Barbara A. Lubin, MD LLC 1124 Jenks Ave, Panama City, FL 32401
Phone (850)785-8246 **Fax** (850)785-8249 **www.lubinMD.com**

Dear new patients,

Welcome to the practice of Barbara A. Lubin, MD. We are very pleased that you have chosen us to be your primary care provider. We are looking forward to take care of all your medical needs. Your health and well-being are very important to us. Please feel free to give us your suggestions and concerns about our services to help us improve our care.

What to Expect

We treat our patients with honesty, courtesy, politeness and respect. Dr. Barbara Lubin provides our patients with the knowledge that they need to make educated decisions regarding their medical needs. We will perform a very thorough evaluation of your condition and medical history. Please schedule enough time for your first visit in order for us to provide the best and most complete care. Our patients are encouraged to ask questions.

Our practice believes in staying current with the latest technology, which in turn helps us to take better care of you. We use a state-of-the-art Electronic Health Records (EHR). We also offer a Patient Portal for electronic communication with our physician and staff.

All payments, co-pays, deductibles and fees are due at the time of service. Please check your insurance coverage and benefits prior to your appointment.

Any cancellations, rescheduled or missed appointments with less than a 24 hour notice, will be assessed a $100.00 fee.

What to Bring to the First Visit

- ✓ Driver's License/ID
- ✓ Insurance card
- ✓ Bottles of all medications/supplements that you currently take
- ✓ It is helpful to bring any previous medical records (labs, tests, office notes)
- ✓ Completed New Patient package (forms can be emailed to you, download from our website or picked up in our practice prior to your visit.)

Thank you for choosing our practice and allowing us to be your healthcare professionals. We look forward to being of service and helping you reach your greatest health potential.

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PATIENT INFORMATION
(Please print)

First and Last Name:_____
Date of Birth:_____ **SSN #** _____
Gender: Male Female **Ethnicity:** Hispanic Non-Hispanic Other **Race:**_____
Mailing Address: _____
City, State, Zip _____
Home Phone # _____ Cell Phone #_____
Email Address_____
Place of Employment _____Work Phone # _____
Full Time_____ Part Time_____ Retired _____ Student_____

Marital Status: Single ____Married ____Divorced ___Widowed ___ Separated____
Spouse's Name:_____ Spouse's Ph. #_____

Emergency Contact Info:
Name:_____ Phone# _____Relationship:_____

Pharmacy and Location: _____

INSURANCE INFORMATION

Primary:
Insurance Company:_____ Policy # _____
Group # _____ **Co-Pay:** _____
Name of Primary Subscriber: _____ Relationship to Patient: _____
Subscriber's D.O.B. _____ Subscriber's SSN _____

Secondary:
Insurance Company:_____ Policy # _____
Group # _____ **Co-Pay:** _____
Name of Primary Subscriber: _____ Relationship to Patient: _____
Subscriber's D.O.B. _____ Subscriber's SSN _____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT AND RELEASE:
I hereby authorize my insurance benefits to be paid directly to Barbara A. Lubin MD and I am financially responsible for any non-covered services as well as any collection fees if my account were to become delinquent. I further understand that Dr. Barbara Lubin's office files my insurance as a courtesy and any balance that remains unpaid by the insurance company over 60 days in effect is my responsibility. I also authorize Barbara A. Lubin, MD to release any information required either medical care or in processing applications for financial benefit of my insurance claims.

Signature _____ Date _____

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PATIENT'S HISTORY

Name: _____Date of Birth_____

List of Allergies: _____

Medication/Supplements: _____

PLEASE BRING ALL OF YOUR MEDICATION/SUPPLEMENT **BOTTLES** TO EVERY VISIT!

Vaccinations (circle all vaccinations you have done and year when you have it done)
Flu_____Shingles_____Pneumococcal_____Tetanus_____HPV_____
Other _____

Date of last Colonoscopy_____ Fecal Occult_____ Bone Density_____ Mammogram _____PSA_____ Pap/Pelvic_____ Breast Exam _____
Prostate Exam _____

Major Operations: _____
List of your medical problems:
_____

Female Patients only:
Number of Pregnancies _____Number of Births _____Birth Control Method:_____
Hysterectomy NO ____ YES____
Do you have a history of urinary incontinence YES_____ NO_____

If Diabetic, Last: Hgb A1C_____ Eye Exam _____ Foot Exam _____
Urine Microalbumin _____
Have you had Diabetes Education? _____ When? _____

Social History
Do you smoke?
Never____ Quit ____Quit Date: _____Yes____ How many packs per day?____
Do you Drink Alcohol? Yes____ No____ How many? _____
Do you have Children? Yes____ No_____ Children's ages? _____
Do you work? Yes____ No___ If yes, Occupation? _____
Do you exercise regularly? Yes___ No___ If yes, How often?_____
Are you sexually active? Yes____ No____ Birth control method _____

_____ _____
Patient Signature Date

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

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PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

_____

_____

_____

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

ANNUAL CARE CHECK LIST:

WELLNESS	DATE COMPLETED	WELLNESS	DATE COMPLETED
Dental Exam		Blood pressure check	
Hearing Exam		Height, weight, BMI	
Eye Exam		Hemoglobin A1C	
Head-to-toe Exam		LDL Cholesterol	

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CONTROLLED SUBSTANCE AGREEMENT

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications, I agree to the following by initialing each line;

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.
_____2.) Refills of controlled substance medications;
_____a) Will be made only during regular office hours *Monday through Thursday, in person, once a month, and during a scheduled office visit.* Refills will not be made at weekends, or during holidays.
_____b)Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.
_____c)I understand that I must call ahead **within 72 hours to schedule an appointment**.
_____3.) It may be deemed necessary by my doctor that I see a medication-use specialist (pain management, Psychiatrist, etc.) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.
_____4.) I agree to comply with urine testing and pill counts at every appointment, thereby, documenting the proper use of any medications.
_____5.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.
_____6.) I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.
_____7.) I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.
_____8.) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

Patient Signature: _____Date: _____
Physician Signature: _____Date: _____

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CONTROLLED SUBSTANCE AGREEMENT

Due to the law signed by Governor Rick Scott, HB 7095, concerning controlled substances, we at Barbara A. Lubin, MD LLC, will be instituting the following policies effective immediately.
All schedule 2, 3, and 4 medications* will be written for only one month at a time. **Every month, I will be seen in the office for prescription refill.**

*This includes the following:
- All forms of hydrocodone – (vicodin, Lorcet, Lortab)
- Most muscle relaxers- (valium, soma, Etc.)
- Most sleeping agents- Ambien (Zolpidem), Lunesta,.
- All Benzodiazepines- Klonopin (clonazepam), Restoril (temazepam), Serax (oxazepam), Xanax (Alprazolam)
- Codeine Preparations (Tylenol # 3, Tussionex)
- Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)

2.) I understand that THERE WILL BE NO REPLACEMENT PRESCRIPTIONS GIVEN WITHOUT A POLICE REPORT.
3.) I understand that I must bring all medication bottles and/or pills to every appointment for pill count verification.

We do not prescribe following medication:
- Concerta
- Ritalin (methylphenidate- any brand)
- Adderall
- Dextroamphetamine
- Vyvanse

We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature _____ Date _____

Barbara A. Lubin, MD_____ Date _____

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FINANCIAL POLICY

Welcome to Barbara A. Lubin MD practice. We are committed to providing the best possible health care experience to you and your family. Understanding your financial responsibility is an essential element of your medical care and treatment.

INSURED PATIENTS: Our office policy is to collect the patient's responsibility for medical care provided at the time of service. Our biller is here to help answer any questions you may have regarding your balances and payments. It is important to understand that your health insurance policy is a contract between you, your employer, and your insurance carrier. It is your responsibility to know what your policy benefits cover. We will collect your co-pay/ deductible or % at the time of service and file your visit to your insurance company. Deductible amounts are based on an ESTIMATE of your contracted rate. After your claim has been processed, you will receive a statement for any difference your insurance company applies to your responsibility. In the event your health plan determines a service is "not covered" you will be responsible for the balance upon receipt of a statement from our office.

UNINSURED/ SELF–PAY PATIENTS: We understand that not all of our patients have health insurance coverage. Our office policy for self-pay patients is very simple. All fees are due at the time of service at check-out. If you need to make payment arrangements, please contact our biller prior to your visit. We utilize the same or lower Medicare fee schedule fees for uninsured individuals. Please note that the charges may vary based upon the complexity of your condition (i.e. level of service received) and other factors related to practicing medicine.

PLEASE INTIAL EACH LINE:

--------- OUR OFFICE POLICY IS TO COLLECT THE PATIENT'S RESPONSIBILITY FOR MEDICAL CARE PROVIDED AT THE TIME OF SERVICE.

-------PLEASE BE AWARE, IF THE PHYSICIAN ORDERS A BLOOD WORK OR ANY TEST, YOU WILL ALSO RECEIVE A SEPARATE BILL FROM DIAGNOSTIC FACILITY FOR TEST CHARGES.

--------IN THE EVENT AN ACCOUNT IS TURNED OVER FOR COLLECTIONS PATIENT WILL BE RESPONSIBLE FOR ACCOUNT BALANCE + ALL COLLECTION FEES.

------- RETURNED CHECK FEE IS **$35.00**.

_____ANY CANCELLATIONS, RESCHEDULED OR MISSED APPOINTMENTS WITH LESS THAN A 24HOURS NOTICE, WILL BE ASSESSED A **$100.00 FEE**.

------I have read and understand Barbara A. Lubin, MD LLC PRACTICE financial policy, and I agree to be bound by its terms.

PATIENT SIGNATURE:_____ Date: _____

RESPONSIBLE PARTY OF A MINOR SIGNATURE _____

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PATIENT CONTACT INFORMATION

It is our primary goal and responsibility to protect your personal health information. Because of the new federal privacy regulations (HIPAA), we are taking extra steps to make sure that we are carrying out your wishes.

A situation could arise where you might want us to share information about you with a family member or friend, without us being able to verify that request with you at that time. Please take this opportunity to designate such a person in the event such a circumstance should arise.

At any time, you may cancel the person(s) listed below:

1. Name:_____ Relationship_____Phone_____
2. Name:_____ Relationship_____Phone_____
3. Name:_____ Relationship_____Phone_____
4. Name:_____ Relationship_____Phone_____

_____ _____

Patient Signature Date:

==========

Request to cancel/modify contact person(s) as listed above:

1. Name:_____ Relationship_____
2. Name:_____ Relationship _____
3. Name:_____ Relationship _____
4. Name:_____ Relationship _____

_____ _____

Patient Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: _____ Date of Birth:_____

Address:_____

Facility Name: Barbara A. Lubin, MD LLC

I have been given a copy of Dr. Barbara A. Lubin's Notice *of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Barbara A. Lubin, MD LLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Manager.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Patient Signature Date

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgment:*

   _____

   _____

   Completed by:

   _____ _____

   Signature of Facility Representative Date

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Consent to Obtain External Prescription History

E-Prescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The e-Prescribe Program also includes:

• Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or need a refill.

• Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by your health care provider at Barbara A. Lubin, MD LLC as well as other health care providers involved in your care.

I, _____, whose signature appears below, authorize Barbara A. Lubin, MD practice and staff to view my external prescription history via the SureScripts service.

I understand my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by Barbara A. Lubin, MD practice and staff, and the information may include prescriptions I had filled over the past several years.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THIS CONSENT AND THAT I AUTHORIZE THE ACCESS

_____ _____

Signature of Patient or Guardian Today's Date

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing.

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:

Full Name: _____ Date of Birth: _____

Other Name(s) Used: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Release my medical records to Barbara A. Lubin, MD LLC

Address: 1124 Jenks Ave, Panama City, FL 32401

Phone: (850) 785-8246 Fax: (850)785-8249 Email: practice@lubinmd.com

Release my medical records from (PROVIDER NAME/PHONE# AND FAX#)

_____

_____

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ 2 Years, including patient histories, office notes, test results, radiology studies, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)

□ Treatment/Continuing Medical Care

□ Personal Use

□ Billing or Claims

□ Insurance

□ Legal Purposes

□ Other (Specify): _____

PATIENTS RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Barbara A. Lubin, MD office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in **one year** from the date signed.

I understand that authorizing the disclosure of this health information voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized disclosure and the information may not be protected by federal confidentially rules.

_____ _____

Signature of Patient or Legal Representative Date