1939 Highland Oaks Blvd

Lutz, Florida 33559

2508 W. Virginia Ave; ST. B

Tampa, Florida 33607

WECOME MESSAGE FROM STAFF AND YOUR DOCTOR

Dear Clients:

Here are some useful hints for accessing care in general, healthy habits & tidbits.

Office hours are 9:00 to 5:00 Monday-Friday, lunch 12:30-2:00. For true medical emergencies we can be reached at ***813-948-1234*** at all times.

We provide courtesy blood pressure check at a reasonable frequency on certain schedule. Dr. Kankotia has privileges to provide care personally by him at ***an area hospital***. We encourage you to use appropriate hospitals for your illness. Dr. Kankotia can provide care at a certain hospital or refer to a provider who works with him closely, if we are kept in the loop before visiting the hospital.

As the saying goes, an ounce of prevention is worth a pound of cure. We encourage yearly physicals and many insurance companies provide coverage to make it easy.

Appropriate vaccinations are highly recommended.

In general, high body mass index (overweight or obesity) have high incidences of health problems like high blood pressure, diabetes, arthritis, back pain, stomach acid reflux, sleep disorders, feet and leg swelling, breathing difficulties and many more. A low salt, low fat, reduced calorie diet and exercise help to promote good health.

If you have chronic medical conditions like high blood pressure, high cholesterol, diabetes, stroke, heart attack, angina or renal failure the chances of getting into serious medical trouble is high. In these situations you should visit your doctor regularly, every 2-4 months depending on the doctor's recommendation, even if you don't have any symptoms.

We encourage you bring all medications with you for your office visit for mutual review, to avoid errors and confusion.

Smoking, tobacco use, injudicious alcohol intake, mental health problems and sedentary life style increase chances of serious physical health. We encourage you to discuss these issues with the doctor.

If there is a family history of heart disease, stroke, diabetes or cancer, please discuss this with the doctor so that appropriate screening tests can be conducted. Generally PSA and other blood tests for cancer screening are not helpful to detect any new cancer.

Cold, bronchitis and upper respiratory infections are generally not helped from antibiotic use, unless symptoms are persistent for more than a reasonable time or there is a complication from viral infection. Unnecessary antibiotics use is at times harmful and creates an additional risk for difficult to cure future infections for you, family and the community.

Telephonic diagnoses are not accurate many times; we encourage a personal visit even though you were helped via Tele Medicine visits. A personal follow up visit is recommended after any test is done to discuss results and future course of action.

To avoid unusual life prolongation with mechanical support in case of terminal illnesses or brain death situation, we encourage you to discuss end of life care within the family and with your doctor. Living Will forms are available at our office and does not require complex legal input.

We will honor any constructive criticism; please do not hesitate to discuss it with us.

We appreciate your business and thank you for your personal recommendation to family and friends.

Office staff, Dr.Kankotia and Tampa Bay Internal Medicine Inc.

JERAM T. KANKOTIA, M.D.

1939 HIGHLAND OAKS BLVD.

LUTZ, FLORIDA 33559

PHONE (813) 948-1234 * FAX (813) 949-8408

Patient Name: _____

Date of Birth: _____Medicare ID/Insurance ID_____

Current address: _____

E Mail address:_____ Telephone: (H)_____(Mobile)_____

Emergency Contact: _____ Phone: _____

Address: _____

Relationship: _____

Insurance: _____

Pharmacy Name:_____Telephone: _____

PLEASE GIVE CARD TO RECEPTIONIST FOR COPYING

Please initial: _____ Up to date living will.

Please initial if no change: _____ No change in advance directive.

MEDICAL RECORDS RELEASE AUTHORIZATION

By my signature I authorize any holder of medical information about me to release this information to my primary care physician or any other physician, in order that I may be provided with continuity of care. Including HIV and psychiatric records.

Furthermore, I understand my signature request that payment be made to the physician, and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes realizing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Co-insurance and deductable are based upon the charge determination of Medicare. Physician or supplier may assign other insurance payment and may not necessarily accept as full payment the amount paid by the other insurance company.

I understand that I am fully responsible for payment and services provided. I will pay any balance due that insurance does not cover or pay. I will pay all expenses incurred by this office for the collection of my account should it become delinquent. 90 days following the date the services.

I also agree to participate in Synchronus (Live) and Asynchronus(eMail/Photograpgh or data evaluation) Tele-Medicne care via Telephone, Audio/Video provided from this office by my doctor. I understand pitfalls of Telehealth and face to face visit may be required for more accurate care.

Signature _____ Date _____

JERAM KANKOTIA, M. D. / TBIM INC

1939 Highland Oaks Blvd
Lutz, FL. 33559

2508 W. Virginia Ave, St. B
Tampa, FL. 33607

Phone: 813-948-1234

Name: _____ DOB: _____

Allergies: _____

Is English your primary language: ( ) Yes ( ) No if not which one? _____

Please answer all questions, thank you.

Purpose of today's visit: _____

Fever	Y N	Tingling	Y N	Abdominal Pain	Y N
Sweats	Y N	Numbness	Y N	Nausea/Vomiting	Y N
Excess Fatigue	Y N	Pass Out Spells	Y N	Diarrhea	Y N
Joint Pain	Y N	Chest Pain	Y N	Eye/Ear Problems	Y N
Muscle Pain	Y N	Shortness of Breath	Y N	Urinary Problems	Y N
Skin Rashes	Y N	Feet Swelling	Y N	Weight Gain/Loss	Y N
Sexual Problems	Y N	Cough	Y N	Passing Blood	Y N
Depression/Blues	Y N	Blood in Phlegm	Y N	Walking Problem	Y N
Menstrual irregularities (if applicable)	Y N	Weight gain/loss in last 1 year	Y N	Fall/major injury	Y N

How often do you exercise in a week? _____
Do you experience any difficulty with exercise? _____
Did you or do you smoke? Y N How long? How much? Until when? _____
Did you or do you drink more than 2 alcohol/beer drinks a day? _____
Did you or do you do street drugs? _____
Do you wear seat belts while driving? _____
Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widow
Do you live alone/with a friend/family/or in an ACLF? _____
Do you have other family in the area? _____
Have you made a Living Will? ( ) Yes ( ) No; Do you want to make one? ( ) Yes ( ) No _____
Are you sexually active? ( ) Yes ( ) No; If so; ( ) Hetero, ( ) Homo, ( ) Bisexual?
Your occupation during the majority of your life and now? _____
Foreign stay in last 10 years _____
Your vaccination status: ( ) TETANUS ( ) INFLUENZA ( ) PNEUMONIA others _____
Have you donated or received any blood in your lifetime? _____
Last labs completed : _____Rectal Exam _____Pap Smear____(N/A)Mammogram_____(N/A)
Have you ever had inpatient / outpatient surgery? _____
Have you had any biopsies in the past? _____
Have you had any listed tests in the past 10 Years: Y/N MRI CT SCAN Bone density Stress test or Heart Catheterization

Medical Illness Suffered P & FMHX

	YOU	MOM	DAD	MGM	MGF	PGM	PGF
Diabetes / Thyroid / Cholesterol							
High BP / Heart Disease							
Cancer							
Stroke / Epilepsy / Alzheimer's Disease/MS							
Asthma / Emphysema/COPD / TB							
Hepatitis / Cirrhosis / Gall Bladder Problems							
Stomach Ulcer / Colitis / Rectal bleeding							
Arthritis/Lupus/Rheumatoid/Spine Disease							
Major Trauma/Hernia							
Kidney Disease/Dialysis							
Depression /Anxiety/ Mental Illness							

TAMPA BAY INTERNAL MEDICINE, INC.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Jeram T. Kankotia, M. D.

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Tampa, Florida 33607

Phone: (813) 948-1234

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ DOB _____

Signature _____

Date _____

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, c1inical 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 Heaith 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.

Consent to Share My Health Information With the BayCare Electronic HealthExchange

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: _____

Living Will

Declaration made this_____ day of _____202___, I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_____ I have a terminal condition.
or _____ I have an end stage condition.
or _____ I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to **designate**, as my **surrogate** to carry out the provisions of this declaration:

Name _____
Address _____
City _____ State _____Zip _____
P hone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

(Signed): _____

Witness _____
Street Address _____
City, State & Zip _____
Prone _____

Witness _____
Street Address _____
City, State & Zip _____
Prone _____

The principal's failure to designate a surrogate shall not invalidate the living will.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —
Alternative form may be used in lieu of suggested form here.