Barbara A. Pacholec, MD

1621 22nd Ave N
St Petersburg, FL 33713
Phone: 727-502-2000
Fax: 727-502-2006

24622 State Rd 54
Lutz, FL 33559
Phone: 813-909-4430
Fax: 813-949-2684

PATIENT INFORMATION

(Please Print)
Patient Name:_____
First MI Last

Date of Birth:_____Age:_____Sex: M F Religion:_____

Social Security Number:_____Martial Status: Single Married Divorced Other

Address:_____

City:_____State:_____Zip Code:_____

Home Phone #( )_____Cell Phone # ( )_____

Email : _____@_____

Employer:_____Work Phone: ( ) Spouse/Partner

Name:_____Contact Phone:( )_____

Whom may we thank for referring you?_____or was it
Magazine Ad? Google? Drive-By? Facebook/Instagram? Physcian (print name):

Person to contact in case of emergency:_____Phone: ( )_____

I understand that is my responsibility to:
Notify the office of any changes to my address and/or phone numbers.
Notify the office at least 24 hours in advance of appointment cancellations

Office Policies:
Payments can be made by CASH, CHECK, MASTERCARD, VISA, AND AMERICAN EXPRESS.
There is a $25.00 charge for missed appointments not cancelled with 24 hours.
There is a **$30.00** fee for all returned checks. Multiple check returns will require patient to pay with cash or credit cards at future appointments and checks will no longer be accepted.
The patient is financially responsible and in the event of default, agrees to pay all costs of collection and reasonable attorney fee's when collecting past due accounts.

Patient Signature:_____Date:_____

Barbara Pacholec, M.D.

Medical History Form

Patient Name:_____ Age:_____ Sex: M F

Family Physician:_____ Phone:_____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____

3. Are you taking any medications at the present time? Yes No
   What:_____ Dosage:_____
   What:_____ Dosage:_____

4. Any allergies to medication? Yes No
   If so, what†_____

5. History of High Blood Pressure? Yes No
6. History of Diabetes? If so, at what age7_____ Yes No
7. History of Heart Attack or Chest Pain? Yes No
8. History of Swelling Feet? Yes No
9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medication for headaches:_____
10. History of Constipation? (difficulty in bowl movements)? Yes No
11. History of Glaucoma? Yes No
12. Do you have sleep apnea? Yes No
13. Gynecologic History:
    Pregnancies: Number:_____ Dates:_____
    Natural delivery or c-section: (specify)_____
    Menstrual: Onset at what age:_____
    Duration:_____
    Are they regula ? Yes No Pain associated? Yes No
    Last menstrual period†_____

    Hormone Replacement Therapy? Yes No
    If yes, what ?_____
    Birth Control Pills: If yes what type:_____ Yes No
    Last check up:_____
14. Serious Injuries? Yes No
    Specify :_____ Date :_____

15. Any Surgeries: Yes No
    Specify:_____ Date:_____
    Specify:_____ Date:_____

16. Family History:

	Age	Health	Disease	Cause of death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following?

Glaucoma:	Yes No	Who:	
Asthma	Yes No	Who:	
Epilepsy	Yes No	Who:	
High Blood Pressure	Yes No	Who:	
Kidney Disease	Yes No	Who:	
Diabetes:	Yes No	Who:	
Tuberculosis	Yes No	Who:	
Psychiatric Disorder	Yes No	Who:	
Heart Disease/Stroke	Yes No	Who:	

Patient Past Medical History:

_____Polio	_____Measles	_____Tonsillitis	_____Jaundice
_____Scarlet Fever	_____Pleurisy	_____Kidneys	_____Mumps
_____Liver Disease	_____Lung Disease	_____Whooping Cough	_____Gout
_____Chicken Pox	_____Rheumatic Fever	_____Bleeding Disorder	
_____Nervous Breakdown	_____Ulcers	_____Thyroid Disease	____Tuberculosis
_____Anemia	_____Heart Valve Disorder	_____Heart Disease	_____Cancer
_____Gallbladder Disorder	_____Psychiatric Illness	_____Drug Abuse	_____Eating Disorder
_____Alcohol Abuse	_____Pneumonia	_____Malaria	_____Typhoid Fever
_____Osteoporosis	_____Blood Transfusion	_____Arthritis	_____Other_____

Nutrition Evaluation:

1. Present Weight:_____ Height (no shoes):_____ Desired Weight:_____
2. In what time frame would you like to be at your desired weight?_____
3. Birth Weight?_____ Weight at 20 years of age:_____Weight one year ago:_____
4. What is the main reason for your decision to lose weight?_____
   _____
5. When did you begin gaining excess weight?_____
6. What has been your maximum lifetime weight? (non-pregnant) and when?_____
7. Previous diets you have followed? Also Give dates and results of your weight loss:
   _____
   _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is her or she overweight?_____
10. How often do you eat out?_____
11. What restaurants do you frequent?_____
12. How often do you eat "fast foods?"_____
13. Who plans meals?_____Cooks?_____Shops?_____
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you shop for groceries?_____
16. Food allergies?_____
17. Do you drink coffee or tea? Yes No How much daily?_____
18. Do you drink cola drinks? Yes No How much daily?_____

19. Do you drink alcohol? Yes No
What?_____How much?_____Weekly?_____
20. Do you use sugar substitute?_____Butter?_____Margarine?_____
21. Do you awaken hungry during the night? Yes No
What do you do?_____
22. What are your worst food habits?_____
23. Snack Habits: What?_____How Much?_____When?_____
24. When you are under a stressful situation at work or family related, do you tend to eat more? Explain

_____

_____

25. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain.

_____

_____

26. Smoking Habits: (answer only one)
_____You have never smoked cigarettes, cigars or a pipe.
_____You quit smoking ____years ago and have not smoked since.
_____You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhale smoking.
_____You smoke 20 cigarettes per day (1 Pack)
_____You smoke 30 cigarettes per day (1 ½ Packs)
_____You smoke 40 cigarettes per day (2 Packs)
_____Do you chew Tobacco?

27.

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten:_____	Time eaten:_____	Time eaten:_____
Where:_____	Where:_____	Where:_____
With whom:_____	With whom:_____	With whom:_____

28. Describe you usual energy level:_____
29. Activity Level: (answer only one):
_____Inactive –no regular physical activity with a sit down job.
_____Light activity- no organized physical activity during leisure time.
_____Moderate activity – occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____heavy activity – consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____Vigorous activity – participation in extensive physical exercise for at least 60 minutes per session 4 times per week.
30. Behavior style: (answer only one):
_____You are always calm and easygoing.
_____You are usually calm and easy going.
_____You are sometimes calm with frequent impatience.
_____You are seldom calm and persistently driving for advancement.
_____You are never calm and have overwhelming ambition.
_____You are hard driving and can never relax.
31. Please describe your general health goals and improvements you wish to make:_____
_____

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PATIENT PRIVACY QUESTIONAIRE

PatientName:_____Date of Birth:_____

Please list the family members or significant others, if any, whom we may infom about your medical condition and your diagnosis (Including treatment, payment, appointments and healthcare options)

Name:_____Relationship:_____Phone #_____
Name:_____Relatiomhip:_____Phone#_____
Name:_____Relationship:_____Phone#_____

Whom would you like us to notify in case of a emergency?
Name:_____Relationship:_____Phone It_____

Please print the address of where you would like yow correspondence from our office to be sent to:

_____

_____

Please indicate whether or not you would want to receive calls about you appoinment reminder, follow ups, test results, etc.__YES___NO
At which phone number would you like these calls: _____
Alternate phone number:_____

Can confidential messages (appt. reminders, lab results, etc) be left on your telephone answering machine or voicemail?___YES___NO

_____

Patient Signature Date

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Weight Loss Program Consent Form

I,_____authorize Dr. Barbara Pacholec and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressants medications. Other treatment options may include a very low calorie diet, or a **protein** supplemented diet. I further understand that if appetite suppressants are used, they may be used for duration exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health **risks** associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks, on occasion, be serious or even fatal. **Risks** associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack, and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase additional weight gain.

I understand that much of the success of the program will depend on my efforts and that are no guarantees or assurances that the program will successful. I understand that obesity may be chronic, life-long condition that may require changes in eating habits arid permanent changes in behavior to be treated successfully,

I have read and fully understand this consent for and realize I should not sign this for if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or together possible treatments, ask your doctor before signing this consent form.

_____ _____

Patient Signature or Guardian Signature if pt under 18 Date

_____ _____

Witness Signature Date

Notice of Privacy Practices

Barbara A. Pacholec, MD

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

PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT.

Barbara A. Pacholec, MD is required by law to maintain the privacy of protected health information (PHI) and to provide individuals with the notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change our privacy practices and the terms of this Notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclose your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. The terms of this Notice of Privacy Practices are effective November 1, 2004.

USE AND **DISCLOSURES REQUIRING YOU TO** HAVE AN OPPORTUNITY **TO OBJECT.**

Family and Friends. With your approval and using our professional judgment, your health information may be disclosed to designated family, friends and others who are directly involved I your care or in the payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval.

Patient Directories. Your name, location, and general condition may be put into our patient directory for disclosure to callers or visitors who ask for you by name. Your religious affiliation may be share with clergy

USES AND **DISCLOSURES OF PHI**

The following uses and disclosures of PHI may be made without your prior consent or authorization

1. Required by Law. If we suspect child abuse or neglect, we may also release health information as required by law, or related to suspected criminal activity, or in response to a court order.
2. To Avert Threats to Health or Safety.
3. For Health Oversight Activities.

4. Relating to Decedents. We may release health information to coroners and/or funeral directors consistent with the law.
5. **For Research Purposes.** In certain circumstances and with your prior authorization, we may use or disclose health information for research purposes.
6. For Public Health Activities. Such as required reporting of disease, injury, birth and death and for required public health investigations.

7. For Specific Government Functions. If you are a member of the military as required by armed forces services. We may also release your individual heath information if necessary for national security or intelligence activities. Also, to workers compensation agencies.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

1. Restrictions on Use and Disclosure if Individual **Health Information. You** have the right to request that we restrict how we use and disclosure your health information. These restrictions must be made in writing and signed by you or your representative. *We are not required to agree to your restrictions.* We cannot agree to limit uses or disclosures that are required by law. In the event of termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.
2. Access to Individual Health Information. You have the right to inspect and copy your health information. All such requests must be made in writing and signed by you or your representative. You will be charged a fee of 1.00 per page if you request a copy of the information. There will also be a charge for postage if you request a mailed copy and, if requested, for preparation of a summary of the requested information. You may obtain a Request for Access form from the Privacy Officer. We will respond within 30 days unless an extension is taken. In certain circumstances, you may not be permitted access. Depending on the circumstances, you may request a review of the decision to deny access. If we deny your request, you will begiven written notice that will explain the basis and your right to appeal.
3. Amendments to Individual Health Information. You have the right to request that your health information be amended or corrected. We will respond within 60days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal, which will be appended to your health information. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative and must state the reasons for amendment. If we make an amendment, we may notify others who work with us and have copied of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the privacy officer.
4. **Accounting for Disclosures of Individual Health Information.** You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. The first accounting in any 12-month period is free; you will be charged a fee of $3.00 for each subsequent accounting within the same twelve-month period. The right to receive this information is subject to certain expectations, restrictions and limitations.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Barbara A. Pacholec, MD is committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purpose of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization in. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations. Except as otherwise provided, we may use and disclose your health information for purposes of treatment, payment, and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to another health care provider who, at the request of your physician, becomes involved in your treatment, for purposes of approval of reimbursement for your health plan, or audit purposes, we may disclose to out account or attorney.

Business Associates. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Appointments and Services. We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by sending your written request to the Privacy Officer.

Questions

You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to our Privacy Officer.

If you have any questions about this Notice, please contact the privacy officer.

How to Complain About Our Privacy Practices:

If you believe that we may have violated your privacy rights, or you disagree with a decision about access to your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D..C 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

If you have questions about this Notice or any complaints about our privacy practices, please contact:

813-909-4430 or 727-502-2000

Effective Date:
This Notice is effective October 19, 2018

By signing below, I hereby acknowledge receipt of this Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date