NEW PATIENT PAPERWORK INSTRUCTIONS

We respect your time and want to make your first visit as smooth and efficient as possible.

To help us prepare your chart in advance and allow your physician to review your history before your visit, please complete your **New Patient Paperwork** ahead of time.

Here's how to make your visit faster:

1. **Arrive 15 minutes before your scheduled appointment time.**
   This allows time for check-in and any last-minute verifications.

2. **Complete your forms in advance and return them** by one of the following options:
   - Mail: Sunstate Doctors Medical Group
   - Fax: (813) 849-9301
   - Drop Off: Monday–Friday, 8 AM – 5 PM

   (If your paperwork is not received before your appointment, **PLEASE** *arrive* **60 minutes** *early to complete it in office.)*

3. Bring the following items with you:
   - Current Insurance Card
   - Photo ID
   - Complete list of prescription and over-the-counter medications

Timely completion of forms ensures your doctor can review your health history before your visit and keeps your appointment on schedule for the best possible care experience as well as the rest of the days' scheduled appointments.

Thank you for your cooperation and for choosing

Sunstate Doctors Medical Group

SENIOR PRIMARY CARE

Your Partner in Preventive Primary Care

Partnering with You, for a Healthier YOU!

Sunstate Doctors Medical Group
5113 SR 674, STE 103
WIMAUMA, FL 33598
813.633.2000
www.sunstatedoctors.com

sunstate
DOCTORS

Sunstate Doctors Medical Group
REGISTRATION FORM

(Please give your photo ID and insurance card to the receptionist) (Please Print)

Patient's Last Name:	**First Name:**	**Middle:**	**Marital status (circle one)** Single / Married / Div. / Sep. / Wid.

Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ☐ M ☐ F

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report/Unreported	**Social Security No.** _____	**Primary Language:**	☐ English ☐ Spanish ☐ Other, specify: _____

RACE: ☐ American Indian or Alaska Native	☐ White	☐ Asian	☐ African American	☐ Native Hawaiian or other Pacific	☐ Refuse to report/Unreported	☐ Other _____

Street address:	**City:**	**State:**	**ZIP Code:**	**E-mail:**

Mailing Address (if different than physical address) P.O. box:	**City:**	**State:**	**ZIP Code:**

Home Phone: ☐ Y ☐ N Can leave message. ( )	**Cell Phone:** ☐ Y ☐ N Can leave message. ( )	**Work Phone**: ☐ Y ☐ N Can leave message. ( )

Living Situation: ☐ Own home	☐ Condo or apartment	☐ Retirement home
☐ Assisted Living	☐ Nursing home	☐ W/family member
☐ Senior Citizen Housing	☐ Mobile home	☐ Other, specify

How did you hear about us (please check all that apply):	☐ Directory	☐ Family/Friend	☐ Facebook	☐ Flyer	☐ Google Search

☐ Hospital Referral	☐ Insurance Plan	☐ Kings Point	☐ Mailer/Postcard	☐ News of Sun City Center	☐ The Observer News	☐ The Pointer

Preferred Pharmacy: Address:	**Mail Order Pharmacy**:

BILLING & INSURANCE INFORMATION

Person responsible for bill:	**Birth date:** / /	**Address** (if different):	**Home phone no.:** ( )

Is this person a patient here? ☐ Yes ☐ No **Relationship**:

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Medicare	☐ Aetna	☐ Blue Cross Blue Shield	☐ CarePlus Health Plans	☐ Freedom Health

☐ Humana	☐ Optimum Healthcare	☐ Tricare	☐ United HealthCare	☐	☐

Subscriber's name (if different than patient):	**Subscriber's S.S. no. (if different than patient):**	**Birth date:** / /	**Policy no./Member ID:**	**Group no.:**	**Co-pay:** $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Policy no./Member ID:**	**Group no.:**

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient**:	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize medical services to be rendered to me by Sunstate Doctors Medical Group. I authorize my insurance benefits be paid directly to Sunstate Doctors Medical Group for services rendered. I understand that I am financially responsible for any balance. I also authorize Sunstate Doctors Medical Group to use or disclose health information about me in ways that are permitted by the federal privacy law, as summarized in Sunstate Doctors Medical Group's Notice of Privacy Practices, including without limitation for treatment, payment and healthcare operations of Sunstate Doctors Medical Group.

_____ _____

Signature of Patient or Patient' Date

Printed Name of Patient or Patient's Representative: _____

Relationship to Patient (if applicable): _____

Sunstate Doctors Medical Group

FINANCIAL/OFFICE POLICIES

For patients to take home

The following is a listing of our office policies. If the patient has any questions regarding them, please contact us at 813-633-2000. Office visit:

- An updated photo ID is required for the patient's first visit. In case of minor, guarantor's photo ID is required.
- The patient is required to give his/her insurance card(s) to front desk to update the patient's account for any changes in their insurance plan.
- To keep the patient's information current at all times, it is patient's responsibility to inform the front office of any address, contact or insurance information changes.
- All self-pay or insurance co-payments, Corporation-insurances and deductibles will be collected at the time of service. Payable by cash, check (with driver's license) or credit card (Visa, MasterCard or Discover).
- A returned check will result in a minimum service charge of $35.00 and check will not be accepted for future payment(s). Unpaid returned checks will be turned over to the state attorney's office.
- If the patient feels ill after normal business hours, on the weekends, or while the patient is out-of-town, please contact our after hour answering service to connect with the provider on call. Our providers are on call 24 hours a day.

Forms/Medical Records:

- There is a $20.00 fee for FMLA form and all other forms (parking permits, physical forms, disability forms, or any special forms requested).
- For medical records there is a $15.00 processing fee (cost of supplies, labor and postage), $1.00 per page for copies up to 25 pages, $0.25 per page for copies of pages 26 and greater.
- Request of medical records/forms requires a minimum of ten (10) business days' notice.
- Request of medical record review requires an appointment with a minimum of seven (7) business days' notice.

Appointments:

- Minimum of 24-hour notice is required to reschedule or cancel appointment.
- Arriving late for an appointment, staff will try to accommodate if there is sufficient time to complete visit. Patient may be asked to reschedule appointment.

Referrals:

- Before being referred to a specialist, the patient must first have an evaluation from the patient's primary care physician.
- Referrals may take up to five (5) business days to get approved by the patient's insurance company.
- Once the referral has been authorized, it is valid for one evaluation from the specialist. If additional testing or visits are required by the specialists, orders for such tests must be made available to the patient's primary care physician for authorization BEFORE tests and/or visits are conducted.
- It is the patient's responsibility to ALWAYS consult with the patient's primary care physician first to avoid any out-of-pocket expenses for specialist visits and/or testing.
- Each time the patient visits a specialist, the patient must make the patient's follow up appointment with the patient's primary care provider.
- Sunstate Doctors Medical Group has developed a network of physicians for each patient's specific needs. Please consult our Referral Coordinator before the patient makes an appointment to verify that the physician the patient would like to see is in our network.

Prescriptions:

- The patient is required to bring all new medications, prescribed by other providers, to the patient's scheduled appointment to keep their medication log current.
- **Prescription refills require three (3) to five (5) business days' notice.**
- It is the patient's responsibility to inform front desk which pharmacy the patient wants to send a particular prescription to when the patient requests a refill.
- Controlled substances **WILL NOT** be filled after 5:00 pm or on weekends.
- **Class 2 and Class 3 narcotics & tranquilizers** are controlled medications. Therefore, the patient must be seen by the patient's physician at least once every month.
- No request for a refill of prescription will be entertained if that medication was never prescribed by the primary care physician.

Messages:

- Telephone messages will have a 48 hour turnaround time.

Billing:

- It is the patient's responsibility to inform us of any changes in the patient's insurance for accurate and timely billing.
- At the patient's office visit, we attempt to verify benefits with the patient's insurance; however, please be advised that this is just an estimate of the coverage based on the information given at the time of inquiry and not a guarantee of payment from the patient's insurance.
- The patient is responsible for any non-covered charges not payable by the patient's insurance policy.
- If the patient already has a PCP assigned to the patient other than our office, it is the patient's responsibility to get an authorization or referral for the visit from the patient's PCP; otherwise, the patient will be fully responsible for whole visit charge.
- Any unpaid balance older than ninety (90) days of first statement may be subject to a 1.5% interest per month.
- In the event of any default of payment on patient's account, all costs of collection, including collection agency fees, attorneys' fees, court costs, and any other costs to collect the debt is the patient's responsibility.
- Sunstate Doctors Medical Group may retain a collection agency to handle delinquent accounts. All necessary legal action will be retained to collect this debt if a default occurs.
- If a patient does not meet their financial obligation, the patient will be given reasonable notice and discharged from the practice.
- All delinquent accounts will be reported to the credit bureaus.

Sunstate Doctors Medical Group
FINANCIAL/OFFICE POLICIES

For practice to file in patient chart

ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICY

I have read and understand the Financial/Office Policies of Sunstate Doctors Medical Group, and agree to meet all financial obligations. I have been given a copy of the same.

PAYMENT AGREEMENT

I understand that any unpaid balances not covered by my health insurance policy will be payable by me. I authorize Sunstate Doctors Medical Group to leave recorded messages on my voice mail or telephone answering machine regarding billing for my care. In the event of my default of payment on my account, I understand and agree that I am liable for 1.5% simple interest per month and all costs of collection, including collection agency fees, attorneys' fees, court costs, and any other costs incurred in collecting this debt. Sunstate Doctors Medical Group may retain a collection agency to handle delinquent accounts. We reserve our right to retain legal counsel to collect this debt if a default occurs. All delinquent accounts will be reported to the credit bureaus.

By signing below, I acknowledge and confirm that I have read and understand the above-mentioned policies and procedures.

_____ _____

Signature of Patient or Patient's Representative Date

Printed Name of Patient or Patient's Representative: _____

Relationship to Patient: _____

Sunstate Doctors Medical Group

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A Covered Entity, as that term is defined under Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is required by law to maintain the privacy of your medical information and to provide you with notice of its legal duties and privacy practices with respect to this information. Certain entities that operate on a cash-pay or self-pay basis, who do not bill third-party payors, or perform other types of covered transactions under the law, are not considered a Covered Entity under HIPAA. Nonetheless, Sunstate Doctors Medical Group seeks to comply with requirements under the law, to ensure our patients privacy is protected in accord with the federal standards. The purpose of this notice is to provide you with that information.

Any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by Sunstate Doctors Medical Group. We will abide by the terms of the notice that is currently in effect at the time your medical information is used or disclosed.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all medical information that we maintain. We will post a copy of the current notice in our office. In addition, each time you come to Sunstate Doctors Medical Group for treatment or health care services, you may request a copy of the current notice in effect.

SECTION A
WE MAY USE AND/OR DISCLOSE YOUR MEDICAL INFORMAITON FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

The following is a description and example of the ways in which we may use and/or disclose your medical information:

Treatment

Your health information may be used by Sunstate Doctors Medical Group staff members or disclosed to other health care professionals who are involved in the provision, management, or coordination of your care. For example:

- Health Care Professionals: Your medical information will be shared among physicians, nurses, or other health care professionals involved in your care.
- Appointment Reminders: We may use and disclose medical information to provide appointment reminders or information about treatment alternatives or other health-related benefits.

Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. We may also disclose your medical information to another health care provider, a health plan or a health clearinghouse for the payment activities of that entity.

Health care operations

We may use and/or disclose your medical information for our activities and operations. These uses and

disclosures are necessary to run Sunstate Doctors Medical Group and to make sure that all of our patients receive quality care. For example:

- Quality Assessment and Improvement: We may use or disclose your medical information to evaluate and improve the quality, efficiency, and effectiveness of healthcare services. This can include analyzing patient outcomes, conducting patient satisfaction surveys, and implementing quality improvement initiatives based on data analysis.
- Training and Education: We may use or disclose your medical information for training and educating healthcare professionals, staff members, and students. This can include training sessions on patient care protocols, medical procedures, and compliance with HIPAA regulations.
- Credentialing and Peer Review: We may use or disclose your medical information for credentialing healthcare providers (e.g., verifying qualifications, licenses, and certifications) and conducting peer review activities to evaluate the professional performance of healthcare providers.
- Healthcare Fraud and Abuse Detection: We may use or disclose your medical information to detect and prevent healthcare fraud, waste, and abuse. This includes analyzing claims data for patterns of fraudulent activity, conducting audits, and investigating suspected cases of fraud or abuse.
- Business Planning and Development: We may use or disclose your medical information for strategic planning, business development, and marketing purposes, so long as patient privacy is protected. This can include analyzing patient demographics, market trends, and healthcare needs to improve services and expand patient outreach.
- Business Management and Administration: We may use or disclose your medical information to comply with the Privacy Rule and other Administrative Simplification Rules of HIPAA, for customer service-related needs, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, or for fundraising for the benefit of Sunstate Doctors Medical Group.

Health Information Exchange (HIE)

We may use or disclose your PHI in connection with an electronic Health Information Exchange ("HIE") in which the Practice participates for treatment, payment and health care operations purposes and other lawful purposes to the extent permitted by law. HIEs make it possible for us to electronically share patients' PHI to coordinate their care, obtain billing information, and participate in quality improvement, public health and population health initiatives, among other purposes. Other healthcare providers (physician practices, ancillary service providers, etc.), health care entities (hospitals, surgery centers, ACOs, etc.), health plans, etc., may also have access to your information in the HIE for similar purposes to the extent permitted by law. The information accessible on the HIE may identify you personally and may include sensitive health information. You have the right to "opt-out" or decline to participate in all HIEs in which the Practice participates. To "opt-out" or decline to participate in the HIE, please notify our Privacy Officer listed at the beginning of this Notice. This opt-out will only apply to the information after we have received your signed request. Please note that if you opt out, your providers may not have the most recent information about you which may affect your care.

Business Associates (BA)

We may utilize companies that provide services for our organization through written contracts and/or service agreements. Examples of these services include answering services, transcriptionists, billing services, electronic health record, practice management and revenue cycle services, interoperability, data liquidity, data aggregation and population health management services, consultants and legal counsel. We disclose your PHI to our business associates (and our business associates may disclose your PHI to their subcontractors), so that they can perform the services we have requested them to do. To protect your information, we require our business associates and their subcontractors to appropriately safeguard your information and comply with the HIPAA Privacy and Security Rules.

Uses and Disclosures That May Be Made *with* Your Consent, Authorization or Opportunity to Object

Appointment Reminders
We may communicate with you using various methods to remind you of your appointment such as by telephone, reminder card, text message, or email unless requested otherwise.

Deceased Individuals
When an individual is deceased, we may disclose to a family member, close friend, or any other person identified by you who was involved in your care or payment for health care prior to your death, your PHI that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference by you that is known by us.

Fundraising initiatives
All fundraising communications will include information about how you may opt out of future fundraising communications. If you elect to opt out of receiving further fundraising communications and we will make reasonable efforts to ensure that no further fundraising communications will be sent to you.

Immunizations
The Privacy Rule permits the disclosure of immunization directly to a school that is required by law with the oral or written agreement of a parent or guardian.

Individuals Involved in Your Care or Payment for Your Care
Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Marketing
The HIPAA Privacy Rule requires a written authorization before the use or disclosure of protected health information can be made for marketing. Communication is not "marketing" if it is made to describe a health-related product or service (or payment for such product or service) that is provided by the covered entity or included in a benefit plan of the covered entity making the communication. Marketing is not coordination of care, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual.

Sensitive Health Information
The use and certain disclosures of sensitive health information require special authorization. This may include the performance or results from a test or treatment of HIV, HIV related conditions, sexually transmitted diseases, tuberculosis, mental health conditions, domestic violence, drug/alcohol programs and treatment, sexuality, or reproductive healthcare. We will not share unless we have a written authorization from you, or it is required by law. In the event a patient travels across state lines for lawful reproductive care, from an unlawful acceptance state, we will attempt to provide patient privacy against any unlawful requests to share patient information.

Treatment Alternatives and Health-Related Benefits
We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services or other activities to include limited marketing in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.

SECTION B
WE MAY USE AND/OR DISCLOSE YOUR MEDICAL INFORMATION WITHOUT YOUR AUTHORIZATION.

The following is a description of ways in which we may use and/or disclose your information for which an authorization or an opportunity to agree or object is not required:

As Required by Law. We may use or disclose your medical information to the extent required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

Law enforcement. Your health information may be disclosed to law enforcement agencies as required by the law. Under limited circumstances we may release your medical information to report a crime or in response to a court order, grand jury subpoena, warrant, or administrative request.

Public Health Activities. To the extent authorized or required by law, we may disclose your medical information to a public health authority to report a birth, death, disease or injury, as part of a public health investigation, or to report child or adult abuse, or domestic violence.

To the extent authorized or required by the Food and Drug Administration ("FDA"), we may disclose your medical information to a person or organization authorized to report adverse events, track products, enable product recalls, repairs, or replacement, and/or conduct post marketing surveillance. This means we may disclose to non-governmental persons information about the quality, safety and effectiveness of FDA regulated products and activities.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

The following is a description of ways in which we may use and/or disclose your information after we have given you an opportunity to object:

We will attempt to obtain your permission prior to making a disclosure for these purposes. This permission may be oral. If we are unable to obtain your permission because you are incapacitated or we are unable to reach you, we may use or disclose some or all this information, if (1) based on our professional judgement use or disclosure is in your best interest or (2) use or disclosure of this information is consistent with your previously expressed preference.

Individuals Involved in Your Care or Payment for Your Care. We may release relevant medical information about you to a friend or family member who is involved in your medical care. We may also notify these individuals of your location, general condition, or death.

Disaster Relief. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

SECTION C
WE MAY USE AND/OR DISCLOSE YOUR MEDICAL INFORMATION FOR OTHER PURPOSES ONCE WE HAVE OBTAINED YOUR WRITTEN AUTHORIZATION.

Other uses and disclosure of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. You may revoke this authorization, in writing, at any time. However, this revocation will not apply to the extent we have taken action in reliance on that authorization. For example:

- Marketing: We'll obtain your authorization prior to any use or disclosure for marketing purposes.

- Sale of Protected Health Information: We'll obtain your authorization prior to any use or disclosure that constitutes a sale of Protected Health Information that is not otherwise incorporated into an appropriate health care operation.

SECTION D
YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you for notification purposes or to someone who is involved in your care or the payment of your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request a restriction, you must make your request in writing to our Privacy Officer. The requested restriction will not be effective unless and until it has been reviewed and approved by the Privacy Officer. For purposes of ensuring proper documentation, we may require that you make your request using a form that we give you.

We may terminate an agreed upon restriction without your consent. In that situation, the restriction will only apply to protected health information created or received before you were informed of the termination of the restriction.

Right to Receive Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. To comply with this request, we may ask you to (1) provide information as to how payment will be handled and (2) specify an alternative method of contact. For purposes of ensuring proper documentation, we may require that you make your request using a form that we give you.

Right to Inspect and Copy: You have the right to inspect and obtain a copy of most of your medical information maintained in a paper or electronic record at Sunstate Doctors Medical Group; you must submit your request in writing to our Privacy Officer. For purposes of ensuring proper documentation, we may require that you make your request using a form that we give you. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain limited circumstances. If you are denied access, you may have the right to request that the denial be reviewed. Another licensed health care professional chosen by Sunstate Doctors Medical Group will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to your paper or electronic record for as long as the information is kept by Sunstate Doctors Medical Group. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. For purposes of ensuring proper documentation, we may require that you make your request using a designated form. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us; (2) is not part of the medical information kept by or for Sunstate Doctors Medical Group; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures. This is a list of the disclosures we made of medical information about you. You have the right to request an accounting of certain disclosures by the covered entity for a period of time as far back as six years from the date of your request. To request an accounting, you must submit a written request to our Privacy Officer. Your request should indicate in what form you want the list (for example, on paper, electronically). We will comply with your request within sixty (60) days, or we will provide you with an explanation for the delay. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The right to an accounting does not apply to all disclosures. *For example, you do not have a right to an accounting of disclosures pursuant to an authorization, disclosures to carry out treatment, payment, or health care operations, or disclosures of a limited data set.*

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you may ask for a copy at registration when you visit Sunstate Doctors Medical Group for services, or you may contact our Privacy Officer.

Sunstate Doctors Medical Group Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with Sunstate Doctors Medical Group or with the Secretary of the Department of Health and Human Services. To file a complaint with Sunstate Doctors Medical Group, you must submit a complaint in writing to our Privacy Officer at:

Dr. Khushi A. Dhaliwal
Sunstate Doctors Medical Group
5113 SR 674, Suite 103,
Wimauma, FL 33598

You will not be retaliated against for filing a complaint.

Contact Person
For further information about matters covered by this notice, you may contact us by reach out to the above address or by e-mail at: info@sunstatedoctors.com.

Sunstate Doctors Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by Sunstate Doctors Medical Group. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Sign below to acknowledge that you have received a copy of our Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

Printed Name of Patient or Patient's Representative: _____

Relationship to Patient: _____

Please return this acknowledgment as soon as possible. If you do not return the form in person, you may return this form by mail to our Privacy Officer at the following address:

Dr. Khushi A. Dhaliwal
Sunstate Doctors Medical Group
5113 SR 674, Suite 103,
Wimauma, FL 33598

Sunstate Doctors Medical Group

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

I. My Authorization

You, Sunstate Doctors Medical Group, may use or disclose the following health care information:

□ **ALL** my health information maintained by you.
□ My health information relating to the following treatment or condition: _____
□ My health information for the date(s):_____
□ Other: _____

To:

Name of Individual or Organization: _____
Relationship: (parent, child, sibling, legal guardian, etc.): _____
Address: _____
Phone Number: _____

Name of Individual or Organization: _____
Relationship: (parent, child, sibling, legal guardian, etc.): _____
Address: _____
Phone Number: _____

Name of Individual or Organization: _____
Relationship: (parent, child, sibling, legal guardian, etc.): _____
Address: _____
Phone Number: _____

This Authorization: □ Stays Active Unless Revoked
□ Ends on (date) _____
□ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization to receive treatment.
I may revoke this authorization at any time, in writing, sent to this medical group at the address provided below.

Once the office discloses health information, the person or organization that receives it may re- disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disabled, etc.) _____

Sunstate Doctors Medical Group
PATIENT PORTAL POLICY & PROCEDURES

DO NOT use the Patient Portal to communicate if there is an emergency.

Proper subject matter:

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow-up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc.) are not permitted
- We do not refill controlled substance medications drugs via the patient portal. You can request a refill but MUST come to the office to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message.

Current functionality of the Patient Portal:

- Email and secure messaging for non-urgent needs.
- Prescription refill request (***must*** include the pharmacy information).
- Viewing of lab results that have been sent to you.
- Viewing and printing of continuity of health record.
- Viewing and updating of health information.
- Viewing of selected health information (allergies, medications, current problems, past medical history). * Note: You can make changes/additions to your health records, medication list, etc., but this will not change your permanent record without our review of the information.
- Referral requests.
- Appointment requests.
- Billing questions.
- Updating your demographic information (address, phone number, etc.) and updating insurance information.

All communication via portal will be included in your chart.

Privacy:

- All messages sent to you will be encrypted.
- Messages from you to the staff should be through the Patient Portal or they will not be secure.
- We will keep all email lists confidential and will not share this with other parties.
- Any member of our staff may read your messages or reply to help the Physician that has been e-mailed. This is similar to how a phone message is handled.
- Our system will check when messages are viewed, so you do not need to reply that you have read it.

Response Time:

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need an immediate response.

Sunstate Doctors Medical Group
PATIENT AND FAMILY REQUEST FOR PATIENT PORTAL

I hereby request access to the Patient Portal maintained by Sunstate Doctors Medical Group for the patient named below. I understand that Sunstate Doctors Medical Group takes seriously its responsibility to safeguard the privacy of its patients and protect the confidentiality of their protected health information. Therefore, I will only access the Patient Portal in a matter consistent with these terms. I will keep safe the sign-on and password that I am assigned and will not share my log-in information with anyone else. I agree that Sunstate Doctors Medical Group will not be liable for any disclosure of information due to unauthorized use of my sign-on and password. If I feel my sign-on and password combination have been compromised, I will contact Sunstate Doctors Medical Group immediately or go to the Patient Portal and request a new password.

I understand that the Patient Portal will only allow me to view my records for the patient. If I accidently gain access to another patient's information, I will cease to view it and notify Sunstate Doctors Medical Group immediately. In no event will I deliberately attempt to access information for any person other than myself. I represent to Sunstate Doctors Medical Group that I am a personal representative of the Patient with the right to access the Patient's health information, or that the patient has expressly authorized me to have access. If my status as personal representative changes so that I no longer have such rights, or if the Patient's authorization expires or is revoked, I will immediately cease using the Patient Portal to access the Patient's information and will notify Sunstate Doctors Medical Group.

Patient Name (print):_____ DOB: _____

Email Address: _____

Patient signature: _____

-OR -

Parental Guardian: _____

Sunstate Doctors Medical Group

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy informing them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Sunstate Doctors Medical Group can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding the above, I hereby provide consent to Sunstate Doctors Medical Group to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient

Sunstate Doctors Medical Group, Inc.
5113 SR 674, Suite 103 Wimauma, FL 33598
Phone: 813-633-2000; Fax: 813-849-9301

MEDICAL RECORDS RELEASE FORM

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name (if any): _____ SSN#: _____

I request and authorize release of my healthcare information:
☐ To ☐From ☐ To ☐ From

Sunstate Doctors Medical Group
5113 SR 674, Suite 103
Wimauma, FL 33598
Phone: 813-633-2000 Fax: 813-849-9301

This request and authorization apply to:

□ All Records for continued care
□ Other: _____

I authorize the release of my entire medical record via either telephonic, face-to face, or written communications to the above-named individual(s).

The following sensitive information must be specifically initialed to be included:

□ My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
□ My diagnosis and/or treatment regarding mental health issues.
□ HIV antibody test results and/or AIDS diagnosis and treatment.
□ Genetic test results and/or related treatment.
□ Other: ___

I understand that:

1. This authorization expires one year after it is signed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it.
2. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. I certify that this request has been made freely, voluntarily and without coercion and that the information above is accurate and complete to the best of my knowledge.

If patient is unable to give consent because of physical/mental condition or age, complete the following:

Patient is: [ ] a minor _____ years of age
Patient is: [ ] is unable to give authorization because _____

Patient Signature: _____ Date: ___/___/_____

If not patient, please circle one of the following selections which applies:
Parent - Guardian - POA - Other
Personal Representative(s) must provide appropriate documentation to verify your legal authority to act on this patient's behalf.

Sunstate Doctors Medical Group

PATIENT CONSENT FOR THE PARTICIPATION WITH HEALTH INFORMATION EXCHANGE (HIE)

Patient Last Name: _____ First Name: _____Middle: ____

Nickname: _____ DOB: _____ SSN: _____

- In most cases your authorization is not required for treatment, payment, or coordination of care, unless you request your information not to be shared.
- Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically thus improving the speed, quality, safety, and cost of patient care.
- This consent form permits your healthcare providers to access your health information from places where you receive medical treatment and makes this vital information available to coordinate your care.
- Right to revoke: If you decide you do not want us to share your health information any longer, request the revocation form and give to the front desk. The revocation would be for future uses and disclosures and will not protect information from previous authorizations.

_____ I consent to participate in my providers Health Information Exchange (HIE).
_____ I authorize disclosure to all my current treating providers who participate in the Health Information Exchange (HIE). I understand that I have a right to receive a list of all such disclosures from the Health Information Exchange. This authorization will automatically expire if a patient has not been seen within two years from the date below.

This form must be signed by EITHER the patient OR by the personal representative. The patient's parent may sign for the patient if the patient is a minor.

Signature of Patient: _____ Date: _____

If this form is not signed by the patient, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

Sunstate Doctors Medical Group

ADVANCE DIRECTIVE QUESTIONNAIRE

Patient Name _____DOB:_____

Sunstate Doctors Medical Group would like to encourage all patients to have an Advance Directive on file with our office.

Under the Patient Self-Determination Act of 1990, each individual has the right to determine the course of his/her medical care and treatment. You make these choices now so that when you become unable, your decisions are known. Advance Directives only take effect if, in the future, you lose the capacity to speak for yourself. It has no effect on your current health care as long as you are able to speak for yourself.

Advance Directives for Health Care consist of three parts:
Health Care Proxy, Living Will and Other Wishes.

Health Care Proxy: Designates another person to make medically related decisions for you.
Living Will: Designates your future health care treatment choices.
Other Wishes: Designates your wishes regarding Death, Organ Donation and Autopsy.

You may, at any time, complete any section and our office will keep a copy of your wishes on file for you. If you are not ready today, please ask at any time for the form. We will review this annually with you.

	Circle One
Do you have a living will?	YES NO
Do you have a Health Care Proxy?	YES NO
If no, would you like the form to fill out?	YES NO
If yes, would you like to have a copy in our chart for you?	YES NO

I am not ready to fill out this form. Please ask me about this in the future. _____

_____ _____

Patient Signature Date

Office use:

Gave patient Advance Directives form_____
Patient completed form and filed in chart_____
Reviewed with Patient _____

Sunstate Doctors Medical Group

Patient Name: _____

DOB: _____

Functional Status Assessment

Cognitive Status O Good O Fair O Cognitive Impairment O Dementia O Alzheimer's O Parkinson's

Ambulatory Status O Independent O Needs assistive device O Cane O Walker O Wheelchair O Scooter O Non Ambulatory

Sensory Ability

Hearing O Good O Fair O Poor O Hearing Aids/Device

Vision O Good O Fair O Poor O Glasses O Contacts O Blind

Touch O Good O Fair O Poor **Taste** O Good O Fair O Poor **Smell** O Good O Fair O Poor

Activities of Daily Livings (ADLs)

Do you need help with following ADLs? O **None** (Fill in only Those that apply)

O Grooming O Dressing O Toilet Use O Housework

O Preparing Meals O Eating O Walking O Bathing

O Taking Meds O Shopping or Errands O Others _____

Advance Care Planning

Do you have the following?

O Living Will O Advance Directives O Surrogate Decision Maker O DNR order

Pain Assessment

Does the patient have any "Chronic pain(s)"? O Yes O No (if no skip rest of this section) If Yes:

Intensity: On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how much does it hurt right now.

No pain Moderate Worst pain

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Location: O Left Side

O Neck O Shoulder O Elbow O Forearm O Wrist O Hand O Knee O Foot O Upper back O Lower back

O Right Side

O Neck O Shoulder O Elbow O Forearm O Wrist O Hand O Knee O Foot O Upper back O Lower back

Current treatment: O On Pain Meds O Under Pain Mgmt.

••••Screen

In the last one year have you had:

An injury from a fall? O Yes O No

More than one fall? O Yes O No

_____ _____

Patient Signature Date

Sunstate Doctors Medical Group

PATIENT HEALTH QUESTIONNAIRE – 9
(PHQ-9)

Depression Screening: Please complete the following questionnaire.

MEMBER: _____

GENDER: _____ DOB: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Sunstate Doctors Medical Group

PATIENT INITIAL INTAKE QUESTIONNAIRE

Please show your answer by filling up the bubble signs e.g. ●

Name: _____ **DOB:** _____ **Sex:** ○ **M** ○ **F**

Who was your previous primary care provider? _____

CURRENT MEDICATIONS (Please list all of your medications):

Name of Medication	Dosage/Strength	Frequency/dosing Instructions
Example: Tylenol	*Example:500 mg*	*Example: 1 pill three times a day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Note: this information may be taken directly from the pharmacy label on prescription bottles

ALLERGIES (Are you allergic or sensitive to any medication?)

○ No Known Allergies ○ Medication Allergies ○ Environmental/Seasonal Allergies ○ Latex Allergy

Allergies	Reaction
Example: Dust, pollen, ibuprofen, amoxicillin etc.	*Example: skin rash, itchy eyes, hives, face bumps etc.*

PERSONAL MEDICAL HISTORY: Only **select** whatever is applicable.

○ NONE

Condition	Yes	Comments	Condition	Yes	Comments
Allergy (Hay Fever)	○		Coronary Artery Disease	○	
Anemia	○		Cancer (What Type) (History or current)	○	
Angina	○		Chicken Pox	○	
Anxiety	○		Colon Polyp	○	
Arthritis	○		Depression (Major) (Bipolar)	○	
Asthma	○		Diabetes (type I) (type II)	○	
Bladder/Kidney Problems	○		Diverticulosis	○	
Blood Clot (leg) (lung)	○		Emphysema (COPD)	○	
Blood Transfusion	○		Fractures (broken bones) (Specify)	○	
Breast Lump (benign)	○		GERD/Acid Reflux/Heartburn	○	

Patient Initials _____ DOB: _____

Condition	Yes	Comments	Condition	Yes	Comments
Heart Attack / Myocardial Infarction (year)	◯		Osteoporosis	◯	
Hepatitis- (specify type)	◯		Prostate (enlargement) (nodules)	◯	
High Blood Pressure/Hypertension	◯		Seizure/Epilepsy	◯	
High Cholesterol	◯		Skin Condition (specify)	◯	
Irritable Bowel Syndrome (IBS)	◯		Sleep Apnea	◯	
Chronic Kidney Disease / Failure (CKD)	◯		Stomach Ulcer	◯	
Kidney Stones	◯		Stroke	◯	
Liver Disease	◯		Thyroid disease	◯	
Migraine Headaches	◯		Other (list)	◯	

PAST SURGICAL HISTORY (Have you had any of the following surgical procedures?): ◯ None.

Surgical Procedure	Yes	MM/YY	Surgical Procedure	Yes	MM/YY
Appendectomy (Appendix removal)	◯		Hysterectomy (total, including ovaries)	◯	
Spine/back Surgery (lumbar)	◯		Hysterectomy (partial, ovaries left)	◯	
Breast Surgery	◯		Knee Replacement	◯	
Pacemaker	◯		LEEP (Cervix Surgery)	◯	
Coronary Stent	◯		Neck Surgery	◯	
EGD (Stomach Endoscopy)	◯		Ovary Ligation("Tubal")	◯	
Cataract Surgery	◯		Ovary Removal/oophorectomy	◯	
Gallbladder Removal/Cholecystectomy	◯		Tonsillectomy	◯	
Heart Surgery /coronary artery bypass	◯		C-Section _____	◯	
Hip Replacement	◯		Other (list)_____	◯	

PAST HOSPITALIZATIONS:

DATE	Reason

Patient Initials _____ DOB: _____

FAMILY HISTORY:

Adopted — ◯ Yes ◯ No (please Check) if yes and you do not know your family history skip this section and continue to next page.

Indicate which relative has had the following diseases (parents and siblings are most important)

Family Members	Status (alive, deceased, or unknown)	Age (yrs)	Conditions
Father			
Mother			
Siblings			
Other Relatives			
Other Relatives			

SOCIAL HISTORY

Personal History

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ No Answer

Adults in household: _____

Children: ◯ Yes ◯ No Number of Children: _____ Ages if under 18 years: _____

Living Situation: ◯ Live Alone ◯ With Significant Other/Spouse ◯ With Children/Family Members ◯ Others

Employment status: ◯ Employed ◯ Unemployed ◯ Retired

Hobbies/Interests: ◯ Fishing ◯ Biking ◯ Reading books ◯ Traveling
◯ Other outdoor activities ◯ Cooking ◯ Other _____

Tobacco

Are you a: ◯ Current Smoker ◯ Former Smoker ◯ Never Smoked (if you never smoked, please go to alcohol use question now)

If former smoker:

How long has it been since you last smoked?

◯ <1 month ◯ 1-3 months ◯ 3-6 months ◯ 6-12 months ◯ 1-5 years ◯ 5-10 years ◯ >10 years

If current smoker:

Are you interested in quitting?

◯ Ready to quit ◯ Thinking about quitting ◯ Not ready to quit

How many cigarettes a day do you smoke?

◯ 5 or less ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31 or more

How soon after you wake up do you smoke your first cigarette?

◯ Within 5 mins ◯ 6-30 mins ◯ 31-60 mins ◯ after 60 mins

How often do you smoke cigarettes?

◯ every day ◯ some days, but not every day

Alcohol

Do you drink alcohol in the last year? ◯ Yes ◯ No

If yes:

How often did you have alcoholic drink?

◯ Never ◯ Monthly or less ◯ 2-4 times a month ◯ 2-3 per week ◯ 4 or more per week

How many drinks did you have on a typical day when you were drinking?

◯ 1 or 2 drinks ◯ 3 or 4 drinks ◯ 5 or 6 drinks ◯ 7 or 9 drinks ◯ 10 or more drinks

How often did you have 6 or more drinks on one occasion?

◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ◯ Yes ◯ No

If yes, please specify type of drug and frequency of use - _____

Diet/Activity

How would you rate your diet? ◯ Good ◯ Fair ◯ Poor

Are you on any special diet? ◯ Yes ◯ No

If yes, how would you describe your diet? _____

Do you exercise regularly? ◯ Yes ◯ No

If yes:

How frequently:

◯ Daily ◯ Every other day ◯ three days a week ◯ weekly ◯ only few days a month

Intensity is:

◯ Mild ◯ Moderate ◯ Mild to Moderate ◯ Moderate to Severe ◯ Severe

How long?

◯ 5-10 mins ◯ 10-15 mins ◯ 15-30 mins ◯ 30-60 mins ◯ more than 1 hr

Sexual Activity

Sexually involved currently: ◯ Yes ◯ No

If yes:

Sexual Partner(s) is: ◯ male ◯ female

Do you use protection? ◯ Yes ◯ No

If yes, how often? ◯ All the time ◯ most of the time ◯ Half the time ◯ sometimes

Protection method: ◯ Abstinence ◯ Condoms ◯ Other

Have you ever had a Sexually Transmitted Disease? ◯ Yes ◯ No

If yes, which?

◯ Chlamydia ◯ GC ◯ Syphilis ◯ Herpes ◯ Other

Patient Initials _____ DOB: _____

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services, please indicate N/A (not applicable).

All Patients:

Last Complete Physical Date: _____ By: _____

Last Tetanus Booster ◯ Within past 10 years ◯ More than 10 years ago ◯ Unknown

Last Eye Exam ◯ Yes ◯ No
Date: _____ By: _____

Last Colon Cancer screening:

Colonoscopy: ◯ Yes ◯ No
Date: _____ By: _____

Stool Card: ◯ Yes ◯ No
Date: _____ By: _____

Last DEXA Bone Scan Date: _____ ◯ Normal ◯ Abnormal ◯ Unknown

Last Pneumonia Vaccine ◯ Yes Date: _____ ◯ No

Flu shot this season? ◯ Yes Date: _____ ◯ No

Only Women:

Last Pap Smear Date: _____ ◯ Normal ◯ Abnormal ◯ Unknown

Last Mammogram Date: _____ ◯ Normal ◯ Abnormal ◯ Unknown

Only Men:

Last Prostate Specific Antigen-PSA Date: _____ ◯ Normal ◯ Abnormal ◯ Unknown

Last Prostate Exam Date: _____ ◯ Normal ◯ Abnormal ◯ Unknown

Patient Initials _____ DOB: _____

List of Current/Previous Providers involved in your care:

NAME, ADDRESS, PHONE and FAX

1. **Previous PCP:** _____
2. **Eye Specialist:** _____
3. **Cardiologist:** _____
4. **Pulmonologist:** _____
5. **Gastroenterologist:** _____
6. **Other Specialists:** _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____