MIDWAY SPECIALTY CARE CENTER

Emmanuelle Allseits, MD AAHIVS
Craig Callam, APRN / Aylin Perez, PA-C
5979 Vineland Rd., Ste. 208
Orlando, FL 32819
(407) 745-1171 tele
(407) 745-0712 fax
www.midwaycare.org

New Patient Questionnaire

(Nouvo Keysonè pasyan)

Personal Information

(Enfomasyon pèsonèl)

Today's Date: _____
(Dat jodi a)

Last Name, First Name, Middle Initial: _____ Date of Birth: _____
(Siyati, Premye Non, Inisyal non mitan) *(Dat nesans)*

Preferred Name: _____ Social Security Number: _____
(Non Prefere) *(Nimewo Sekirite Sosyal)*

Gender Assigned at Birth: □ Female □ Male □ Intersex □ Prefer not to answer
(Sèksyo bay nan nesans) *(Fi)* *(Gason)* *(Fi &gason)* *(Pito pa reponn)*

Relationship Status: □ Single □ Sig Other □ Separated □ Married □ Divorced □ Widowed
(Estati Relasyon) *(Selibatè)* *(Patnè)* *(Separe)* *(Marye)* *(Divòse)* *(Vèv)*

Home Address: _____ City, State and Zip Code: _____
(Adrès Lakayou) *(Vil, Eta ak Kòd Postal)*

Mailing Address □ Same as Above _____ City, State and Zip Code: _____
(Adrès Postal) (Menm jan ak lakayou) *(Vil, Eta ak Kòd Postal)*

Phone Number(s) □ Home: _____ □ Cell: _____ □ Work: _____
(Nimewo(s) telefòn) *(Lakay)* *(Pòtab)* *(Travayou)*

Check box representing preferred number for patient reminders, etc.(*Tcheke kare ki reprezante nimewo pi pito pou rapèl pasyan yo*)

Email Address: _____ Enable Patient Portal: □ Yes*(Wi)* □ No*(Non)*
(Electronik) *(Aktive Pòtal pasyan:)*

Emergency Contact: _____ Phone: _____ Relationship: _____
(Kontak pouljans:) *(Telefòn)* *(Risaliye Pouou)*

Name of Primary Care Provider: _____
(Non doktè swen prensipal)

Address: _____ City, State and Zip Code: _____
(Adrès) *(Vil, Eta ak Kòd Postal)*

Employment Status: □ Full time □ Part time □ Retired □ Self □None
(Sitiyasyon Travay:) *(Tan plen)* *(Tan pasyèl)* *(Ou retrèt)* *(Pou ko)* *(Okenn)*

Student: □ Full time □ Part time □None
(Elèv) *(Tan plen)* *(Tan pasyèl)* *(Okenn)*

Employer Name/School Name: _____
(Non anplwayè/Non lekòl la:)

Address: _____ City, State and Zip Code: _____
(Adrès) *(Vil, Eta akKòd Postal)*

Occupation: _____
(Okipasyon:)

Who may we thank for referring you: _____
(Kiyès nou ka remèsye pou refere w?)

Insurance Information *(Enfòmasyon sou Asirans)*

Primary Insurance Company: _____ Policy Holder: _____
(Konpayi asiranss Prensipal:) *(Titulè kontra a:)*

Policy Number: _____ Group Number: _____
(Nimewo règleman:) *(Nimewo Gwoup)*

Secondary Insurance Company: _____ Policy Holder: _____
(Compañía de seguros secundario) *(Titulè kontra a:)*

Policy Number: _____ Group Number: _____
(Nimewo règleman:) *(Nimewo Gwoup)*

Financial Responsible Party: _____
(Pati responsab finansye:)

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New Patient Questionnaire – Continued
(Nouvo Keysonè pasyan – Kontinye)

Race:*(Ras)*
□ American Indian*(Endyen Ameriken)*
□ Asian *(Azyatik)*
□ Native Hawaiian *(NatifnatalAwayi)*
□ Black or African American *(NwaoswaAfriken Ameriken)*
□ White *(Blan)*
□ Other Race *(Lòtras)*
□ Other Pacific Islander *(Lòtmoun nan zilePasifik)*
□ Decline to answer *(Refizereponn)*

Ethnicity: *(Etnisite)*
□ Hispanic or Latin *(Panyòloswa Latin)*
□ Not Hispanic or Latin *(Pa panyòloswa Latin)*
□ Decline to answer*(Refizereponn)*

Preferred Language: *(Lang prefere:)*
□ English *(Angle)*
□ Spanish *(Panyòl)*
□ Portuguese *(Pòtigè)*
□ Other: *(Lòt:)* _____

Name of Your Local/Mail Order – Check the preferred one *(Non lokalou/KomandLapòs - Tchekesa ki pi pito a)*

Pharmacy*(Famasi)* **Address *(Adrès)*** **Telephone Number *(Nimewo telefòn)***

□_____

□_____

<u>Use of 340B Contract Pharmacy</u>*(Itilize 340B Famasi Kontrat)*

Contract pharmacies offer a range of customizable clinical and operational services that enhance the safety, quality, and affordability of care for our patients. Our 340B network of pharmacies was chosen based on a wide variety of performance and cost-saving criteria. We review each pharmacy that we add to our network to determine their true capabilities and services before entrusting our patients to their care. Using our 340B program helps to provide funds for increased client services such as a case manager and in-house lab and mental health and help us provide care for uninsured patients.

(Famasi kontra yo ofri yon seri sèvis klinik ak operasyonèl ki ka personnalisable ki amelyore sekirite, bon jan kalite, ak abòdab swen pou pasyan nou yo. Yo te chwazi rezo 340B nou an nan famasi baze sou yon gran varyete kritè pèfòmans ak ekonomize pri. Nou revize chak famasi ke nou ajoute nan rezo nou an pou detèmine vrè kapasite yo ak sèvis yo anvan nou konfye pasyan nou yo ba yo swen. Sèvi ak pwogram 340B nou an ede bay lajan pou plis sèvis kliyan tankou yon manadjè ka ak laboratwa anndan kay ak sante mantal epi ede nou bay swen pou pasyan ki pa gen asirans.)

□ Yes, Sign me up *(Wi, Enskri m)* □ No, not at this time *(Non, pa nan momansa a)* □ I would like more information *(Mwen ta renmenplisenfòmasyon)*

I hereby consent to Midway Specialty Care Center, Inc .obtaining my **Prescription History** from any/all sources.

Mwen dakò pou Midway Specialty Care Center, Inc jwenn Istwa Preskripsyon mwen nan nenpòt/tout sous

Patient's Signature: *(Siyati pasyan an:)*

_____

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Medication History*(Istwa Medikaman)*

Please list all medications you are currently taking *(Tanpri lis tout medikaman w ap pran kounye a)*

(Include Over-The-Counter Medications and/or Supplements) *(Mete medikaman san preskripsyon ak/oswa sipleman)*

Name of Medication *(Non Medikaman)*	Dosage *(Dòz)*	Directions for use *(Enstriksyon pou itilize)*	Reason for use *(Rezon pou itilize)*

Do you have any Drug or other Allergies: *(Èske w gen nenpòt dwòg oswa lòt alèji?)* □ Yes *(Wi)* □ No *(Non)*

Drug allergy *(Alèji dwòg)* Reaction *(Reyaksyon)* Age of onset *(Laj kòmansman)*

_____
_____
_____
_____

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Current/Past Medical History ***(Istwa medical aktyèl/pase)***

Do you <u>currently</u> have any of the following symptoms? *(Check those that apply)*
(Èske w gen nenpòt nan sentòm sa yo <u>kounye a</u>? *(Tchekesayo ki aplike)*

□ Rash, itchy skin or skin disorder *(Gratèl, po grate oswamaladi po)*
□ Sinus congestion *(Konjesyon sinis)*
□ Hearing loss *(Pèt tande)*
□ Cough *(touse)*
□ Fever *(Lafyèv)*
□ Chest pain or palpitations *(Doulè nan pwatrin oswa palpitasyon)*
□ Constipation or diarrhea *(Konstipasyon oswa dyare)*
□ Vaginal or penile discharge *(Ekoulman nan vajen oswa nan penis)*
□ Genital or rectal warts or ulcers *(Veri oswa ilsè jenital oswa rektal)*
□ Muscle pain or joint swelling *(Doulè nan misk oswa anfle jwentiyo)*
□ Poor appetite *(Manb apeti)*
□ Suicidal thoughts *(Panse swisid)*
□ Anxiety/stress *(Enkyetid/Estrès)*
□ Change in vision *(Chanjman nan vizyon)*
□ Difficulty swallowing *(Difikilte pou vale)*
□ Dental problems *(Pwoblèm dantè)*
□ Shortness of breath *(Souf kout)*
□ Night sweats *(Swe lannwit)*
□ Nausea and/or vomiting *(Kè plen ak/oswa vomisman)*
□ Blood in stool or hemorrhoids *(San nan poupou oswa emoroid)*
□ Painful urination *(Pipi fè mal)*
□ Muscle weakness *(Feblès nan misk)*
□ Tingling burning, pain or numbness in extremities *(Pikotman boule doulè oswa pèt sansasyon nan ekstremite yo)*
□ Sudden weight loss or gain *(Pèt oswa pran pwa touden kou)*
□ Suicide attempts *(Tantativ swisid)*
□ Unexplained fatigue/weakness *(Fatig/feblès san rezon)*

Please list any other symptoms or health concerns that you would like to discuss with your healthcare provider today:

(Tanpri lis nenpòt lòt sentòm oswa pwoblèm sante ke ou ta renmen diskite avèk founisè swen sante ou jodi a:)

_____ _____

_____ _____

_____ _____

Thinking of the last two weeks:*(Panse a de semèn ki sot pase yo:)*
Have you been feeling down, depressed or hopeless? *(Èske w tesanti w desann, deprime oswa san espwa?)* □ Yes *(Wi)* □ No*(Non)*
Have you had little interest or pleasure in doing things? □ Yes*(Wi)* □ No*(Non)*
(Èske w te gen tienterè oswa plezi nan fè bagay sayo?)

Have you ever been non-consensually hit, slapped, kicked or otherwise been physically hurt by an intimate partner?
(Èske w tejanm frape, souflete, choute, oswa blese fizikman pa yon patnè entim?)
□ Yes*(Wi)* □ No *(Non)* If yes, how long ago?*(Si wi, depi konbyen tan?)* _____
Have you ever been forced to have sexual activity against your will? □ Yes*(Wi)* □ No *(Non)*
(Èske w tejanmoblikefèaktiviteseksyèlkontvolonte w?)
If yes, when did this happen? _____ Was the incident reported to authorities? □ Yes*(Wi)* □ No*(Non)*
(Si wi, ki lè sa te rive?) *(Èske ensidan an te rapòte bay otorite yo?)*

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Current/Past Medical History *(Continued)* ***(Istwa medical aktyèl/pase)*** *(Kontinye)*

Do you have any of the following conditions? *(Check those that apply)*
(Èske w gen nenpòt nan kondisyon sa yo? *(Tcheke sa yo ki aplike)*

□ AIDS *(SIDA)*
□ Alcoholism *(Alkòl)*
□ Anemia *(Anemi)*
□ Anorexia *(Anoreksi)*
□ Arthritis *(Atrit)*
□ Asthma *(Opresyon)*
□ Blood Disorder *(Twoubsan)*
□ Breast lump *(Boul nan tete)*
□ Bronchitis *(Bwonchit)*
□ Bulimia *(Boulimi)*
□ Heart disease *(Maladi kè)*
□ Cancer, type: *(Kansè, kalite:)* _____
□ Chemical dependency *(Depandans chimik)*
□ Depression *(Depresyon)*
□ Diabetes *(Dyabèt)*
□ Emphysema *(Anfizèm)*
□ Epilepsy/seizures *(Epilepsi/kris)*
□ Reflux *(Reflu)*
□ Glaucoma *(Glokòm)*
□ Goiter *(Goit)*
□ Gout
□ Hair loss *(Pèt cheve)*
□ Heart Attack *(Atak kè)*
□ High cholesterol *(Gwokolestewòl)*
□ Neuropathy *(Newopati)*
□ High blood pressure *(Tansyon wo)*
□ HIV positive *(VIH pozitif)*
□ Kidney Disease *(Maladi ren)*
□ Liver Disease *(Maladi fwa)*
□ Multiple Sclerosis *(Sklewozmiltip)*
□ Pacemaker
□ Mental illness *(Maladi mantal)*
□ Migraines *(Migrèn)*
□ Osteoporosis *(Osteyopowoz la)*
□ Stroke *(Konjesyonserebral)*
□ Thyroid disease *(Maladi tiwoyid)*
□ Heart disease *(Maladi kè)*
□ Lung problems *(Pwoblèm nan poumon)*
□ Rheumatic fevers *(La fyèv rimatism)*
□ Rhinitis *(Rinit)*
□ Back or joint problems *(Pwoblèm do oswajwenti)*
□ Prostate problem *(Pweobèm pwostat)*
□ cervical problem *(Pwoblèm nan matris)*
□ Other: *(Lòt:)*
_____

Have you had any of the following diseases or other issues? ***(Èske w te gen nenpòt nan maladi sa yo oswa lòt pwoblèm?***

□ Syphilis, If yes, what was your most recent titer and when? *(Sifilis, Si wi, ki dènye tit outegenyenak ki lè?)* _____
□ Gonorrhea *(Gonore)*
□ Chlamydia *(Klamidya)*
□ Venereal warts *(Veri veneryen yo)*
□ Genital herpes *(Èpès jenital)*
□ Hepatitis A, B, or C, if yes, which one(s) and most recent viral load if chronic? *(Epatit A, B, oswa C, si wi, kiyès ak chaj viral ki pi resan si kwonik?)*
_____

Any other conditions you are followed by a doctor or take any medication for *?(Nenpòt lòt kondisyon yo swiv pa yon doktè oswa pran nenpòt medikaman?)* _____

Hospitalization History ***(Istwa Iopital)***

Hospital/Facility *(Lopital/Etablisman)*	Reason *(Rezon)*	Year *(Ane)*

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Vaccination & Healthcare History: ***(Istwa vaksinasyon ak swen sante:)***

BOTH MEN AND WOMEN ***(GASON AK FANM)***

□ Flu Shot, if yes when? *(Vaksen grip, si wi, ki lè?)* _____
□ Hepatitis A Shot, did you complete the series and when? (2 shots) _____
(Piki epatiti A, èske w te konplete seri a e ki lè? (2 piki)
□ Hepatitis B Shot, did you complete the series and when? (3 shots) _____
(Piki epatiti B, èske w te konplete seri a e ki lè? (3 piki)
□ Measles, Mumps Rubella (MMR) shot, did you complete the series and when? _____
(Piki lawoujòl, malmouton, ribeyòl (MMR), èske w te konplete seri a e ki lè?)
□ Varicella Shot, if yes when? *(Piki varisèl, si wi, ki lè?)* _____
□ Pneumonia Vaccine, if yes which one (s) *(Vaksen kont Nemoni, si wi, kiyès)* _____
□ Tetanus Booster, if yes when? *(Si wi, ki lè?)* _____
□ Tdap/TD, if yes when? *(Si wi, kilè?)* _____
□ HPV, if yes did you complete series and when (3shots)? _____
(HPV, si wi, èske ou te konplete seri ak ki lè (3 vaksen)?)
□ Tuberculosis (PPD) test, if yes when? *(Tès Tibèkiloz (PPD), si wi, ki lè?)* _____
Have you ever had a positive PPD test? □ Yes, Explain: _____ □ No
(Èske w te janm fè yon tès PPD pozitif? □ Wi, Eksplike:) *(□ Non)*
Have you ever had Meningitis? □ Yes, Explain: *(Èske w te janm gen menenjit? □ Wi, Eksplike:)* _____ □ No*(□ Non)*
Last Cholesterol testing: *(Dènye tès kolestewòl:)* _____
Last eye exam: *(Dènye egzamen je:)* _____
Last dental exam: *(Dènye egzamen dantè:)* _____
Last Colonoscopy: *(Dènye koloskopi:)* _____
Last Dexa scan: *(Dènye eskanè Dexa:)* _____
Have you ever had a blood transfusion? □ Yes, Year: _____ Explain: _____ □ No*(□ Non)*
(Èske w te janm fè yon transfizyon san? □ Wí, Ane:) *(Eksplike:)*

WOMEN ONLY ***(FANM SÈLMAN)***

Last Pap Smear: *(Dènye fwoti PAP:)* _____
Last Mammogram: *(Dènye mamogram:)* _____
Last menstrual cycle: *(Dènye sik règ:)* _____

MEN ONLY ***(GASON SÈLMAN)***

Last PSA (Prostate blood test): *(Dènye PSA (Tès san pwostat:)* _____
Digital rectal exam: *(Digital egzamen rektal:)* _____

Surgical History*(Istwa Chirijikal)*

Surgery Name *(Operasyon Non)* Year *(Ane)*

_____

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Sexual and behavioral Questionnaire *(Kesyonè seksyèl ak konpòtman)*

My gender identity is: □ Female □ Male □ Transgender (MTF) □ Transgender (FTM) □ Other _____ □ Decline
(Idantite sèks mwen se:) (Fi) (Gason) (Transganr(MTF)) (Transganr (FTM)) (Lòt) (Dekline)

I live: □ alone □ with spouse □ with roommate(s) □ with parents/family □ am homeless □ Other _____
(Mwen rete:) (poukont mwen) (Mari oswa madanm) (Kolokasyon) (Paran/fanmi) (Mwen san kay) (Lòt)

My sexual orientation is: □ Bisexual □ Heterosexual □ Homosexual □ Other_____ □ Not sure
(Oryantasyon seksyèl mwen an se:) (Biseksyèl) (Etewoseksyèl) (Omoseksyèl) (Lòt) (Pa sèten)

My pronoun is:*(Pwonon mwen se:)* □ She/her*(Li)* □ He/Him*(Li)* □ They/Them/Their*(Yo)* □ Other*(Lòt)* _____

Do you currently have sex? *(Èske ou fè sèks kounye a?)* □ Yes *(Wi)* □ No *(Non)*

Sexual practices? *(Pratik seksyèl?)* □ Vaginal*(Vajen)* □ Anal □ Oral □ Other*(Lòt)* _____

Do you use condoms or some type of barrier protection? *(Èske w itilize kapòt oswa kèk kalite pwoteksyon baryè?)* □ Yes *(Wi)* □ No *(Non)*

Birth control method? □ Oral Contraception □ IUD or other implant □ None □ N/A
(Metòd kontwòl nesans?) (Kontrasepsyon oral) (Esterilè oswa lòt implant) (Okenn) (Pa disponib)

Have you ever been in jail or prison? *(Èske w te janm nan prizon?)*□ Yes *(Wi)*When? *(Ki lè?)*_____ □ No *(Non)*

Do you use tobacco products? □ Yes*((Wi)* □ Smoke*(Fimen)* □ Chew*(Moulen)* □ Vape □Other: *(Lòt)* _____□ No*(Non)*
(Èske e itilize pwodui tabak?)

If yes, what are they? _____ And how often? _____ Are you ready to quit? □ Yes*(Wi)* □ No*(Non)*
(Si wi, kisa yo ye?) (Ak konbyen fwa) (Èske w para pou w kite fimen?)

If no, have you ever smoked? _____ How long ago did you quit? _____
(Si non, èske ou janm fimen?) (Depi konben tan ou te kite?)

Do you have a history of using IV drugs or "street" drugs? □ Yes*(Wi)* □ No*(Non)*
(Èske w gen yon istwa nan itilize dwòg IV oswa dwòg "lari"?)

If yes, which one(s): _____ How long ago did you quit? _____
(Si wi, kiyès:) (Depi konbyen tan ou te kite fimen?)

Do you drink alcohol? *(Ou bwè alkòl)* □ Yes*(Wi)* □ No*(Non)*

If yes, how many drinks per day? _____ How many times a week? _____
(Si wi, konbyen bwason pa jou?) (Konbyen fwa pa semèn?)

Did you ever have a problem with alcohol or other substances? □ Yes*(Wi)* □ No*(Non)*
(Èske w te janm gen yon pwoblèm ak alkòl oswa lòt sibstans?)

If yes, please explain: _____
(Si wi, tanpri eksplike:)

Do you drink coffee or other caffeine products? *(Èske ou bwè kafe oswa lòt pwodwi kafeyin?)* □ Yes*(Wi)* □ No*(Non)*

If yes, which _____ How many cups per day? _____
(Si wi, ki) (Konbyen tas pa jou?)

Place of Birth? City, State, Country *(¿Kote ou fèt? Vil, Eta, Peyi)*_____

Have you traveled out of the country? *(Èske w te vwayaje andeyò peyo a?)* □ Yes*(Wi)* □ No*(Non)*

If yes, where and when? _____
(Si wi, ki kote ak ki lè)

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Si VIH pozitif, tanpri reponn kesyon ki anba yo. Si VIH negatif, sote paj sa a.

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Medical Questionnaire
(Kesyonè Medikal)

What was the date of your positive diagnosis? _____
(Ki dat ou te fè dyagnostik pozitif?)

Where were you living at the time of diagnosis?_____
(Ki kote w t ap viv nan moman dyagnostik la)

How did you contract HIV? _____
(Ki jan ou te pran VIH?)

What is the lowest your Absolute CD4 count (T-cells) have been in the past?_____
(Ki pi ba konte absoli CD4 ou (selil T) te genyen nan tan lontan?)

Are you enrolled in Ryan White? □ Yes □ No
(Èske w enskri nan Ryan White) *(Wi)* *(Non)*

Are you enrolled in ADAP? □ Yes □ No
(Èske w enskri nan ADAP?) *(Wi)* *(Non)*

Are you of Haitian descent? □ Yes □ No
(Èske ou se desandan ayisyen?) *(Wi)* *(Non)*

Are you a migrant worker? □ Yes □ No
(Èske w se yon travayè migran?) *(Wi)* *(Non)*

Are you a vetern? □ Yes □ No
(Èske w se yon veteran?) *(Wi)* *(Non)*

Highest level of education? (check one) □ 8th Grade or Less □ Between 8th Grade and 12th Grade □ College
(Pi wo nivo edikasyon? (tcheke youn)) *(8yèm ane oswa mwens)* *(Ant 8yèm ane ak 12yèm ane)* *(Kolèj)*

HIV Treatment History *(Skip if you are newly diagnosed with HIV)*
(Istwa Tretman VIH (*Sote si ou fè lis Medikaman HIV ou ye kounye a:))*

Please list your current HIV Medication(s): _____ _____
(Tanpri fè lis Medikaman VIH ou ye kounye a:)

_____ _____, how long have you been on this? (these) _____
(konbyen yan ou te sou sa? (sa yo))

Are you allergic to any HIV medications? □ Yes □ No, if yes which one(s)? _____
(Èske ou fè alèji ak nenpòt medikaman VIH?) *(Wi)* *(Non, si wi, kiyès?)*

(Turn over to the other side ->)
(Vire sou lòt bò a ->)

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Please circle any HIV medication that you were on in the past:
(Tanpri make nenpòt medikaman VIH ou te pran nan tan lontan:)

Multi tab Regimens *(Multi tab rejim)*

Legacy Drugs*(Sa ki annapre yo pa gen okenn ankò, oswa raman preskri)*

Agenerase	Crixivan	Kaletra	Retrivir	Viracept
Aptivius	Fuzeon	Lexiva	Trizivir	Viramune XR
Combivir	Invirase	Rescriptor	Videx EC	Zer

Entry/Attachment Inhibitors

Selzentry	Trogarzo	Fostemsavir

Non-Nucleoside reverse transcriptase Inhibitors*(Non-nukes)*

Edurant	Intelence	Pifeltro	Sustiva

Nucleoside Reverse Transcriptase Inhibitors*(Nukes)*

Cimduo	Emtriva	Epzicom	Viread	Temixys
Descovy	Epivir	Truvada	Ziagen	

PK Inhibitors*(Boosters)*

Tybost	Norvir

Protease Inhibitors*(Boosted and unboosted)*

Evotaz	Prezcobix	Prezista	Reyataz

Integrase Inhibitors

Isentress HD	Tivicay

Single-tab regimens

Acreptiga	Complera	Genvoya	Stribild	Symtuza
Atripla	Delstrigo	Juluca	Symfi	Triumeq
Biktarvy	Dovato	Odefsey	Symfi Lo	

MIDWAY SPECIALTY CARE CENTER

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Patient Self Determination Act Questionnaire
(Kesyonè Lwa sou Otodetèminasyon Pasyan an)

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of the Florida Statutes, Please answer the following questions by initialing the applicable response: *(Pou konfòme yo ak Omnibus Budget Reconciliation Act 1990 ak Chapit 745 Lwa Florid yo, Tanpri reponn kesyon sa yo lè w inisyal repons ki aplikab la:)*

Declaration to decline Life-Prolonging Procedure *(Deklarasyon pou refize Pwosedi pou pwolonje lavi)* (Living Will) *(Testaman vivan)*
_____I have such a declaration *(Mwen gen yon deklarasyon konsa)* (Please provide a copy) *(Tanpri bay yon kopi)*
_____I have NOT made such a declaration *(Mwen PA fè yon deklarasyon konsa)*

Health Care Surrogate *(Ranplasan Swen Sante)* Name: *(Non:)* _____
_____I have a designated health care surrogate *(Mwen gen yon ranplasan swen sante deziyen)*
_____I have NOT designated a health care surrogate *(Mwen PA deziyen yon ranplasan swen sante)*

Durable Power of Attorney *(Pwokirasyon dirab)*
_____I have appointed a durable power of attorney *(Mwen te nonmen yon avoka dirab)*
(Please provide a copy) *(Tanpri bay yon kopi)*
_____I have NOT appointed a durable power of attorney *(Mwen PA nonmen yon svoka dirab)*

24-Hour Cancellation & No-Show Policy
(Anilasyon 24 èdtan ak Règleman pa prezante)

Each time a patient misses an appointment without providing proper notice, another patient is unable to receive care. Midway Specialty Care Center, Inc. reserves the right to charge a fee of $25.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice. *(Chak fwa yon pasyan rate yon randevou san li pa bay bon avi, yon lòt pasyan pa kapab resevwa swen. Midway Specialty Care Center, Inc. rezève dwa pou fè w peye yon frè $25.00 pou tout randevou ki rate ("No-shows") ak randevou ki, san yon rezon irezistib, yo pa anile ak yon avi 24 èdtan.)*

"No-Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple no-shows in any twelve (12) month period may result in discharge from the Practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients. *(Y ap faktire frè "No-show" bay pasyan an. Frè sa a pa kouvri pa asirans, epi yo dwe peye anvan pwochen randevou w la. Plizyè no-show nan nenpòt peryòd douz (12) mwa ka lakòz egzeyat nan Pratik la. Mèsi pou konpreyansyon w ak koperasyon w pandan n ap fè efò pou nou pi byen sèvi bezwen tout pasyan nou yo.)*

By signing below, you acknowledge that you have reviewed this notice and understand the policy.
(Lè w siyen anba a, ou rekonèt ke ou te revize avi sa a epi ou konprann règleman an.)

Printed Name: *(Non enprime:)* _____

□ Self *(Pwòp tèt ou)* or Relationship to Patient: *(oswa Relasyon ak pasyan)*_____

Signature: *(Siyati)* _____ Date: *(Dat:)* _____

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CONSENTS
(KONSANTMAN)

Health Insurance Portability and Accountability Act
(Lwa sou Transparans ak Responsablite Asirans Sante)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we ask your permission before disclosing certain healthcare information to certain people or entities. *(Lwa 1996 sou Transparans ak Responsablite Asirans Sante (HIPAA) egzije pou nou mande pèmisyon w anvan nou divilge sèten enfòmasyon sou swen sante a bay sèten moun oswa antite)*

In accordance with the Act, I *(An akò ak Lwa a, mwen)* _____Hereby
(Patient signature) *(Siyati pasyan an)*
authorize Midway Specialty Care Center, Inc. to release any information regarding my health to the following persons or entities: *(otorize Midway Specialty Care Center, Inc. pou divulge nenpòt enfòmasyon konsènan sante mwen bay moun oswa antite sa yo:)*

Name *(Non)*	Date of Birth *(Dat nesans)*	Relationship *(Relasyon)*	Phone Number *(Nimewo telefòn)*

Leaving Messages for You ***(Kite Mesaj pou ou)***

In the event that I am not available when Midway Specialty Care Center, Inc. calls with medical information: *(Nan ka mwen pa disponib lè Midway Specialty Care Center, Inc. rele ak enfòmasyon medikal:)*

*(Please check the applicable box **and** initial beside it.)* *(Tcheke kare ki aplikab la **ak** inisyal akote li.)*

□ _____ Please DO leave messages on my answering machine or voicemail. *(Tanpri kite mesaj sou repondè oswa mesajri mwen an)*
□ _____ Please DO NOT leave messages on my answering machine or voicemail. *(Tanpri PA kite mesaj sou repondè oswa mesajri vwa mwen*
□ _____ I DO NOT HAVE an answering machine or voicemail. *(MWEN PA GENYEN yon mesajri.)*

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
(AVI SOU PRATIL KONFIDITE REKONÈS)

I understand that under the Health insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
(Mwen konprann ke dapre Lwa 1996 sou Transparans ak Responsablite Asirans Sante (HIPAA) mwen gen sèten dwa sou vi prive konsènan enfòmasyon medikal mwen pwoteje. Mwen konprann ke enfòmasyon sa yo kapab epi yo pral itilize pou:)

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly. *(Fè, planifye ak dirijie tretman mwen ak swivi pami plizyè founisè swen sante ki ka patisipe nan tretman mwen an direkteman ak/oswa endirèkteman..)*
2. Obtain payment from third party payers. *(Jwenn pemann nan moun ki peye twazyèm pati.)*
3. Conduct normal healthcare operations such as quality assessments and physician certifications. *(Fè operasyon swen sante nòmal tankou evalyasyon kalite ak sètifikasyon doktè.)*

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **Notice of Privacy Practices**. *(Mwen te resevwa, li ak konprann **Avi sou Pratik Konfidansyalite** w la ki gen yon deskripsyon pi konplè sou itilizasyon ak divilgasyon enfòmasyon sante mwen yo. Mwen konprann ke òganizasyon sa a gen dwa chanje **Avi sou Pratik Konfidansyalite** li yo detanzantan epi mwen ka kontakte òganizasyon an nenpòt ke lè oswa ale sou sit entènèt Konpayi an pou jwenn yon kopi aktyèl **Avi sou Pratik Konfidansyalite** a.)*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions. *(Mwen konprann ke mwen ka mande alekri pou ou mete restriksyon sou fason yo itilize oswa divilge enfòmasyon prive mwen an pou fè tretman, peman oswa operasyon swen sante. Mwen konprann tou ke ou pa oblije dakò ak restriksyon mwen mande yo, men si ou dakò ke ou oblije respekte restriksyon sa yo.)*

Printed Name: *(Non enprime:)* _____

□ Self *(Pwòp tèt ou)* or Relationship to Patient: *(oswa Relasyon ak pasyan)*_____

Signature: *(Siyati)* _____ Date: *(Dat:)* _____

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Insurance Authorization and Assignment
(Asirans Otorizasyon ak Plasman)

All Charges are payable at the time of service. *(Tout frè yo peye nan moman sèvis la.)*

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage; it is also customary to pay for services when rendered unless other arrangements have been made in advance. *(Tout sèvis pwofesyonèl yo bay yo sou kont pasyan yo pou peye. Nou pral konplètè tout fòm ki nesesè yo pral konplè pou ede akselere peman konpayi asirans yo. Sepandan, pasyan an responsab pou tout frè, kèlkeswa kouvèti asirans lan; li abitye tou pou peye pou sèvis yo lè yo rann yo sof si yo te fè lòt aranjman davans.)*

Insurance Authorization and Assignment: I hereby authorize Midway Specialty Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. *(Otorizasyon ak Devwa Asirans: Mwen otorize Midway Specialty Care Center, Inc. pou bay konpayi asirans yo enfòmasyon konsènan maladi mwen ak tretman mwen epi mwen bay tout peman pou sèvis medikal mwen menm oswa pou moun ki depandan mwen yo. Mwen konprann ke mwen responsab pou nenpòt ki kantite lajan asirans mwen pa kouvri.)*

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges. *(Anplis de sa, mwen konnen si mwen gen yon Plan HMO yo dwe jwenn yon referans nan men founisè swen prensipal mwen an pou CHAK vizit nan Midway Specialty Care Center. Si yo PA jwenn youn, mwen konprann ke mwen pral responsab pou tout chaj yo.)*

Printed Name: *(Non enprime:)* _____

□ Self *(Pwòp tèt ou)* or Relationship to Patient: *(oswa Relasyon ak pasyan)*_____

Signature: *(Siyati)* _____ Date: *(Dat:)* _____

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Authorization for Disclosure of Protected Health Information
(Otorizasyon pou Divilgasyon Enfòmasyon sou Sante Pwoteje)

I hereby request and authorize release copies of my medical records to Midway Specialty Care Center, Inc.
(Mwen mande epi otorize kopi dosye medikal mwen yo bay Midway Specialty Care Center, Inc.)

Records can be sent to the address above.
(Yo ka voye dosye yo nan adrès ki pi wo a.)

I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorized the release of the following to Midway Specialty Care Center, Inc.
(Mwen konprann ke dosye medikal mwen an ka genyen kopi enfòmasyon yo resevwa nan men yon lòt etsblisman swen sante oswa doktè. Mwen te otorize tou divilgasyon sa ki annapre yo bay Midway Specialty Care Center, Inc.)

Type of information to be disclosed: (Please check all that apply)
(Kalite enfòmasyon yo dwe divilge: (Teleke tout sa ki apolikab yo))

□Entire Medical Record *(Tout Dosye Medikal)*	□ Radiology Reports *(Rapò Radyoloji)*	□ All Hospital Records *(Tout Dosye Lopital yo)*
□ Consultation *(Konsiltasyon)*	□ Billing Statements *(Deklarasyon bòdwo)*	□ Laboratory Reports *(Rapò Laboratwa)*
□ Dental Records *(Dosye Dantè)*	□ Pathology Reports *(Ralò Patoloji)*	□ Other: _____ *(Lòt:)*
□ Office Chart Notes *(Nòt Tablo Biwo)*	□ Emergency Department Reports *(IRapò Depatman Ijans)*	

In addition, I authorize and I am aware that this information may include health information relating to (**INITIAL** if applicable):*(Anplis de sa, mwen otorize epi mwen konnen enfòmasyon sou sante ki gen rapò ak **(INISYAL** si sa aplikab))*

_____HIV/AIDS Infection _____Substance Abuse (alcohol/drugs) _____ Genetic Testing _____ Mental Health
(Enfeksyon VIH/SIDA) *(Abi sibstans (alkòl/dwòg))* *(Tès Jenetik)* *(Sante mantal)*

Printed Name: _____ DOB: _____
(Non ekri an lèt detache:) *(Dat nesans:)*

□ Self or Relationship to Patient: _____Date: _____
(Pwòp tèt ou) *(Oswa relasyon ak pasyan an:)* *(Dat:)*

Signature: _____ Last 4 digits of Social: _____
(Siyati:) *(4 dènye chif Sosyal yo:)*

This request is set to expire on: _____
(Demann sa a ap ekspire sou:)

MIDWAY
SPECIALTY CARE CENTER

Konsantman Jeneral pou Swen ak Tretman

POU PASYAN AN: Ou gen dwa, antanke yon pasyan, pou yo enfòme w sou kondisyon ou ak pwosedi chirijikal, medikal oswa dyagnostik yo rekòmande pou w itilize pou w ka pran desizyon si w ap suiv oswa p ap suiv nenpòt tretman oswa pwosedi yo sigjere w apre w fin konnen risk ak danje yo. Nan pwen sa a, pou sante w, yo pa rekòmande w okenn plan tretman espesyal. Fòm konsantman sa a se senpleman yon efò pou w jwenn pèmisyon pou ka fè evalyasyon ki nesesè pou idantifye tretman ak/oswa pwosedi ki apwopriye pou nenpòt kondisyon ou idantifye.

Konsantman sa a pèmèt nou jwenn pèmisyon w pou n fè egzamen medikal, tès ak tretman ki bon pou fèt epi ki enpòtan. Tretman an gen ladan medikaman FDA Etazini otorize oswa apwouve nan moman an pou tretman COVID 19 oswa lòt nouvo maladi respiratwa kontajye. Tès yo gen ladan yo, men se pa sèlman, tès fizik, radyolojik ak laboratwa. Lè w siyen pi ba a, ou fè konnen (1) ou gen entansyon konsantman sa a ap kontinye menm apre yo fin fè yon dyagnostik espesifik epi rekòmande yon tretman; epi (2) ou dakò pou fè tretman an nan biwo sa a oswa nan nenpòt lòt anèks ki gen menm pwopriyetè. Konsantman sa a ap rete an vigè jiskaske ou ekri nou pou kanpe l.

Ou gen dwa nenpòt moman pou anile sèvis yo. Ou gen dwa pou w pale sou plan tretman an ak doktè w la konsènan objektif, risk ki ka genyen epi avantaj tout tès yo mande pou w fè. Si ou gen nenpòt enkyetid konsènan tès oswa tretman pwofesyonèl swen sante w la rekòmande w, nou ap ankouraje w pou poze kesyon.

Volontèman mwen mande yon doktè, ak/oswa yon pwofesyonèl swen sante nan nivo mwayen (Enfimyè Pratisyen, Medsen Asistan, oswa Enfimyè Klinik ki Espesyalize), ak lòt pwofesyonèl swen sante oswa moun ki deziyen si yo wè sa nesesè, pou yo fè egzamen medikal, fè tès, fè foto pwoblèm sante mwen genyen an epi tretman pou pwoblèm sante sa a ki rann mwen ap chèche swen nan kabinè sa a.

Mwen dakò pou pèmèt yo (MSCC/laboratwa) trete echantiyon tès laboratwa mwen yo (ki gen ladan, men se pa sèlman echantiyon san, pipi, oswa krache) nan entèn oswa voye yo nan yon laboratwa referans si Midway Specialty Care Center Inc. jije sa nesesè. Epitou mwen konprann yo ka itilize espesimèn mwen yo pou rezon validation.

Mwen konprann si yo rekòmande plis tès, itilize enstriman oswa lòt objè nan kò m oswa pwosedi pou entèvansyon, y ap mande m pou mwen li epi siyen yon lòt fòm konsantman anvan tès oswa pwosedi a (yo).

Mwen te li epi mwen byen konprann pwen ki dekri anwo a epi mwen bay konsantman m ak sa ki ladan l yo.

Siyati Pasyan an (oswa Reprezantan Pèsonèl) _____ Dat_____

Non Pasyan an ak Lèt Detache (oswa Reprezantan Pèsonèl) _____ Relasyon_____

Non Temwen an ak Lèt Detache: : _____ Tit Pòs Anplwaye a _____

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KONSANTMAN PASYAN POU EGZAMEN PELVIK/EGZAMEN GENITOURINÈ

(Daprè Seksyon 456.51 F.S. - aplike pou TOUT Pasyan)

Eta Florid defini yon egzamen basen kòm yon egzamen manyèl nan ògàn yo nan sistèm repwodiktif fi a lè l sèvi avèk men founisè a oswa enstriman. Yon Egzamen Basen se yon egzamen vajen, kòl matris, matris, tib tronp, òvèj, rèktòm oswa tisi ekstèn basen oswa ògàn yo. Yon egzamen jenitourinè nan gason yo enkli jenital, rèktòm, pwostèn, ak nœuds lenfatik basen yo. Pwosedi sa yo itilize pou fè dyagnostik ak/oswa trete kondisyon ki enplike basen an. Li ka prefòme lè l sèvi avèk nenpòt konbinezon de mòd, ki ka gen ladan men founisè swen sante a gan oswa enstriman. Pou rezon konsantman sa a, yo enkli sonografi nan vajen.

Lè mwen siyen konsantman sa a, mwen _____ otorize ak dirije

(Ekri non pasyan an ekri an lèt detache)

Midway Specialty Care Center, Inc.

ak founisè swen sante k ap trete m nan, anplwaye ak/oswa pèsonèl medikal ki gen kontra Midway Specialty Care Center, Inc. jan doktè k ap trete m nan konsidere l nesesè, ak etidyan medikal yo ak/oswa elèv k ap resevwa fòmasyon kòm yon founisè swen sante ki ka patisipe. nan swen mwen, fè yon egzamen basen, ki gen ladan sonografi nan vajen, jan sa dekri pi wo a. Mwen konprann ke yon egzamen basen ka nesesè pandan y ap resevwa swen medikal nan Midway Specialty Care Center, Inc. alavni, epi mwen dakò ak rekonèt ke konsantman alekri sa a aplike a nenpòt ak tout egzamen basen ki fèt jodi a, oswa nan lavni, pa yon founisè swen sante, etidyan medikal, oswa fòmasyon elèv kòm yon founisè swen sante anplwaye ak/oswa kontra avèk Midway Specialty Care Center, Inc. sof si mwen anile konsantman sa a alekri alamen bay yon kopi revokasyon an bay Midway Specialty Care. Center, Inc.

Pa siyati mwen anba a mwen rekonèt mwen te li oswa mwen te li pou mwen epi mwen konprann sa ki nan fòm sa a.

Siyati Pasyan/Reprezantan Legal Non ak dat enprime

Siyati Temwen Non ak dat enprime

Siyati Doktè/Founisè a Non ak dat enprime