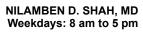
NILAMBEN D. SHAH, MD Weekdays: 8 am to 5 pm



New Patient Registration Form

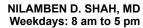
Note: -*indicates	mandatory field.				
Last Name*:		First Name*:		Middle Initial*:	
Patient DOB*:	(mm/dd/yyyy)	Social Security No.*:	<u> </u>	Sex*: □Male □	Female □ Unknown
Address*:				Start Date*:	(mm/dd/yyyy)
Zip*:		City*:		State*:	
147		Home Phone Number*:		Cell:	
Employer:		Email Address:			
Who Should We 1	Γhank For Referring Yoυ	ı:			
Marital Status*:	☐ Single ☐ Married ☐	☐ Divorced ☐ Widowed	☐ Separated		
Employment*:	Full Time Part Time	e □ Not Employed □ Se	elf Employed Retire	ed Military Duty	
Preferred method		Email	□ Mail □ Mobile Pho	ne Patient declined	d to specify
Insurance Infor	mation				
Insurance(s)*:		Plan*:	ID*:		ffective ate*: (mm/dd/yyyy)
Guarantor/Insu	red Person Informati	on			
Holder*:		Relationship to the patien	t*: Self Spouse	☐ Child ☐ Other	
		Social Security No.*:		_	
					(mm/dd/yyyy)
Home No.*:		Work Number:		Cell Number:	
Emergency Cor	ntact Information				
Name*:		Phone Number*:		Relationship*:	
Address*:		-		Start Date*:	(mm/dd/yyyy)
Florida is request understanding of o office.	our practice and patient	needs. This confidential in	e of the overall diver formation will assist us	sity of our patient poper in improving the quali	oulation and have a better by of care you receive in our
<u>Please place a ch</u>	eck mark to the left of w	hichever option applies:			
1) Primary Language*:	☐ English ☐ Geri	man □ Italian □ Spanis	h □ French □ Othe	r	
2) Race*:	☐ American Indiar	or Alaska Native Afric	an American □ N	ative Hawalian	☐ Asian
	☐ Other Pacific Isl	ander	e than one Race 🔲 U	nreported/Refuse to Re	eport White
3) Ethnicity*:	☐ Hispanic or Latir	no 🛚 Not Hispanic or Latin			•
Patient/Repres	sentative Signature*:		Name*:		
Date*:		(mm/dd/ssss	- \		
Date*:		(mm/dd/yyyy)		





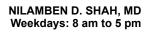
Health History

NAME:Last*:		First*:			Middle*:					
Sex*: ☐ Male ☐ Fer	male Unknown	Birthdate*	: (mm/	/dd/yyyy)	Reason for visit*:					
PHARMACY:Name*:		City*:			State*:					
Pharmacy Address*:										
Allergies*:	Medication or Sul	<u>bstance</u>	Reaction							
☐ No Allergies										
Ü										
Current Medications:	<u>Label - Name</u>		<u>Dose</u>			<u>Frequency</u>				
See - Attached List***				• •						
-***Please bring your list	t of medication with	, , ,	ent. Social History							
Marital Status*:		☐ Single ☐ Married ☐ Domestic Partner	(Name:(Name:)) N	lumber of Kids					
Are you sexually active	e?*:	☐ Yes ☐ No Pa	artners: Male Fem	ale Birth	n Control:					
			□ Never □ Yes □ No s/Week: Type: □ Be			(mm/dd/yyyy)				
Are you working?*:		☐ Yes ☐ No ☐ Re	etired Disabled What	do you do	?					
Do you use tobacco pre	oducts?*:		Days Quit Passive (mm/dd/yyyy) Type(s) of Chuff							
Do you use recreationa	al drugs?*:	□ Never □ Yes □	No □ Quit -Use/Week		ate Quit	(mm/dd/yyyy)				
Have you ever used inj	jected/IV drugs*:		s: Cocaine Marijua sants Hallucinogens(L							
	Medical History	- Please select for th	nose conditions you have	e now or h	nave ever had	*				
☐ No Past Medical Hi	storv Conge	estive Heart Failure	☐ Gynecologic Problem	☐ Muscl	e or Joint Pain	☐ Allergies				
☐ COPD/Emphysema			☐ Heart Attack	☐ Anem		☐ Heart Disease				
☐ Hepatitis or Liver Pi		porosis (Thin Bones)	☐ Anxiety	☐ Depre	ession	☐ HIV/AIDS				
□ Diabetes Type 1		Hypertension/High BP	☐ Seizures or Ep		□ PPD	☐ Arthritis				
☐ Bleeding/Clotting P		Diabetes Type 2	☐ Insomnia/Sleep			☐ Asthma				
☐ GERD (Acid Reflux		Gastric Ulcer/Stomach	-		☐ Cancer	☐ Tuberculosis				
□ Substance/Drug Ab	, _	High Cholesterol	☐ Thyroid Diseas		☐ Glaucom	a 🗆 Migraine				
☐ Blood Transfusion		Other(Please list):								



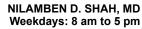


	Health Ma	intenance
	Mammogram*: Yes No When/	# of pregnancies # deliveries Vaginal Discharge:
	Inimun	zations
	Tetanus or TDAP*: Yes No When/ Flu*: Yes No When/ Prevnar*: Yes No When/_ Zostavax(Shingles)*: Yes No When/_ Pneumovax*: Yes No When/	Where Where Where Where Where
	Review of Systems (current symptoms) - please	select only if these are bothering you at this time
□ Poo	nstestinal: r Appetite □ Vomiting □ Heartburn/Indigestion □ Rectal ck Tarry Stools □ Nausea □ Diarrhea □ Abnominal Swall	Bleeding □ Stomach Pain □ Constipation □ Vomiting Blood ing □ Trouble Swallowing □ Other
Dl.		
	iety/Nerves □ Abusive Relationship □ Sexual Problems □ ling Worthless □ Want to Hurt Yourself □ Want to Hurt Oth	
Muscle	s/Bones	Genitourinary
□ Chr	onic Pain	□ Sexual Problems □ Burning with Urination □ Blood in Urine □ Leakage of Urine
Endocr	ine E	ars/Nose/Mouth/Throat
☐ Hot	Flashes Bothered by Heat	☐ Hearing Loss ☐ Chronic Sinus Congestion☐ Heavy Snoring ☐ Bad Teeth
Neurolo	ogical	Heart
	daches Seizures(Epilepsy) fusion Tremor(shaking)	□ ChestPain □ Palpitations
_	nusion — Tremor(snaking)	☐ Irregular Heart Beat ☐ High Blood Pressure
Respira		
□ Cou	atory(lungs) gh	Head/Eyes Cataracts Dry Eyes Poor Vision Color Blindness
□ Cou	atory(lungs) igh	Head/Eyes □ Cataracts □ Dry Eyes □ Poor Vision □ Color Blindness
Constit	atory(lungs) igh	Head/Eyes
Constit	atory(lungs) Igh	Head/Eyes Cataracts Dry Eyes Poor Vision Color Blindness





	Surgical	History - P	iease :	sele	CUE	OX IO	or a	ny si	ırge	ery y	you nav	ve na	a, inc	lica	te yea	ar (m	ım/y	ууу)	•	
☐ No Past Surgical History ☐ Cancer Surgery/							☐ Pacemaker/Defibrillator/ ☐ Appendix Removal/													
☐ Gall Bladder Surgery _/ ☐ Splenectomy _/							□ Back Surgery _/_ □ Colonoscopy _/_													
	irgery/								☐ Colposcopy _/							☐ Tonsillectomy/				
☐ Breast Sur		☐ Abdominal Surgery/							· · · · · · · · · · · · · · · · · · ·											/
☐ Hernia Re			ar Surg					_			Heart B									cement/
☐ Valve Rep			ataract	-							Hystere								t Loss	
Repair/			L Impl								Remova				_				ry/	
☐ Other(Plea	ise List)																			
					om	ilv L	licto	ry Cl	200	k al	I that a	nnly								
				'	all	шуп	ISLO	ту-С	IEC	n ai	ı ınaı a	ippiy						()		
Relationship	First Name	Status	No Known Problems	Arthritis	Asthma	Birth Defects	**Cancer	Clotting Disorder	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hypertension	Kidney Problems	Mental Illness	Stroke	Substance/Drug Abuse	Vision Loss	Other
Mother		Alive Deceased																		
Father		Alive Deceased																		
Brother		Alive - Deceased																		
Sister		Alive Deceased																		
Other		Alive Deceased																		
Other		Alive Deceased																		
**Type of Can	cer or Disease:	. "1																		
								Scre	eni	na_										
In the past two	weeks, how oft	en have you	ı been	both	nere	d by					Please	select	t one	resp	onse	per	state	ement	t.)	
		-				-														
	or pleasure in do	•							-		More				-		_		-	
Feeling down,	depressed, or h	nopeless*:		ot at	all		Seve	eral d	ays		More	than h	nalf th	e da	ays (□ Ne	arly	ever	y day	
Feeling down, depressed, or hopeless*:																				





Patient Self Determination Act Questionnaire

Patient Name*:		Patient DOB*:	(mm/dd/yyyy)
	DON'T LOSE YOUR RIGH	IT TO DECIDE	
You cannot remove all uncertainty about your that comes from making your wishes known in		y having an advance directi	ve you can have the peace of mind
Declaration to Decline Life-Prolonging	Procedures		
I have made a Living WillI do NOT designate a Living Will			
Health Care Surrogate			
I have designated a Health Care SuI do NOT designate a Health Care S	•		
Durable Power of Attorney			
☐I have appointed a Durable Power o☐I have <u>NOT</u> appointed a Durable Po	,		
Patient/Representative Signature*:		Name*:	
Date*:	(mm/dd/yyyy)		



NILAMBEN D. SHAH, MD Weekdays: 8 am to 5 pm

Statement of Patient Financial Responsibility

Patient Name*:	Patient DOB:*	(mm/dd/yyyy)
Sunrise Medical Clinic appreciates the confidence you have shown in choosi have elected to participate in implies a financial responsibility on your part. The fees. As a courtesy, we will verify your coverage and bill your insurance carripayment of your bill.	ne responsibility obligates	s you to ensure payment in full of oເ
You are responsible for payment of any deductible and co-payment/co-insurar We expect these payments at time of service. Many insurance companies have responsible for any amounts not covered by your insurer. If your insurant physician elects to continue past your approved period, you will be responsible	ave additional stipulations ance carrier denies any	s that may affect your coverage. Yo
I have read the above policy regarding my financial responsibility to Sunrise I to me or the above named patient. I certify that the information is, to the best pay any benefits directly to Sunrise Medical Clinic, the full and entire amor applicable any amount due after payment has been made by my insurance care	of my knowledge, true ar unt of bill incurred by me	nd accurate. I authorize my insurer t
<u>Co-Pay Policy</u>		
Some health insurance carriers require the patient to pay a co-pay for service is rendered for the patients to pay at EACH VISIT. Some insurers required high deductible insurances, we may charge allowable amounts up-fro cooperation in this matter.	uire a coinsurance, a ḋec	ductible for services rendered as wel
Consent for Treatment and Authorization	on to Release Informatio	<u>vn</u>
I hereby authorize Sunrise Medical Clinic, through its appropriate personnel, patient, appropriate assessment and treatment procedures.	to perform or have perfo	ormed upon me, or the above name
I further authorize Sunrise Medical Clinic, to release to appropriate agencies named patient's examination and treatment.	s, any information acquir	ed in the course of my or the abov
Cancellation / No Show	w Policy	
We understand there may be times you miss an appointment due to emergence However, we urge you to call 24-hours prior to cancelling your appointment.	cies or obligations to work	or family.
I understand if I no show for two consecutive appointments, no show for three be discharged from care.	appointments or cancel t	for a total of four appointments, I ma
The practice will notify you in writing, via certified mail, if you are discharged from	om care.	
I have read and understand the above information, and I agree to the terms de	escribed.	
Patient/Guarantor Signature*:	Date*:	(mm/dd/yyyy)



HIPAA Information and Consent

NILAMBEN D. SHAH, MD Weekdays: 8 am to 5 pm

The Health Insurance Portability and Accountability Act(HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 18, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

- 1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records.PHI and other documents or information.
- 2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes of office policy and new technology that you might find valuable or informative.
- 3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- 4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
- 5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- 6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or servicies.
- 7. We agree to provide patients with access to their records in accordance with state and federal laws
- 8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
- 9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to your request.

I *	date *	(mm/dd/yyyy) do hereby c	onsent and acknowle	edge my agreeme	ent to the terms
set forth in the HIPAA INFORMATION I	ORM and any su	ubsequent changes in office p	policy. I understand	that this consent	shall remain in
force from this time forward.					

NILAMBEN D. SHAH, MD Weekdays: 8 am to 5 pm

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask
 us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- · You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- · We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- · You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- · We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, costbased fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- · We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

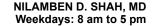
- · You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with Nilam D Shah, MD, Sunrise Medical Clinic by sending a letter to 5778 5th Ave N, St Petersburg, FL 33710, or calling 727-388-2625
- · We will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- · Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

continued...





· Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- · Sale of your information
- · Most sharing of psychotherapy notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- · Preventing disease
- · Helping with product recalls
- · Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- · Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

continued...



Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- · For workers' compensation claims
- · For law enforcement purposes or with a law enforcement official
- · With health oversight agencies for activities authorized by law
- · For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

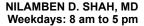
Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

This notice is effective on or after January 1, 2021.

The name and contact of the person you can contact for further information concerning our privacy practices is: Deval Shah
Email- info@sunrisemedclinic.com
Phone number- 727-388-2625





Notice of Privacy Practices Receipt Acknowledgement

Sunrise Medical Clinic has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact the front desk staff at your physician's office to obtain a current copy of the Notice of Privacy Practices or to ask questions. It is also posted on our website at http://sunrisemedclinic.com/NoticeOfPrivacyPractices.aspx.

By my signature below, I agree that I have received the Notice of Privacy Practices of Sunrise Medical Clinic.

Date*:	(mm/dd/yyyy)
Printed name of the patient*:	
Patient or legally authorized individual signature*:	
Printed name (if signed on behalf of the patient):	
Relationship (parent, legal guardian, personal representative):	