Memory Care Specialists
3231 Gulf Gate Dr. Suites 203 A&B
Sarasota, FL 34231
Phone: 941-343-9441
Fax: 941-349- 9301

INITIAL VISIT QUESTIONNAIRE

FAX all Pages When Completed to: 941-349-9301

Name: _____ Today's Date:_____

Date of Birth: _____ Age: _____ Soc. Sec. #: _____

PHYSICIAN INFORMATION:

Who is your Primary Care Physician? Date of last visit: _____

Name: _____

Address: _____

Phone: _____

Please list other doctors that you are seeing or have seen in the past.

(Note: Don't worry if you don't know their phone number)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

PHARMACY INFORMATION:

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

Secondary Pharmacy Name: _____

Pharmacy Phone Number: _____

Other Pharmacy info: _____

Name: _____ Date: _____

ALLERGIES:

_____

_____

_____

PAST MEDICAL HISTORY: Circle any of the following that you have had.

Allergies or Asthma	Congestive Heart Failure	Hemorrhoids	Migraines
Alcoholism	Depression	Hepatitis (Jaundice)	Phlebitis
Anemia	Diabetes	High Blood Pressure	Psoriasis
Arthritis	Drug Abuse	Heart Blockage	Hernia
Breast lumps/cysts	Eczema-Hives	Kidney Stones	Stroke
Cancer (Tumors)	Epilepsy or Seizures	Liver Disease	Suicide Attempt
Cataracts	Heart Attack	Lung Disease	Thyroid Disease
Blood Clot	Glaucoma	Macular Degeneration	High Cholesterol

Other: _____

_____

_____

PAST SURGICAL HISTORY:

Ear or eye surgery Year(s) _____

Skin lesion removal Year(s) _____

Heart surgery Year(s) _____

Lung surgery Year(s) _____

Appendix Year(s) _____

Gall bladder Year(s) _____

Hysterectomy Year(s) _____

Ovaries Year(s) _____

Prostate Year(s) _____

Stomach surgery Year(s) _____

Bowel surgery Year(s) _____

Joint surgery Year(s) _____

Other _____

_____

Name: _____ Date: _____

MEDICATIONS: [List all current drugs, the dosage (strength), and how often you take it.]

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

SOCIAL HISTORY:

Tobacco Use: Cigarettes: Y N Cigars: Y N Pipe: Y N

For cigarettes, how many packs per day do you smoke? _____

For cigars or pipe, how much per day? _____

If you do not smoke, have you ever smoked? _____ How long ago did you quit? _____

Alcohol: Number of drinks _____ Daily / Weekly / Monthly

Drugs: Have you ever used injectable drugs? Y N

Marital Status: Are you married? _____ If so, for how long? _____

Children: How many children do you have? _____ How is their health? _____

_____

_____

Name: _____ Date: _____

FAMILY HISTORY:

Please check off conditions in your family:

Condition	Mother	Father	Grand-parents	Sibling	Aunt/Uncle	Other
Heart						
High blood pressure						
Stroke						
Diabetes						
Lung problems						
Thyroid						
Kidney						
Stomach						
Bowel						
Anxiety						
Depression						
Dementia						
Cancer						

Other: _____

_____

_____

Do you have a living will? Y N If yes, may we have a copy? Y N

Have you designated a health care surrogate or someone to make medical decisions for you in the event that you cannot make decisions for yourself? Y N

If yes, please provide Name: _____

Phone number(s): _____

Do you have a signed Do Not Resuscitate (DNR) form? If yes, may we have a copy? Y N

The information above was reviewed with the patient. Physician: _____

Name: _____ Date: _____

Review of Systems

Do you have any ongoing or current symptoms listed below? Check either "Yes" or "No" for each.

Constitutional		**Genitourinary**	
Weight Loss or Gain	☐ Yes ☐ No	Blood in your urine	☐ Yes ☐ No
Appetite changes (increased or decreased)	☐ Yes ☐ No	Menstrual changes	☐ Yes ☐ No
Fatigue, profound and impairs daily function	☐ Yes ☐ No	Urinating that is painful or difficult	☐ Yes ☐ No
Fever or chills	☐ Yes ☐ No	Erection problems	☐ Yes ☐ No
Shakes/sweats from lack of alcohol or drug	☐ Yes ☐ No	Vaginal discharge or bleeding	☐ Yes ☐ No
Eyes		**Musculoskeletal**	
Eye pain or drainage	☐ Yes ☐ No	Broken bones	☐ Yes ☐ No
Visual changes	☐ Yes ☐ No	Joint pain or swelling	☐ Yes ☐ No
Dry, irritated eyes	☐ Yes ☐ No	Muscle aches	☐ Yes ☐ No
ENT/Mouth		Muscle weakness	☐ Yes ☐ No
Ear pain or drainage	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Frequent sinus infections	☐ Yes ☐ No	**Skin/Breasts**	
Hearing changes or loss	☐ Yes ☐ No	Masses or lumps	☐ Yes ☐ No
Nosebleeds	☐ Yes ☐ No	Nipple discharge	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Rashes or nonhealing ulcers	☐ Yes ☐ No
Respiratory		**Neurologic**	
Blood in your sputum	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Chest tightness	☐ Yes ☐ No	Coughing or choking with	☐ Yes ☐ No
Cough lasting >1 month (productive or not)	☐ Yes ☐ No	Excessive daytime sleepiness	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Extremity pain or burning	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Hallucinations	☐ Yes ☐ No
Chest pain with inhalation or coughing	☐ Yes ☐ No	Numbness or tingling	☐ Yes ☐ No
Cardiovascular		Difficulty falling asleep, staying	☐ Yes ☐ No
Chest pain or heaviness	☐ Yes ☐ No	**Endocrinologic**	
Palpitations	☐ Yes ☐ No	Hair loss	☐ Yes ☐ No
Fainting or near fainting spells	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No
Swelling of feet or legs	☐ Yes ☐ No	Increased thirst	☐ Yes ☐ No
Shortness of breath lying flat in bed	☐ Yes ☐ No	Heat or cold intolerance	☐ Yes ☐ No
Gastrointestinal		Hot flashes or night sweats	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	**Heme/Lymph**	
Blood in your stool	☐ Yes ☐ No	Bleeding from gums or nose	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Unexplained bruising	☐ Yes ☐ No
Diarrhea or Food Intolerance	☐ Yes ☐ No	Swollen, painful lymph nodes	☐ Yes ☐ No
Heartburn or Indigestion	☐ Yes ☐ No	**Allergy/Immun**	
Vomiting or nausea lasting for >1 day	☐ Yes ☐ No	Watery eyes	☐ Yes ☐ No
Swallowing difficulty	☐ Yes ☐ No	Runny nose	☐ Yes ☐ No
Psych		Food intolerance	☐ Yes ☐ No
Anxiety without clear explanation	☐ Yes ☐ No	Frequent skin sores	☐ Yes ☐ No
Sadness lasting for days or weeks	☐ Yes ☐ No	**Other**	
Hearing voices	☐ Yes ☐ No	Do you exercise	☐ Yes ☐ No
Thoughts of hurting yourself	☐ Yes ☐ No	Do you eat red meat	☐ Yes ☐ No
Thought of hurting others	☐ Yes ☐ No	Do you take supplements	☐ Yes ☐ No
Fear of people, places or things	☐ Yes ☐ No	If yes, have supplements changed	☐ Yes ☐ No

The information above was reviewed with the patient. Physician: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group # (if any): _____ ID #: _____

Primary Insurance Type: Original Medicare _____ PPO _____ HMO _____

Policyholder Social Security Number: _____
(This is sometimes needed to confirm insurance.)

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ ID #: _____

Is this a Medicare supplement plan? Yes _____ No _____

Comments on insurance? _____

_____

_____

MEMORY CARE SPECIALISTS **(a specialty arm of Leggett Medical Group, Inc.)**

Karen Leggett D.O. ~ Geriatric Medicine ~ 3231 Gulf Gate Dr Suites 203 A&B ~ Sarasota FL~ 34231

HIPAA Policies and Procedures / Assignment of Benefits

Notice of Privacy Practices:

In 1996, the Federal Government established uniform privacy and security standards to protect patients' medical information. The standard is known as the Health Insurance Portability and Accountability Act (HIPAA).

The purpose of this notice is to ensure that you (the healthcare recipient) or your designated representatives are aware of your rights to ensure the privacy of your healthcare information. Leggett Medical Group retains the right to update this notice at anytime. To obtain the most recent notice, please summit a request in writing to the above address or to info@mindhealthtoday.com.

1. Privacy of the Patient Information:

We have created a record of the services and treatment that you receive from Dr. Karen Leggett and/or other providers for Leggett Medical Group. The privacy of your medical information is important to us and we are committed to protect it. We are required by law to keep your medical information private and notify you of your legal rights and privacy practices.

2. Uses and Disclosure of Patient Information:

Your medical information will be used for treatment, payment, and operations to maintain the highest quality of care possible. HIPAA allows disclosure of this information to your designated/authorized next of kin, licensed healthcare providers involved in your care, and other healthcare entities including insurance companies, billing services, Electronic Health Records (EHR) partners, state and federal regulation agencies, as well as law enforcement agencies in the interest of public safety. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. Any other uses and disclosures of your personal health information will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

3. Your rights regarding Medical Information About You:

You have the right to inspect and copy your personal health information kept on file with Leggett Medical Group. You have the right to amend information we have about you that is incorrect or incomplete. You have a right to request restrictions on the medical information we use or disclose about you for treatment and payment. You have a right to an accounting of disclosures we made of medical information about you. All of the above request may be submitted in writing to David Leggett at the address listed above.

4. Patient's Access to Medical Information

You have the right to see and obtain a copy of your medical records at any time. You may request changes in your health information and request the reason for any disclosure (not including treatment, payment, and healthcare procedures). If Leggett Medical Group does not agree with your changes, you must be allowed to insert a statement of disagreement into the record. Leggett Medical Group is not required to agree to your requested restrictions. However, if we agree, the restriction is binding.

5. Confidentiality of Patient Information
Leggett Medical Group will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes progress information at the end of treatment sessions, written information and electronic transmission of information to physicians and other licensed healthcare providers, insurance companies, billing companies, EHR partners, state and federal entities, and law enforcement agencies in the interest of the public safety. Leggett Medical Group will not be held responsible in the event of natural disaster, theft, or burglary of their physical or electronic property, having taken reasonable precautions.

6. How to File a Complaint
You may file a complaint if you feel that your privacy rights have been violated. Leggett Medical Group will not retaliate against you if you file a complaint. You may file a formal, written complaint with us at the address below, or with Department of Health & Human Services, Office of Civil Rights, in the Event you feel your privacy rights have been violated.

7. Leggett Medical Group's Contact Information
You may contact David Leggett for more information on our privacy policy at the following address and telephone number: **Address: 3231 Gulf Gate Dr Suite 203A, Sarasota, Florida 34231. Phone: 941-365-2434.**

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

You can read the entire *Health Insurance Portability and Accountability Act of 1996* at:
https://www.cms.gov/HIPAAGenInfo/Downloads/HIPAALaw.pdf

Assignment of Benefits:

If we bill any insurance company on your behalf, you request/agree that payment of authorized insurance benefits, including Medicare if you are a Medicare beneficiary, be made on your behalf to Leggett Medical Group for any medical services provided to you by any of Leggett Medical Group's providers.

If we bill any insurance company on your behalf, you understand/agree that you are financially responsible to Leggett Medical Group for any allowed charges not covered by health care benefits. It is your responsibility to notify Leggett Medical Group of any changes in your health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. You are responsible for the entire bill or balance of the bill as determined by Leggett Medical Group and/or your health care insurer if the submitted claims or any part of them are denied for payment.

If you are a "self pay" patient (meaning we do not bill any insurer on your behalf), you are financially responsible to Leggett Medical Group for all scheduled charges for services rendered to you by Leggett Medical Group.

Acknowledgement of Notice of Privacy Practices and Benefits Assignment:

By signing below, I certify that I have received a copy of Leggett Medical Group's Notice of Privacy Practices with an effective date of August 16, 2011. I am aware and acknowledge that this Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that I may direct any questions, concerns, or complaints about the privacy practices of Leggett Medical Group.

By signing below, I am also giving my consent to Leggett Medical Group, and/or its operating subsidiaries to use and/or disclose my protected health information for the purposes of treatment, payment, and operations. I understand Leggett Medical Group may in the course of rendering care to me, disclose personal health information about me to my family, close friends, or any other person that I identify as long as the information disclosed is relevant to their involvement in my care or the payment of my care. I understand that I may opt-out or otherwise restrict the disclosure of my information to such persons by providing notice to Leggett Medical Group.

I also understand that by signing below I am accepting financial responsibility (as explained above on page 2) for payment for all services I receive from Leggett Medical Group.

_____	_____
Signature (Parent/Legal Guardian)	Relationship to Patient
_____	_____
Printed Name	Date

***** PLEASE RETURN THIS PAGE TO US *****

Memory Care Specialists

Karen Leggett D.O. ~ Geriatric Medicine ~ 3231 Gulf Gate Dr Suites 203 A&B ~ Sarasota FL~ 34231

COMMUNICATION RELEASE FORM

Patient Name: _____ Date of Birth ____/____/____

Address: _____

_____

Home Phone: _____ Work: _____

Cell Phone: _____ Other Phone: _____

Your 1st Preference? □ Home □ Cell □ Work □ Other Phone □ E-Mail □ Text

E-Mail: _____

Designated/Authorized Next of Kin # 1: _____

Relationship to Patient: _____

Designated/Authorized Next of Kin # 2: _____

Relationship to Patient: _____

I give permission for messages to be delivered to me by: **(Please check ALL that apply.)**

□ U.S. MAIL □ VOICE MAIL / ANSWERING MACHINE

□ FAX □ E-MAIL

The following information can be left: **(Please check ALL that apply.)**

□ APPOINTMENTS
□ LAB RESULTS
□ PATHOLOGY RESULTS
□ RADIOLOGY REPORTS
□ PRESCRIPTIONS
□ MEDICAL ADVICE
□ REFERRALS

_____ _____

Signature (Self / Parent / Legal Guardian) Relationship to patient

_____ _____

Print Name Date

***** PLEASE RETURN THIS PAGE TO US *****

On the next page, please fill in only the entries highlighted in yellow, which are:

Signature

Print Patient Name Date of Birth

Please do not fill in the other areas of the form. Dr. Leggett will decide which records, if any, she will need. Dr. Leggett will only request records with your permission.

Note: You do not have to print the form on a color printer; the yellow color is there only to show you on the computer monitor which entries are to be filled in after you print the form.

MEMORY CARE SPECIALISTS

Karen F. Leggett, D.O.

Authorization to Release Medical Records/Information

I authorize release of the following medical information to Leggett Medical Group; Karen F. Leggett, D.O., at the contact information in the footer of this form:

_____ All medical records from _____ (date) to _____ (date)

_____ Immunization records

_____ Most recent history and physical

_____ All lab results in past six months

_____ All radiology reports in past year

_____ Hospital discharge and summary in past 3 years

_____ Mental health records

_____ OR the following specific items: _____

_____

Purpose of the record release: _____

I understand that this will include information relating to (initial if applicable):
_____ Acquired immunodeficiency syndrome (AIDS) or Human immunodeficiency virus (HIV) infection
_____ Mental Health
_____ Treatment for alcohol and/or drug abuse
_____ Sexually Transmitted Disease

_____ Mail records _____ Fax records to **941-349-9301**

This authorization is valid 90 days from the date of the signature. Authorization may be revoked at any time by written request.

_____ _____
Signature (Patient or legal guardian) Date of Request

_____ _____ _____
Print Patient Name Date of Birth SSN

Area below this line is for the sending office's use.

Records released: Records from _____ (date) to _____ (date)

Immunization record	_____	Most recent H&P	_____
Laboratory reports	_____	Radiology reports	_____
Hospital D/C	_____	Mental Health records	_____

Other _____

Date released: _____ By whom: _____

3231 Gulf Gate Dr Suites 203 A&B ~ Sarasota FL 34231 ~ Phone (941) 343-9441 ~ Fax (941) 349-9301

Karen Leggett D.O. ~ Geriatric Medicine ~ 3231 Gulf Gate Drive Suite 203A ~ Sarasota FL~ 34231

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical care to Memory Care Specialists (a specialty arm of Leggett Medical Group, Inc.). We strive to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, Memory Care Specialists uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your appointment or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. Missed appointments can also cause the doctor to wait at the office when he or she could be at the hospital or some other healthcare facility. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 941-343-9441.

2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment and a $100.00 fee will be assessed to you.

3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact us at the above phone number or at info@mindhealthtoday.com and we will be glad to clarify any questions you may have.

By signing below, you are acknowledging the following:

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

I have received advance notification that Medicare and commercial insurance companies will NOT pay the appointment cancellation fee and will not be billed by Leggett Medical Group.*

_____ _____

Patient Signature (or Parent / Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

***Note: All services performed by Dr. Leggett or other providers for Memory Care Specialists are billed through Leggett Medical Group, Inc., TIN 83-0381126**