

PATIENT INFORMATION (Informacion del Paciente)

Patient Name: _____

Nombre del Paciente

Home Address: _____

Direccion del Hogar

City: _____ **State:** _____ **Zip Code:** _____

Ciudad Estado Codigo Postal

Occupation: _____ **Email:** _____

Ocupacion

Employer: _____

Empleo

Name of Spouse or Emergency Contact: _____

Contacto de Emergencia

How did you hear about us? Internet newspaper doctor patient other _____

Quien refirio a nuestra oficina?

Primary Language: _____ **Race:** _____

Lenguaje primario

Raza

Home Phone: _____

Telefono del Hogar

Mobile Phone: _____

Telefono del Trabajo

Date of Birth: _____ **Age:** _____

Fecha de Nacimiento

Social Security #: _____

Numero de Seguro Social

Marital Status: _____

Estado Civil

Phone Number: _____

Telefono

Referring Physician: _____

Nombre de su Medico

Ethnicity (circle)? Non-hispanic or Hispanic.

Etina? Non-hispano o Hispano

INSURANCE INFORMATION (Informacion de Seguro)

Name of Primary Insurance: _____

Nombre del Seguro

Name of Subscriber: _____

Nombre del Asegurado

Relation to Patient: _____

Relacion al Paciente

Subscriber's Employer: _____

Empleo del Asegurado

Insured ID: _____

Numero de indentificacion de Asegurado

Subscriber's SS#: _____

Numero de Seguro Social del Asegurado

Subscriber's Date of Birth: _____

Fecha de Nacimiento del Asegurado

Subscriber's Work Number: _____

Telefono de Trabajo del Asegurado

Name of Secondary Insurance: _____

Nombre del Seguro Secundario

Name of Subscriber: _____

Nombre del Asegurado

Relation to Patient: _____

Relacion al Paciente

Subscriber's Employer: _____

Empleo del Asegurado

Insured ID: _____

Numero de indentificacion de Asegurado

Subscriber's SS#: _____

Numero de Seguro Social del Asegurado

Subscriber's Date of Birth: _____

Fecha de Nacimiento del Asegurado

Subscriber's Work Number: _____

Telefono de Trabajo del Asegurado

Do you have any other form of medical insurance that is not indicated above as a Primary or Secondary insurance? YES NO

If YES, complete above or provide the information below:

I understand I am responsible for disclosing ALL health insurance policies that are active in my name as well as when my insurance policy renews or terminates. Failure to disclose a policy could result in responsibility for all charges related to the services. This includes primary, secondary insurance, tertiary insurance, Medicaid and Medicare plans, commercial plans, government plans, etc. **INITIALS:** _____

Entiendo que soy responsable de divulgar TODAS las pólizas de seguro de salud que estén activas en mi nombre, así como también cuando mi póliza de seguro se renueve o termine. No revelar una política podría resultar en responsabilidad por todos los cargos relacionados con los servicios. Esto incluye seguro primario, secundario, seguro terciario, planes de Medicaid y Medicare, planes comerciales, planes gubernamentales, etc. **INICIALES:**

PATIENT SIGNATURE: _____ **DATE:** _____

Firma del Paciente

COMPREHENSIVE PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

Pharmacy (local) Name: _____ Phone Number: _____

The reason for your visit to Dr. Bass? _____

ALLERGIES: List names of ALL allergens and the reaction to the allergen (attach a separate sheet if necessary)

NO DRUG ALLERGIES NO NON-DRUG ALLERGIES (ex. latex, adhesive, dyes or food)

MEDICATION & SUPPLEMENTS: Include name, dose and frequency (attach a separate sheet if necessary)

PATIENT SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced Widowed Partnered

Employed: Yes No Occupation: _____

Alcohol Use: Never Rarely Moderate, drinks per week? _____ Daily, drinks per day? _____

Tobacco Use: Never Quit, date _____ Current, packs per day _____

Drug Use: Never Type/Frequency _____

Carbonated Beverages: Never Rarely Moderate, how often? _____ Daily, how many? _____

Fast Food: Never Rarely Moderate, how often? _____ Daily, how many? _____

FAMILY MEDICAL HISTORY:

	Age(s)	Diseases (including obesity)	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children # _____	_____	_____	_____

PREVIOUS SURGERY:

List previous surgeries or serious injuries & date

PREVIOUS DIAGNOSTIC TESTING:

Check all that were performed in the past 2 years

- | | |
|---|--|
| <input type="checkbox"/> CXR | <input type="checkbox"/> Stress Test- Nuclear |
| <input type="checkbox"/> ECHO | <input type="checkbox"/> Ultrasound of Gallbladder |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Ultrasound of Lower extremities |
| <input type="checkbox"/> Heart Catheterization | <input type="checkbox"/> Upper Endoscopy |
| <input type="checkbox"/> Mammogram | <input type="checkbox"/> Upper GI |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> Pulmonary Function Tests | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sleep Study | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stress Test- Exercise | |

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Circle YES to all that apply and include DATE)

CONSTITUTIONAL		DATE	GENITOURINARY		DATE
Good general health lately	YES		Frequent urination	YES	
Night sweats	YES		Burning or painful urination	YES	
Fevers	YES		Blood in urine	YES	
Chronic Fatigue	YES		Change of force or strain	YES	
Hereditary Defects	YES		Kidney Stones	YES	
EYES		DATE	Venereal Disease	YES	
Eye disease or injury	YES		Male: testicle pain	YES	
Wear glasses or contacts	YES		Female: pain with periods	YES	
Blurred vision	YES		Female: irregular periods	YES	
Double vision	YES		Female: vaginal discharge	YES	
ENT		DATE	Female: #pregnancies_____		
Hearing loss	YES		# miscarriages_____		
Ringing in the ears	YES		Female: date of last pap smear		
Earaches or drainage	YES		Female: findings of last pap smear <input type="checkbox"/> normal <input type="checkbox"/> abnormal		
Sinus problems	YES		MUSCULOSKELETAL		DATE
Bleeding gums	YES		Joint pain	YES	
Bad breath or bad taste	YES		Arthritis	YES	
Sore throat or voice change	YES		Joint stiffness or swelling	YES	
Swollen glands in the neck	YES		Weakness of muscles/joints	YES	
CARDIOVASCULAR		DATE	Muscle pain or cramps	YES	
Heart trouble	YES		Gout	YES	
High Blood Pressure	YES		Back pain	YES	
Chest pains/ angina	YES		Cold extremities	YES	
Sudden heart beat changes	YES		Difficulty in walking	YES	
Swelling of feet, ankles, or hands	YES		SKIN		DATE
RESPIRATORY		DATE	Rash, itching or dry skin	YES	
Frequent coughing	YES		Change in skin color	YES	
Pulmonary embolism	YES	Oxygen Use	Change in hair or nails	YES	
Shortness of breath or Asthma	YES	Yes No	Varicose veins	YES	
Obstructive Sleep Apnea	YES	CPAP?	Raised scars	YES	
Snoring	YES	Yes No	Breast pain	YES	
GASTROINTESTINAL		DATE	Breast lump	YES	
Loss of appetite	YES		Breast discharge	YES	
Change in bowel movements	YES		NEUROLOGICAL		DATE
Nausea or vomiting	YES		Frequent/ recurring headaches	YES	
Diarrhea or constipation	YES		Lightheaded or dizzy	YES	
Blood in stool	YES		Convulsions or seizures	YES	
Reflux or heartburn	YES		Numbness/ tingling sensations	YES	
Stomach pain	YES		Tremors	YES	
ENDOCRINE		DATE	Paralysis	YES	
Glandular or hormone problem	YES		Stroke	YES	
Thyroid disease	YES		Pseudotumor	YES	
Low blood sugar	YES		PSYCHIATRIC		DATE
Excessive thirst or urination	YES		Memory loss or confusion	YES	
Heat or cold tolerance	YES		Nervousness	YES	
Diabetes mellitus	YES		Depression	YES	
Change in hat or glove size	YES		Sleep problems	YES	
Elevated cholesterol	YES		Psychiatric problems	YES	
HEMATOLOGIC/LYMPHATIC		DATE	<div style="border: 2px solid blue; padding: 10px;"> <p><i>All information provided above and on the preceding forms of the Comprehensive Patient History is accurate and honest to the best of my knowledge.</i></p> <p>Patient Signature:</p> <p>_____</p> </div>		
Slow to heal after cuts	YES				
Easily bruise or bleed	YES				
Anemia	YES				
Phlebitis	YES				
Past blood transfusion	YES				
Enlarged glands	YES				
Cancer	YES				
*Type?					
Bleeding disorder	YES				
Acute Infection	YES				

CONFIDENTIAL INFORMATION

I **DO AUTHORIZE** Surgical Consultants of SW Florida, LLC to discuss my confidential information with the following people. I have also designated my primary emergency contact person below.

Primary Contact

Additional Contact

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Phone number: _____

Phone number: _____

I **DO NOT AUTHORIZE** Surgical Consultants of SW Florida, LLC to discuss my confidential information with others.

If there is someone specific, please let the person below:

Name: _____

Relationship: _____

INITIALS: _____

PHONE MESSAGES, EMAIL & TEXT CORRESPONDENCE

May we leave a phone message? **Yes** **No**

Phone number to leave a voice message? _____

May we text you regarding appointments? **Yes** **No**

Phone number to text a message? _____

May we contact you via email? **Yes** **No**

Email address: _____

I understand that emails from this office will be titled as Gulf Coast Bariatrics, Dr. Bass’s office or some variation of the practice name unless otherwise identified by the sender and/or in the case of the office staff returning an email with a title of origin from sender: **INITIALS:** _____

I understand that email correspondence does not take the place of a phone call to the office should I feel I am having a medical emergency. **INITIALS:** _____

FEES AND INSURANCE RELEASE OF INFORMATION & STATEMENT OF UNDERSTANDING (initial below)

I understand all fees are payable at the time of services rendered. Cash, certified check, and Credit card are accepted.

INITIALS: _____

I would like my insurance company to release any information to Surgical Consultants of SW Florida, PA to determine eligibility, benefits, co-payments or any out-of-pocket expenses. I also give permission for any insurance company to inform Surgical Consultants of SWFL, LLC of the reasonable and customary reimbursements for a surgical procedure.

INITIALS: _____

I understand my medical insurance is a contract between me and my insurance carrier and therefore, my responsibility to contact my insurance company and or employer for benefit/ exclusion information as it relates to office visits or surgery. This information includes out of pocket expenses (deductibles, copays, coinsurance preoperative testing, anesthesia, etc.) and possible limits of coverage on my policy as related to office visits and surgical procedures.

INITIALS: _____

NO SHOW POLICY

I understand the practice strives to increase patient accessibility to the practice and in order to do so, it is important to minimize the no-show rate.

A no-show fee will be charged to my account if I fail to show to a scheduled appointment without 24 – hour prior cancellation notice:

- **Office visits: \$25.00**
- **Hospital outpatient procedures (ex. EGD): \$75.00**
- **Hospital outpatient and inpatient surgery: \$100.00**

Patient Signature

Initials

Date



Gulf Coast Bariatrics
Surgical Consultants of Southwest Florida, LLC

Physician Contact information
Authorization for release of information

Please complete the below information in entirety.

This information is important for communication with your other doctors' offices as well as authorized records release.

Patient Name: _____

Date of Birth: _____ **Patient Initials** _____

****Please "x" the box and initial to ensure proper authorization for release of information.***
(If you do not wish to authorize records releases do not check or initial.)

Primary Doctor: _____

_____ **I authorize release of my medical information**

Address: _____

Phone: _____ Fax: _____

Cardiologist: _____

_____ **I authorize release of my medical information**

Address: _____

Phone: _____ Fax: _____

Pulmonologist: _____

_____ **I authorize release of my medical information**

Address: _____

Phone: _____ Fax: _____

Other Specialty Type: _____

_____ **I authorize release of my medical information**

Address: _____

Phone: _____ Fax: _____

Facility: _____

_____ **I authorize release of my medical information**

Address: _____

Phone: _____ Fax: _____

Other: _____

_____ **I authorize release of my medical information**

Address: _____

Phone: _____ Fax: _____

I hereby authorize the hospital/facility/physician(s) named above to release my complete medical records to:

Surgical Consultants of SW Florida, L.L.C

Gulf Coast Bariatrics

4519 Tilton Court

Ft. Myers, FL 33907

Phone# 239-494-8777

Fax# 239-221-0277

Patient Signature

Date

Surgical Consultants of Southwest Florida, LLC
Notice of Privacy Practices (Short Form)

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA regulations.

What is HIPAA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient’s personal information as it relates to healthcare. The privacy rule was created to protect your rights as a patient of our practice, and we are required by law to be compliant with this regulation on April 14, 2003. Effective 9/23/2013, the U.S. Department of Health & Human Services adopted new rules called the “HPIAA Omnibus Rule”, which make changes to the existing privacy, security and breach notification requirements. The new rules are as a result of changes made under the Health Information Technology for Economic and Clinical Health (HITECH) which is part of the law that created the Electronic Health Records (EHRS) Incentive Program under Medicare and Medicaid.

Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice’s policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Protected Health Information (PHI)?

It is any individually identifiable health information that you provide our practice, including your mailing address. It is also information that is created and retained by our practice or by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual. The medical record is the property of this medical practice, but the information in the medical record belongs to you.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in the waiting room informing patients about their rights surrounding the protection of your PHI and our obligations concerning the use and disclosure of your Personal Health Information. This notice applies to all records created or retained by our practice. Except as described in the Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization.

The following categories describe the different ways in which we may use and disclose your PHI:

- TREATMENT
- PAYMENT
- HEALTH CARE OPERATIONS
- APPOINTMENT REMINDERS
- SIGN IN SHEET
- NOTIFICATION & COMMUNICATION WITH FAMILY
- MARKETING
- SALE of HEALTH INFORMATION
- REQUIRED by LAW
- PUBLIC HEALTH
- HEALTH OVERSIGHT ACTIVITIES
- JUDICIAL & ADMINSTRATIVE PROCEEDINGS
- LAW ENFORCEMENT
- CORONERS
- ORGAN or TISSUE DONATION
- PUBLIC SAFETY
- PROOF of IMMUNIZATION
- SPEACIALIZED GOVT FUNCTIONS
- WORKERS’ COMPENSATION
- CHANGE OF OWNERSHIP
- BREACH NOTIFICATION
- PSYCHOTHERAPY NOTES
- RESEARCH
- FUNDRAISING

What are your Health Information Rights?

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect & Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper or Electronic Copy of this Notice

Changes to this Notice of Privacy Practices:

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints:

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer as per below. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov. The complaint form may be found at: www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

Surgical Consultants of Southwest Florida, LLC
C/O Privacy Officer: Tiffany Bass RN, BSN, CBN
4519 Tilton Court
Fort Myers, FL 33907
Phone 239-494-8777

I have read the short Notice provided by Surgical Consultants of Southwest Florida, LLC practice and have been informed of how to obtain more information regarding our Notice of Privacy.

Patient Signature _____ Date _____