ADVANCEDCARE
Physicians Group, P.A.

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Kingsley Asare, DO, MPH
Board Certified Internal Medicine
Board Certified Infectious Disease

Michael Schaefer, DC, MPH, MCAP, DACACD
Board Certified Addictions and Compulsive Disorders

Welcome to our Clinic! We focus on individualized medical care that recognizes the interactions between genetic and environmental factors and between the body's interconnected systems. We **do not** prescribe controlled substances for chronic pain. We are honored that you have chosen us to help in your search for optimum health. This is your New Patient Information Packet. **Please read, fill out and sign the attached forms.** We are an appointment only clinic however we strive to offer same day appointments when you are sick. If you have an emergency call 911 or go to your nearest emergency department then once you are stable contact our office. If you need to cancel or reschedule your appointment, please notify our office **24 hour** or more before your appointment**. We charge $40.00 missed appointment fee if less than 24 hour notice is given. We require a credit card on file which will be charged in the event you do not show for your appointment or cancel 24 hours prior.** Please provide a phone number you wish us to call when we need to contact you**.** ***If you have an answering machine or voice mail, a message will be left unless you cross out this section out and initial*** _____. In some cases the doctor may request fasting lab tests, so we ask that you have no food 8 hours prior to your lab appointment. **Please do not fast, if you have diabetes, hypoglycemia or simply cannot do so.** We look forward to meeting you!

Please tell us how you were referred to us_____ Date_____

Name_____Birthdate_____
Last First Middle Initial

Address_____
Street City State/Prov. Zip/Postal code

Telephone: Home_____ Cell_____ Work_____

Email_____ Insurance name and policy #_____

Primary insured name and date of birth if other than patient_____

Employed by_____ Occupation_____

Age: _____ Height:_____ Weight:_____ Dominant Hand: (Right) (Left)

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1. What is your current gender identity? (Check and/or circle ALL that apply)

☐ Male

☐ Female

☐ Transgender Male/Transman/FTM

☐ Transgender Female/Transwoman/MTF

☐ Genderqueer

☐ Additional category (please specify): _____

☐ Decline to answer

2. What sex were you assigned at birth? (Check one)

☐ Male

☐ Female

☐ Decline to answer

Emergency contact_____
Name Telephone Address

List the main problems that you are having, or reason for this appointment example: Headache, Cold, Anxiety, Substance Abuse, Stomach problems, Fever, Infectious problems, Wound care, Neck or Back Pain etc... If an accident include date of accident: (Motor vehicle accident) Please explain in detail the reason/s for your appointment (Please ask for additional page/s if necessary). _____
_____
_____
_____
_____
_____
_____
_____

Past Medical History (Major Past Illnesses): Hepatitis A, B, or C, HIV, Syphilis, Stroke, Heart attack, etc:
_____
_____
_____
_____

Have you been tested for HIV? (YES) (NO) Would you like to be tested for HIV? (Yes) (No)
Have you been tested for HEP B? (YES) (NO) Would you like to be tested for HEP B? (Yes) (No)
Have you been tested for HEP C? (YES) (NO) Would you like to be tested for HEP C? (Yes) (No)

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Accidents or major trauma (Scars –Please give location) List current accident also even if this is the reason for today's visit.

_____
_____
_____

Hospitalizations/Surgeries – please give month/year if possible:

_____
_____
_____
_____

Dental Procedures (root canals, ect.)

_____
_____
_____

Current Prescription Medications (names and doses):

_____
_____
_____
_____

Allergies and Sensitivities: Foods, environmental, etc.–Ever tested? Copies of reports?

_____
_____

Occupational Exposures:

_____
_____

SOCIAL HISTORY:

Your Lifestyle factors (Please fill in the approximate amounts example Daily 1 pack, 3 drinks etc.):

	Never	**Occasional**	**Weekly**	**Daily**
Coffee				
Tobacco				
Alcohol				

If you smoke or use Tobacco Do you want to quit? (YES) (NO)
Does anyone in the family smoke? (YES) (NO)
Inside the home? (YES) (NO)

- Have you felt you need to **cut** down on your drinking **ALCOHOL**? (Y) (N)
- Have you ever felt **annoyed** by criticism of your drinking? (Y) (N)
- Have you felt bad or **guilty** about your drinking? (Y) (N)
- Have you ever drank **E**arly upon waking to steady your nerves or get rid of a hangover? (Y) (N)

During the **past three months**, how often have you failed to do what was normally expected of you because of your use of alcohol (beer, wine, spirits, etc.)? (never) (1-2 times) (monthly) (weekly) (daily)

During the past month, have you often been bothered by feeling down, depressed, or hopeless? (Y) (N)

During the past month, have you often been bothered by little interest or pleasure in doing things? (Y) (N)

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GAD-7 Anxiety Severity (0-21 : 5/10/15 mild, moderate, and severe anxiety**). Please answer all questions.**
0—not at all, 1—several days, 2—more than half the days, and 3—nearly every day, respectively

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days (2-3 days a week)**	**More than half the days (4-5 days a week)**	**Nearly every day (6-7 days a week)**
1. Feeling nervous, anxious or on edge	**0**	**1**	**2**	**3**
2. Not being able to stop or control worrying	**0**	**1**	**2**	**3**
3. Worrying too much about different things	**0**	**1**	**2**	**3**
4. Trouble relaxing	**0**	**1**	**2**	**3**
5. Being so restless that it is hard to sit still	**0**	**1**	**2**	**3**
6. Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
7. Feeling afraid as if something awful might occur	**0**	**1**	**2**	**3**

Hearing Screen

Answering the following statements help us determine whether you should have your hearing evaluated. >2+	**No**	**Sometimes**	**Often**
1. I hear but I don't always understand what others are saying.			
2. I have trouble hearing when people speak softly.			
3. I have trouble understanding someone if they are speaking in a different room			
4. I have trouble hearing others speak when they are not facing me			
5. People tell me to turn down the TV			
6. I find it hard to hear when I am in a group setting			
7. I have difficulty catching most of the words when I go see a play or movie			

8. I have trouble hearing on the telephone.			
9. I have trouble hearing others when I am at a restaurant.			
10. I have trouble making out the words in songs.			

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please Circle your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING

____ + _____ + _____ + _____

=Total Score: _____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Do you feel like you are overweight? (Y) (N)
If yes would you like to get to a healthier weight? (Y) (N)

Exercise Activities

Never Minutes Hours Weekly Daily

Swim_____
Run_____
Walk_____
Dance_____
Bike_____
Garden_____
Golf_____
Tennis_____
Ski_____
Weights_____
Other_____

PLEASE LIST ANY VITAMIN, MINERAL, AMINO ACID, OTHER SUPPLEMENTS OR MEDICATION THAT YOU MAY BE TAKING. **SUPPLEMENTS MANUFACTURER FORM DOSAGE FREQUENCY** EXAMPLE: VITAMIN C TABLET 250 MG, 2 PER DAY

_____
_____
_____
_____
_____

IMMUNIZATIONS

Flu: YEAR _____
Varicella (chickenpox): YEAR _____
HAD VACCINE (Y) (N) HAD CHICKENPOX (Y) (N)
PPD (test for tuberculosis test) _____
CHILDHOOD Vaccinations (Y) (N)
COVID 19 Vaccination (Y) (N)

Prior or current treating DOCTOR/s. Please list all Allopathic (MD), Chiropractors (DC), Optometrists (OD), Osteopaths (DO), Podiatrists (DPM) etc.

_____

_____

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How did you hear about us (who referred you)_____
If you want notes from treatment sent to your treating physicians please sign below and we will forward records to your current treating physicians.

_____

Printed Full Name Signature Todays Date

Please give us you physicians name and fax number if you would like your records forwarded to them. Specialist or primary care physician please list below so we can forward notes to them.

Name, address and fax #:_____

Name, address and fax #:_____

Family Medical History
Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother (M) Age:_____ Father (F) Age:_____

Possible Illnesses

Allergies (M) _____ (F) _____

Asthma (M) (F) Diabetes (M) (F) Diabetes-Age at Onset _____ Epilepsy (M) (F)

Heart Disease (M) (F) Bleeding Tendency (M) (F) Glaucoma (M) (F) Chrons Disease or IBS (M) (F)

Cancer (M) (yes) (no) If yes type:_____

Cancer (F)) (yes) (no) If yes type:_____

Bleeding Tendency (M) (F) Glaucoma (M) (F) Drug Abuse (M) (F)

Alcohol Use Disorder (M) (F) Gall Bladder (M) (F) Liver Disease (M) (F)

Hypoglycemia (M) (F) Hearing Loss (M) (F) Kidney Disease (M) (F) Lupus (M) (F)

Thyroid Disease (M) (F) Mental Illness (M) (F) Multiple Sclerosis (M) (F) Rheumatoid Arthritis (M) (F)

Tuberculosis (M) (F) Skin Disease (M) (F) Other Conditions_____

_____

Brothers and or Sisters: _____

_____

Mother's Parents: _____

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_____

Father's Parents: _____

_____

Children:_____

_____

Highest level of school you completed: (5) (6) (7) (8) (9) (10) (11) (12) Grade (High School Diploma) (College) (Associate) (Bachelor's) (Master) (Doctorate)

(Single) (Married) (Divorced) Children (1) (2) (3) (4) (5) _____

Current living environment: (Apartment) (House) other:_____

Major support system/s: (friend) (Spouse) (family) other:_____

Trauma Section: Head, Neck, Back or other muscle or joint injury (Y) (N)

If yes list date of injury, and what was injured or injury happened? _____

_____

Have you ever lost consciousness/awareness? (Y) (N) Date of occurrence_____

Are there any conditions that were not covered in the above? (Y) (N) If so please include below:_____

_____

_____

HIPAA policy: This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.
Uses and Disclosures of staff and others (business associates) that are involved your treatment, payment, and healthcare operations and any other use required by law.
Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to home health agency that provides care to you or diagnostic facility, or a physician that we have referred you to or who referred you to our office.
Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment, or a hospital stay which may require that relevant protected health information to be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose as needed, your PHI in order to support business activities of your physician's practice. These activities includes, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging of other business activities. For example we may disclose your PHI to medical students that see patients at our office. In addition we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements:

Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements HIPAA privacy rule section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action on the use or disclosure indicated in the authorization.
Your Rights, Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; substance abuse notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI.
You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved with your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice form us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.
We reserve the right to change the terms of the notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your

policy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on or before August 01, 2013
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information (PHI). If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number (727) 729-9000.
Signature below is only acknowledgement that you have read and understand our Notice of our Privacy Practices:

Lastly *Very Important Information *
Please Read Carefully, and Sign After Reading
We at Advanced Care Physicians Group, P.A. are here to help you take care of your health in the best way that we know how. We realize you came in about health and not finances. The following is to assist you in understanding that our Clinic financial policies. We maintain privacy of your medical records/information and this will serve as your notification of this. Anytime you would like to review privacy practices please feel free to make an appointment and go over any questions that you have. We reserve the right to change those terms and any changes will be made available to you. I have reviewed and understand the HIPAA policies of this office. **Payment Requirements:** Appointments must be paid for at time of service. We accept check, cash, or Traveler's checks, letter of protection from your attorney, most Health Insurance, PIP insurance. Please contact bookkeeping for more details. You will be charged a $40.00 fee for returned checks. Any services rendered at the Clinic or additional Lab work must be paid and kept current.

Appointments: We require **24 hour advanced notice** if you need to change or cancel your appointment. You will be charged a fee of **$40.00** for a missed appointment if office was not notified 24 hours advance cancellation policy was not met. **Records: We maintain a file of your records.** Patients are given their patient records upon written request at no charge for the first copy. Subsequent copies are 25 cents per page plus postage. We will furnish you with a copy of your medical records upon your signing an authorization form and returning it to our records department. Please allow a minimum of 5 working days for us to process the request. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to. All employees, and business associates are held to all Federal HIPAA compliance rules. Due to your privacy we prefer you to pick up your records however upon written request we will fax or mail your records as explained above.
Insurance and Medicare is a contract between you and them: Advanced Care Physicians Group, P.A. does not bill Medicare or Medicaid for auto accident or work related accidents. Otherwise we will bill your commercial insurance or **Medicare. We do not bill secondary insurance except those associated with a Medicare policy. We do not except Medicaid as primary coverage (However we are looking into and may except in the future, and you are welcome to check back in the future).** We do have staff available to answer any of your HIPAA and insurance questions. *A photocopy of this agreement shall be considered as effective and valid as the original.* **I understand that I will have asked a practitioner of the Advanced Care Physicians Group, P.A. for help if I did not understand any of the above and that he/she answered my questions if any to my satisfaction prior to me signing below.**

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AUTHORIZATIONS, RELEASES AND CONSENT FOR TREATMENT

I the undersigned hereby authorize Kingsley A. Asare, DO, MPH, and or Michael T. Schaefer, DC, MPH, MCAP, DACACD, of Advanced Care Physicians Group, P. A., and whomever they may designate as their assistant(s) to perform treatments, diagnostic tests including but not limited to administer treatment/s as is necessary. I understand that at anytime I can be requested to have in office, and/or referred to outside laboratory for blood and or urine test to include DRUG SCREENS. I understand that, as in all health care, some risks to treatment exist, including, but not limited to the following: Medical care contribute to my overall well- being. I do not expect the doctor/s to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor, or practitioner/s feel at the time, based upon the current facts then known, and is in my best interest. The **weight loss patient understands** that there is a lack of scientific data regarding the potential danger of long term use of combination weight loss treatments and require dietary intervention as well as physical exercise. Excessive physical activity can lead to the breakdown of muscle fibers and release muscle fiber contents (myoglobin) into the bloodstream, and can cause kidney damage, so it is important to start exercise program off with caution and progress slowly. Additional notice in reference to hCG that there has not been "substantial evidence" to conclude hCG offered any benefit above that achieved on a restricted calorie diet. Research different treatments i.e. acupuncture, allopathic medicine, etc. as well as no treatment at all. In consideration of treatment/s it is important to choose risk/benefit profile that best fits your personal needs. I understand that no guarantee or assurance of treatment results have been or can be made as to the results that may be obtained. Patient response to various treatments preformed in this office will vary from patient to patient.

Insurance, Assignment of Benefits, and Power of Attorney

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself furthermore I assign all insurance policy benefits and any other third party benefits paid directly to Advanced Care Physicians Group, P.A. (ACPG), I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I authorize payment of medical benefits to Advanced Care Physicians Group, P. A., or their assignees. I permit this office to endorse remittances for the conveyance of credit to my account. I authorized the release of any medical information necessary to process my insurance claim(s), PIP suits, etc. I certify that all insurance and medical history information given to this clinic is correct and complete. I hereby appoint Advanced Care Physicians Group, P. A., or their assignees as my true and lawful attorney, irrevocable, and with full power of substitution, for me and in my name, to ask, demand, sue for, collect, endorse, sign, and receive proceeds from insurance or any other third party relating to services rendered by said healthcare provider. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. It is my responsibility to obtain all required referrals and if I the patient or guardian does not obtain prior referral/s ACPG will still be paid in full by myself or legal responsible party.

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I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills (Medical cost/ and charges can vary due to differing health insurance coverages) and this agreement is solely for the doctor's additional protection and consideration of his awaiting payment. I understand that any additional time requested will be paid for by myself or guardian such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I further understand that any medical legal work required from any of the employees of (ACPG) will be paid to (ACPG) in advance at a hourly rate of $400.00 for any dortoral level provider/s and $250.00 per hour for master level provider/s including but not limited to record review as well as portal to portal travel time and expenses. However I can obtain Medical records upon written request as discussed prior in this intake form. I have read and understand this office policy as well as HIPAA notice of Privacy Practices as it pertains to my protected health information, and that ***a photocopy of this ENTIRE agreement shall be considered as effective and valid as the original.***

Patient's/ Guardian's Signature_____ Date____/____/____

Credit Card Authorization Form

Please complete all fields. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security code (_____)
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Advanced Care Physicians Group, P.A. to charge my credit card above for unpaid services ONLY. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date