of treatment, evaluate for side effects of medication, & monitor lab work if necessary. New patients need to arrive 30 minutes early for your appointment so you can complete any necessary paperwork. All other patients need to arrive 15 minutes early. Arriving on time helps us to stay on schedule & minimize waiting time for you as well as other patients.

Auto Accident Appointments: Appointments made for auto cases are billed to the Auto Insurance carriers. Therefore any medical issues not pertaining to the auto accident will not be discussed at these visits. If you would like to discuss other medical issues (high blood pressure, weight loss, diabetes, etc.) you will need to schedule a separate office visit. The medical office visit will be billed through your medical insurance therefore your health insurance copay and deductible will apply. We will do our best to accommodate both visits on the same day.

Weight Loss Appointments: St. Luke's has recently implemented a weight loss program. Patients interested should inquire at the front desk for more information. **Patients enrolled in the weight loss program may only discuss weight loss issues. Any other medical concerns** will need to be scheduled a separate office visit due to payment and billing differences. We will do our best to accommodate both visits on the same day. **Please note that this is a CASH ONLY program and cannot be billed to your medical insurance.**

Tag Alongs: There are several instances when family members and friends accompany patients to an office visit. Please note that if medical concerns are addressed for an accompanying member (e.g. such as medication refills) an office visit will be charged. The applicable co payment and deductible will also apply. So please respect the other patients and the doctors time and schedule an appointment.

 Patient Initials:_____

Insurance/Payment: Patients who have insurance coverage should provide their insurance card at each visit. If there are any changes to your health care coverage you must notify us in advance of the appointment so that the insurance may be verified prior to the appointment in an effort to minimize wait time.

Payment is due at time of service. All copays, deductibles & balances (including family member balances) will be collected at the time of each office visit. Amounts not covered by insurance are patients responsibility. We accept MasterCard, Visa, cash & money orders. **Due to the recent increase in returned checks effective December 1, 2008 personal checks will no longer be accepted!**

If you have not met your deductible with your insurance carrier, you will be asked to leave a $100 deposit to cover your office visit. Adjustments will be made on your account after your insurance company has paid their portion.

Medicare Supplement Insurance: We are a participating provider with Medicare Part B program; and as such we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the allowable amount) and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductible of $135 are the patients responsibility by federal law.

Nonpayment: Invoices are sent every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. A rebilling fee of $10 will be charged for each additional invoice sent out after 30 days. You acknowledge that you will be charged, and agree that you will pay, interest at a rate no higher than the maximum permitted by law on any overdue amounts until they are paid in full. If your account remains past due, you understand that your account may be referred to a Collections Agency and agree to pay for all costs of collection, including but not limited to, reasonable attorneys' fees and court costs. You will also be responsible for the agency fee, which is currently 25% of the outstanding balance. You understand that any overpayments collected with regard to any care, treatment, or services provided to you may be applied to any outstanding amounts then due and payable for which you am legally responsible. You understand that in the event you (or your family members) have an outstanding balance, you (they) will be discharged from this practice. If this is to occur, you understand that you will be notified by regular and certified mail that you have 30 days to find alternative primary care.

Cancellations: We require 24 hours notice if you are canceling your appointment. If you cancel without 24 hour notice or fail to appear, you will be responsible for a $30 no show fee.

Form Fees: There will be a fee charged for the completion of forms (disability parking, adoption, FMLA, physical, prescription etc). The fee is $15 for the first page & $10 for each additional page. This fee must be paid, up front, at the time the forms are dropped off.

Medical Records : All medical record requests must be submitted in writing. After you sign an authorization of release, we will provide any doctor's office with a copy of your records free of charge. If you or your legal representative needs copies of these records, we will provide them for the cost of $1.00 per page for the first 20 pages then $.50 per page thereafter. Please allow 7-10 business days for records processing. Prepayment is required for this service.

 Patient Initials:_____

Prescription refills: Prescription refills take **48-72** hours to process due to the need to evaluate whether labs or office visits are necessary. Requests should therefore be made before you run out of your medication so that we have ample time to approve your refill or notify you that an appointment is needed. Prescription refills will be handled during regular business hours. Calling after regular office hours should not be necessary.

Controlled Substances: Prescription for medications with the potential for misuse, abuse, or addiction are carefully monitored. Prescriptions for these medications will not be filled without an office visit first. Patients who lie or are otherwise dishonest about the use of these medications will be dismissed from the practice immediately & the proper authorities will be notified. **We must abide by the Federal Regulations for these medications.**

Controlled substances should NOT be obtained from multiple physicians and/or multiple pharmacies. Lost prescriptions will not be refilled early. Stolen prescriptions require a police report.

Referrals: Not all insurance companies require a referral to a specialist. If you do require a referral please notify the office 48 to 72 hours in advance of the appointment. We will try our best to complete these in a timely manner but please remember we are at the mercy of the insurance company. Failure to do so may result in rescheduling or non payment by the insurance carrier.

Test Results: Patients will be contacted with test results (labs, x-rays, MRI's etc.) within two (2) weeks. If you have not received your results within this amount of time you should contact our office to make sure that they have been received.

Privacy: We will maintain the privacy of your medical & personal information in accordance with the HIPAA laws established by the federal government. A copy of the HIPAA regulations will be provided to you. Unless authorized by the patient, family members are not to inquire about patient medical information.

_____ _____

Patient and/or Guardian name (please print) Date

_____

Patient and or Guardian signature

_____ _____

Witness signature Date