



## **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](http://IMCFamilyDoctors.com)

### **BRADENTON OFFICE**

6150 State Road 70 E  
Bradenton, FL. 34203  
(P) 941 822-8777  
(F) 941 822-8770  
[IMCFamilyDoctors.com](http://IMCFamilyDoctors.com)



**FAMILY DOCTORS**  
*Always here. Always available.*



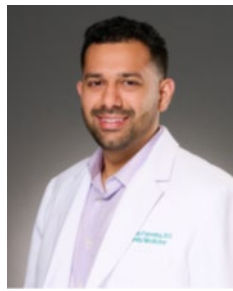
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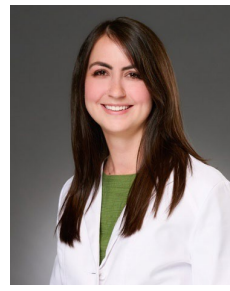
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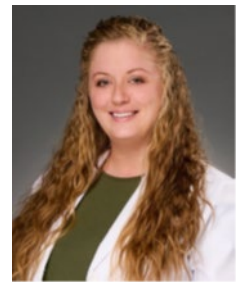
**Michelle DiBetta, MD**  
Bradenton



**Steven Ferreira, DO**  
Bradenton & Manatee



**Melissa Beljan, DO**  
Manatee



**Kayla J Weiner, ARNP-C**  
Bradenton

**Proudly Accepting:**

**Humana®**



# 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.

## **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!**

**Please bring the following to your first appointment:**

**ALL Prescriptions and**  
**Over the Counter Medication bottles**  
**that you are currently taking.**

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

## Patient Consent

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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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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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:

\_\_\_\_\_

## Prescription Renewal, Patient Conduct, Exam Room Escort & Health Policy

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### 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 threatening, 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: \_\_\_\_\_

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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.



## **YEARLY INSURANCE AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENT**

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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 not billable to your insurance company.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES**

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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: \_\_\_\_\_

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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: \_\_\_\_\_

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

## WRITTEN ACKNOWLEDGEMENT FORM

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

Immediate MedCare & Family Doctors Notice of Privacy Practices.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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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: \_\_\_\_\_

## AUTHORIZATION FOR THE RELEASE OF INFORMATION

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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 Medicare & 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 : \_\_\_\_\_

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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: \_\_\_\_\_

## **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.**

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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Falls	<input type="checkbox"/>	<input type="checkbox"/>	Ostomy	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Overuse	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sexually	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Transmitted Disease		
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	(CHF/CAD)			Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker: _____			Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	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):** \_\_\_\_\_

\_\_\_\_\_

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

FAMILY MEMBER	CIRCLE SEX	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brother(s) / Sister(s)	M    F				
	M    F				
Husband / Wife	M    F				
	M    F				
Son(s) / Daughter(s)	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	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

## 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.

<u>Preventative Service</u>	<u>NO</u>	<u>YES</u>	<u>Month/Year Testing Performed</u>	<u>Findings &amp; Recommendations</u>
<u>Bone Mass Measurement</u> (Bone Density)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<u>Bloodwork</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<u>Colorectal Cancer Screening</u>				
Colonoscopy – NOT High Risk	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Fecal Occult Blood Test (Stool Card)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<u>Vision Screening</u>				
Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<u>Female Screening</u>				
PAP & Pelvic Examination	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<u>Male Screening</u>				
PSA – Prostate Specific Antigen (Blood Test)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

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**FOR PHYSICIAN USE**

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\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date Reviewed



**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: \_\_\_\_\_

**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

## 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?	<input type="checkbox"/> Not difficult at all	<input type="checkbox"/> Very difficult
	<input type="checkbox"/> Somewhat difficult	<input type="checkbox"/> 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



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).			<input type="checkbox"/>
Patient educated on what their medication is intended to do and the reason that they are taking it. Potential side effects discussed.			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

1170F

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

Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Transferring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Using the toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**Treatment plan discussed with patient**

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

1157F OR 1158F

**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

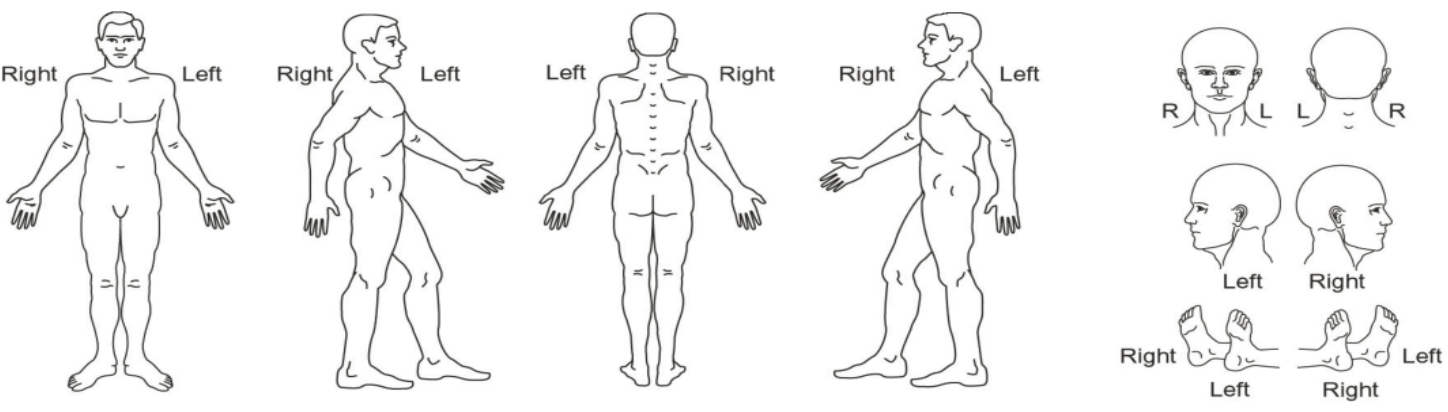
Patient participates in activity regularly  Yes  No    If so, what type? \_\_\_\_\_

**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:** \_\_\_\_\_

**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	_____
<b>*****STAFF ONLY BELOW THIS FOR MINI NUTRITIONAL ASSESSMENT*****</b>		
F1. Body Mass Index (BMI)      (weight in kg / height in M <sup>2</sup> ) 0 = BMI less than 19 1 = BMI 19 - less than 21 2 = BMI 21 - less than 23 3 = BMI 23 or greater	<b>*If BMI is not available, replace question F1 with F2. Do not answer question F2 if question F1 is already completed.</b>	_____
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 threatening, 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

# 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.

## OFFICE

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*Bradenton, Fl. 34203*

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## SERVICES

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IMMUNIZATIONS  
TELEMEDICINE  
PREVENTATIVE CARE  
DISEASE MANAGEMENT  
SKIN CANCER SCREENING  
LAB WORK  
DIABETIC CARE  
TRIGGER & JOINT INJECTIONS  
& MORE!

## INSURANCE

HUMANA MEDICARE ADVANTAGE,  
ORIGINAL MEDICARE, &  
MEDICARE SUPPLEMENTS

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We are accepting new patients.*

## WHY VALUE-BASED CARE

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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# 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.

## OFFICES

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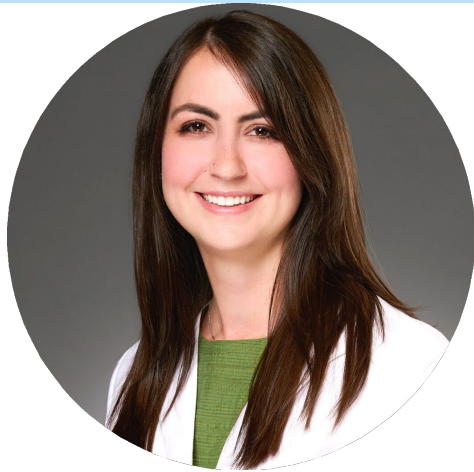
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# MELISSA BELJAN, DO



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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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# KAYLA WEINER, APRN-C



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## ABOUT ME

Kayla Weiner, APRN-C is a board-certified and licensed family nurse practitioner specializing in primary care. She received her graduate degree in nursing from the University of South Florida.

In 2016 while working at Tampa General Hospital, she received the National Daisy Award for Extraordinary Nurses. She is a member of the American Academy of Nurse Practitioners and Sigma Theta Tau, the Honors Society of Nursing.

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# 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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Michelle DiBetta, M.D.



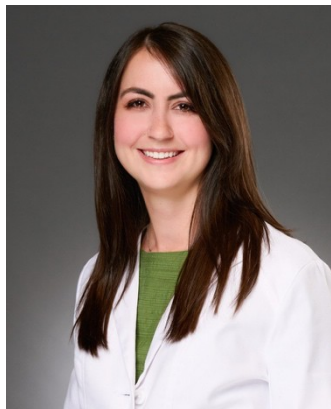
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Kayla Weiner, APRN-C



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Comprehensive Primary Care

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- Geriatric Care
- Preventative Care
- Telemedicine
- Routine Physical Exams
- Immunizations
- Well Woman Exams
- Disease Management Care
- Patient Education
- Joint Injections
- OMT Procedures
- PRP Therapy
- Physical Therapy
- Home Visits\*
- Post-Surgical Care
- Cardiac/Pulmonary Care
- Wound Care Management
- Infusion Therapy
- Ostomy Care
- Catheter Care
- Blood Pressure Monitoring
- Diabetic Teaching & Care
- Chronic Joint Pain
- Osteoporosis
- Mobility Issues
- Post-Joint Surgery
- & More!



Our patients' physical and emotional well being is extremely important to us. Whether recovering from an injury, illness or facing the challenges of aging in your home environment, Immediate MedCare and Family Doctors are *always here, and always available*. We frequently add and update our list of services for our patients, to give them the truly best care possible.

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## WHY CHOOSE A VALUE-BASED CARE PRACTICE

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\*\* If necessary, determined by provider.