SMC
SARASOTA MEDICAL CENTER

Patient Information - Please Print

Today's Date:_____ Email Address:_____

Patient's Name:_____
(LAST) (FIRST) (MIDDLE INTIAL)

Local Address:_____

City:_____ State:_____ Zip Code:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: ( )_____ Pref Y / N Cell Phone: ( )_____Pref Y / N

Age:____ Date of Birth: ____/ ____/ ____ Sex □ M □ F Social Security #:_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Minor

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Declined to Specify

Race: □ American Indian/Alaskan Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White □ Other Race □ Declined to Specify

If Minor, Responsible Parties:_____

If different address than above:_____

City:_____ State:_____ Zip Code:_____

Primary Insurance Carrier:_____ Policy #:_____

Secondary Insurance Carrier:_____ Policy #:_____

Insurance Policy Holder:_____ Date of Birth:_____/ _____/ _____

Employer:_____ Occupation:_____

How did you hear of SMC? □ Internet □ Family/Friend □ Print Media □ Other _____

If Auto Accident Case:

Auto Insurance Carrier:_____ Phone:_____

Claim #: _____ Policy #: _____

Adjuster's Name: _____ Date of Accident: _____

Attorney: _____ Attorney Phone: _____

Contact/ Case Manager: _____

If Worker's Compensation Case:

Employer: _____ Date of Injury: _____

Work Comp Insurance Company: _____ Case Manager: _____

Claims Mailing Address: _____

Claim #: _____ Phone #: _____

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Medical History

Please fill out to the best of your ability and focus on what is pertinent to today.

Name:_____ Age:_____ Date of Birth:_____ Sex:_____ Date: _____

General Health Status:

Please rate your health: ___ Excellent ___ Good ___ Fair ___ Poor

Exercise: ___ Athlete ___ Heavy ___ Daily ___ Moderate ___ None

Health Habits: Smoking ___No ___ Yes, ___ packs/day ___Years Alcohol ___No ___Yes, ____ drinks per week

Family History:

Please list if your father, mother, sibling, grandparent, or aunt/ uncle has had any of the following conditions.

Arthritis :_____ Cancer:_____

Cholesterol: _____ Diabetes: _____

Heart Disease: _____ Hypertension: _____

Psychological: _____ Seizure/ Epilepsy:_____

Stroke: _____ Other: _____

Allergies: _____

Prescription Medications: _____

_____

_____

Non-Prescription Medications/ Vitamins/ Supplements/ Herbs: _____

_____

Previous Surgeries/ Hospitalizations: _____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

Cardiovascular:	Yes	No
Heart Attack	( )	( )
Chest Pain	( )	( )
Pacemaker/Defibrillator	( )	( )
Leg/Ankle Swelling	( )	( )
Palpitations	( )	( )
Irregular Pulse	( )	( )
Muscle pain/cramps	( )	( )
Heart Murmur/Arrhythmia	( )	( )
Abnormal EKG	( )	( )
High Blood Pressure	( )	( )
Eyes, Ears, Nose, Throat	**Yes**	**No**
Hearing Loss	( )	( )
Uncorrectable Vision Loss	( )	( )
Fever Blisters	( )	( )
Swallowing Difficulty	( )	( )
Blood/ Lymphatic	**Yes**	**No**
Bleeding Disorder	( )	( )
Anemia	( )	( )
Transfusions	( )	( )

Respiratory	Yes	No
Recent Infection	( )	( )
Asthma	( )	( )
Pneumonia	( )	( )
Tuberculosis	( )	( )
Chronic Cough	( )	( )
Shortness of Breath	( )	( )
COPD	( )	( )
CPAP Machine	( )	( )
Neurological	**Yes**	**No**
Stroke/ TA	( )	( )
Migraine	( )	( )
Black Out Spells	( )	( )
Dizziness	( )	( )
Weakness/Paralysis	( )	( )
Motion/Car Sickness	( )	( )
Endocrine	**Yes**	**No**
Diabetes	( )	( )
Thyroid Problems	( )	( )
Pituitary Problems	( )	( )

Gastrointestinal	Yes	No
Hepatitis	( )	( )
Jaundice	( )	( )
Ulcer	( )	( )
Hiatal Hernia	( )	( )
Pancreatitis	( )	( )
Vomiting Blood	( )	( )
Colitis	( )	( )
Blood in Stool	( )	( )
Hemorrhoids	( )	( )
Change in Bowels	( )	( )
Genitourinary	**Yes**	**No**
Bladder Infection	( )	( )
Kidney Infection	( )	( )
UTI	( )	( )
Stones in Urine	( )	( )
Blood in Urine	( )	( )
Incontinence	( )	( )
Blockage of Urine	( )	( )
Prostrate Problem	( )	( )

Musculoskeletal	Yes	No
Fractures	( )	( )
Dislocations	( )	( )
Joint Pains	( )	( )
Arthritis	( )	( )
Back Pain	( )	( )
Neck Stiffness	( )	( )
Neck Immobility	( )	( )

Last Menstral Period:

_____

Using Other Providers?

Cardiologist	( )	( )
Chiropractor	( )	( )
Dentist	( )	( )
Family Doctor	( )	( )
Gastroenterology	( )	( )
Neurologist	( )	( )
OB/GYN	( )	( )
Orthopedist	( )	( )
Rheumatologist	( )	( )

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Patient Consent for Receipt and Transmittal of Protected Health Information

DOES SARASOTA MEDICAL CENTER HAVE PERMISSION TO:

1. Mail notices to your home address: Yes No

2. Leave the following information on your **HOME/ CELL** voicemail:
   - Appointment Information Yes No
   - Billing Information Yes No
   - Medical Information Yes No
   - Prescription Refills Yes No
   - Authorizations or Referrals Yes No

3. Leave the following information on your **WORK** voicemail:
   - Appointment Information Yes No
   - Billing Information Yes No
   - Medical Information Yes No
   - Prescription Refills Yes No
   - Authorizations or Referrals Yes No

4. I give permission to Sarasota Medical Center to share appointment and billing information with the following people listed below:
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____

5. I give permission to Sarasota Medical Center to share medical information with the following people listed below:
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____

Patient Name (printed):_____ Date of Birth:_____
Patient Signature:_____ Date:_____
Guardian Signature: _____ Date:_____
(if patient is under 18 years old)

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Please Read Each Section Carefully, Initial All Boxes and Indicate Your Agreement By Signing At The Bottom

Financial Responsibility and Assignment of Benefits:

☐ All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. All unpaid balances will be considered delinquent 60 days from the date of service. Any delinquent accounts can be referred to a collection agency and will incur the cost of collection including reasonable attorney fees.

☐ I the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Sarasota Medical Center (Good Business LLC) all medical and surgical benefits to include all major medical benefits to which I am entitled, if any, otherwise payable to me for services rendered to myself and/or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Sarasota Medical Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

☐ I understand that medical treatment of an immediate nature is necessary and that such care, treatment and procedures will be provided during office hours only. I grant authorization and consent to treatment and certify that no guarantee or assurance has been made at to the results which may be obtained. I acknowledge that neither Sarasota Medical Center nor any of its owners, officers, directors or employees shall have any liability, whether direct or indirect, if I do not follow the prescribed course of treatment, including prescribed return visits or the failure to properly use prescribed medications and/or treatments.

Medicare Authorization

☐ I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Sarasota Medical Center (Good Business LLC) for any services furnished me by their physicians and staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Important Notice from the Government:

☐ It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments, even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "Take What Insurance Pays" Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws.

Late Policy "10 Minute Rule"

☐ Being late by more than 10 minutes for your scheduled appointment will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. If you are being seen as a "walk-in" visit and want to see a particular provider, you will have to wait for an opening to see that provider instead of seeing the first available provider.

Patient/ Responsible Party Signature:_____

Printed Name:_____ **Date:**_____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, **SARASOTA MEDICAL CENTER** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that **SARASOTA MEDICAL CENTER** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organizations has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **SARASOTA MEDICAL CENTER** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **SARASOTA MEDICAL CENTER** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

X_____ _____

Patient's Signature (or authorized representative signing for the patient) Date

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FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

TPO CONSENT FORM

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Effective Immediately

A **$25 charge** will be placed on your account for any scheduled appointments that are a **NO-SHOW**.

Please plan accordingly, reschedule or cancel any appointments you cannot attend.

Signature:_____ Date:_____