ST. PETERSBURG
HEALTH & WELLNESS

Welcome to St. Peterburg Health & Wellness!

Thank you for inquiring about St. Petersburg Health and Dr. Les Cole, MD and Kathie Gonzales, ARNP. for your Health care needs.

Attached, please find a new patient packet to be completed and dropped off at the office or emailed to **SPHW@StPeteHW.com** before your scheduled appointment.

Additionally, please send or bring:

1. *Copy of any recent labs or scans from the last year pertaining to your chief complaint.*
2. *Copy of Photo I.D.*
3. *Copy of Insurance Card*
   We do not accept insurance for your physician visit; however, we do keep it on file for any lab work that may be ordered. If you would like to be provided a "superbill" for your office visit for insurance reimbursement, please inform your medical assistant at the end of your appointment. Insurance reimbursement is between you and your insurance company only.

If you have any questions, regarding the New Patient packet, please feel free to contact us at 727-202-6807 and we will be happy to answer your questions. We look forward to meeting you.

Live Well!

St. Petersburg Health & Wellness

727-202-6807
2100 Dr. Martin Luther King Jr St. North
St. Petersburg, FL 33704

Email: SPHW@stpetehw.com

Please feel free to check our websites or social media sites.
https://stpetehw.com/
https://vitalsolutionsiv.com/
https://www.facebook.com/vitalsolutionsiv
https://www.facebook.com/StPeteHW
https://www.instagram.com/vitalsolutionsiv

ST. PETERSBURG HEALTH & WELLNESS

Patient Name _____ Date _____Date of Birth ___/___/____

Social Security # ___ - __ - ___ Sex **M F** Marital Status _____ Who referred you? _____

Address _____ City _____ State _____ Zip _____

Mobile Phone # (_____) _____-_____ Home Phone # (_____) _____-_____

Email Address_____ Do you wish to receive emails regarding service and/or specials? **Y/N**

Emergency Contact Name _____ Phone # _____

Name of Primary Care Physician _____ Phone # _____

Are we allowed to contact your PCP regarding your personal health information? **Y / N**

Main reason for today's appointment: _____

Due to HIPPA regulations only those persons who you may list below will be allowed access to your medical information.

Name _____ Relationship _____

Name _____ Relationship _____

Insurance Information:

PRIMARY:

Insurance Carrier: _____

Name of Insured: _____ Relationship: _____

Member ID: _____ Group: _____

SECONDARY:

Insurance Carrier: _____

Name of Insured: _____ Relationship: _____

Member ID: _____ Group: _____

Please allow us to make a copy of your insurance card and driver's license

Medical History:

Check **(C)** for current medical complaint Check **(P)** for past medical complaint.

C	P		C	P	
		Arthritis or Sore Joints			Abnormal EKG
		Anemia or Low Blood Counts			Anxiety
		Asthma or Hay Fever			Abnormal Bruising or Bleeding
		Broken Bones			Bronchitis or Emphysema
		Cancer / Type_____			Circulation Issues
		Chemical Dependency /Alcoholism			Chest Pain
		Deafness, Dizziness, Ringing in the ears			Diabetes (Type 1 or 2)
		Ear Infections			Epilepsy or Seizures
		Gall Stones			Heart Attack or Disease
		Head Injury (Open or Closed)			Hepatitis (A, B or C)
		Headaches / Migraines			Gout
		Heart Murmur			Hemorrhoids
		High Cholesterol			High Blood Pressure
		HIV / AIDS			Kidney or Bladder Issues
		Jaundice			Night Sweats
		Liver Disease			Phlebitis or Clot Issues
		Psychiatric Care			STDs
		Shortness of Breath			Skin Diseases
		Stomach Disorders / Ulcers			Stool or Bowel Problems
		Sinus Troubles / Chronic Sinusitis			Stroke
		Thyroid Condition			Tuberculosis (TB) Test Positive
		Trouble Falling or Staying Asleep			Tremors

Social Habits:

Smoke Tobacco? Y/ N If yes, how many packs/day _____

Chew Tobacco? Y / N If yes, how many tins/bags/day _____

Drink Caffeine? Y/ N If yes, how many cups/day ____

Drink Alcohol? Y / N If yes, how many cups/day____

Do you exercise? Y / N If yes, how many times/day_____

how many hours/day_____ Cardio or Weight Bearing? _____

Have you ever been hospitalized? If so, please list the dates and reasons below:

Date	Reasons

Medication List:

Please list all the medications you are currently taking, including the dose and daily times

Preferred pharmacy:

Name: _____ Address: _____

Phone #: _____

Supplement List:

Please list all the supplements, over the counter and herbals that you are currently taking, including the dose and daily times.

Allergies:

Please list all your allergies to include medications, foods, additives and insect stings… Also, include the reaction (mild, moderate, severe) and type (rash, vomiting, anaphylaxis) to each source.

Allergen	Reaction	Type

Immunizations / Vaccines:

Hepatitis B	YES / NO	Date:
Pneumonia	YES / NO	Date:
Tetanus	YES / NO	Date:
Influenza	YES / NO	Date:
COVID-19	YES / NO	Date: Type:

Family History:

Alcoholism	Y / N	Relative:	High Blood Pressure	Y / N	Relative:
Allergies	Y / N	Relative:	Kidney Disease	Y / N	Relative:
Anemia	Y / N	Relative:	Leukemia	Y / N	Relative:
Arthritis	Y / N	Relative:	Liver Disease	Y / N	Relative:
Asthma	Y / N	Relative:	Mental Illness	Y / N	Relative:
Birth Defects	Y / N	Relative:	Migraines	Y / N	Relative:
Cancer & Type(s)	Y / N	Relative:	Obesity	Y / N	Relative:
Diabetes	Y / N	Relative:	Sickle Cell Anemia	Y / N	Relative:
Emphysema	Y / N	Relative:	Ulcers	Y / N	Relative:
Epilepsy	Y / N	Relative:	Stroke	Y / N	Relative:

Personal Health Information:

Women Only		Men Only	
Pelvic Pain	Y / N	Straining or Pain with Urination	Y / N
Abnormal Vaginal Bleeding	Y / N	Pain or Lump on Testicle(s)	Y / N
Vaginal Discharge	Y / N	Discharge from Penis	Y / N
Sexual Dysfunction	Y / N	Difficulty with Erection	Y / N
Date of Last Menses	____ /_____	Sexual Dysfunction	Y / N

Health Maintenance Tests: *Please list the approximate dates and outcomes to the following tests/procedures.*

Colonoscopy: _____ Sigmoidoscopy: _____

Bone Density test: _____ Other(s): _____

MEN ONLY Prostate Exam: _____ Prostate Specific Antigen (PSA): _____

WOMEN ONLY Pap Smear: _____ Mammogram/Thermography: _____

Sensitivities:

When scheduling or confirming an appointment please let our staff know if you have any chemical or scent sensitivities. We will be diligent in trying to accommodate your needs. We only use Plant Therapy 100% Pure Essential Oils in our office.

Authorization to Treat.

I, _____ (initials) hereby give permission to the practitioners and staff of St. Petersburg Health & Wellness, to administer treatment, prescribe testing procedures indicated by practitioner that he/she may deem necessary to diagnose and/or treat my condition.

Patient Signature _____

Date _____

Printed Name _____

Minor Consent

I, _____ (parent or guardian) hereby request and authorize for the practitioners and staff of St. Petersburg Health & Wellness, to render treatment to my minor child _____ (child's name). This authorization is extended to all affiliated doctors and/or staff members and is intended for the performance of diagnostic tests, laboratory phlebotomy and/or other treatment necessary for the minor child's care.

On this date, _____ (date), I have the legal right to select and authorize health care services for the minor child above.

Parent or Guardian Name: _____ Date: _____

Signature of Parent or Guardian: _____

Witness: _____ Date: _____

HIPPA- Notice of Practice Privacy

We collect information from you and store it in a password protected computer. Passwords are only afforded to the appropriate personal. Medical records are stored in a compliant electronic record keeping software. Housekeeping, maintenance and other non-office personnel have no access to these records. Within our office we restrict the disclosure of this information to doctors, nurses, technicians, medical assistants and healthcare personnel. We may use your medical information for treatment, payment to outside vendors and health care operations.

Outside of our office, we restrict the disclosure of this information to those people, entities, and agencies for which you authorize disclosure such as other health care providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is RB-approved or privacy board-approved
- Specialized government functions (military, inmates)
- Workers compensation
- Disaster Relief and Fund Raising

We will not use or disclose your medical information for any purpose note listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by your written request.

Privacy Rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and receive a copy of your record. There will be a copy fee to provide this service to you. We must respond within (30) days if the record is readily available and within (60) days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request, directed to our office, to amend your chart. We must respond within (60) days.
- Receive an accounting of any disclosures made from your record over the last six years. You can do this with a written request, directed to our office, to amend your chart. We must respond within (60) days.
- Request restrictions as to the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosure noted above. You may revoke or restrict consent.
- Request Confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to our office, and a copy of this notice will be given with all new patient packets.

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change. Copies will be made available. If you have questions or would like to lodge a complaint regarding our privacy policy, you may contact our Privacy Officer at 727-202-6807.

I have received a copy of St. Petersburg Health & Wellness privacy notice as required by HIPAA.

Print Name of Patient: _____ Date: _____

Signature of Patient: _____

HIPAA CONSENT FORM

YOUR RIGHTS & CONFIDENTIALITY

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care.

From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity, hormonal, and functional medicine. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION

Uses and Disclosures of Information that We May Make Without Written Authorization: Treatment, payment, healthcare operations, required by law, abuse or neglect, communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donations, research, workers compensation, appointments and services, marketing, business associates, military, inmates, or person in policy custody.

Uses and Disclosures of Information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. If you object, please notify the Privacy Contact identified at the end of this document.

Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home or mobile phone unless you direct otherwise.

Name of person(s) we may speak to regarding your health care:

_____

_____

Notification: Unless you object, we may use or disclose protected health information to notify a family members or other person responsible for your care of your location and condition.

Your Rights Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.

1.) To request additional restrictions
2.) To receive communications by alternative means
3.) To inspect a copy record
4.) To request amendment to your record
5.) To request accounting of certain disclosures
6.) To receive a copy of our complete confidentiality notice
7.) To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note that in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.

Complaints: You may complain to us or to the Secretary of the Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complains must be in writing. We will not retaliate against you for filing a complaint.

Entities to Whom This Notice Applies: This notice applies to Les Cole, MD, St. Petersburg Health and Wellness; the physicians, employees and volunteers who work here.

Privacy Officer Contact: If you have any questions about this Notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Privacy Officer, Cathie Asay. Address: 2100 Dr. Martin Luther King St., N., St. Petersburg, FL 33704. (727) 202-6807.

I, the undersigned, have reviewed this information on this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

Patient Signature _____

Date _____

Printed Name: _____

HIPAA Consent

Informed Consent Regarding Email or the Internet Use of Protected Personal Information:

St. Petersburg Health & Wellness provides patients the opportunity to communicate with administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has several risks, both general and specific, that should be considered before using email.

1. Risks
    a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
    b. Specific e-mail risks are the following: e-mail containing information pertaining t diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected persona health information will have access to the e-mail messages, patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of St. Petersburg Health & Wellness that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of the patient's protected health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. St. Petersburg Health & Wellness will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication not caused by its employee's gross negligence or wanton misconduct.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals such as St. Petersburg Health & Wellness physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. St. Petersburg Health & Wellness may forward e-mail messages within the practice as necessary for diagnosis and treatment. St. Petersburg Health & Wellness will not, however, forward the email outside the practice without the consent of the patient as required by law.
    c. St. Petersburg Health & Wellness will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail promptly. Therefore, e-mail must not be used in a medical emergency.
    d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. Because some medical information is s sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communication concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmissible or communicable diseases. Such as syphilis, gonorrhea, herpes, and the like; Behavioral; health, Mental health, or developmental disability; or alcohol and drug abuse.
f. ST. Petersburg Health & Wellness cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication, but St. Petersburg Health & Wellness is not liable for improper disclosure of confidential information.
g. If consent is given for the use of e-mail, it is the responsibility of the patients to inform St. Petersburg Health & Wellness of any types of information you do not want sent by e-mail.
h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from St. Petersburg Health & Wellness to protect confidentiality. St. Petersburg Health & Wellness is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to St. Petersburg Health & Wellness. I have read this form carefully and understand the risks and responsibilities associate with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Patient Signature _____

Date _____

Printed Name _____

Office Financial Policy:

BASIC POLICY
Payment for service is due in full at the time service is provided in our office.

MISSED APPOINTMENTS
In fairness to other patients and practitioners, we require at least a 48-hour notification of an appointment cancellation. If a 48-hour notification is not given and no acute emergency medical condition arises then a $100 no-show fee will be charged and must be paid in full before any future services are rendered in this office.

ASSIGNMENT OF INSURANCE BENEFITS (Health Insurance)
Patients with insurance please read and sign below that you understand and agree with the following statement.

I understand that I am financially responsible for all charges unpaid by health insurance and or those services that are not included in my health insurance policy. The office of St. Petersburg Health & Wellness has informed me that they are not contracted with any health insurance plans and therefore all services rendered by the staff of St. Petersburg Health & Wellness will be self-payment.

I have read, understood and agreed to the above financial policies for payment of professional fees.

Signature of Patient: _____Date: _____

Credit Card Authorization

Name on Credit Card	
Type of Card	____ Visa ____ MasterCard ____ Amex ____Discover
Type of Account	____ Personal ____ Business
Company Name	
Account Number	
	Expiration CVV Code
Billing Address	
City, State, Zip	
Authorized User	
Phone Number	
Email Address	

Types of Charges: Any charge related to treatment program including office visits, professional fees, laboratory charges, supplements and compounded medications. Change in appointment must have 48-hour notification or not showing for your appointment will be charged a $100 penalty. Not showing for a scheduled IV therapy may result in the IV being charged to the card, if the formula was already made and had to be discarded.

Authorization: Authorization may be cancelled at any time at which time any outstanding payments will be required to be made.

Authorization of Card Use: I certify that I am the authorized holder and signer of the credit card referenced above. I certify that all information is complete and accurate. I hereby authorize collection of payment for all charges indicated above. I understand this authorization is for any treatment charges that are not paid for at the time of treatment. I agree to provide a new credit card prior to expiration of card on file.

CARDHOLDER NAME _____

SIGNATURE _____ DATE _____

To be signed only if you are 65 yrs old or older.

Medicare Program Opt Out Agreement:

This agreement is between E. Les Cole, M.D., whose principal place of business is 2100 Dr. Martin Luther King Drive N., St. Petersburg, FL 33701 and

Beneficiary Name: _____

Who Resides At: _____

_____

Medicare # _____

And is a Medicare Part B beneficiary seeking services covered by Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on May 1, 2018, for a period of at least 2 years, to expire on June 19, 2021. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands, and expressly acknowledges the following:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physicians charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters this contract with knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and Practitioners who have not opted out of Medicare, and beneficiary is not compelled to enter private contracts that apply to other Medicare-covered services furnished by other physicians or Practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on:

Date _____

By Signing below, I agree to the above contractual agreements and affirm that I have no legal Representative to speak for me in this matter.

Please Print

Beneficiary Name _____

*or Legal Representative*_____

Signature _____

And:

_____

E. Les Cole, M.D., ABAARM, ABIHM

ST. PETERSBURG HEALTH & WELLNESS

MEDICAL RECORD REQUEST

Patient Name: Last _____First _____ Middle _____

Parent / Legal Guardian: Last _____First _____Middle _____

Address _____

City_____State_____Zip_____

Phone # _____ SS# _____

Date of Birth _____ Date of Request _____

I hereby request that (Physician or facility) _____release medical records to St. Petersburg Health & Wellness.

Patient Signature _____ Date _____

Please fax or mail the following:

____ Laboratory Notes Other _____

____ Radiology / MRI Reports

____ Consultation Notes

____ Rx History

____ Complete Medical Chart

Please mail or fax information to: St. Petersburg Health & Wellness

2100 Dr. Martin Luther King Jr St N

St. Petersburg, FL 33704

PHONE: 727-202-6807 **FAX 727-498-6642**

COVID-19 Screening Tool

Name:_____

Date of birth: _____

1.	Are you vaccinate?	YES	NO
2.	Do you have any of the symptoms below?		
	• Fever > 38 degrees C (100.4 degrees F) or subjective fever	YES	NO
	• Cough	YES	NO
	• Shortness of breath/ breathing difficulties	YES	NO
3.	• Other symptoms such as muscle aches, fatigue, headache, sore throat, runny nose, diarrhea. Note symptoms in young children may be non-specific- (lethargy, poor feeding).	YES	NO
4.	Have you had close contact (face-to-face contact within 6 feet) with someone who is ill with cough and/or fever who has traveled internationally within 14 days prior to their illness onset?	YES	NO
5.	Have you been in contact/had exposure in the last 14 days with someone that is being investigated or confirmed to be a case of COVID-19?	YES	NO
6.	Have you recently been tested for COVID-19 and are awaiting test results?	YES	NO
7.	Do you live at or have you recently visited a nursing home, living facility or rehab center?	YES	NO
8.	Have you had a recent hospitalization within the last 14 days?	YES	NO