As a Reminder:

For ALL your upcoming appointments please bring the following:

- ☐ ***New Pt paperwork *filled out***
- ☐ ***Insurance *cards*in hand***
- ☐ ***Photo I.D***
- ☐ ***Prescription drug card***
- ☐ ***List of medications with dosage***
- ☐ ***List of surgeries***
- ☐ ***Authorization/PCP script***

IF applicable

We require all of the listed items at the time of appointment or we may need to reschedule.

If you need to cancel or reschedule please be sure to call our office at a timely manner during our business hours at (813) 876-9191.

If there are any records that you need to have sent to us please contact the provider and have them send us the records at our fax (813) 876-3103.

Thank you,
Dr.Hanan and Staff

Morris R. Hanan, MD, P.A.

Please Complete Entire Form

Name_____DOB___/___/___Today's Date__/__/__

Marital Status: Single____ Married____ Divorced____ Widowed____

Email Address: _____

Primary Care Doctor _____

Chief Complaint(s) _____

Medical History_____

Allergies_____

Surgical History_____

Hospitalizations_____

Family History: Please Check All That Apply. For Status: A=Alive, D-Deceased, U-Unknown

Member	Status	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Father								
Mother								
Siblings								
Children								

Health Care Surrogate yes or no if yes, Name _____

Advance Directive yes or no

How Many Siblings Do You Have

Males _____ A=Alive, D=Deceased _____ Females _____ A=Alive, D=Deceased _____

How Many Children Do You Have

Males _____ A=Alive, D=Deceased _____Females _____ A=Alive, D=Deceased _____

Social History:

	Never	Former	Current	Frequency	How Many Per Day
Smoking Status					
Caffeine Use					
Alcohol Use					
Exercise					

If You Have Quit Smoking How Long Has It Been (approximately)_____

Your Caffeine Use is it: Coffee _____Tea _____Soda_____

Pharmacy (Name and Phone Number_____

Morris R. Hanan, M.D., P.A.
Gastroenterology
508 S. Habana Ave Suite 260
Tampa, Florida 33609
(813) 876-9191 Office / 813-876-3103 Fax

Please Print

First Name _____ Last Name _____

Social Security # _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Employed By _____

Occupation _____ Work Phone # _____

Nearest Relative Not Living With You _____

Address _____ Phone # _____

Insurance Information

Insurance Name _____

ID # _____ Group # _____

Name of Insured _____ SS# _____

DOB _____ Employed By _____

Please Present Insurance Cards and Driver's License to Be Copied for Your Chart

I authorize the release of any and all medical information to my insurance company which pertains to the treatment and/or diagnosis rendered to me by Dr. Hanan. This authorization also extends to any past present and/or future medical treatment provided to me by Dr. Hanan.

Please understand that insurance is considered a method of reimbursing the doctor. Some companies pay fixed allowances for certain procedures while other pay a percentage of the charge. It is your responsibility to pay the deductible, coinsurance or any service not covered by your insurance. I hereby authorize payment of medical benefits to be made directly to Dr. Hanan for his Services.

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE

Date _____ Signature _____

MORRIS HANAN, M.D.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a message on your mobile voice/text mail.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information _____

  _____

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print): _____

_____ _____ _____

Signature | Print name of person signing if other than patient | Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP _____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____ Date: _____

E-PRESCRIBING CONSENT FORM

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing **Morris R. Hanan, M.D.PA** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **Morris R. Hanan, M.D. PA** to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____ Patient DOB _____

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____

RX LIST

Name _____ DOB _____

Date _____

_____ Dosage: _____

_____ Dosage. _____

_____ Dosage: _____

_____ Dosage. _____

_____ Dosage: _____

_____ Dosage. _____

_____ Dosage. _____

_____ Dosage: _____

_____ Dosage. _____

_____ Dosage. _____

_____ Dosage _____

_____ Dosage. _____

NAME. _____

TODAY'S DATE. _____

Allergies to medications

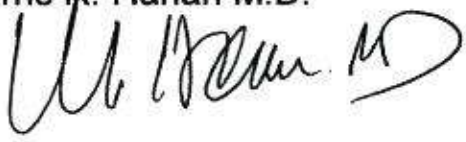
Cancellation and No Show Policy

Thank you for selecting me as you medical care provider. You are a valued patient at our office. As you are aware, I am dedicated to treatment of the whole patient not just the illness. When we schedule appointments. We set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within 24 hours of the scheduled visit to avoid a missed appointment fee of $20.00. This courtesy allows my office staff to schedule another patient who is also in need of medical care. Again, I am committed to providing you with the best care possible and to answering any questions you may have regarding your health and well-being.

Thank you

Morris R. Hanan M.D.



_____

Patient Signature