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

New Patient Form

GENERAL PATIENT INFORMATION

Patient (FULL, LEGAL) Name: _____

Date of Birth: _____ Last Four Digits of SSN: _____

Referring Physician: _____ Family Physician: _____

Patient Gender: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Language: _____ Have you ever been a patient in this practice before? ☐ Yes ☐ No

Ethnicity (select one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ Black/African American ☐ American Indian ☐ Asian ☐ White ☐ Hawaiian/Pacific Island ☐ Other_____

Home Address: _____

Alternate Address (If applicable): _____

E-Mail:_____ Home: _____ Cell: _____

Emergency Contact: _____ Phone#: _____

I DO NOT HAVE INSURANCE AND PLAN TO PAY FOR TODAY'S VISIT WITH:

☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

YOUR INSURANCE CARDS, PHOTO I.D., and CO-PAY IS REQUIRED AT TIME OF SERVICE.

Primary Insurance: _____ Secondary Insurance: _____

Are you the policyholder for your primary insurance: ☐ Yes ☐ No – If no, complete the information below:

Policyholder's Name: _____

Are you the policyholder for your secondary insurance: ☐ Yes ☐ No – If no, complete the information below:

Policyholder's Name: _____

My signature below acknowledges that I understand that I am financially responsible for all charges provided to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for the physician's services to the physician furnishing the services.

Patient Signature: _____ **Date:** _____

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

New Patient Form

Name: _____ **DOB:** _____

****Please provide a brief explanation for today's visit:** _____

Smoking Status: ☐ Former ☐ Never a smoker ☐ Current smoker, Packs per day_____

Have you had: Pneumonia Vaccine? ☐ No ☐ Yes, when? _____ **Flu Vaccine?** ☐ No ☐ Yes, when? _____

Review of Systems: Do you have any of problems related to the following symptoms? Check the appropriate box.

	Yes	No		Yes	No
Fatigue	☐	☐	**Abdominal Pain**	☐	☐
Fever	☐	☐	**Black or tarry stool**	☐	☐
Chills	☐	☐	**Bloody stool**	☐	☐
Eyes watering or discharge	☐	☐	**Urinary frequency**	☐	☐
Loss of hearing	☐	☐	**Urinary incontinence**	☐	☐
Nasal passage blockage	☐	☐	**Muscle weakness**	☐	☐
Sore throat	☐	☐	**Easy bruising**	☐	☐
Chest pain or discomfort	☐	☐	**Joint Pain, where_____**	☐	☐
Palpitations	☐	☐	**Dizziness**	☐	☐
Feeling of the feet being cold	☐	☐	**Fainting**	☐	☐
Shortness of breath	☐	☐	**Depression**	☐	☐
Cough	☐	☐	**Skin Lesion**	☐	☐
Coughing up blood	☐	☐	**Numbness in hands/legs/feet**	☐	☐
Nausea	☐	☐	**Tingling in hands/legs/feet**	☐	☐
Vomiting	☐	☐	**Swelling in legs/feet**	☐	☐

Family History: (please select all that apply)

	Father	Mother	Brother	Sister
Breast Cancer				
Ovarian Cancer				
Other Cancer				
Heart Disease				
Stroke				
Hypertension				
Diabetes				
Atherosclerotic Vascular Disease				
Aneurysm				
Other (please specify)				

For nurse, only: BP_____ HR _____ Temp _____ RR _____ Sat _____ Ht _____ Wt _____

Patient Signature: _____ **Date:** _____

Allergies: ☐ None **Latex Allergy:** ☐ Yes ☐ No

Medication Allergies Reaction

_____

_____

_____

_____

Food Allergies: ☐ No ☐ Yes _____

Dye Allergies: ☐ No ☐ Yes _____

Shellfish/Iodine Allergies: ☐ No ☐ Yes _____

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: _____

Social History: Occupation (previous occupation if retired): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol: ☐ No ☐ Yes Drinks per day/week: _____

Drug Use or Addiction: ☐ No ☐ Yes Drug(s): _____ Caffeine use: ☐ No ☐ Yes How often? _____

Past Medical History: ☐ No Medical History Check all that apply.

- ☐ Aortic Aneurysm
- ☐ Carotid Artery Stenosis
- ☐ Stroke
- ☐ Peripheral Arterial Disease
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Intermittent Claudication
- ☐ Atrial Fibrillation
- ☐ Murmur
- ☐ Heart Attack (MI)
- ☐ Venous insufficiency
- ☐ Colitis
- ☐ Constipation
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallbladder disease
- ☐ Esophageal reflux
- ☐ Gastrointestinal Bleeding
- ☐ Hernia: _____
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Intestinal obstruction
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Kidney Disease
- ☐ Colon polyps
- ☐ Hematuria
- ☐ Kidney stones
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Diabetes Mellitus
- ☐ Neuropathy
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer's Disease
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Coagulation Defects
- ☐ Sickle Cell Disease
- ☐ DVT: _____
- ☐ Pulmonary Embolism
- ☐ Lymphedema
- ☐ Cancer: _____
- ☐ Other: _____

Past Surgical History: ☐ No Surgical History *Please list surgeries and approximate date*

- ☐ AAA Repair
- ☐ Angiogram
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Graft/Fistula
- ☐ Brain Surgery
- ☐ Breast Biopsy
- ☐ Cataract Removal
- ☐ Cardiac Bypass
- ☐ Gallbladder Removal
- ☐ Heart Catherization
- ☐ Heart valve replacement
- ☐ Hemorrhoid Surgery
- ☐ Hernia: _____
- ☐ Hysterectomy
- ☐ Transplant: _____
- ☐ Mastectomy ☐ L ☐ R
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ Prostate Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils/Adenoids
- ☐ Splenectomy
- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Foot Surgery ☐ L ☐ R
- ☐ Total Hip ☐ L ☐ R
- ☐ Total Knee ☐ L ☐ R
- ☐ Tubal Ligation
- ☐ PD Catheter
- ☐ Amputation:_____
- ☐ Carotid Surgery
- ☐ Leg bypass
- ☐ Stab phlebectomy
- ☐ Ablation [ ] L [ ] R
- ☐ Colon surgery

Other: _____

Other: _____

Patient Signature: _____ Date: _____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

☐ I give my permission to **Surgical Specialists of Southwest Florida, P.A**., to disclose my protected health information to the following family or friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

☐ I request that all my protected health information be disclosed only to "Me" and no one else other than my other healthcare providers.

May we leave a message on your answering machine/voice message about your medical care? ☐ Yes ☐ No

By signing this form, you are granting consent to Surgical Specialists of Southwest Florida to use and disclose your protected health information for purposes of treatment payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I understand that I am financially responsible for all charges of services to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for physicians' services to the physician furnishing the services.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8555. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

We utilize an automated system to remind you of your next appointment. By signing this you also give us permission to include you in this automated calling system. If you do not wish to be reminded of future appointments, please let the receptionist know this.

Patient Signature: _____ Date: _____

CONSENT FORM FOR ePrescribe PROGRAM

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 healthcare providers and/or third-party pharmacy benefit payers 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 the above, I hereby provide informed consent to Surgical Specialists of Southwest Florida, PA 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 Name Patient DOB

_____ _____

Patient Signature Date

_____

Relationship to Patient

SURGICAL SPECIALISTS OF SWFL, P.A.

PATIENT FINANCIAL POLICY & NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our business office is committed to providing outstanding customer service for all financial questions, and our professional staff members are experts working with commercial insurance companies, Medicare, and Workers Compensation.

Commercial Health Insurance

- **Co-Payment**
  - **Insurance companies require that co-payments are collected prior to service**
- **Co-Insurance / Deductibles**
  - **New co-insurance or deductible amounts will be collected prior to any scheduled surgery.**
  - **These amounts can only be calculated after your appointment.**
- **Non-Participating Insurance**
  - **SSSWFL does not contract with every insurance company**
  - **Patients are responsible for asking if SSSWFL is a participating provider with their insurance company**
  - **SSSWFL will bill non-participating insurance. However, outstanding balances are the responsibility of the patient**
- **Secondary Insurance – as a courtesy SSSWFL will file to your secondary insurance carrier at the time**

Medicare

- **SSSWFL will submit claims to Medicare, however you may need to sign an ABN form for all diagnostic services.**
- **SSSWFL will submit to Medicare as your secondary insurance carrier one time**

Workers Compensation

- **Patients claim adjusters shall supply WC contact information prior to services being rendered.**

Motor Vehicle / Third Party Liability

- **Patients are financially responsible for medical services related to motor vehicle accidents**
- **Patients shall supply auto insurance, third party, and / or attorney information as requested by SSSWFL**

Self-Pay

- **Self-pay accounts exist if patients have no insurance coverage**
- **Full payment is due at the time of service of all self-pay patients**

Statements / Payments

- **Statements**
  - **Statements are sent to patients on a monthly basis and will show outstanding balances.**
  - **After insurance pays, patients are responsible for all outstanding balances**
- **Payment Methods**
  - **We accept all major credit cards, checks, money orders, and cash**
  - **Low interest payment plans are available. Patients need to discuss options with the Customer Service Representative**
- **Returned Check Fee a fee of $25.00 will be charged for all returned checks**
- **Durable Medical Products (DME) purchased in our office are non-refundable.**
- **A fee of $40 will be charged for all missed appointment or no-show.**

I _____, hereby assign to Surgical Specialists of SWFL, payments of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Sign: _____ Date_____