Rehabilitation and Electrodiagnostics, P.A.
Pediatric Patient History Questionnaire

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Doctors	Specialty	Phone Number	Indicate (√) as appropriate	
			Primary Care	Referring Doctor

- What is the main reason you are here today? ☐ Evaluate for Rehabilitative Needs ☐ Spasticity
  ☐ Other reason *(specify)*: _____

HISTORY OF PRESENT ILLNESS (HPI):

- Describe the reason for your visit in further details: _____
- What has been done previously for this problem? _____
- Current Therapies (PT, OT, ST) and frequency: _____
- Any improvement or worsening with the above interventions? *Describe:* _____
- The patient has difficulties with:

Skills	Indicate (√)			Comments *(special equipment needs, quality of assistance needed)*
	No difficulties	Needs Assistance	Task performed by Caregiver	
Walking/mobility				
Dressing				
Bathing				
Toileting				
Feeding				
Chewing/swallowing				
Speech/communication				
Fine-Motor Skills/Dexterity				
Transferring				

PAST MEDICAL, FAMILY, SOCIAL HISTORY:

- Child's Medical History

Current Medications: _____

Allergies: History of skin or other reaction to Drugs/Medications: _____

Other: _____

Rehabilitation and Electrodiagnostics, P.A.
Pediatric Patient History Questionnaire

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Birth History:

Pregnancy: ☐ Uncomplicated ☐ Complicated (explain): _____

Labor & Delivery: ☐ Uncomplicated ☐ Complicated (explain): _____

☐ Spontaneous ☐ Induced ☐ Vaginal ☐ C-section

☐ Full-Term ☐ Premature Length of Pregnancy (week's gestation): ____ Birth Weight: ____

Prenatal Problems: _____

Place / Hospital of Birth: _____

Length of hospitalization after Birth: _____

Condition (√)	Yes	No	Condition (√)	Yes	No	Condition (√)	Yes	No
Cerebral Palsy			Spina Bifida			Asthma		
Mental Retardation			Spasticity			Muscular Dystrophy		
Traumatic Brain Injury			Seizures			Joint Contracture		
Spinal Cord Injury			Reflux			Pain		
Other								

Family History: Please list (**Y**=Yes, **N**=No) any medical problems in relatives: **M**=Patient's Mother, **F**=Patient's Father, **S**=Patient's Siblings

Condition	Y/N	M	F	S	Condition	Y/N	M	F	S
Congenital Birth Defects					Diabetes				
Mental Retardation					Stroke				
Syndromes/Delays					Tuberculosis				
Seizures					Heart Disease				
Muscular Dystrophy					Arthritis				
Autoimmune					Allergies				
HIV/AIDS					Cancer				
Kidney Disease					Asthma				
Anemia					Other				

- **Prior Interventions** for spasticity and outcomes (serial casting, splinting, oral medications, Botox, Intrathecal, baclofen, etc,): _____
- **Past Surgeries:** _____
- **Other Past Hospitalizations:** _____

Social History:

Parents' Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Does someone smoke tobacco in the home? ☐ Yes ☐ No

Homes Structure (house, apartment, etc.): _____

☐ 1 Story ☐ 2 Story ☐ Other ☐ Stairs (if yes, how many? _____) ☐ Ramp Access

Persons living in household: _____

Others involved in child's care: _____

Caregiver's employment: Mother_____ Father _____ Other _____

School Status: School: _____ Grade: _____ Classroom Type: _____

School Concerns: ☐ None Yes (explain) _____

Immunizations ☐ Up to date ☐ Not up to date (explain): _____

Rehabilitation and Electrodiagnostics, P.A.
Pediatric Patient History Questionnaire

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Constitutional	Yes	No	Ears/Nose/Mouth/Throat	Yes	No	Eyes	Yes	No
Good General Health			Hearing loss or ringing			Visual loss		
Recent Weight Change			Sinus Problems			Blurred/double vision		
Night Sweats/fevers			Nose Bleeds			Eye disease or injury		
Fatigue			Sore throat/voice change			Glaucoma		
Cardiovascular			**Respiratory**			**Gastrointestinal/Nutrition**		
Chest Pain			Shortness of breath			Nausea/Vomiting		
Palpitation			Cough			Abdominal Pain/Bleeding		
Heart murmur			Wheezing/Asthma			Difficulty Chewing/swallowing		
Swelling hands/feet			Swelling hands/feet			Bowel/constipation		
Coughing up blood			Lung Disease			Diarrhea		
Musculoskeletal			**Neurological**			**Integumentary Skin**		
Arthritis			Frequent Headaches			Change in hair/nails		
Back Disorder			Paralysis or Tremors			Rashes or itching		
Backache			Convulsions/seizures			Breast lump		
Cold Extremities			Dizziness			Breast pain or discharge		
Difficulty Walking			Memory loss			**Allergic / Immunologic**		
Joint Pain			Nervous Disorder			Food Allergies		
Joint swelling/stiffness			Numbness/Tingling			Aspirin Allergies		
Leg Pain			Spasticity			Antibiotic Allergies		
Muscle pain/cramps			**Endocrine**			**Psychiatric / Cognitive**		
Weakness Muscles			Excessive thirst/urination			Insomnia		
Hematologic/Lymphatic			Thyroid Disease			Confusion/memory loss		
Bruise Easily			**Genitourinary**			Depression		
Slow to Heal			Hormone problem			Difficulty Concentrating		
Enlarged Glands			Blood in urine			Impulsivity		
Anemia			Kidney Stones			Difficulty Reasoning/Problem Solving		
Bleeding Disease			Sexual Problems					

- If you answered "yes" to any of the above questions, please explain in more detail only if the condition is related to your "present Problem: _____

- Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance: _____

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____

PHYSICIAN STATEMENT: I have reviewed the questionnaire with the patient.

Signed: _____ Date: _____

FOR OFFICE USE ONLY:

Physician Notes: _____

CC/Hx of Present Illness Past, Fam. & Social History Review of Systems	Brief (1-3 elements) None None	Brief (1-3 elements) None Problem Specific (1 system)	Extended (4+) 1 or 2 history areas Extended (2-9 systems)	Extended (4+) 3 history areas Complete (10+ systems)
Type of history	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Comprehensive**

Rehabilitation and Electrodiagnostics, PA

Patient Demographic Sheet			
Name Last First M.I.			Date
Street Address			Apt#
City	State		Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Social Security Number ___ ___	Date of Birth / /	Age	___Male ___Female
Email Address			
Height _____ Weight _____	Marital Status S M D W		

Emergency Contact/Name	Emergency Phone ( )	Relationship to Patient
Guarantor (Financially Responsible Person) Last First		Relationship to Patient
Guarantor Social Security Number ___ ___	Guarantor Phone Number ( )	
Street Address		Apt#
City	State	Zip Code

Referring Physician	Phone ( )
Primary Care Physician	Phone ( )

Patient Signature_____ Date_____

Patient Name: _____ Today's Date: _____

PLEASE NOTE: All co-payments, deductibles and co-insurance are due at time of service. If your insurance requires a referral, this MUST be obtained from your primary care physician prior to office visit. It is your responsibility to obtain referral.

Primary Insurance Information		
Insurance Name: Are you the policy holder? **YES** **NO**		
Policy Number:	Group Number:	
If you are not policy holder, fill in required fields below		
Policy Holder Name:	P.H. Date of Birth / /	Policy Holder Social Security # ___ ___

Secondary Insurance Information		
Insurance Name: Are you the policy holder? **YES** **NO**		
Policy Number:	Group Number:	
If you are not policy holder, fill in required fields below		
Policy Holder Name:	P.H. Date of Birth / /	Policy Holder Social Security # ___ ___

Patient Signature_____ Date_____

Office Use Only	
Method of Payment: Cash___ Check___ Credit Card___	Amount $_____
Charges applied to: Co pay/Ded___ Pt Bal___ Both___	Taken By:

Patient Name:_____ Today's Date: _____

FINANCIAL AGREEMENT

(Financial responsibility, Assignment of Benefits, Non-covered services)

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to Rehabilitation and Electrodiagnostics, P.A. I hereby authorize Rehabilitation and Electrodiagnostics, P.A. to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Rehabilitation and Electrodiagnostics, P.A.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide Rehabilitation and Electrodiagnostics, P.A. with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). Rehabilitation and Electrodiagnostics, P.A. is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. I will notify Rehabilitation and Electrodiagnostics, P.A. immediately upon any change in my insurance.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am responsible for any applicable deductible or co-payments prior to the provision of services. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection. (This section does not apply to Workers' Compensation patients)

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature: _____

Employee's signature who reviewed intake of form: _____

Patient Name:_____ Today's Date: _____

Acknowledgment
Of Receipt of Privacy Notice
For Rehabilitation and Electrodiagnostics, P.A.

Refer to Rehabilitation and Electrodiagnostics, P.A.'s Notice of Privacy Practices for a more complete description of use and disclosure of Protected Health Information. Rehabilitation and Electrodiagnostics, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rehabilitation and Electrodiagnostics, P.A. Privacy Officer at 2914 North Boulevard, Tampa, FL 33602.

With my consent, Rehabilitation and Electrodiagnostics, P.A. may use and disclose *Protected Health Information (PHI)* about me to carry out *Treatment, Payment and Healthcare Operations (TPO).*

I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, Rehabilitation and Electrodiagnostics, P.A. may:

1. Call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others;

2. Mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential;

3. E-mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rehabilitation and Electrodiagnostics, P.A. restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to Rehabilitation and Electrodiagnostics, P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

_____ _____
Signature of Patient or Legal Representative Date

Patient Name: _____ Today's Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at (813)228-7696.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

Patient Name: _____ Today's Date: _____

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities: We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings: We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding. To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation: We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation: We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising: Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in should with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders: We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership: In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all

your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Laura Porter at (813)228-7696.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

REHABILITATION AND ELECTRODIAGNOSTICS, PA

Venerando I. Batas, MD
Rodolfo D. Eichberg, MD
Roberto V. Dominguez, MD
Melinda H. Hayes, MD
Paul B. Kornberg, MD
Sheryce M. Andrews, MD

HIPAA Patient Questionnaire

1. Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____

_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": Yes: _____ No: _____

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number:

_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes: _____ No: _____

7. I understand the Privacy Protection Act.

PATIENT NAME: _____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

PHONE: 813.228.7696 ▪ FAX: 813.228.0677 ▪ INFO@PMRDOCS.COM ▪ WWW.PMRDOCS.COM

MAIN OFFICE: 2914 N BOULEVARD, TAMPA, FL 33602

500 VONDERBURG, EAST TOWER, STE 205, BRANDON, FL 33511 ▪ 3001 W DR MARTIN LUTHER KING JR. BLVD, 3RD FLOOR, TAMPA, FL 33614

Patient Name: _____ Today's Date: _____

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY
PLEASE SIGN ONLY AFTER YOU READ AND UNDERSTAND THE FOLLOWING

Patient Name (please print)_____

I, _____, whose signature appears below, authorize Rehabilitation and Electrodiagnostics P.A. to view the external prescription history via the RxHub service for the patient listed above.
I understand that a prescription history from multiple unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by the providers and staff of Rehabilitation and Electrodiagnostics P.A. and may include past prescriptions from several years ago.

MY SIGNATURE CERTIFIES THAT I HAVE READ THE ABOVE, UNDERSTAND AND AUTHORIZE THE ACCESS OF MY EXTERNAL PRESCRIPTION HISTORY.

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
If Guardian, Relationship to Patient **Date**

_____ _____
Witness to Patient/Guardian's Signature **Date**

BayCare
Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX only:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, c1inical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Heaith System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

BayCare
Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of healthcare, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. **Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☐ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

Printed Name of Patient/Representative	Signature of Patient/Representative	Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____

Rehabilitation and Electrodiagnostics, PA
Patient Portal Consent Form

Emergencies: Call 911; DO NOT use the Patient Portal to communicate

For urgent problems, call our office at **813-228-7696**

The Patient Portal is a secure web portal that allows you as a patient to access your personal health information. It also allows you to communicate with our office via secure messaging. You may request medication refills, and request, change or cancel appointments.

Important Information:

- Our hours of operation are Monday through Friday 8:30am-5:00 pm. We encourage you to use the Patient Portal at any time. However, messages are held for us until we return the next business day.
- Messages are typically handled within one business day. If your doctor is out of the office that day, your request may be held until your doctor returns to the office. You must call our office at 813-228-7696 if you have an urgent matter to discuss.
- Staff members other than your physician will be involved in receiving your messages, and routing them to the doctor or other staff person.
- Prescription Refills:
  - Be sure we have your pharmacy information.
  - We do NOT refill controlled substances over the portal.
- If you are not receiving e-mails from us, please check your JUNK e-mail folder before contacting us.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen.
- We strive to keep all of the information in your medical record correct and complete. If you notice information in your record that is incomplete or inaccurate, you agree to notify us immediately. In addition, you also agree not to provide false or misleading information.
- You agree to not hold Rehabilitation and Electrodiagnostics, PA responsible for any network infractions beyond our control.
- We offer the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.

The information on this site is maintained by Rehabilitation and Electrodiagnostics, PA. Our mailing address is 2914 N. Boulevard, Tampa, FL 33602. For questions about this site, you may contact our Practice Administrator at 813-865-4777.

I have read, understand and agree to the above information regarding the Rehabilitation and Electrodiagnostics, PA Patient Portal

Signature: _____

Full Name: _____ Email Address: _____