

RALPH R. GARRAMONE, MD, FACS

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

First

Middle

Last

Address

Street & Apt #

City

State

Zip

Home Phone

Cell Phone

Other Phone

Any restrictions for contacting you?

No

Yes

E-mail

Contact Restrictions:

Age _____ Birthdate _____ SS# _____ Gender Female Male

Marital Status Single

Married to: _____

Other: _____

Patient's Employer

Occupation

Work Phone

Ext: _____

Is it okay to call you at work?

Yes

No

Address

Street & Suite #

City

State

Zip

How did you hear about ?

(Mark all that apply)

TV News

TV Ad

Phone Book

Magazine

Newsletter

Seminar

Salon

Web

Friend/Relative: _____

Doctor: _____

Other: _____

If you were referred by a specific person, may we thank them?

Yes

No

Emergency Contact

(Not in your household)

Relationship to Patient

Home Phone

Work Phone

Other Phone

Primary Health Insurance Company

Policy #

Group #

Ins. Phone

Referral Required?

No

Yes

Copay?

No

Yes, \$

Insured: Name

DOB

Employer

Secondary Health Insurance Company

Policy #

Group #

Ins. Phone

Referral Required?

No

Yes

Copay?

No

Yes, \$

Insured: Name

DOB

Employer

I understand that office visit charges are payable on the day service is rendered. I authorize to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between and myself.

Signature

Date

MEDICAL HISTORY

| <i>HAVE YOU HAD OR DO YOU CURRENTLY HAVE?</i> | <i>YES</i> | <i>NO</i> | <i>NOTES</i> | <i>HAVE YOU HAD OR DO YOU CURRENTLY HAVE?</i> | <i>YES</i> | <i>NO</i> | <i>NOTES</i> |
|---|------------|-----------|--------------|---|------------|-----------|--------------|
| Rheumatic Fever | | | | Stroke | | | |
| Damaged Heart Valve | | | | Thyroid Trouble | | | |
| Heart Murmur | | | | Diabetes | | | |
| High Blood Pressure | | | | Low Blood Sugar | | | |
| Low Blood Pressure | | | | Kidney Trouble | | | |
| Chest Pain, Angina | | | | Dialysis | | | |
| Heart Attack | | | | Arthritis | | | |
| Irregular Heart Beat | | | | Rheumatoid Arthritis | | | |
| Cardiac Pacemaker | | | | Stomach Ulcers | | | |
| Heart Surgery | | | | Phlebitis | | | |
| Asthma | | | | HIV or AIDS | | | |
| Hayfever, Sinus Problems | | | | Sexually Transmitted Disease | | | |
| Tuberculosis | | | | Skin Cancer | | | |
| Emphysema | | | | Pain Medications | | | |
| Difficulty Breathing | | | | Do you Bruise Easily? | | | |
| Do you smoke or use tobacco | | | | Mental Health Problems | | | |
| Blood Disorder, Anemia | | | | Fainting Spells/Dizziness | | | |
| Allergies | | | | Dry Eye | | | |
| Hives/Rash | | | | Contact Lenses | | | |
| Jaundice/Hepatitis | | | | Chemotherapy | | | |
| Liver Disease | | | | Joint Pain or Aches | | | |
| Eye Disease | | | | Chronic Fatigue | | | |
| Bronchitis/Chronic Cough | | | | Infectious Mononucleosis | | | |
| Blood Transfusion | | | | Implants - - i.e. dental, joint, breast | | | |
| ACCUTANE - | | | When? | Fever Blisters/Cold Sores | | | |

| | | |
|---------------------|------------------|-------------|
| Patient Name: _____ | Signature: _____ | Date: _____ |
| MD Review: _____ | Date: _____ | |

RALPH R. GARRAMONE, MD, FACS

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

I, _____, understand that as part of my health care, Dr. Ralph Garramone MD 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 and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. 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 Dr. Ralph Garramone MD 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 organization has already take 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 Dr. Ralph Garramone MD 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 Dr. Ralph Garramone MD 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, email).

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 health care 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.

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the physician listed above has elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

PHOTOGRAPHIC CONSENT FORM: I hereby grant permission to Ralph R. Garramone, M.D., to take photographs of me to use for documentation of the doctor's records and/or to submit to my insurance carrier for prior authorization for surgery or for proof of disability. These photographs may be used for educational purposes, i.e., publications and/or lectures, both on a national, state and local level, as well as televised programs and the internet.

PAYMENT POLICY:

You are responsible directly to the office for payment of your account regardless of the status of medical or liability insurance claims. The office of Dr. Ralph Garramone MD will file your claim as a courtesy to you. This office does not accept responsibility for collecting your insurance claims or negotiating settlement on a disputed claim.

I fully understand and accept the terms of this consent.

Patient's Signature

Date

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 _____.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

I _____ **acknowledge that I have received information regarding:**

- . **Fee and payment policies**
- . **Billing dispute resolution policy**
- . **Identification of principal ownership of the practice**
- . **Credentials of the practitioners responsible for care**
- . **Any relationships with other health care providers or contractors**
- . **Patient rights and responsibilities**

Patient Signature _____ **Date** _____