

  
**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](mailto: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 /

Primary Care's Phone: ( ) \_\_\_\_\_

Other: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Pharmacy Phone : ( ) \_\_\_\_\_

**EMERGENCY CONTACT**

**INFORMATION ON SPOUSE/PARENT**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**INSURANCE INFORMATION**

**SUPPLEMENTAL INURANCE CARRIER Insurance**

Insurance Carrier: \_\_\_\_\_

Carrier: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Policy ID#: \_\_\_\_\_

Policy ID#: \_\_\_\_\_

Group#: \_\_\_\_\_

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.

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

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**Please print your name here**

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**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.

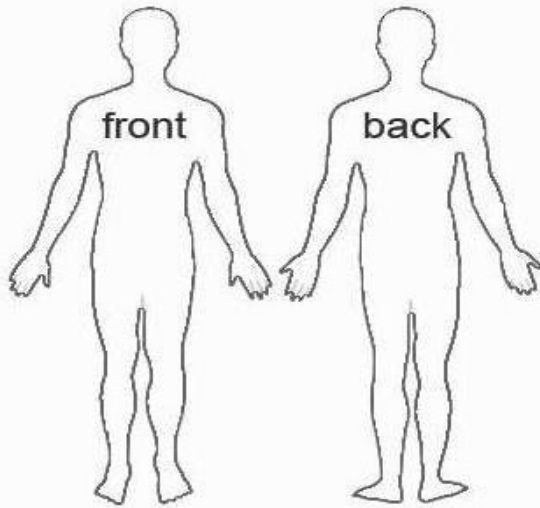
- |                                       |   |   |   |
|---------------------------------------|---|---|---|
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Back pain                      | <input type="checkbox"/> Bruise easily  |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Cardiac/circulatory problems | <input type="checkbox"/> Contagious disease             | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Epilepsy or seizures         | <input type="checkbox"/> Frequent headaches             | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pregnant                     | <input type="checkbox"/> Sensitive to touch or pressure |   |
| <input type="checkbox"/> Stress       | <input type="checkbox"/> Varicose veins               | <input type="checkbox"/> 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.

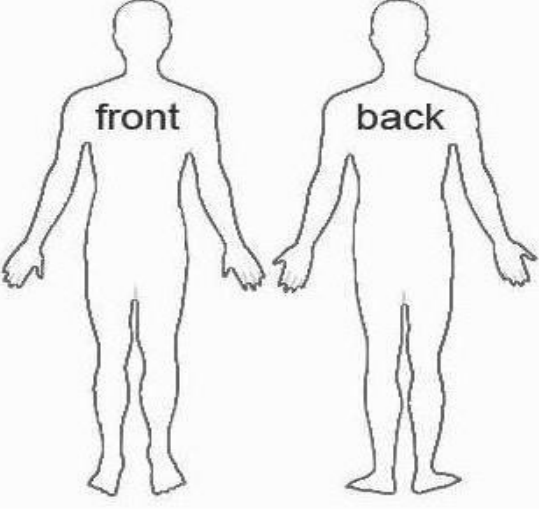
Comments: \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

**CONSENT FOR TREATMENT**

**Patient Name:** \_\_\_\_\_

**CONSENT TO TREAT:** I request and give consent to Anne Hermann, MD. PA 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 Anne Hermann, MD. PA., 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 Anne Hermann, MD. PA 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 Anne Hermann, MD. PA, 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 Anne Hermann, MD. PA 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. Anne Hermann, MD. PA will assist patients in obtaining insurance benefits. I agree that the insurance company will make payments to Anne Hermann, MD. PA. 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:** \_\_\_\_\_

