

MELISSA C. VERDE, D.P.M., P.A.
1385 W. STATE ROAD 434 SUITE 103
LONGWOOD, FL. 32750
PHONE 407-332-6700 FAX 407-332-6226

DATE: _____

PATIENT ACCOUNT: _____

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____
DOB: _____ AGE: _____ SEX: _____ RACE: _____ ETHNICITY: _____
PRIMARY LANGUAGE: _____ OTHER LANGUAGE: _____
SOCIAL SECURITY: _____ MARITAL STATUS: _____
SPOUSE: _____

PATIENT CONTACT INFORMATION

ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE: _____
HOME PHONE: _____ CELL PHONE: _____
EMAIL: _____
PREFERRED METHOD OF CONTACT: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PRIMARY CAREGIVER: _____ RELATIONSHIP: _____ PHONE: _____
COMMENTS: _____

LEGAL GUARDIAN: _____ RELATIONSHIP: _____ PHONE: _____
COMMENTS: _____

HEALTHCARE PROXY: _____ RELATIONSHIP: _____ PHONE: _____
COMMENTS: _____

EMPLOYMENT INFORMATION

____ EMPLOYED ____ UNEMPLOYED ____ FULL TIME STUDENT ____ PART TIME STUDENT ____ DISABLED ____ OTHER
EMPLOYER: _____ WORK PHONE: _____ EXT: _____
DEPARTMENT: _____ OCCUPATION: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY ID #: _____ GROUP#: _____
POLICY HOLDER NAME: _____ HOLDER DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ POLICY ID #: _____ GROUP#: _____
POLICY HOLDER NAME: _____ HOLDER DOB: _____ RELATIONSHIP: _____

OTHER INSURANCE: _____ POLICY ID #: _____ GROUP#: _____
POLICY HOLDER NAME: _____ HOLDER DOB: _____ RELATIONSHIP: _____

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO I.D. FOR THE RECEPTIONIST TO COPY

HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

AGE: _____ years HEIGHT: _____ ft _____ in WEIGHT: _____ lbs

REASON FOR TODAY'S VISIT: _____

PREVIOUS TREATMENT FOR THIS PROBLEM: _____

ALLERGIES: _____

CURRENT MEDICATIONS (PLEASE INCLUDE NAME, DOSE, AND FREQUENCY): _____

PREFERRED PHARMACY:

NAME: _____ LOCATION: _____ PHONE: _____

NAME: _____ LOCATION: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ LAST VISIT: _____

SPECIALIST: _____ LAST VISIT: _____

SPECIALIST: _____ LAST VISIT: _____

SPECIALIST: _____ LAST VISIT: _____

PAST/CURRENT MEDICAL CONDITIONS:

- | | | |
|---|--|---|
| <input type="checkbox"/> RECENT DECLINE IN OHEALTH | <input type="checkbox"/> STOMACH/DIGESTIVE DISORDERS | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> MIGRAINE HEADACHES | <input type="checkbox"/> AMPUTATION | <input type="checkbox"/> SCARRING TENDENCIES |
| <input type="checkbox"/> EYE PROBLEMS | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> SKIN DISORDERS |
| <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> SLOW HEALING WOUNDS |
| <input type="checkbox"/> ASTHMA / BRONCHITIS / COPD | <input type="checkbox"/> GOUT | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> SLEEP APNEA | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> OTHERBREATHING PROBLEMS | <input type="checkbox"/> PARALYSIS/MUSCLE WEAKNESS | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> POOR BALANCE | <input type="checkbox"/> POOR CIRCULATION |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> PREVIOUS FRACTURES | <input type="checkbox"/> HIV |
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> DEMENTIA | <input type="checkbox"/> BLOOD THINNERS |
| <input type="checkbox"/> HIGH / LOW BLOOD PRESSURE | <input type="checkbox"/> DEPRESSION/ANXIETY | <input type="checkbox"/> SICKLE CELL |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> EPILEPSY/SEIZURE DISORDER | <input type="checkbox"/> KIDNEY DISORDERS |
| <input type="checkbox"/> LIVER DISORDERS | <input type="checkbox"/> STROKE | <input type="checkbox"/> AUTOIMMUNE DISORDERS |
| <input type="checkbox"/> GASTRIC REFLUX | <input type="checkbox"/> NUMBNESS OF FEET | <input type="checkbox"/> OTHER |

PLEASE EXPLAIN: _____

HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

FAMILY HISTORY OF MEDICAL CONDITIONS:

MATERNAL GRANDPARENTS: _____ PATERNAL GRANDPARENTS: _____

MOTHER: _____ FATHER: _____

SIBLINGS: _____

CHILDREN: _____

OTHER: _____

SURGICAL HISTORY (PLEASE INCLUDE NAME OF PROCEDURE, DATE, AND SURGEON):

COMPLICATIONS WITH ANESTHESIA? _____ WITH HEALING? _____

SOCIAL HISTORY:

___ALCOHOL ___TOBACCO ___RECREATIONAL DRUG USE ___ADDICTIONS

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Financial Policy

I understand and agree that all fees are due at the time of service, unless previous arrangements have been made. I authorize Dr. Melissa C. Verde to release any medical information or records concerning diagnosis and treatment when requested for the use in determining a claim or payment to any third party such as, insurance companies or governmental agencies.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled; including Medicare, private insurance, and any other health plan to Dr. Melissa C. Verde.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Signature (patient/responsible party): _____ Date: _____

Relationship: _____ Date: _____

\$35 Non-Sufficient funds fee will be charged for ALL RETURNED CHECKS.

\$35 Missed appointment fee will be charged for missed/cancelled appointments without 24 hours notification to us.

A fee of 40%of the total outstanding balance will be charged for ALL DELINQUENT ACCOUNTS sent to collections.

I have read and understand the above statements and accept financial responsibility for these additional fees.

Signature (patient/responsible party): _____ Date: _____

Relationship: _____ Date: _____

MELISSA C. VERDE, D.P.M., P.A.
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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of the notice.

The law permits us to use or disclose your health information to those involved in your treatment. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one or more of our staff will enter your information into our computer.

We may share your medical information with our business associates such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may want to call and remind you of an appointment or to discuss details of a surgery with you. If you are not at home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request, in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact your from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for your copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, B.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint or for more information or assistance regarding your health information privacy, please contact our Privacy Office at (407) 332-6700.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices for Melissa C. Verde, D.P.M.

Date: _____

Signature: _____ **Print name:** _____

If signing as a parent or guardian, please note the name of the patient: _____

Melissa C. Verde, D.P.M., P.A.
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Patient's Name: _____ Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for -

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you, in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

I_ I Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items *or* services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision. _____

I_ I Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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E-Prescribing/Medical History Consent Form

Dr. Melissa C Verde uses an electronic medical records system that allows electronic prescribing of medications. Prescriptions are sent to your pharmacy through a secure connection (Surescripts) which improves the accuracy and timely transmission of

are several standards that have to be included in an e-prescription program. These include:

- Formulary and benefit transactions--Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transaction--Provides the physician with information about previous and current medications the patient is taking to minimize the number of adverse drug reactions.
- Fill status notification--Allows the prescriber to receive an electronic notice from the pharmacy stating if the patient's prescriptions has been picked up or partially filled.

My signature certifies that I have read and understood the scope of my consent and that I authorize Dr. Verde to electronically prescribe and to access my medication history.

Patient Name

Patient Signature

Date