West Coast Medical Associates, Pasco, P.A.
5824 State Road 54 • Suite 101 • New Port Richey, FL 34652 • (727) 845-1933 • Fax (727) 845-7307

ORIENTATION AND WELCOME GUIDE

Welcome the office of Syed Hasan M.D. This orientation guide will provide you with information and guidelines that will be helpful for you while you are receiving services at this office.

Rights and Responsibilities and Notice of Privacy Practices: You have received a Patient's Rights and Responsibilities list explaining all your rights and responsibilities and a Notice of Privacy Practices informing you of how your Health Information is used.

Office Hours: Our regular office hours are Monday thru Friday; from 8:00 a.m. until 5:00 p.m. Visits are by appointment only. If you are unable to reach us by phone, please leave a message on our voicemail and someone will call you back as soon as possible.

Attendance: Your attendance at all appointments is very important. This is a commitment you will make for yourself. If you cannot attend a scheduled appointment, please call the office at least 24 hours in advance of the appointment.
If you do not call at least 24 hours in advance, you will be charged a late cancellation/no show fee of $25.00. Frequent or successive late cancellation/no show for appointments may lead to termination from treatment.
In order for appointments to remain on time, please make an effort to be on time for your appointments. Appointments will not be extended in length to accommodate late arrivals.

Applicable Fees: Prior to your visit, your health plan information was gathered sp we might verify coverage for the services you will be receiving. You may be responsible for a deductible or co-pay amount, depending upon your health plan. You are responsible for all fees at the time of service. There are some fees that may be part of your treatment that are not covered by your health plan and will be billed directly to you. These include:

Self Pay	$150.00	First initial visit / $100 every visit after
No show/late cancellation fee	$25.00	
FMLA	$35.00	1st form / $25.00 2nd form
Medical Letter	$15.00	
Flu Shot	$20.00	
Strep Test	$25.00	
Urinalysis	$25.00	
Dexamethasone	$20.00	
EKG	$45.00	

Disability, Worker's Comp, and Legal System: Please note, we can complete disability forms, but you will need to bring the forms in and pay the required fee for the forms to be completed. The forms should be brought in with at least a week in advance. Once the forms are completed, you will be notified to come pick them up. We do not complete worker's comp evaluation forms, reports for attorneys, or testify in court. If you wish a Worker's Compensation carrier or attorney to receive a copy of your chart, a copy can be mailed or faxed to them for $1.00 per page, payable in advance.

Emergency Medical Care: 911 will be contacted for services.

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Smoking: Smoking is not permitted in the front office or in front of the entrance to the office. Smoking is permitted in the parking lot only.

Contraband: At no time are you permitted to bring to the office any contraband that may include, but is not limited to, alcohol, illegal or non-prescribed drugs or weapons. Bringing these items may be cause for immediate dismissal from treatment.

Medication Refills: It is important to keep track of your medications. Please notify your provider if you will need a refill at your medication check. Medication refills will only be handled during regular office hours, and give at least a 48 hour request before your medication is due, and routine medication refills will not be considered as urgent or emergent issues.

Reporting Abuse, Neglect, and Exploitation: As required by law, any physician/clinician who knows, or has reason to suspect, that a person has been, or is being abused, neglected, or exploited shall immediately report any such knowledge or suspicion to THE CENTRAL ABUSE REGISTERY AND TRACKING SYSTEM AT 1-800-962-2873. If this step is necessary, it will be discussed with you and documented in your medical record.

Purpose and Process for Involvement in Evaluation, Treatment, and Discharge: You will be asked to participate in an initial evaluation at your first visit. Please give us as detailed and accurate information as possible, as this information will assist in determining a diagnosis and the most effective and appropriate treatment options for you.

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PHOTO RELEASE FORM

_____ I give permission to West Coast Medical Associates, Pasco, P.A. to use and publish my photograph for use in their office for my electronic medical record without compensation.

_____ I do not give permission for the use of my photo, I am aware that without this photo I will be asked to show a government issued photo ID prior to each visit.

Date: _____

Name: _____

Date of Birth: _____

Signature: _____
(If participant is a minor, signature of parent/guardian is necessary.)

This photo will be uploaded into the electronic medical record kept in our office, for use in patient identification purposes; it will not be used for any other purpose or released as part of any medical record. Adding patient photos in the medical chart is one way to reduce treatment errors. Patient safety is our top priority; please know this is in the best interest of all our patients. This is an additional step we are taking to ensure all our patients get the proper care and treatment.

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PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

Name of person completing this form: _____
If not the patient, relationship to patient: _____Date: _____

Confidential Record. Information will not be released unless authorized, except as required by law.

GENERAL INFORMATION

Patient's Name:_____S.S.#:_____Date of Birth:_____Sex:_____
Street Address:_____Apt#:_____City:_____
State:_____Zip Code:_____Hm Phone:_____Cell Phone: _____
Employer:_____Employer Phone: _____
Emergency Contact:_____Relationship:_____Phone: _____

May we call your cell phone? YES__ NO__
May we call your work phone? YES__ NO__
May we leave a message on your answering machine? YES__ NO__

Date of last Physical Exam: _____ Name of Physician:_____
Indicate if you and/or blood relative have or had any of the following, Note which blood relative or self.

__ Arthritis	__ Epilepsy	__ Migraine	_____
__ Asthma	__ Goiter	__ Nervous Breakdown	_____
__ Bleeding Tendency	__ Gout	__ Rheumatic Fever	_____
__ Cancer	__ Hay Fever	__ Sickle Cell Anemia	_____
__ Colitis	__ Heart Attack	__ Stomach Ulcers	_____
__ Congenital Heart Disease	__ High Blood Pressure	__ Stroke	_____
__ Diabetes	__ Kidney Disease	__ Tuberculosis	_____
__ Emphysema	__ Leukemia		_____

Other (Please describe): _____

DO YOU HAVE A LIVING WILL? YES__ NO__

ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize direct payment of surgical/medical benefits to **Dr. Syed Hasan** for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize **Dr. Syed N. Hasan** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Patient: _____ Date: _____

Parent/Guardian: _____ Signature: _____

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NEW PATIENT HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name:		
List your prescribed drugs		
Drug	Strength	Frequency Taken

Allergies to Medication (circle one) YES or NO If yes, please list & explain		
Name of Drug	Reaction	Date of Onset

Past Surgical History:	
Date	Surgical Procedure

Social History:	
Do you drink alcohol?	
Do you smoke cigarettes?	
Have you felt down depressed or hopeless in the past two weeks?	
Have you lost interest or pleasure in doing things in the past two weeks?	

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Authorization to Release Healthcare Information

Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

I request and authorize: _____

To release/obtain healthcare information to/from:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

This request/authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

If the information described above includes information in any category below, I specifically authorize the use or disclosure of such information:

☐ **YES** ☐ **NO** STD results or HIV/AIDS testing, whether negative or positive

☐ **YES** ☐ **NO** Generic testing/results

☐ **YES** ☐ **NO** Any records regarding drug, alcohol, or mental health treatment

This authorization will remain in effect:

☐ Until West Coast Medical Associates, Pasco, P.A. fulfills this request

☐ Until I revoke this authorization in writing

☐ From the date of this authorization until the following date: _____

☐ Other: _____

I understand that I may revoke this authorization by notifying the Medical Records Department at any time in writing; however, if I do, it will not have any effect on actions taken by West Coast Medical Associates, Pasco, P.A. before they received the revocation notification.

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Authorization to Release Healthcare Information – Continued from previous page

I may refuse to sign this authorization. My healthcare, the payment for my healthcare, and my healthcare benefits will not be affected by not signing this form (Except if healthcare services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

PLEASE NOTE: A charge will apply when releasing records directly to patient. Please see separate sheet for fees.

I have read this form, and all my questions about this form have been answered. By signing below, I acknowledge that I have read, and I accept, all the above statements.

Patient Signature: _____ Date: _____

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Syed N. Hasan, M.D.

AUTHORIZATION TO TREAT CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES

I HEREBY AUTHORIZE AND CONSENT TO A PHYSICIAN OF WEST COAST MEDICAL ASSOCIATES, P.A. OR OTHER HEALTH PROFESSIONAL AS DESIGNATED, TO PERFORM A PHYSICAL EXAM AND ROUTINE DIAGNOSTIC PROCEDURES UPON ME.

I ALSO AUTHORIZE AND CONSENT TO A PHYSICIAN TO PRESCRIBE A THERAPEUTIC REGIME WHICH I SHALL FOLLOW. UNLESS I EXPLICITLY REFUSE, I AUTHORIZE AND CONSENT TO THE DIAGNOSTIC PROCEDURES TO BE PERFORMED ON ME DESPITE THE RISKS INVOLVED OR COMPLICATIONS WHICH MIGHT FOLLOW, AS EXPLAINED TO ME AT THE TIME THEY WERE ORDERED.

DATE: _____ SIGNATURE: _____
Patient or person authorization to consent for patient

WITNESS: _____

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AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you are taking for pain management. This is to help both you and **Dr. Syed N. Hasan** comply with the laws regarding controlled pharmaceuticals.

I understand this Agreement is essential to my treatment and if I refuse to sign this Agreement, or if I break this Agreement, **Dr. Syed N. Hasan** will stop prescribing pain-controlling medicines.

I will communicate fully with **Dr. Syed N. Hasan** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I understand that I must have proper testing; including labs, x-ray or MRI's to confirm my diagnosis.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opiod pain medicines, controlled stimulants, or any anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines **WILL NOT** be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **NO REFILLS WILL BE AVAILABLE DURING EVENINGS OR ON WEEKENDS.**

I agree to use _____ Pharmacy, located at

_____

Telephone #: _____ for filling prescriptions for all of my Pain Medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

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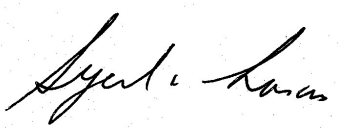
Dear Patient,

As I am sure you are aware, abuse of prescription medications has become a national issue and because of this problem, like many of our fellow physician's offices, our practice is forced to use new protocol in treating patients that require Schedule II medications.

Please read the agreement carefully and make sure you understand, as there will be NO exceptions.

It is regrettable that we have had to take such extreme measures; however it is necessary. If you feel that it is not possible for you to comply with our protocol, feel free to choose another Primary Care physician.

Sincerely,



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I understand and agree to submit to a urine test to determine my compliance with the medicines.
I understand that this test will be at my expense. (Cost of test being $25.00)

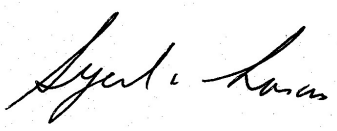
I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I WILL BRING ALL UNUSED PAIN MEDICINE TO EVERY OFFICE VISIT.

I agree to follow these guidelines that have been fully explained to me. A copy of this document has been given to me.

This agreement is entered into this _____ day of _____ in the year 20_____.

_____
Patient Signature



Physician Signature

_____
Witnessed by

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Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize West Coast Medical Associates, Pasco, P.A. to view my external prescription history via the RxHub service.

I understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFGIES THAT I READ AND UNDERSTOOD THE SCOPE OF
MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

DATE: _____ SIGNATURE: _____
Patient Signature

DATE: _____ WITNESS: _____
Witness Signature

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Consent to Disclose Protective Health Information

Patient Name: _____ DOB: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Primary Care Provider: _____

By signing below, I hereby authorize West Coast Medical Associates, Pasco, P.A. to disclose my protected health information to the following family members and/or friends:

Name	Relationship to Patient	Phone Number

I understand I may revoke this authorization by notifying the Medical Records Department at any time in writing; however, if I do, it will not have any effect on actions taken by West Coast Medical Associates, Pasco P.A. before they received the revocation notification.

I have read this form, and all my questions about this form have been answered. By signing below, I acknowledge that I have read, and I accept, all the above statements.

Patient Signature: _____ Date: _____

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Purpose of Patient Self-Determination Act

The Patient Self-Determination Act (PSDA) is a federal law. It is the purpose of this act to ensure that a patient's right to self-determination in health care decisions be communicated and protected. Through advance directives – the living will and the durable power of attorney – the right to accept or reject medical or surgical treatment is available to adults while competent, so that in the event that such adults become incompetent to make decisions, they would more easily continue to control decisions affecting their healthcare.

The goals of the "purpose" of the Patient Self-Determination Act are/were (1) to prevent cruel over treatment of elderly/disabled Medicare/Medicaid patients for the profit motive and (2) to save money for Medicare and the private insurers in the form of the reduction of end-of-life costs for Medicare and the private insurers when elderly Medicare/Medicaid patients would ELECT/CHOOSE to refuse expensive ICU/CCU life-extending or life-saving treatments in the hospital in order to shorten their suffering unto a certain death. It was envisioned by the framers of the 1991 PSDA that the elderly/disabled on Medicare/Medicaid would die less expensively and more comfortably (out of pain) on the palliative care/Hospice Medicare Entitlement in their own personal residence or in the setting of a residential nursing home when the treating physicians consulted with them about their terminal diagnoses.

Patient rights include:

- The right to facilitate their own health care decisions.
- The right to accept or refuse medical treatment.
- The right to make an advance health care directive.

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PATIENT SELF DETERMINATION ACT QUESTIONAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please review the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration

☐ I have NOT made such a declaration

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

_____ _____
Print Full Name Social Security #

_____ _____
Patient Signature or Representative Date

Relationship of Patient Representative (if applicable) _____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate

_____ _____ _____ _____
Patient Signature or Representative Date Patient Signature or Representative Date

_____ _____ _____ _____
Patient Signature or Representative Date Patient Signature or Representative Date

☐ I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but declined to answer the above questions.

_____ _____
Patient Signature or Representative Date

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Please Let Us Know Your Wishes:

Check ALL that apply:

_____ I have a living will. (If yes, please provide a copy.)
_____ I have a document I signed that allows another person to make healthcare decisions for me. (If yes, please provide a copy.)
_____ If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me: have a living will. (If yes, please provide a copy.)
Name: _____
Phone Number: _____

If I become so ill that I cannot tell my doctor what I want, and two doctors agree they cannot make me better, please: (Check ALL that apply)

_____ Keep me comfortable and free from pain.
_____ Do NOT use tube for: _____ Breathing _____ Feeding _____ IV Fluids
_____ Let my appointed person decide.
_____ If my heart stops, _____ do _____ do not try to restart it.
_____ Do EVERYTHING possible.
_____ I do not wish to complete an advanced directive at this time.

Additional Instructions:

_____
_____
_____

Signatures:

Printed Name: _____ Date: _____

Signature: _____ Date: _____

1st Witness: _____ Date: _____
Relationship of 1st Witness: _____

2nd Witness: _____ Date: _____
Relationship of 2nd Witness: _____

Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures the surrogate feels are in your best interest and make health care decisions for you the surrogate believes that you would have made yourself under the circumstances if you were capable of making such decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate persons to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.