Patient Id #_____

SURGICAL GROUP OF NAPLES
2335 Tamiami Trail N. Ste. 501
Naples, FL 34103
(239) 263-0011

I CAME HERE TODAY TO SEE DR. _____.

DATE: _____

PATIENT INFORMATION

(Please Print Patient's Complete Legal Name)

PATIENT NAME: First_____ MI____ Last_____
DATE OF BIRTH:_____ GENDER (Circle One): Male Female
ADDRESS:_____ Unit # :_____ CITY/STATE/ZIP:_____
HOME PHONE # (INC. AREA CODE):_____ CELL/BEEPER # (INC. AREA CODE):_____
EMAIL ADDRESS:_____ SOCIAL SECURITY # :_____
MARITAL STATUS (Circle One): Single Married Divorced Widowed
LOCAL PRIMARY PHYSICIAN:_____ REFERRING PHYSICIAN:_____
NON-LOCAL PRIMARY PHYSICIAN (if applicable):_____
PHARMACY:_____ PHONE # and/or LOCATION:_____
EMERGENCY CONTACT NAME:_____
RELATIONSHIP TO EMERGENCY CONTACT:_____
EMERGENCY PHONE # (INC. AREA CODE):_____

PATIENT EMPLOYER / SCHOOL INFORMATION

NAME OF EMPLOYER/SCHOOL:_____
(CIRCLE ONE): Full Time Part Time Retired Self Unemployed
STREET ADDRESS:_____ Unit # :_____ PHONE # :_____
CITY/STATE/ZIP:_____ (INC. AREA CODE & EXT. #)

NORTHERN ADDRESS

STREET ADDRESS:_____ Unit # :_____ PHONE # :_____
CITY/STATE/ZIP:_____ (INC. AREA CODE)

INSURANCE INFORMATION

**NOTE: If the policy holder is not the patient, please complete the following:
**MEDICARE PATIENTS: Please complete if patient is not the holder of secondary insurance:

POLICY HOLDER'S NAME:_____
RELATIONSHIP TO POLICY HOLDER (Circle One): Self Spouse Child
DATE OF BIRTH:_____ GENDER (Circle One): Male Female
STREET ADDRESS:_____ Unit # :_____ PHONE # :_____
CITY/STATE/ZIP:_____ (INC. AREA CODE)
SOCIAL SECURITY # :_____
EMPLOYER:_____

By signing below, I acknowledge the following:

1. **I hereby authorize this provider to treat me.**
2. **I hereby attest that the personal and financial information given above is true and that my personal identification or insurance information has not been falsified.**
3. **A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. Surgical Group of Naples cannot be bound by any divorce or other family relationship.**
4. **I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid (CMS) and it's agents, or any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.**
5. **I have reviewed and understand all the information on the second page of this document, including the HIPPA Notice of Privacy Practices Statement, as indicated with my signature and date below.**

Signature:_____ **Date:**_____

This office is a division of 21st Century Oncology
Please see reverse for Financial Agreement

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

21st Century Oncology, LLC
The Surgical Group of Naples
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

THE SURGICAL GROUP OF NAPLES
COMPASSIONATE SURGICAL CARE

Jacob H. Jordan, M.D. F.A.C.S.
Justin D. Warner, M.D. F.A.C.S.
A. Samuel Tunkle, M.D. F.A.C.S.
Board Certified by American Board of Surgery

HEALTH HISTORY FORM

Date: _____ Age: _____

_____
Last Name First Name MI

Referring doctor: _____ Primary doctor: _____

Reason you are here: _____

OPERATIONS: (when, type of surgery)

_____
_____
_____
_____

HOSPITALIZATIONS: (when, where, why?)

_____
_____
_____
_____

MEDICATIONS: _____

_____
_____
_____
_____

ALLERGIES: Circle if you have an allergy to any of the following. Please describe reactions.

Dye_____ Codeine_____
Foods _____ Tape_____
Penicillin_____ Latex_____
Sulfa_____ Erythromycin _____
Iodine_____ Other_____

PERSONAL HISTORY AND HABITS: ❑**Married** ❑**Single** ❑**Widowed**

Employed: ❑No ❑ Yes, occupation: _____

Children: ❑ No ❑ Yes, number of children: _____

Tobacco Use: ❑ Current, # packs daily: _____ ❑ Past, date stopped: _____ ❑Never

Alcohol Use: ❑Current, type/frequency: _____ ❑ Past ❑Never

Immunization: Influenza: _____ **Date**_____

FAMILY HISTORY: Check all that apply.

M=Mother **F**=Father **GM**= Grandmother **GF**=Grandfather **A**=Aunt **U**=Uncle

Cancer: ❑M ❑F ❑GM ❑GF ❑A ❑U **Cancer Type**: _____

Heart Disease: ❑M ❑F Diabetes: ❑M ❑F Stroke: ❑M ❑F High Blood Pressure: ❑M ❑F

Are parents still living: ❑Yes ❑ No, cause of death: _____

Name: _____

GENERAL

Good general health lately	❑ No	❑Yes
Chills or sweats	❑ No	❑Yes
Fever	❑ No	❑Yes
Fatigue	❑ No	❑Yes

EYES

Recent visual problem	❑ No	❑Yes
Blurred vision	❑ No	❑Yes

EARS/NOSE/THROAT

Decreased hearing	❑ No	❑Yes
Ear pain	❑ No	❑Yes
Nasal congestion	❑ No	❑Yes
Sore throat	❑ No	❑Yes

LUNGS/RESPIRATORY SYSTEM

✪Shortness of breath	❑ No	❑Yes
If yes: ❑At rest ❑With activity ❑Both		
Chronic/frequent cough	❑ No	❑Yes
✪Sleep apnea	❑ No	❑Yes
✪Blood clots in lungs	❑ No	❑Yes
✪Asthma	❑ No	❑Yes
✪COPD	❑ No	❑Yes
✪Tuberculosis	❑ No	❑Yes

HEART/CARDIOVASCULAR SYSTEM

Chest pain	❑ No	❑Yes
✪Palpitations	❑ No	❑Yes
Swelling of the legs	❑ No	❑Yes
Frequent fainting	❑ No	❑Yes
✪Mitral valve prolapse	❑ No	❑Yes
✪Coronary artery disease	❑ No	❑Yes
✪Heart failure	❑ No	❑Yes
✪Heart attack	❑ No	❑Yes, at age_____
Rheumatic fever	❑ No	❑Yes
✪High blood pressure	❑ No	❑Yes

DIGESTIVE/G.I. SYSTEM

Nausea and vomiting	❑ No	❑Yes
Diarrhea	❑ No	❑Yes
Constipation	❑ No	❑Yes
✪Heartburn/GERD	❑ No	❑Yes
Abdominal pain	❑ No	❑Yes
Stomach ulcers	❑ No	❑Yes
✪Hepatitis	❑ No	❑Yes
✪Diverticulitis	❑ No	❑Yes
✪Crohn's disease	❑ No	❑Yes
✪Ulcerative colitis	❑ No	❑Yes
Colon polyps	❑ No	❑Yes
✪Colon cancer	❑ No	❑Yes

URINARY SYSTEM

✪Prostate disease or cancer	❑ No	❑Yes
Blood in urine	❑ No	❑Yes
Painful urination	❑ No	❑Yes
Frequent urinary tract infection	❑ No	❑Yes
Kidney failure	❑ No	❑Yes

BLOOD/HEMATOLOGIC SYSTEM

Bruises easily	❑ No	❑Yes
✪Blood clots in legs	❑ No	❑Yes

ENDOCRINE

✪Thyroid disease	❑ No	❑Yes
✪Diabetes	❑ No	❑Yes
Heat intolerance	❑ No	❑Yes
Cold intolerance	❑ No	❑Yes
Adrenal disease	❑ No	❑Yes
Pituitary disease	❑ No	❑Yes

MUSCULOSKELETAL SYSTEM

Gout	❑ No	❑Yes
Osteoporosis	❑ No	❑Yes
Arthritis	❑ No	❑Yes
Back pain	❑ No	❑Yes

SKIN/INTEGUMENTARY SYSTEM

Rash	❑ No	❑Yes

NERVOUS SYSTEM

Frequent or recurring headaches	❑ No	❑Yes
Lightheaded or dizziness	❑ No	❑Yes
✪Stroke	❑ No	❑Yes
✪Seizures	❑ No	❑Yes
Neuropathy	❑ No	❑Yes

PSYCHIATRIC

✪Anxiety	❑ No	❑Yes
Depression	❑ No	❑Yes
Alcohol/drug withdrawal	❑ No	❑Yes

BREAST

Fibrocystic breasts	❑ No	❑Yes
✪Breast cancer	❑ No	❑Yes

OTHER

_____

_____

_____

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Statement of Financial Responsibility:

Patient Name: _____Date:_____

The Surgical Group of Naples physicians are participating providers in most insurance plans. If you are in a Managed Care Plan that requires you to have a Primary Care Physician (PCP) you must obtain the referral form from your PCP and bring it to the office on your first visit. You are responsible for payment of any co-payment at the time of service. If surgery is needed we will obtain precertification from your insurance carrier. Each insurance company (plan) has different reimbursement guidelines. Our office will verify your coverage and benefits prior to your surgery. You will be responsible for any deductible/coinsurance as determined by your contract with your insurance carrier. We will file the claim to your primary insurance carrier. As a courtesy to our patients, we will file a claim to your supplemental (secondary) insurance carrier. If we do not receive payment after sixty (60) days from the date we filed the claim, we will transfer the balance over to the patient. Many insurance companies have stipulations that may affect your coverage. You are responsible for any amount not covered by you insurer. If you elect to continue with your surgery and your insurance carrier denies any part of your claim, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to The Surgical Group of Naples. I accept financial responsibility and agree to these terms.

Signature: _____Date:_____

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number

Address (Street, City, State, ZIP Code)	Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**

***DO NOT** discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

_____

_____

_____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

_____

_____

Physician Office Representative: Date:

21st Century Oncology, LLC
The Surgical Group of Naples

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

****

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

_____

_____

_____ _____

Signature of Employee Date