Stephen J Shields, MD. PA.
American Board of Internal Medicine
Stephen J. Shields, MD.
Denise Palazzola, MS, ANP-BC
1211 Reynolds Ave. Suite B
Clearwater, Florida 33756
727-466-6564 office
727-466-9434 fax

Welcome to Stephen J. Shields, MD PA.

Congratulations!!

You have chosen Stephen J. Shields, MD PA as your new PCP, WELCOME!!

We are requesting that you now contact our office to establish and get to meet your new physician. Dr. Stephen J. Shields is a Board Certified Internist with 36 years of experience. Denise Palazzola is a Board Certified, Masters Level, Nurse Practitioner in our community for over 15 years. Our staff has worked with Dr. Shields an average length of time of 9 years. Our office serves generations of families and patients, from 14 years to 104 years of age.

Our goal and desire is to help you achieve YOUR BEST HEALTH possible. To do that, we need for you to assist us and establish with our office.

Please contact our office at 727-466-6564 and we will gladly make your initial visit. If you have made your appointment already, we look forward to assisting you in your BEST HEALTH!

We look forward to serving you as your PCP and for many years to come.

Please feel free to check out our website and speak with our staff to help you with access to your medical records 24/7. www.shieldsmd.com

Should you have any questions, Please feel free to contact my staff at 727-466-6564.

Team Shields Welcomes You!

Sincerely,
Stephen J. Shields, MD
Denise Palazzola, MS, ANP-BC

New Patient Information- Welcome to the Office of Stephen J. Shields, MD. PA.

Patient's Name (Please Print) ____________________

S.S. #____________ **Birth Date**____________ **Sex** ___M___F

Street Address:____________________

City____________ **State**________ **Zip Code**________

Phone :____________ **Cell Phone:**____________

Pharmacy Name: ____________ **Telephone:**____________

Marital Status ___S ___M ___W ___D ___Sep **Language: English, other** ________

E-mail Address: ____________________

Northern Address:____________________

Employer's Name/ Address:____________________

Employer Phone:____________ **Occupation**____________

Emergency-Contact:____________ **Relationship**____________

Phone:____________ **Cell:**____________

2nd Emergency Contact (In case primary contact cannot be reached)****

Name____________ **Relationship** ________ **Phone** ________

Can our office release medical information to above contact? Yes________**No**________

Our office accepts Medicare and most commercial insurances. If we are part of your insurance network, we will gladly submit your claim to your insurance carrier and/or secondary insurance carrier. Patients are responsible for any services not covered by their insurance carrier. **Copayments are due at the time of service. Failure to pay copay at time of service may incur monthly finance charges/collection/legal costs.**

Primary Insurance____________ Effective____________

Member ID#____________ Group #____________

Secondary Insurance____________ Effective____________

Member ID#____________ Group #____________

Responsible party for services: Self, Other____________

For your convenience, we accept Visa, Mastercard, American Express and Discovery Cards.

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Stephen J. Shields MD,PA for any services furnished me by that physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature____________________ Date____________

Stephen J. Shields M.D, PA

HEALTH QUESTIONNAIRE

Reason for Visit				
FAMILY HISTORY	IF ANY BLOOD RELATIVES HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE			
1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) HIGH CHOLESTEROL	
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM	
3) MENTAL ILL.	8) ASTHMA	13) HEART DISEASE	18) CANCER	
4) GLAUCOMA	9) ANEMIA	14) STROKE	19)	
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20)	

HOSPITAL ADMISSIONS *not including pregnancies*	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING -	including over the counter medications	ALLERGIES	VACCINE year	TEST/EXAM year
			TETANUS / Td :	RECTAL/STOOL:
			INFLUENZA (FLU):	CHOLESTEROL:
			PNEUMONIA:	EYE:
			HEPATITUS:	
			TUBERCULOSIS:	

Medical History Mark (C) for current Problem, Check ✓ and indicate age when you had any of the following symptoms or diseases.

- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Ear Infections - Frequent
- ☐ Dizzy Spells ☐ Fainting Spells
- ☐ Failing Vision ☐ Eye Pain
- ☐ Double or Blurred Vision
- ☐ Eye Infections -Frequent
- ☐ Nose Bleeds - Recurrent
- ☐ Sinus Trouble
- ☐ Sore Throats - Frequent
- ☐ Hayfever /Allergies
- ☐ Hoarseness - Prolonged
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic Cough
- ☐ Asthma / Wheezing
- ☐ Shortness of Breath: ☐ on Exersion ☐ lying Flat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur ☐ Swollen Ankles
- ☐ Irregular Pulse ☐ Palpitations
- ☐ Leg Pain - When Walking
- ☐ Vericose Veins / Phlebitis
- ☐ Loss of Appetite - Recent
- ☐ Difficulty Swallowing

- ☐ Heartburn ☐ Peptic Ulcer
- ☐ Persistant Nausea / Vomiting
- ☐ Abdominal Pain - Chronic
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Change in Bowel Habits
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids ☐ Hernia
- ☐ Urine Infections - Frequent
- ☐ Blood in Urine ☐ Kidney Stones
- Urination - ☐ Overnight > than twice
  - ☐ Painful ☐ Loss of Control
  - ☐ Decrease in Force / Flow
- ☐ Venereal Disease
- ☐ Urethral Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss - Recent
- ☐ Anemia ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes ☐ Thyroid Disease
- ☐ Seizures ☐ Stroke
- ☐ Tremors / Hands Shaking
- ☐ Muscle Weakness

- ☐ Numbness / Tingling
- ☐ Headaches - Frequent
- ☐ Arthritis /Rheumatism
- ☐ Back Pain - Recurrent
- ☐ Bone Fractures / Joint Injury
- ☐ Gout ☐ Osteoporosis
- ☐ Foot Pain ☐ Cold Numb Feet
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping - Difficulty
- ☐ Depression ☐ Nervousness
- ☐ Memory Loss
- ☐ Moodiness - Excessive
- ☐ Mental Illness ☐ Phobias
- ☐ Rheumatic Fever ☐ Polio
- ☐ Scarlet Fever ☐ Mumps
- ☐ Chicken Pox ☐ Measles
- ☐ German Measles ☐ Herpes
- ☐ Tuberculosis
- ☐ Alcohol ______oz per week
- ☐ Smoking ___ cig/day
  - # yrs ______ Yr Quit_____
- ☐ Coffee / Tea _____ cups/day
- ☐ Regular Exercise

Males - ☐ Prostate ☐ PSA Test

Females - Please Complete

Menstrual Flow:
☐ Reg ☐ Irreg. ☐ Pain/cramps
Days of Flow_____ Length of Cycle_____
Date - 1st day of last period_________
☐ Pain / Bleeding during or after sex

Number of:
Pregnancies___ Abortions____
Miscarriages_____ Live Births_____
Birth Control Method
B.C. Pill (name)

☐ Flushing / Menopause
Date of last PAP Test ______
☐ Normal ☐ Abnormal
Date of last Mammogram ________
☐ Normal ☐ Abnormal

Patient Name: Date:

Stephen J. Shields, M.D., P.A.
1211 Reynolds Avenue, Clearwater, Fl 33756
(727) 466-6564 Fax (727) 466-9434

PF-300 Standard Authorization of Use and Disclosure of Protected Health Information

Your protected health information will be used by Stephen J. Shields, M.D., P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Information to be used or disclosed:

- ❑ Office Notes
- ❑ Laboratory Findings
- ❑ AIDS/HIV Reports
- ❑ EKG's
- ❑ Demographic Information
- ❑ Insurance Information
- ❑ Radiology Reports
- ❑ Medication List
- ❑ Vital Statistics
- ❑ Hospital Reports
- ❑ Specialists' Consultation Notes

Persons authorized to use or disclose information:
Stephen J. Shields, M.D., P.A.

Expiration Date of Authorization:
This is an open-ended authorization until revoked in writing by the patient.

Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to Stephen J. Shields, M.D., P.A. Attention: Office Manager. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Potential for Re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand that by refusing to sign this consent or revoking this consent, Stephen J. Shields, M.D., P.A. may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Stephen J. Shields, M.D., P.A. reserves the right to change their notice of practices with notification prior to implementation in accordance with Section 164.5200 of the Code of Federal Regulations. Should Stephen J. Shields, M.D., P.A. change their notice, they will send a copy of any revised notice to the address I have provided.

Name of Patient (Print) ____

Signature of Patient ____

Date ____

PF-2000 Consent to Use and Disclose Protected Health Information Effective April 1, 2003

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Stephen J. Shields, M.D., P.A. or disclosed to others for the purposes of treatment, obtaining payment, law enforcement, public health reporting or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information by making a request in writing to Stephen J. Shields, M.D., P.A. Stephen Shields, M.D., P.A. may or may not agree to restrict the use or disclosure of your protected health information. If Stephen Shields, M.D., P.A. agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Stephen Shields, M.D., P.A. reserves the right to modify the privacy practices outlined in the notice.

Request to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager. All inspections of records will occur in our office under staff supervision.

Complaints or Further Information

You may address your concerns/inquiries in writing to Attention Office Manager, 1211 Reynolds Avenue, Clearwater, Florida 33756.

I also authorize Stephen J. Shields, M.D., P.A. to leave messages on my answering machine regarding:

- Upcoming appointment times ______________________________ (initials)
- Laboratory and/or Radiology findings _________________________ (initials)
- Requests to return a call to Dr. Shields' office __________________(initials)

I have reviewed this consent form and give my permission to Stephen Shields, M.D. , P.A. to use and disclose my health information in accordance with it.

I authorize ____ as Spouse /Representative to discuss my treatment and or billing issues with Dr. Shield's office. Telephone ______________________________

Name of Patient (Print or Type) ____
Signature of Patient ____
Date______________________________
Signature/Relationship of Patient Representative (POA)_________________________________

Stephen J. Shields, M.D., P.A.
1211 Reynolds Avenue, Clearwater, FL 33756
(727) 466-6564 Fax (727) 466-9434

Financial/Office Policy- last updated April 1, 2003

We are pleased to serve you as your healthcare provider and are committed to your good health. Please understand that payment for our services is considered a part of your treatment and your obligation to us. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

All payments due at time of service
The office maintains a "Payment at time of service policy". It is your responsibility to arrange ahead of time the ability to pay in full at the time of your appointment. You need to know your insurance policy in advance to know the portion of your visit for which you will be responsible.

Insurance
Our office has made arrangements with many insurance carriers to submit your claims for you. Upon your arrival to our office and prior to your appointment, please notify us of any changes in your health care coverage that will affect our ability to submit and collect your insurance claims for you. We cannot bill your insurance company unless you give us clear and accurate insurance information. Your insurance policy is a contract between you and your insurance company- we are NOT a party to that contract. Please understand that any such claim delays or denials will become your responsibility if not collectible from your insurance carrier. Certain fees and services will not be covered by insurance and are your responsibility. These fees/services include, but are not limited to, co-payments, deductibles, non-covered services (Oximetry, Pre-Op Labs/EKG's), and collection fees. If any such services are incurred, they are due at time of service. As a courtesy to our patients we will bill to Secondary Insurance Plans.

If your insurance plan(s) does not pay the office/hospital fee(s) within 90 days, the balance will be automatically transferred to the patient's responsibility.

Statements
We will send a statement to you, should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. After three consecutive statements, we reserve the right to send your account to an outside collections agency which may affect your credit rating. There will be a $35.00 charge for checks denied by your bank and returned to the office for any reason. We accept cash, checks, Visa, and MasterCard payments for your convenience.

Missed Appointments
Unless cancelled at least 24 HOURS in advance our policy is to charge the patient at the rate of $40.00 for each missed appointment. Patients who miss 3 or more appointments may be dismissed.

Insurance Authorizations/Referrals/Precertifications
If your insurance company requires an authorization or a referral in order to see a specialist, it is your responsibility to notify our office ONE WEEK prior to your appointment.

Diagnostic/Laboratory Testing
Most lab and diagnostic test results are returned to us within 72 hours. You can expect a call from our office within one week. If you have not been contacted within this time, please call our office.

Prescriptions
If you require a refill on a prescription that originated from our office, please call our office 48 HOURS prior to needing the prescription refill. This will insure the doctor will have time to review and comply with your request.

I have read and understand the Policies and Procedures as outlined above and I agree to be bound by its terms. I also understand that it may become necessary to amend these policies and will be notified at such time.

Print Patient Name ______________________________ **Date** ________________

Patient Signature ____

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 health care, 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: ______________________________

BC100345-0710

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize ________________________ (healthcare provider) to use and disclose the protected health information described below to: **Dr. Stephen Shields, 1211 Reynolds Ave, Clearwater Florida 33756 Fax: 727-466-9434**_(individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ __________ to __________

OR

b. ☐ all, past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/Drug abuse treatment
- ☐ Other (please specify): ________________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force until ____________(date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand the a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of patient or personal representative D.O.B

____

Printed name of patient or personal representative and their relationship to the patient

____

Date