DR. GOLD'S
OPTIMAL LIVING INSTITUTE
Board Certified in Family & Holistic Medicine

2901 W Busch Blvd, Suite 604
Tampa, FL 33618
www.dgoli.com / 813-379-7092

Intake Form

Please print neatly and complete accurately, so we can fully serve you.☺

Name: _____ Date of Birth: _____ Age:_____

Address: _____ Gender : ☐F / ☐M / ☐Other: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Work #: _____ Home #:_____

Preferred method of contact: ☐Cell ☐Work ☐Home

E-mail:_____

May we leave a confidential Message? ☐Yes ☐No

Drivers License #: _____ SS#: _____ - _____ - _____

Marital Status: ☐Married ☐Single ☐Partnered ☐Divorced ☐Widowed ☐Separated

Emergency Contact: _____ Phone: _____ Relationship: _____

Who can we thank for having you come here?

_____

How did you find us?

☐ Google ☐ dgoli.com ☐Other Online: _____

What brings you to our office today? Please list all reasons:

_____

_____

Patient Name: _____

Social and Wellness History

Who do you live with (include all family members, friends, pets, aliens, etc & ages)☺:

_____

What do you do for a living? _____
Employed by (if applicable) _____

Do you enjoy what you do? ☐ Yes ☐ No
Please explain: _____

Spouse/Partner Name (if not above) _____Phone _____

Do you currently or have you ever used any Tobacco Products? ☐ Yes ☐ No If yes, explain?

_____

Do you currently or have you ever used any alcohol? ☐ Yes ☐ No If yes, explain?

_____

Do you currently or have you ever used any drugs including marijuana? ☐ Yes ☐ No If yes, explain?

_____

Personal Safety

Do you feel safe at home? ☐ Yes ☐ No If no, explain?

_____

List all Activities you do (include when, where, how long, intensity, enjoyment, and if compete) or ☐ Not Active

_____

List all healthy items you consume, including beverages (include where, when, amount). If numerous healthy items, include the most common or ☐ I do not consume healthy items

_____

Sleep

What time do you go to sleep?
What time do you wake up?

Do you feel well rested when you wake up? ☐ Yes ☐ No
If no, explain?

Patient Name: _____

Medical History

List all medical conditions with which you have been diagnosed (include date of diagnosis, location, and by whom), or ☐ No medical conditions.

_____

List all allergies (include when and how diagnosed, and reactions) or ☐ No allergies

_____

List all meds & supplements (include frequency, strength, and length of use) or ☐ No meds ☐ No supplements

_____

List all surgeries (Include when, where and by whom) or ☐ No surgeries

_____

List all hospitalizations (Include when, where and why) or ☐ No hospitalizations

_____

List all Family illnesses (include relationship, illness, age/date diagnosed, if died age/date & reason) or ☐ Adopted ☐ No Family illnesses ☐ Unknown

_____

List any concerns with any parts of your body (include area, reason for concern, when began, evaluation & who is managing this) or ☐ No concerns with any body parts

_____

Patient Name: _____

Vaccinations

Please obtain a copy of your vaccination records or ☐ I do not get any or certain vaccinations. Please explain _____

☐ I am aware of the CDC guidelines & possible risks of not obtaining vaccinations

_____ (Please Initial)

Last Exams (include when, where & who performed, any findings):

Physical_____

Dentist_____

Eye_____

Skin_____

Colonoscopy (if applicable)_____

Mammogram (if applicable)_____

Other, Explain_____

Last Labs and Tests (include name, when, where, why done, who ordered, & any findings). Please bring a copy of the results with you to your appointment; do not fax or email.

_____

If seeing a specialist not listed above (include name, location, last visit, why seeing, contact #)

_____

Any other pertinent information?

_____

**Please note if you were a patient of Dr. Gold's at Florida Wellness and Rehab or HealthPoint, she does not have access to those records unless you fill out a medical records request form.

Patient Name: _____

Women only

Number of pregnancies # Deliveries_____ # Miscarriages_____

Currently Pregnant ☐ Yes / ☐ No Breastfeeding ☐ Yes / ☐ No

Method of birth control_____ Date of last menstrual period_____

Date last pap smear _____ Any abnormal pap smears? ☐ Yes / ☐ No

If yes, when & who is treating? _____

Menopausal since_____

Acknowledgement and Signature

Are you interested in learning about our Weight management program? ☐ Yes / ☐ No

Are you interested in learning about Increasing your energy? ☐ Yes / ☐ No

Are you interested in learning about our Stress relief program? ☐ Yes / ☐ No

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I further understand that I will receive a superbill which I can submit to my insurance for reimbursement. Reimbursements are determined by the insurance company and Dr. Gold's Optimal Living Institute makes no claims regarding any reimbursements or authorized services.

Patient Signature_____ Date: _____

Printed Name: _____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services - www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

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HIPAA Information and Consent Form (continued)

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____on _____ (date) do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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CANCELLATION POLICY AND PAYMENT AUTHORIZATION

Our schedule is usually booked several weeks in advance. This makes it difficult for patients to make appointments on short notice. We try to accommodate everyone the best we can.

CANCELLATION POLICY

Please note that if you fail to notify the office of an appointment cancellation 24 hours prior to that appointment, you will be charged a $50 fee for that appointment. We ask that you leave a credit card number to hold your appointment. In the event that you do not show or cancel an appointment in less than 24 hours from the time of the appointment, we will charge the fee to the card. **Please sign below to let us know that you have read and understand our cancellation policy.**

Accepted and Acknowledged:

_____	_____	_____
Print Patient Name	Signature	Date

I understand the above text and agree to comply.

_____		
Credit Card Number	Exp. Date	PIN

_____	
Name of Card Holder	Type of Card

Print name of patient

Signature of patient Date

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INFORMED CONSENT

In consideration of your undertaking to treatment, I agree to the following:

CONSENT TO TREAT: I request and give consent to Tanya Gold, MD, and Dr. Gold's Optimal Living Institute, to provide and perform medical/surgical treatments, tests, procedures, medications and other services and supplies as are considered necessary or beneficial for my health and well-being. I understand that if Tanya Gold, MD, is not my primary care physician that she is only responsible for treating medical conditions associated with my reason for seeking treatment with her. I further acknowledge that if Tanya Gold, MD is my primary care physician, that she only provides select medical services as disclosed in her form Select Primary Care Services and that another provider should perform all other routine medical screening and immunizations not performed by Tanya Gold, MD (e.g. EKGs, PAP smears). I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL: _____

MEDICARE CERTIFICATION: I acknowledge that Dr. Gold's Optimal Living Institute is a par provider with Medicare, but provides non-covered services, and will not submit any claims to Medicare on my behalf. I further acknowledge that Dr. Gold's Optimal Living Institute has given me the opportunity to discuss financial arrangements and has provided an Advanced Beneficiary Notification (ABN) for services rendered. I will pay Dr. Gold's Optimal Living Institute out of pocket.

INITIAL: _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. Dr. Gold's Optimal Living Institute will not assist patients in obtaining insurance benefits, but will provide patients with the necessary documentation so that they may submit their own claims to their insurance provider. Dr. Gold's Optimal Living Institute makes no representations about the services provided and whether or not they will be covered by the patient's insurance carrier. I will pay Dr. Gold's Optimal Living Institute out of pocket. In the case of default payment, I promise to pay any legal interest on the balance due, together with collection costs and reasonable attorney fees incurred to effect collection of this account and future outstanding accounts. If I fail to notify the office of a cancellation of an appointment within 24 hours of that appointment, I understand that I will be responsible for the full payment of that appointment

INITIAL: _____

PATIENTS NAME: _____ DATE: _____

PATIENTS SIGNATURE: _____ DATE: _____

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

Doctor's Name & Address:_____

Phone #:_____ Fax #:_____

I authorize the health information to be disclosed to and used by the following individual organization:

Dr. Gold's Optimal Living Institute
2901 W Busch Blvd, Suite 604
Tampa, FL 33618
Telephone 813-379-7092 • Fax 888-479-3526

The type and amount of information to be disclosed is as follows (as applicable):

Last TWO Progress Notes, Complete Vaccination Record, All Laboratory Results, Latest Colonoscopy and EGD with reports, Most recent EKG, Most recent stress test, and Last complete physical. Also include any abnormal EKGs, stress tests, or other abnormal test results.

For women, please include most recent pap smears, mammograms, breast ultrasound, breast MRI, and breast biopsy with diagnosis (if done).

PLEASE DO NOT SEND COMPLETE MEDICAL RECORDS, ONLY SEND WHAT IS REQUESTED.

Other: _____

1. The medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
2. This authorization will expire without my express revocation, 180 days from the date below.
3. My signature on this authorization form is strictly voluntary.
4. My treatment, payment, enrollment or eligibility for benefits may not be conditional on signing this authorization.
5. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation.
6. A copy of this authorization or my signature thereon, may be utilized with the same effectiveness as an original.

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Printed Name of Patient or Authorized Personal Representative Relationship to Patient

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Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Here**'s How Recurring Payments Work**:
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Dr. Gold's Optimal Living Institute to charge my credit card
(full name)

indicated below for $_____ on the _____ of each week / month for payment of my medical bill.
(day or date) (circle one)

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Dr. Gold's Optimal Living Institute in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Dr. Gold's Optimal Living Institute may at its discretion attempt to process the charge again within 30 days, and agree to an additional $50 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.