Anne HERMANN M.D., P.A.
3040 W. Cypress Street, Suite 103 Tampa, Florida 33609
6387 Central Avenue, St. Petersburg, Florida 33710
Phone (813) 902-9559 (727) 278-3992 Fax (813) 315-6611
Contact@DoctorHermann.com

REGISTRATION

PLEASE PRINT

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **Marital Status: M S D W**

City: _____ **State:** _____ **Zip:** _____ **Social Security#:** _____-_____-_____

Home Phone: ( ) _____ **Employer:** _____

Work Phone: ( ) _____ **Ext.**_____ **Occupation:** _____

Cell Phone: ( ) _____ **Student: ( ) Yes ( ) No ( ) Fulltime ( )Part time**

E-Mail Address: _____ **Primary Care Physician:** _____

How did you hear about us: Family/Friend /Dr./ Yellow Pages /
Other: _____ **Primary Care's Phone: ( )** _____

Pharmacy: _____

Pharmacy Phone : ( ) _____

EMERGENCY CONTACT

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Relationship: _____

INFORMATION ON SPOUSE/PARENT

Name: _____

Social Security #: _____

Employer: _____

Occupation: _____

Phone Number: ( ) _____

Date of Birth: _____

INSURANCE INFORMATION

Insurance Carrier: _____

Subscriber: _____

Policy ID#: _____

Group#: _____

SUPPLEMENTAL INURANCE CARRIER Insurance

Carrier: _____

Subscriber: _____

Policy ID#: _____

Group#: _____

□ SELF PAY □ INSURANCE ACU COVERAGE: □ YES □ NO

□ LABCORP □ QUEST □ OTHER **(INTEROFFICE USE ONLY)**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING PURPOSES

I authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to Anne Hermann, MD. I authorize Anne Hermann, MD to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I declare all the information on this form is complete and correct to the best of my knowledge.

I understand that I am financially responsible for any and all balances not covered by my insurance carrier and for any required authorization for service. A copy of this signature is as valid as the original

SIGNATURE: ______________________________ **DATE:** ______________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

Telephone number for messages: ( ) _____

(please check below for consent)

_____ May we leave a message for an appointment reminder?
_____ May we leave a message on your answering machine?
_____ May we leave a message with your spouse/significant other or family member?

Please list whom: _____
_____ May we discuss your medical records with your spouse/significant other or family member?

Please list whom: _____
_____ May we place you on our email list for listings of events, special promotions, and educational opportunities presented by Dr. Hermann?

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

INITIAL PATIENT VISIT

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Patient Name _____Date of Service _____ Age_____

Your reason for coming in today (If you have already written this down, skip this section)_____
_____

PAST MEDICAL HISTORY	CURRENT MEDICATIONS

LIST ANY ALLERGIES TO MEDICATIONS	Please list any SURGICAL PROCEDURES that you have had.

FAMILY HISTORY
Please list any illness that the following relatives have:
Mother
Father
Sister(s)
Brother(s)
Grandparents
Aunts and uncles

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Name _____ Date of Service _____

SOCIAL HISTORY	
Do you smoke?	If so, how many packs per day?
Do you drink alcohol?	If so, how many per day? How often?
Do you drink caffeine?	How often?
What do you do for a living?	
Do you exercise?	

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ Changes in vision
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Difficulty swallowing
- ☐ Mass or lump in neck
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Skin rash
- ☐ Atypical mole or other skin lesion
- ☐ Weakness in legs, arms, hands, or feet
- ☐ Shooting pain in back, legs, arms or neck
- ☐ Muscle soreness
- ☐ Gum bleeding?
- ☐ Difficultly urinating?
- ☐ Difficulty sleeping?
- ☐ Depression, anxiety or memory loss
- ☐ Decreased libido?
- ☐ Women only: Please list date of last Pap smear and mammogram
  - ☐Vaginal dryness ☐ Hot Flashes
  - ☐Irregular periods ☐ Breast lumps or tenderness
  - ☐Painful periods

Please describe any other complaints not covered in the list:

_____

_____

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Massage Therapy Consent Form

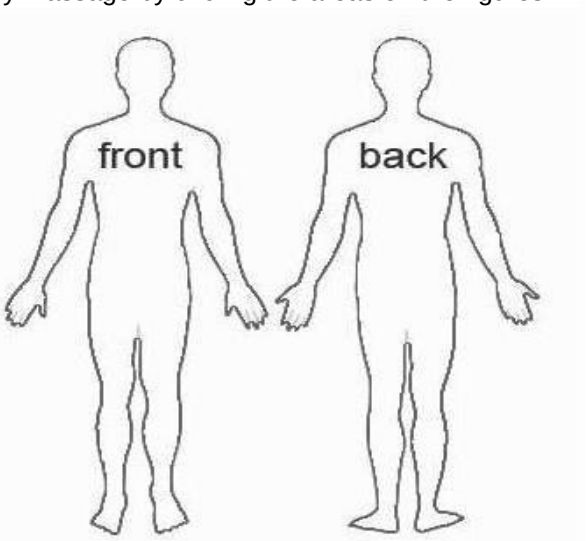
Have you ever experienced a professional massage? _____
Which areas would you like to focus on during this massage? _____
Do you have any of the following conditions? If yes, please explain below as clearly as possible.

_____ **Allergies**	_____ **Arthritis**	_____ **Back pain**	_____ **Bruise easily**
_____ **Cancer**	_____ **Cardiac/circulatory problems**	_____ **Contagious disease**	_____ **Depression**
_____ **Diabetes**	_____ **Epilepsy or seizures**	_____ **Frequent headaches**	_____ **Joint swelling**
_____ **Osteoporosis**	_____ **Pregnant**	_____ **Sensitive to touch or pressure**	
_____**Stress**	_____ **Varicose veins**	_____ **Wear contact lenses**	

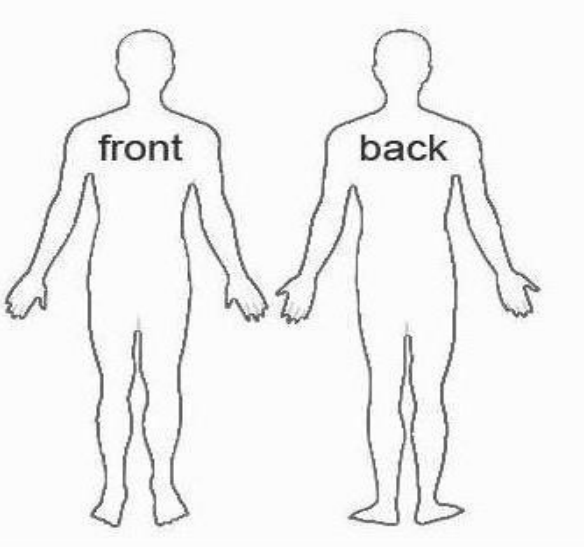
_____ Numbness or stabbing pains?
_____ High blood pressure. If yes, are you taking medication for this? Explain below.
_____ Surgery in the past five years? Explain below.
_____ Accident or suffered any injuries in the past 2 years? Broken bones, etc. Explain below.
_____ Other medical conditions not listed. Explain below.

Comments:_____
_____
_____

Please indicate the areas you do not want included in my massage by circling the areas on the figures



Please indicate the areas of pain, tension or discomfort



I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Client Signature _____ Date: _____

NAME: _____ Date: _____
(PRINT NAME

THERAPIST'S NAME: _____ Date: _____

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CONSENT FOR TREATMENT

Patient Name: _____

CONSENT TO TREAT: I request and give consent to _____ to provide and perform medical/surgical/acupuncture treatments, tests, procedures, medications and other services and supplies as are considered necessary or beneficial for my health and well-being. 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: _____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize _____, to release information from my medical record to my insurance carrier(s) or government agency for the processing of claims for medical benefits. I request that my insurance carrier(s) honor my assignment of insurance benefits applicable to the services rendered. I will pay _____ out of pocket
INITIAL: _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under XVII of the Social Security Act is correct. I authorize _____, to release information from my medical records to the Social Security Administration and /or the Medicare program or its intermediaries or carriers, or benefits. I will pay _____ 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. _____ will assist patients in obtaining insurance benefits. I agree that the insurance company will make payments to _____. 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: _____

PRINT NAME: _____ **DATE:** _____

PATIENTS SIGNATURE: _____ **DATE:** _____

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Please initial below to indicate that you understand:

___ Hermann Wellness is not taking primary care patients.

Please initial that you understand our policy on notifying you of testing results:

_____ Please note that we call all patients when we receive new test results such as blood work or reports. If you do not receive a call from us within 7 to 10 days after a test is performed, please contact the office.

_____ All providers prescribe enough refills to last until you are supposed to be seen again in clinic. Please schedule your follow up visit prior to your prescriptions running out. There will be a charge for refills on prescriptions if you do not return to the clinic prior to the prescription running out.

CANCELLATION POLICY

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 a $50 cancellation fee to the card.

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