MEDICAL HISTORY

Date: / /

Name_____ Age _____ Birth date_____

SSN_____

Address_____ Sex: ☐ M ☐ F

_____ Home Phone_____

Alternate _____ Cell Phone_____

Address _____ Work Phone_____

Occupation_____

Emergency Contact and Relation Phone (Other than Spouse)_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list name of medicine AND type of reaction):

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History and Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. Hypertension	14. Cancer (type?)	27. Unexplained weight gain/loss	40. Skin diseases
2. Heart disease	15. Persistent cough	28. Hemorrhoids	41. Blood disorders
3. MI (heart attack)	16. T.B.	29. Gall bladder disease	42. Venereal diseases
4. Diabetes	17. Hay fever	30. Colitis	43. Anxiety
5. Asthma	18. Abdominal discomfort	31. Hepatitis or jaundice	44. Depression
6. Bronchitis	19. Indigestion	32. Hypothyroid	45. Anemia
7. Pneumonia	20. Nausea	33. Hyperthyroid	46. Alcohol abuse
8. GERD	21. Vomiting	34. Headache	47. Drug abuse
9. Gastritis/esophagitis/ulcers	22. Constipation	35. Kidney disease	48. Gout
10. Diverticulitis	23. Diarrhea	36. Kidney stones	49. Heart Arrhythmia
11. Rheumatic fever	24. Blood in stool	37. Difficulty urinating	50. Shingles
12. Chest pain/chest tightness	25. Ulcers	38. Arthritis	52. _____
13. Shortness of breath	26. Change in bowel habits	39. Low back problems	53. _____

Gynecologic and Obstetric History

Age at onset of periods:_____ Frequency:_____ Length of period:_____

Pregnancies:_____ Births:_____ Miscarriages:_____

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe):_____

Leakage of urine: ☐ No ☐ Yes (Please describe):_____

Pelvic pain: ☐ No ☐ Yes (Please describe):_____

Abnormal discharge: ☐ No ☐ Yes (Please describe):_____

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment):_____

This information is for use by your physician as part of your confidential medical record.

PATIENT NAME: _____ **Date:** / /

Please List and Supply the Dates of any major
Surgeries: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history – have you had: Pneumonia Vaccine? ☐ No ☐ Yes When? _____
Shingles Vaccine? ☐ No ☐ Yes When? _____ Flu Vaccine? ☐ No ☐ Yes When? _____
Other? _____ ☐ No ☐ Yes When? _____ Tetanus Vaccine? ☐ No ☐ Yes When? _____

When was your last:
Pap smear? _____ Eye Exam? _____
Mammogram? _____ Prostate exam? _____
Colonoscopy? _____ Stress Test? _____
Skin Check? _____ Bone Density/DEXA? _____

Do you smoke? Please circle one: **No / In the Past / Yes** How many packs per day/Quit Date? _____
Do You Drink? **Y / N** How Often? _____ Quantity? _____ Type: _____

Family History
Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age When diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other: _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Times Per Day	Drug Name	Dose	Times Per Day

This information is for use by your physician as part of your confidential medical record.

PATIENT NAME: _____

OTHER PROFESSIONAL PROVIDERS

(Please Specify If In Naples Or Out Of Town)

Primary Care Physician _____

Allergist _____

Cardiologist _____

Chiropractor _____

Dermatologist _____

Endocrinologist _____

ENT _____

Gastroenterologist _____

Gynecologist _____

Nephrologist _____

Neurologist _____

Oncologist _____

Ophthalmologist _____

Orthopedist _____

Pain Management _____

Podiatrist _____

Psychologist/Psychiatrist _____

Pulmonologist _____

Rheumatologist _____

Urologist _____

Other _____

Other _____

Other _____

Financial Policy

I authorize *Collier Medical Specialists, Inc* to apply for benefits on my behalf for covered services rendered by *Collier Medical Specialists, Inc* and request the payments be made directly to *Collier Medical Specialists, Inc.* I authorize the release of any information to my insurance company which may help in the processing of my claim. I understand I am legally responsible for any charges if the claim is not settled or my insurance is not effective or in network on the day services were rendered. I am responsible for ensuring that my insurance is in network with the physician and understand that it is purely my obligation. I understand I am legally responsible for co-payments, coinsurance and/or deductibles and will pay any balance in full at the time of service. I understand that if I allow my account to go unpaid for more than 90 days from the date of invoice I will no longer be seen by the doctor and will be released from the practice.

We bill your insurance company on the condition that you have provided us with the correct billing information including name, address, phone number, and claim/policy number(s). It is YOUR responsibility to know what your plan covers and if there are any "special conditions" that your insurance company requires for payment. You are responsible for what your insurance does not pay, including applicable deductibles, co-payments, and/or the percentage not covered by your plan. **Payment is due AT THE TIME OF EACH VISIT**. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You will be responsible for these services should your insurance not cover them. If your deductible has NOT BEEN MET for the plan year, you will be REQUIRED TO PAY for services as they are rendered. We will submit your claims to the insurance company as a courtesy to you so that they will be applied toward your deductible.

Late Fees: *Collier Medical Specialists, Inc* has a 30 day billing cycle. You have 30 days from the date on the statement to make your payment. If payment is not received within the 30-day limit, we will send out a reminder statement. If you are not able to make your payment within our time limits you must call us and advise us immediately. After 90 days, your account will roll over to collections.

Private Pay Patients: If you **DO NOT** have insurance coverage or **DO NOT** want us to bill insurance for any reason, payment will be required at the time of each service. We accept cash, debit cards, Visa, and MasterCard. We **DO NOT** accept personal checks for private pay patients.

I have read, understand, and agree to the above listed policy.

Patient/Guardian Signature_____ Date_____

MISSED APPOINTMENT POLICY

We are very dedicated to the treatment of our patients. When we schedule appointments, we set aside time and professional resources to meet each individual needs of our patients. When a patient fails to show up for their appointment, or cancels within 24 hours of their appointment, our valuable resources are idle. More importantly, another patient care opportunity is missed. We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control has arisen. In any event, we ask that you please contact our office and cancel your appointment within 24 hours of the scheduled visit. This courtesy allows the office staff to schedule another patient who is also in need of medical care. As a consideration, an appointment card is provided to you when you schedule your appointment and an appointment reminder call is made to you with our automated system two business days prior to your scheduled appointment, however, it is ultimately the responsibility of the patient to arrive to their appointment at the scheduled time.

Patients who do not show up for their appointment without the courtesy of calling and cancelling over 24 hours prior will be subjected to a non-refundable $25 cancellation/no show fee which will need to be collected before the next appointment.

NURSE PRACTITIONERS AND OUR OFFICE

We understand the importance of your relationship with our health care team and in order to ensure we provide you with the best and most timely care, our team includes a Nurse Practitioner to serve our patients. As a patient of our practice, at times you will be seen by our Nurse Practitioner who will help to ensure that all patients are seen in a timely manner and your needs continue to be addressed according to our quality standards.

Nurse Practitioners are licensed health care professionals and are required to complete extensive education and training before they are granted their state license to practice and see patients. In addition to a college degree, Nurse Practitioners are required to complete a Nurse Practitioner program, clinical rotations, and ongoing continued education classes. Our nurse practitioner works under the supervision and collaboration of Dr. Rajani.

Please sign below indicating that you have read and understand the above policies.

_____ _____

Patient Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: __/__/__

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnoses, records; examination rendered to me and claims information. This information may be released to:

_____ (Name and relationship)

_____ (Name and relationship)

_____ (Name and relationship)

This RELEASE OF INFORMATION will remain in effect until terminated by me in writing.

MESSAGES

If unable to reach me by telephone, on any of my phone numbers provided by me:

[ ] you may leave a detailed message

[ ] you may leave a message asking me to return your call

[ ] other: _____

Signed: _____ Date: _____

Collier Medical Specialists, Inc.
Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

I. My Authorization

You (Entity being authorized to disclose records):

_____

may use or disclose the following health care information (initial all that apply):

All my health information maintained by the above-named practice

(Initial for each of the following)

_____My health information related to drug abuse

_____My health information related to alcohol abuse

_____My health information related to HIV/AIDS

_____My health information related to psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Collier Medical Specialists, Inc

Address: 6615 Hillway Cir #200 Naples, Fl 34112 Phone: 239-774-0345 Fax: 239-774-1783

This authorization ends One Year from the date it was signed unless specified here:

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient representative, etc.) Relationship (parent, legal guardian, personal

Collier Medical Specialists, Inc
Notice of Privacy Practices for Protected Health Information
Effective Date: March 11, 2010

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office/hospital is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:
We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

    - Is not part of the health information kept by or for the office/hospital;

    - Is not part of the information that you would be permitted to inspect and copy; or,

    - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Collier Medical Specialists, Inc Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date