SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A.
& SWFL VASCULAR CENTER

New Patient Forms

Name: _____ **DOB:** _____

Current Medications: ☐ Check here if attaching a home medication list

Preferred Pharmacy: Name_____ Phone Number: _____
Is this a mail-in pharmacy? ☐ Yes ☐ No

Medication	Dosage	Times per day	Prescribing Doctor

Patient Signature: _____ **Date:** _____

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Gordon D. Burtch, MD, FACS
General and Vascular Surgery
Ajay Kalra, MD, FACS
Endovascular, Vascular & General Surgery
Jose F. Manibo, MD, FACS
General Surgery
Anthony J. D'Angelo, MD, FACS
Endovascular, Vascular & General Surgery
Thad C. Kammerlocher, MD, FACS
General & Vascular Surgery
Biju K. Thomas, MD, FACS, RPVI
General & Vascular Surgery

Paul W. Sams, PA
Mary Hoke, NP
Emily Randall, PA-C

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is way for doctors to send an accurate, error free, and understandable electronic prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: Compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

Consent

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other health care providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Surgical Specialists of Southwest Florida to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient's Printed Name | Patient's DOB

_____ _____

Signature of Patient or Guardian | Today's Date

_____

Relationship to Patient