Hermann Wellness
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 / **Primary Care's Phone: ( )** _____

Other: _____ **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: _____

I understand that I am financially responsible for any and all balances not covered 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 **Date**

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?
_____ I give permission for my photos to be taken for purpose of evaluating treatment effectiveness for office use only.

_____ Circle One: I do/ do not consent to allow before/after pictures to be used in promotional materials.

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)*

_____

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YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

INITIAL PATIENT VISIT

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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Medical Intake Form

Patient Name: _____
Date of Birth: _____

Please describe your reason for your visit today: _____
_____
_____
_____
_____
_____

How long have you had this complaint? _____

Was there an injury or accident that originally caused the problem? If so, please describe.
_____
_____

Have you had any medical treatments for your symptoms, such as exams, blood work, x-rays or medical procedures?
_____
_____
_____

Have you ever had acupuncture before? If so, what for and did it work?
_____
_____
_____

How did you find us?

- ☐ Yellow Book
- ☐ Super Pages
- ☐ Newspaper ad
- ☐ Referral from friend or physician

Internet

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CONSENT FOR TREATMENT

Patient Name: _____

CONSENT TO TREAT: I request and give consent to the providers of Hermann Wellness (Anne Hermann, MD, Robin McClain ARNP, Jeanna Hepler ARNP, Mandy Brown LE 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: _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. I agree that I the responsible party 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: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Phone #:

Patient's Name: Date of Birth:

Address: City, State, Zip: _____

DR'S NAME PH# FAX#

I request and authorize release healthcare information of the patient named above to:

ANNE HERMANN, MD, PA

3040 W CYPRESS STREET
SUITE 103
TAMPA, FL 33609
PHONE: (813) 902-9559
FAX: (813) 315-6611

6387 CENTRAL AVENUE
ST. PETERSBURG, FL 33710
PHONE: (727) 278-3992
FAX: (813) 315-6611

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of my medical records to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Patient Signature_____ **Date**_____

Please initial below to indicate that you understand:

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__Hermann Wellness is not taking new primary care patients. Hermann Wellness is still accepting insurance for problem focused visits with Anne Hermann, MD and Robin McClain, ARNP for treatment of allergies, nutrition, hormones, and well women exams including pap smears. I understand that with insurance a new visit is ½ hour and a follow-up visit is 15 minutes.

__**Nutrition and bio-identical hormones** services are performed as **separate** appointments from standard medical visits. If you wish to receive nutrition or hormone treatments on the same day as a standard medical visit, you will need to schedule the extra time in advance and there may be an additional charge.

Please check the box and boxes that apply to you:

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