ELIAS KANAAN M.D. P.A.

1173 Turner St, Clearwater, FL 33756
(727)298-8496 (727)445-7566

Patient Registration Form Date:

Patient Information

Last Name:	First Name:	M.I.
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Date of Birth:	Sex: ☐ Male ☐ Female	Marital Status:
Social Security #:	Employed: ☐ Yes ☐ No	Pharmacy:
Email:		Can we leave you voicemails? ☐ Yes ☐ No
Emergency Contact:	Phone:	Relationship:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company:	Insurance Company:
ID/Policy #:	ID/Policy #:
Group #	Group #
Policy Holder:	Policy Holder:
Relationship to Policy Holder:	Relationship to Policy Holder:

Scanned to chart

Responsible Party

☐ Check if Respoinsible Party Information is same as Patient Information

Last Name:	First Name:	M.I.
Mailing Address:		
City/State/Zip:		
Date of Birth:	Social Security #:	

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Patient Information Sheet

Date:

Name:	Date of Birth:	Gender:

ALLERGIES:

PERSONAL MEDICAL HISTORY: (Please check all that apply)

- ☐ ADHA
- ☐ Alcoholism
- ☐ Allergies, Seasonal
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bladder Problems/Incontinence
- ☐ Bleeding Problems
- ☐ Cancer Type:
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: Type I Type II
- ☐ Diverticulitis
- ☐ DVT (Blood Clot)
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack (MI)
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Neuropathy
- ☐ Osteopenia/Osteoperosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer
- ☐ Peripheral Vascular Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke (CVA)
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis

Other Medical Problems Not Listed Above

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

SURGICAL HISTORY: Please list all surgeries and month/year performed

Specialists and Other Medical Providers you see: (i.e. Cardiologist, Nephrologist, Rheumatologist, Neurologist, Psych, etc)

Recent Testing/Imaging:

Colonoscopy Date: ☐ Normal

Mammogram Date: ☐ Normal

DEXA Date: ☐ Normal

PAP Date: ☐ Normal

SOCIAL/CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College

Vission Issues: _____

Hearing Issues: _____

Preferred Language: _____ Race/Ethnicity: _____

Are there any limitations to understanding/following instructions (written or verbal)? ☐ YES ☐ NO

Current Housing Situation: (Please check all that apply)

☐ Independently ☐ With Spouse ☐ With Family

☐ Single Family Home ☐ Apartment ☐ Skilled Nursing Facility ☐ Assisted Living Facility ☐ Shelter ☐ Homeless

SmokingTobacco Use: ☐ Never ☐ Current ☐ Past # of Years: _____

Type: ☐ Cigarettes ☐ Chew ☐ Snuff ☐ Electronic/Vape Amount: _____

Alcohol Use: ☐ Never ☐ Current ☐ Past Amount: _____

Recreational Drug Use: ☐ Never ☐ Current ☐ Past Type: _____

Are you sexually active? ☐ YES ☐ NO

Family History:

FATHER: ☐ Living ☐ Deceased Age: _____

Conditions: _____

_____

_____

MOTHER: ☐ Living ☐ Deceased Age: _____

Conditions: _____

_____

_____

SIBLINGS: _____

_____

CHILDREN: ☐ None Daughter(s): _____ Son(s): _____

Medication List

Name: _____

Date of Birth : _____

Medication	Strength	Frequency
		☐ 1xday ☐ 2xday ☐ 3xday ☐ 4xday ☐ prn
		☐ 1xday ☐ 2xday ☐ 3xday ☐ 4xday ☐ prn
		☐ 1xday ☐ 2xday ☐ 3xday ☐ 4xday ☐ prn
		☐ 1xday ☐ 2xday ☐ 3xday ☐ 4xday ☐ prn
		☐ 1xday ☐ 2xday ☐ 3xday ☐ 4xday ☐ prn
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		☐ 1xday ☐ 2xday ☐ 3xday ☐ 4xday ☐ prn

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the provided address/phone number to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations; I also understand you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____

Patients Name

_____

Signature

_____

Date

ELIAS KANAAN M.D. P.A.

Elias Kanaan, M.D.
Mouna Bacha, M.D.
Nicole Garland, ARNP
Wendy Reitz, ARNP
1173 Turner St.
Clearwater Fl, 33756
(PH) 727-298-8496 (FAX) 727-445-7566

It is with pleasure that we welcome you to the office of Dr's Elias Kanaan and Mouna Bacha. We strive to exceed your expectations and provide you with the best service possible.

APPOINTMENTS

For urgent, but non emergency situation, we will make every effort to ensure that you see you physician promptly, in case of medical emergency, always call 911. Our answering service will handle all calls received after normal business hours. We have a physician on call 24 hours a day, 7days a week, for your convenience. ***Please remember that the answering service should only be used for emergencies or urgent issues.***

To schedule or change an appointment, please call 727-298-8496. If you will be late for an appointment, we will see you no later than 15 minutes after your appointment time. If you need to iss your appointment, we ask that you notify us as early as possible or at least 24 hours in advance so that we can better serve our patients. Any appointments not cancelled 24 hours in advance or if you are later than 15 minutes for your appointment, you will be considered a "No-Show".

Because cancellations adversely affect our ability to serve our patients appropriately, we charge a $25.00 fee for appointments that are patient no-show, cancelled or rescheduled with less than 24 hours notice.

This fee is not billable to your insurance company and will need to be paid prior to your next appointment. If you miss two appointments by cancelling within 24 hours notice, or no-show, it will require us to discharge you from the practice. **THANK YOU FOR YOUR COOPERATION!!!!**

Patient's Name: _____

Patient Signature: _____

Date: _____

Medical Information Release Form

(HIPAA Release Form)

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

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

ELIAS KANAAN M.D. P.A.

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Mouna Bacha, M.D.
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Chronic Care Management Agreement

Name: _____

This new service will allow your primary care physician to manage your medical problems.

Your PCP or his staff, would be able to refill your medications to the pharmacy electronically, review your medications, review and discuss your medical reports coming from other specialists, respond t your concerns, review your labs, medication reconciliation, arrange for preventive services remotely, offer patient/family education, respond to patient/family questions, communicate with home health or pother providers.

By signing this consent, you give us permission to provide CCM services to you.

Please be advised that only one primary care physician at a time can furnish CCM for you. Medicare/insurance billing rules will apply to this service. Please note that at any time, you can revoke this agreement upon written request, and will stop this service in the beginning of the following month.

Patient name: _____

Patient Signature: _____

Date: _____

ELIAS KANAAN M.D. P.A.

1173 Turner St, Clearwater, FL 33756
☎(727)298-8496 🖷(727)445-7566

PATIENT NAME:	
DATE OF BIRTH:	SS#:

I authorize Elias Kanaan M.D. P.A. to ☐ Disclose to ☐ obtain from: _____ and send to below requestor.

Name: Elias Kanaan M.D. P.A.	Address: 1173 Turner Street, Clearwater, FL 33756
Phone: (727) 298-8496	Fax: (727) 445-7566

PROVIDER:

☐ Elias Kanaan, MD ☐ Mouna Bacha, MD ☐ Nicole Garland, ARNP ☐ Wendy Reitz, ARNP

Please furnish the following information specified below. (Check appropriate boxes)
☐ Abstract of Record (Dictated Reports, laboratory, cardiology, radiology) ☐ Emergency Department Records Discharge ☐ Summary Operative Report(s) ☐ History & Physical ☐ Laboratory Reports ☐ Billing Records ☐ Pathology Report ☐ Radiology Report(s) ☐ Complete chart ☐ other: _____

_____

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, and diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying the office in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. Elias Kanaan M.D. P.A. will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I can request to receive a signed copy of this form.
6. I further agree to pay charges to provide the information request per Florida Statute 395.3025.
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: _____. If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

☐ I am the patient and I understand and agree to the provisions of this form/authorization

☐ I understand and agree to the provisions of this form on behalf of the individual indicated below to be the patient. I have signed my name individually as the representative of the patient and have attached a copy of the court order designating me as the guardian of the patient, or documentation designating me as the Legally Authorized Person (LAP) of the patient.

Printed Name: _____ Signature: _____ Date: _____

BayCare
Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX only:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, if You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

BayCare
Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of healthcare, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. **Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying **"Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."**

If you check the **"I DENY CONSENT"** box below, you are saying **"No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."**

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☐ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

Printed Name of Patient/Representative _____ Signature of Patient/Representative _____ Date _____

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____

ELIAS KANAAN M.D. P.A.

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NEW PATIENTS WELCOME!!!!

Health Insurance is a contract between YOU and YOUR INSURANCE CARRIER. Our office will submit electronically, insurance information submitted to our office by you, the patient. Health Care Insurance is intended to cover a portion, but not all, of the costs of your medical care treatment. Failure to provide correct insurance information at the time of services (including your insurance card) may directly result in your having to pay additional out of pocket cost. **ALL COPAYS ARE DUE AT THE TIME OF SERVICE.** Most plans including Medicare include a deductable or co-insurance/co=pay amount deemed patient responsibility by the insurance carrier. Some patients have secondary policies to cover the co-pay or 20% patient responsibility due. Some plans pay for "Preventative Treatment" and others only pay for "Sick Visits". Our office will electronically submit claims to your primary insurance company. If they fail to respond after our 3rd attempt, it then becomes patient responsibility. Failure to give your most current and/or accurate insurance information at the time of service will delay claims and cause larger patient responsibility. Please contact our billing office or office manager if you have insurance questions. **Please be prepared to present your insurance cares at each visit to ensure accuracy.**

If you participate in an HMO please speak to your insurance carrier and make sure Dr. Kanaan and Dr. Bacha are designated as your primary care providers and are in network to ensure continuity of care. If the doctors are not the PCP on record, you cannot receive services in our office until they have been designated as your PCP.

Please contact your carrier to verify provider participation and network to ensure continuity of care.

CASH PATIENTS: Cash Patients should be prepared to pay at the time of service, when services are rendered. Should you need a payment plan, please contact our office prior to your appointment and speak with our Administrator/Office manager. Payment plans are available and must be made prior to services being rendered.

Please speak with our billing office if you have additional questions.

Due to the constant changes in medical plans, Please help our office to assist you by making sure our insurance information is correct therefore reducing cost to you at every visit by presenting your insurance card. Our patient portal, designed for your convenience, gives you the ability to update your address, contact number, insurance information, pharmacy information, emergency contact info and other vital information at any time 24/7. **Log on to our patient portal and have secure access to your medical records from any computer or smart device. Download the Healow app today to any android or apple device and login to get started.**