FAMILY DOCTORS
Always here. Always available.

Welcome to the Family Doctors! Always here, always available! Thank you for trusting us with your health care! This welcome packet includes your new patient paperwork to fill out and bring with you to your first visit as other information about our providers, locations, and services.

We will provide you with same-day office visits for any acute needs during normal office hours and provide one of our own highly trained providers on call 24/7 to meet any acute needs that might come up.

In the coming days, one of our staff members will be reaching out to you to give you information, answer any questions and schedule your new patient appointment. In the meantime, please take the time to review the information contained in this packet.

I am excited for the opportunity for us to meet you and to help meet your healthcare needs!

Respectfully,

John Noffsinger, BSN
Practice Administrator
Bradenton & Manatee

MANATEE OFFICE
3930 8th AVE W
Bradenton, FL. 34205
(P) 941 708-9421
(F) 941 708-9424
IMCFamilyDoctors.com

BRADENTON OFFICE
6150 State Road 70 E
Bradenton, FL. 34203
(P) 941 822-8777
(F) 941 822-8770
IMCFamilyDoctors.com

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Bradenton, FL. 34205
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(F) 941 708-9424
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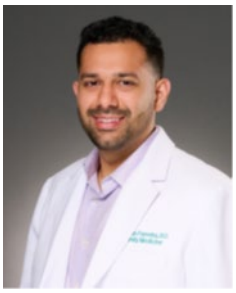
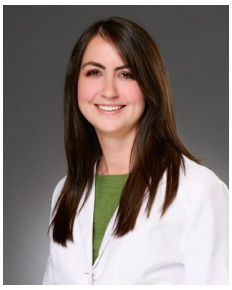
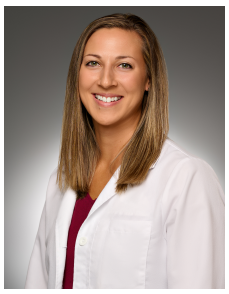
Michelle DiBetta, MD
Bradenton



Steven Ferreira, DO
Bradenton & Manatee



Melissa Beljan, DO
Manatee



Sara Wemlinger, DO
Bradenton

Proudly Accepting:

Humana®

Medicare

FAMILY DOCTORS
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In order to properly thank your friends and acquaintances, please check all that apply:

How Did You Hear About Us?

____ Friend or Relative: Name_____
____ Letter or Postcard:
____ Newspaper Ad:
____ Online Advertisement:
____ Humana.com:
____ Medicare.gov:
____ Insurance Agent: Name_____
____ Billboard:
____ TV or Radio Ad:
____ Community Newsletter:

If you are a Humana member, how did you enroll?

____ Agent ____ Online ____ Educational Talk
____ Telephone ____ Called Medicare ____ Assigned to Center

If you enrolled with an agent, what is his/her name? _____

_____

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New Patient Verification

Welcome to Family Doctors…. If you need any assistance or have questions about your paperwork, please let the front desk know.

Last Name_____ First Name_____ Middle_____

SS# _____ Birth date _____

Home Phone # _____ Cell # _____

Street Address _____

City_____ State _____ Zip _____

Sex _____ M _____ F Age_____ Significant other ___ Yes ___ No Name: _____

Do you have any specialist appointments scheduled? ____ Yes _____ No

Where & When _____

Prior Doctor and Phone Number: _____

Insurance: _____

---------- Office Use Only: ----------

Availity Done ____ Yes _____ No ID/License Scanned ____Yes ____ No

Med Records Requested ___ Yes ___ No

Labs: _____ Dr: _____

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Welcome To Our Practice!

Please keep this form so that you have access to this information when needed.

Our physicians are available 24 hours a day, after hours, for your urgent healthcare needs. Upon contacting our office after hours, one of our providers will personally return your call. Avoid expensive emergency room co-pays, long wait times, and physicians who are not familiar with your specific healthcare history.

Please contact our office

- If you have an urgent healthcare need during business hours, Monday – Friday 8:00 – 4:30, our staff will make necessary arrangements to see you in the office.

- Preferred Hospitals – Our providers have selected the following hospital because of their confidence and professional relationship with the hospital and the specialists.
  - Manatee Memorial Hospital, Lakewood Ranch Medical Center or Blake Medical Center

- Preferred Laboratory
  - Lab Corp

- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your provider will need to see you in the office for a follow up visit within 24 to 48 hours after discharge to assure your continued recovery.

- Medicare patients – Your provider encourages you to be seen at least every six (6) months. This will help both you and your provider maximize preventative care.

- Scheduling Appointments – Call our office to schedule your appointment and be sure to always bring a current list of medications with you to each appointment. If you are unable to keep your appointment, please contact our office at least 24 hours in advance so we may offer that opening to someone else with a healthcare need.

- To Avoid Receiving a Bill – Call the office prior to seeing a specialist or undergoing any procedure, as your Humana insurance requires a referral. DO NOT go for lab tests, x-rays, physical therapy, etc. until our office is notified.

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Understanding Your Insurance & the Referral Process

The insurance plan you have selected is a HMO/managed care plan.

1. Your Primary Care Provider (PCP) will be able to see the total picture of your overall health. This allows your provider to make the best decisions in managing your health and well-being.

2. While your Primary Care Provider (PCP) can provide most of your care, if you need a specialist, your PCP manages the care you receive from these healthcare specialists within the network.

3. Your Primary Care Provider (PCP) needs to issue a referral for you before you see any specialists.

4. Your Primary Care Provider (PCP) will choose a specialist that will best suit your needs within your HMO Network.

5. Within the HMO, there are a select number of Providers that have demonstrated outstanding care and improved outcomes.

6. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

7. The referral process serves as a way for your PCP and your specialist to communicate with each other. When a referral is issued for you to see a specialist, your PCP will inform the specialist of the reason(s) for the referral, as well as the goal(s) for the visit. In other words, your PCP will help coordinate your visit; the referral helps ensure you receive the proper care when seeing a specialist.

Thank you for joining our Practice!

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<u>Please bring the following to your first appointment:</u>

<u>ALL Prescriptions</u> and

<u>Over the Counter Medication bottles</u>

that you are currently taking.

PLEASE ARRIVE 15 – 20 MINUTES EARLY FOR YOUR FIRST APPOINTMENT TO AVOID DELAYS

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HIPAA/Patient Authorization for use and Disclosure of Protected Health Information.

I hereby give my consent for Immediate MedCare & Family Doctors to use and disclose protected health information (PHI) about me, to include HIV/Aids testing/status, to carry out treatment, payment and healthcare operations (TPO). (Immediate MedCare & Family Doctors "Notice of Privacy Practices" provides a more complete description of such uses and disclosures.)

I have the right to review the "Notice of Privacy Practices" prior to signing this consent, Immediate MedCare & Family Doctors reserves the right to review its "Notice of Privacy Practices" at any time. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to Immediate MedCare & Family Doctors, Attn: Privacy Officer, 6150 State Road 70 East, Bradenton, FL 34203-9712.

With this consent, Immediate MedCare & Family Doctors may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Immediate MedCare & Family Doctors may mail to my home or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal & Confidential".

With this consent, Immediate MedCare & Family Doctors may email to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Immediate MedCare & Family Doctors restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Immediate MedCare & Family Doctors use and disclosure of my PHI to carry out TPO, including third party payors.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke consent, Immediate MedCare & Family Doctors may decline to provide treatment to me.

List other people that you would like this information released to:_____

_____

Patient Signature:_____**Date:** _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal

RepresentativePrinted Name of Parent/Legal Guardian/Legal Representative: _____

FAMILY DOCTORS
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Prescription Renewal, Patient Conduct, Exam Room Escort & Health Policy

Prescription Renewal Policy

Immediate MedCare & Family Doctors physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the medical assistants between the hours of 8am to 4pm, Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality of medical care.

Patient Conduct and Examination Room Escort Policy

If at any time a patient is physically threating, verbally abusive, or demeaning to staff (or other patients) whether it is in person or other means of communication, we at Immediate Medcare and Family Doctors have the right to refuse treatment to the patient and dismiss them from the practice.

To ensure your comfort, at your request, you may have an escort present with you during your examination. Escorts may be a friend or a family member, or we can furnish a member of our staff to be present during your examination. At the physician's discretion, an escort may also be asked to be present at the time of the examination.

Health Maintenance

To maintain your good health, it is important to us that you, our patient adhere to the following:

- Not smoke
- Lose weight, if necessary. Maintain your optimum weight
- Exercise daily – walk, swim, etc.
- Follow a healthy diet: Decrease – cholesterol, calories, saturated fats, use salt substitutes
- Do not use alcohol or use in moderate amounts only
- Use your safety belts
- Use child safety belts
- Wear your bicycle helmet
- Get regular mammograms and pap smears (start pap with onset of sexual activity or at 18 years)
- Have yearly eye exams
- Stop use of illegal drugs, marijuana, designer drugs
- Use safe sexual practices; HIV protection, venereal diseases
- Regular prostate exams for the older male

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

Advance Directive

What is an Advance Directive?

It is a statement which tells your doctor and family what care you would like to have when you are not able to make those decisions because of the seriousness of your injury or illness.

There are two kinds of advance directives:

- A Living Will
- Durable Power of Attorney for Health Care

A Living Will – What is it?

It is a statement that lets you tell your doctor and family your wishes if there were no hope for your recovery and you become unable to make your own decisions. An example of this would be whether to continue to use a breathing machine to keep you alive if you were in a permanent coma following an automobile accident.

Durable Power of Attorney for Health Care – What is it?

It is a statement in which you appoint a person to make medical judgement(s) for you if you become unable to make those decisions for yourself. That person should be someone you trust to make health decisions like the ones you would make yourself if you were able. Usually that person would be a close relative or close friend.

Is one better than the other?

They are different and are used for different things so they both are good. These statements are to help your family and your doctor make decisions concerning your healthcare at a time when you are not able to. You may use one, or both of these forms of advance directives to provide direction for your medical care. You may combine them into a single statement that appoints a person to make medical decisions for you but also tells that person of your wishes if there is no expectation for reasonable survival.

Can I change my mind?

Yes! You can change your mind or cancel your statement at any time. Changes should be written, signed and dated. You can also make your change of opinion by telling someone (an oral statement).

Who should make out an Advance Directive?

Because we may have a serious illness or injury at any age, all adults should have an advance directive.

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YEARLY INSURANCE AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Immediate MedCare & Family Doctors or any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.

I request that payment under the Medicare or other medical insurance program(s) be made to Immediate MedCare & Family Doctors for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by Immediate MedCare & Family Doctors from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Immediate MedCare & Family Doctors for services rendered.

I understand that I am responsible for payment of all charges and fees to Immediate MedCare & Family Doctors that they are entitled to collect that which are not paid for by Medicare or other insurance.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

A charge of $35 will be billed to your account for any missed appointments. This is <u>not</u> billable to your insurance company.

Patient Signature:_____ Date: _____

CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of
(Print Patient Name)

Immediate MedCare & Family Doctors Notice of Privacy Practices.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

FAMILY DOCTORS
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AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby give my permission to (list physician / facility name, address & phone number):

_____ _____

_____ _____

_____ _____

_____ _____

To release a copy of my Protected Health Information (PHI) to: **Immediate Medcare & Family Doctors**

I instruct the above named entity to produce the following information (check ONE only):

☐ Release Entire Record
☐ I would like specific records released: _____

My PHI is to be disclosed for: ☐ Continuation of Care ☐ Other: _____

Please forward records to the following location:

6150 State Road 70 E
Bradenton, FL 34203

Phone: (941) 822-8777
Fax: (941) 822-8770

Unless otherwise noted, this authorization expires one year from date signed.

I authorize Immediate MedCare & Family Doctors or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including, but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment, unless specified below which may be a part of the medical records. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on the Authorization. I am entitled to a copy of this authorization upon request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. This recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the discloser is specifically required by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Patient Name (Print) : _____ DOB : _____

Patient Signature : _____ Date : _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

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Family Doctors of Bradenton

Michelle R. Dibetta, M.D. Steven R. Ferreria, D.O. Sara E. Wemlinger, D.O.

PREVIOUS PROVIDERS

Down below, please list all previous providers with phone numbers so we can request your previous medical records. If the provider is a specialist, please specify.

1) _____

2) _____

3) _____

4) _____

5) _____

Family Doctors of Bradenton
6150 State Road 70 East
Bradenton, FL. 34203
Phone: (941) 822-8777
Fax: (941) 822-8770

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Personal Health Risk Assessment

Please complete the following packet and bring with you to your first appointment.

This information is extremely important as your doctor will need to review your health risk assessment.

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Patient Last Name:_____ **Patient First Name:**_____ **DOB:** _____

Past Medical History: Have you ever had one of the follow illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	Diabetes	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Falls	☐	☐	Ostomy	☐	☐
Alcohol Overuse	☐	☐	Gout	☐	☐	Paralysis	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐	Sexually	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Transmitted Disease		
Bleeding Disorders	☐	☐	Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
Cancer	☐	☐	(CHF/CAD)			Sleep Disorder	☐	☐
Location:_____			Hepatitis	☐	☐	Stomach Ulcer	☐	☐
Cardiac Arrhymias	☐	☐	High Blood Pressure	☐	☐	Stroke, CVA/TIA	☐	☐
Pacemaker:_____			Kidney Disease	☐	☐	Thyroid Disease	☐	☐
Colitis	☐	☐	Mental Illness	☐	☐	Vascular Disease	☐	☐
COPD/Emphysema	☐	☐	Other Medical History: _____					

Symptoms you would like to discuss: _____

Personal Habits: Have you ever?

Smoked tobacco? ☐ Yes ☐ No If yes, packs per day____#of years_____ Year quit _____

Used chewing tobacco? ☐ Yes ☐ No If yes, # of cans_____# of years_____Year quit_____

Do you drink alcohol regularly? ☐ Yes ☐ No If yes, how often_____# of drinks per day_____

Have you ever used? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Meth ☐ Other

Operations: List with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Serious Injuries: List with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalization (Other than operations with approximate date):_____

_____

Immunizations (please include the date):		Covid-19 _____	Prevnar 13 _____
Tetanus _____	Shingles _____	Flu _____	Prevnar 20 _____
Other _____	MMR _____	Hep _____	Pneumovax 23 _____

FAMILY HISTORY

FAMILY MEMBER	CIRCLE SEX	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brother(s) / Sister(s)	M F				
	M F				
	M F				
Husband / Wife					
Son(s) / Daughter(s)	M F				
	M F				
	M F				
	M F				

Check if any blood relative has or had any of the following and enter their relationship to you:

	Yes	No	Relationship to you	Comments
Bleeding Tendency	☐	☐		
Cancer	☐	☐		
Colitis	☐	☐		
COPD	☐	☐		
Diabetes	☐	☐		
Epilepsy	☐	☐		
Heart Attack	☐	☐		
High Blood Pressure	☐	☐		
Kidney Disease	☐	☐		
Sickle Cell Anemia	☐	☐		
Stroke	☐	☐		
Suicide	☐	☐		
Tuberculosis	☐	☐		
Other:	☐	☐		

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Preventative Service History

This form needs to be completed to the best of your ability.

We need to know if the below listed testing has: Never Been Done (NO), Has Been Done (YES). If yes, your best estimate as to the month/year the test was performed, and the result.

Preventative Service	NO	YES	Month/Year Testing Performed	Findings & Recommendations
Bone Mass Measurement (Bone Density)	☐	☐		
Bloodwork	☐	☐		
Colorectal Cancer Screening				
Colonoscopy – NOT High Risk	☐	☐		
Fecal Occult Blood Test (Stool Card)	☐	☐		
Vision Screening				
Eye Exam	☐	☐		
Female Screening				
PAP & Pelvic Examination	☐	☐		
Mammogram	☐	☐		
Male Screening				
PSA – Prostate Specific Antigen (Blood Test)	☐	☐		

FOR PHYSICIAN USE

Physician Signature

Date Reviewed

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SOCIAL / LIFESTYLE HISTORY: Primary Language: _____

Interpreter Required: ☐ Yes ☐ No

Is there someone that lives with you in your residence? ☐ Yes ☐ No

If yes, please list name & relationship: _____

Type of Residence: ☐ Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story

☐ Independent Living Facility Facility Name: _____

☐ Assisted Living Facility Facility Name: _____

Durable Medical Equipment? ☐ Yes ☐ No ☐ Wheelchair ☐ Walker ☐ Cane

☐ Oxygen ☐ Nebulizer ☐ CPAP/BIPAP

Other: _____

Can you afford medicine? ☐ Yes ☐ No Potential Referral to Patient Assistance Program: _____

Transportation provided by? _____

EXERCISE / ACTIVITY:

Current Activity: _____ How Often: _____

Physical Limitations: _____

ACTIVITIES OF DAILY LIVING:

Do you require assistance to bathe or groom? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance for your toilet needs? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance to eat? ☐ Yes ☐ No

If yes, explain: _____

Do you have hearing loss? ☐ Yes ☐ No

Do you wear hearing aids? ☐ Yes ☐ No

Date of last hearing exam: _____

Additional Comments & Notes: _____

REVIEW OF SYSTEMS

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Feeling Poorly
- ☐ Feeling Tired
- ☐ Recent Weight Gain _____ lbs.
- ☐ Recent Weight Loss _____ lbs.

Eyes
- ☐ Blurry Vision
- ☐ Glaucoma
- ☐ Eye Infection
- ☐ Dry Eyes
- ☐ Red Eyes

ENT
- ☐ Ringing in the Ears
- ☐ Throat Clearing
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Mouth Sores

Cardiovascular
- ☐ Heart Rate Slow
- ☐ Heart Rate Fast
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Lower extremity Edema

Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath on Exertion
- ☐ Spitting up Blood

Genitourinary
- ☐ Dysuria
- ☐ Incontinence
- ☐ Testicular Pain
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Abnormal Vaginal Bleeding
- ☐ Genital Lesion

Heme/Lymph
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands

Musculoskeletal
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness

Integumentary
- ☐ Skin Rash
- ☐ Skin Wound
- ☐ Itching
- ☐ Jaundice

Neurological
- ☐ Confusion
- ☐ Numbness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache

Psychiatric
- ☐ Suicidal
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances

Endocrine
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Cold Tolerance
- ☐ Excessive Urination

Gastrointestinal
- ☐ Poor Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Black Tarry Stools
- ☐ Belching
- ☐ Regurgitation
- ☐ Constipation
- ☐ Recent change in Bowel Habits

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MEDICATION LIST / ALLERGIES / PHARMACY

Please help us provide better care by providing us with your current prescription and over-the-counter medications taken regularly.

PRESCRIPTIONS:

Medication Name	Dosage	Times Daily	When Started?

OVER-THE-COUNTER MEDICATIONS / HERBAL REMEDIES / VITAMINS:

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No**

If yes, please list medication and the reaction.

MEDICATION ALLERGIES & REACTIONS:

Medication Name	Reaction

PHARMACY INFORMATION (Required):

Pharmacy Name: _____

Pharmacy Address or Cross Streets: _____

Pharmacy Phone: _____

Patient label:

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? **(circle the number to indicate 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 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

Add Columns ☐ + ☐ + ☐

TOTAL ☐

10. If you checked off any problems, how difficult 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	☐ Very difficult
	☐ Somewhat difficult	☐ Extremely difficult

Bladder and Additional Screening

- Are you having any bladder control problems? ☐ Yes ☐ No
  - *If "yes", please answer the remaining questions. This information will help your practitioner better understand your bladder control problem.
  - I started having bladder trouble: ☐ A Month(s) ago ☐ 1 to 2 years ago ☐ ___ years ago
- Do you require assistance to walk? ☐ Yes ☐ No
- Do you have any problems with your hearing, vision or speech?
  - Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Speech: ☐ Yes ☐ No

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ANNUAL PATIENT ASSESSMENT - Continued

Patient Label:

Mini Nutritional Assessment (MNA)

Sex: ☐ M ☐ F Age:_____ Weight:_____ Height: _____

A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake	_____
B. Weight loss during the last 3 months?	0 = weight loss greater than 6.6 lbs. (3kg) 1 = do not know 2 = weight loss between 2.2 = 6.6 lbs. (1 - 3kg) 3 = no weight loss	_____
C. Mobility	0 = bed or chair bound 1 = able to get out of bed/chair but do not go out 2 = go out	_____
D. Suffered psychological stress within the past 3 months?	0 = yes 2 = no	_____
E. Neuropsychological problems	0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems	_____
*******************STAFF ONLY BELOW THIS FOR MINI NUTRITIONAL ASSESSMENT****************		
F1. Body Mass Index (BMI) (weight in kg / height in M^2) 0 = BMI less than 19 1 = BMI 19 - less than 21 2 = BMI 21 - less than 23 3 = BMI 23 or greater	***If BMI is not available, replace question F1 with F2. Do not answer question F2 if question F1 is already completed.**	_____
F2. Calf Circumference (CC) in cm	0 = CC less than 31 1 = CC 31 or greater	_____
Screening Score: (Max 14 points) 12 - 4 = Normal Nutritional Status	8 - 11 = At risk of Malnutrition 0 - 7 = Malnourished	_____ _____

Annual Patient Conduct Agreement

If at any time a patient is physically threating, verbally abusive, or demeaning to staff (or other patients) whether it is in person or other means of communication, we at Immediate Medcare and Family Doctors have the right to refuse treatment to the patient and dismiss them from the practice.

_____ _____

Patient Signature Date

FOR PHYSICIAN USE

_____ _____

Physician Signature **Date Reviewed**

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Patient label:

Date of service: _____/____/_____(mm/dd/yyyy)

Physician name:

This document is intended to capture requested clinical quality information only. Other write-in information will not be considered.

1159F AND 1160F

Prescription (Rx)	Dosage	Disease being treated/reason for medication	Side effects discussed
Please see attached medication list. All medications verified with patient (including name, dose, quantity, route and frequency).			☐
Patient educated on what their medication is intended to do and the reason that they are taking it. Potential side effects discussed.			☐
			☐
			☐
			☐

1170F

Functional assessment: Does patient have difficulties performing the following activities? Date assessed:

Bathing	☐	Yes	☐	No	☐	N/A	Transferring	☐	Yes	☐	No	☐	N/A
Dressing	☐	Yes	☐	No	☐	N/A	Using the toilet	☐	Yes	☐	No	☐	N/A
Eating	☐	Yes	☐	No	☐	N/A	Walking	☐	Yes	☐	No	☐	N/A

Treatment plan discussed with patient

☐ Occupational therapy referral ☐ Review of Rx ☐ Physical therapy referral ☐ Assistive device evaluation

Physical activity assessment Date assessed:

Patient is physically active	☐Yes ☐No	Patient is active 30 minutes a day most days of the week	☐Yes ☐No
Patient plans to become active in the next few months	☐Yes ☐No	Patient expresses fear to become active or participate in physical activity	☐Yes ☐No
Patient participates in activity regularly	☐Yes ☐No	If so, what type? _____	

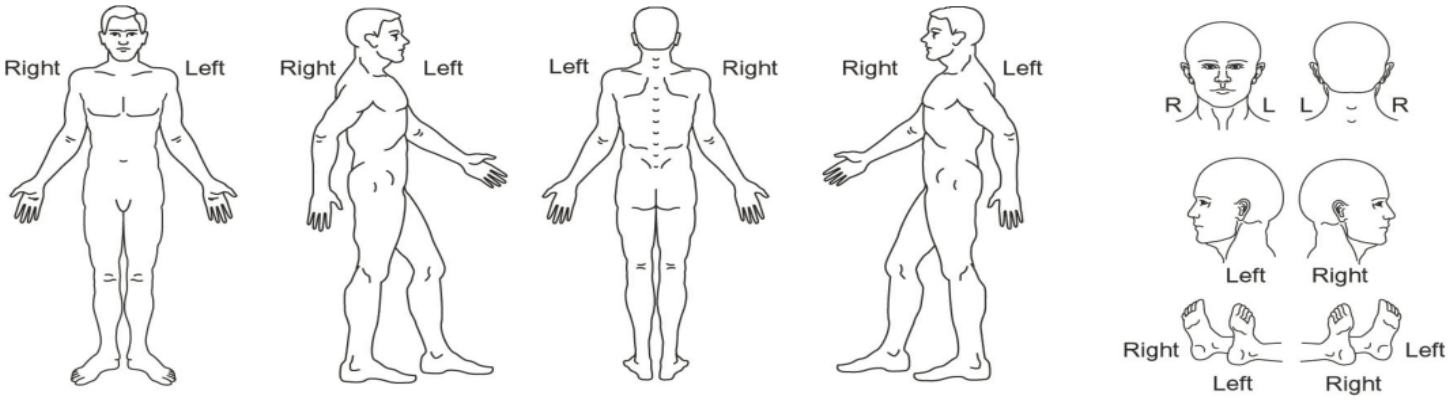
1158F OR 1157F

Patient advised: ☐ Daily walks ☐ Stretching ☐ Start taking the stairs ☐ Increase walking as tolerated

Advance care planning: ☐ Advance directive in medical record Discussion on _____/_____/_____

1125F Pain OR 1126F No Pain

Pain assessment Date assessed:



Pain intensity (0 lowest to 10 highest)_____ Present pain_____ Worst pain_____ Best pain _____

Quality of pain: _____ Onset, duration, variation and rhythms? _____

What causes the pain? _____ What relieves the pain?_____

Physician name and credentials:

MICHELLE DIBETTA, M.D.

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ABOUT ME

Dr. Michelle DiBetta, M.D. earned her master's degree in interdisciplinary medical sciences and her medical degree from the University of South Florida and completed her family medicine residency at Bayfront Health St. Petersburg. During her residency, Dr. Michelle DiBetta, M.D. was an active member of the Bayfront Critical Care Committee, Residency Curriculum Committee, and the hospital records committee. She is a member of the Alpha Phi Omega service fraternity where she has donated hundreds of volunteer hours to the community.

Dr. Michelle DiBetta, M.D. was a staff coordinator at the BRIDGE free health clinic in Tampa, Florida and she also volunteered at the Brandon outreach free clinic. She was inducted into The Barness/Behnke Chapter of the Gold Humanism Honor Society in March 2012.

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Traditionally, health care providers are paid based on how many care services they provide. *This didn't work for us.* We wanted to be advocates for our patients, in all aspects, with their health and wellbeing as our top priority.

With the value-based care (VBC) model, our providers are compensated for ***how well*** this care works. We're holding ourselves to higher standards, to ensure you get the truly best care. As the patient, when you win, we win.

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to leave a review!!

STEVEN FERREIRA, D.O.

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ABOUT ME

Steven Ferreira, D.O. graduated from Florida State University with a BS in Psychology, and later Nova Southeastern University – Osteopathic Medical School. At NOVA he was recognized and awarded into the Gold Humanism Honor Society. His desire to stay and support Florida medicine led to his enrollment in the Family Medicine Residency Program at St. Petersburg General Hospital where he was the Chief Resident. Steven Ferreira D.O. was a selected member of the national ACOFP Resident Council. He continues his role in academics as a preceptor in training physician residents. Taking the mind, body, and spirit into consideration of the treatment of the patients' health. Steven Ferreira D.O. looks forward to partnering with his patients to best care and optimize their health.

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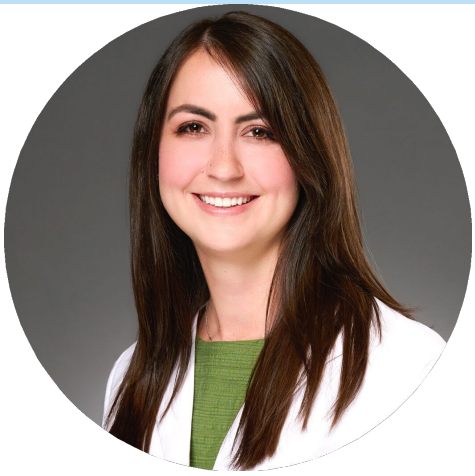
MELISSA BELJAN, DO



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ABOUT ME

Melissa Beljan, D.O. graduated from the University of Central Florida with a B.S. in Microbiology and Molecular Biology. She then attended Lake Erie College of Osteopathic Medicine in Bradenton, Florida where she obtained her Doctorate in Osteopathic Medicine. She completed her Family Medicine residency at Manatee Memorial Hospital, where she was selected as Chief Resident and Senior of the Year.

As a committee member working with the Manatee County Community Paramedic program, she was privileged to aid in increasing health care literacy in the underserved community. She is grateful to stay in her hometown and support our local community.

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SARA WEMLINGER, DO/MBA

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ABOUT ME

Dr. Wemlinger's passion for healthcare was ignited by her own experiences as a college basketball player. The challenges she faced while recovering from injuries inspired her pursuit of musculoskeletal medicine. This personal history fuels her commitment to helping others stay active, despite injuries and pain.

She began her academic journey at Maryville University, earning a Bachelor of Science degree in Biology. Following this, she pursued a dual degree program, earning a Doctor of Osteopathic Medicine degree from Kansas City University of Medicine and a Master of Business Administration in Healthcare from Rockhurst University Helzberg School of Management.

Dr. Wemlinger further honed her skills through a Family Medicine Residency at Manatee Memorial Hospital, facilitated by Lake Erie College of Osteopathic Medicine (LECOM) in Bradenton, Florida. Her pursuit of excellence continued as she completed a Fellowship in Sports Medicine at Millcreek Hospital in Erie, Pennsylvania, also through LECOM. She distinguished herself during this program, serving as the Chief Fellow.

As an osteopathic physician,

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ABOUT ME CONTINUED

Dr. Wemlinger incorporates osteopathic manipulative therapy/treatment (OMT) in her practice, offering a holistic approach to patient care that considers the whole person, not just the area of pain. When necessary, she utilizes ultrasound-guided therapies for pain management. Dr. Wemlinger's care philosophy is anchored in offering therapeutic options that minimize the use of medications wherever possible.

Passionate about community service, Dr. Wemlinger conducts pre-participation sports physicals for local high schools and covers football games for Palmetto and Parrish High Schools. When not serving patients, she stays active through cross-fit and enjoys walking her three dogs.

Please join us in welcoming Dr. Wemlinger to our team. Her exceptional skills, compassionate care philosophy, and dedication to community service truly set her apart.

DEVIKA SURI, PHARMD

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ABOUT ME

Hello everyone! My name is Devika Suri, and I am a clinical pharmacist working with your physician. I graduated from the University of South Florida College of Pharmacy with my Doctor of Pharmacy and went on to complete a clinical residency at St. Joseph's Hospital in Tampa, Fl.

As your clinical pharmacist, I will be working very closely with your physician. My role will be to help manage your care by optimizing the medications best suited for you. I will be calling and reaching out to discuss your lab results, medications, side effects and asking you how you are doing overall. I will be here for any questions you have regarding your medications or general patient education questions. We have added this service to better assist our patients in understanding and managing their health.

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