GoPrivateMD

CONSENT FOR MEDICAL TREATMENT

1. CONSENT TO MEDICAL CARE AND TREATMENT: I am being treated by GoPrivateMD, and I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Physician Office is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I may be charged for testing related to the exposure.

2. CONSENT TO USE OF ELECTRONIC HEALTH RECORD: I understand that the Physician Office may collaborate with other health care providers, including the Syncronys (formally NM Health Information Exchange) to coordinate, manage and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I understand I can opt out of Syncronys by calling 505-938-9900 or on their website at www.syncronys.org. I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse. The electronic health records (EHR) may be accessible by other credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

3. FINANCIAL RESPONSIBILITY: I understand and agree that I am financially responsible for payment of all charges incurred, including any and all products provided or services rendered to me and that GoPrivateMD does not participate in my insurance network and will not bill my insurance.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

_____ _____

Signature of Patient or Patient's Legal Representative Date of Signature

_____

If Applicable, Print Name of Legal Representative & Relationship to Patient (e.g., parent, guardian)

GoPrivateMD

Authorization to Release Medical Records

Name of Patient _____

Date of Birth _____

I authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient. I request that the designated record custodian of all covered entities under HIPPA identified below disclose full and complete protected medical information.

INFORMATION TO BE RELEASED OR ACCESSED: History & Physical, Consultation Report, Emergency Room Record, Operative Reports, Discharge/Death Summary, Face Sheet, Lab/Path Reports, X-Ray Reports/Images, ECG Copy/Report

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

FROM:

_____

TO:

GoPrivateMD, LLC
Thomas A. Pascuzzi, MD
8208 Louisiana Blvd NE Suite B
Albuquerque, NM 87113

Fax: 505-508-5249

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ Signature: _____

Patient or Representative

_____

Print Name of Legally Authorized Representative

GoPrivateMD

General Information & History

Name:				Date:	
Date of Birth:		Age		Gender:	Male ☐ Female ☐
Address:					
City:		State:		Zip:	
Telephone:		Email:			
Preferred method of Communication	☐ Email	☐ Phone	☐ Text		

Preferred Pharmacy Name and Location:

Preferred Lab:	☐ Quest	☐ Tricore

Primary Physician:	
Specialists:	

Insurance GoPrivateMD will not bill your insurance. Insurance is used for labs, prescriptions and other tests that may be necessary. We can make a copy of your card instead of entering information.	
Name of insurance company:	
Member ID:	
Group#	

Current Issues/Problems

Current Medications Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements.

Past Medical History
Do you now or have you ever had:

☐ Angina	☐ Epilepsy	☐ Kidney stones
☐ Anemia	☐ Heart murmur	☐ Leukemia
☐ Asthma	☐ Heart Problems	☐ Pneumonia
☐ Cancer (type):	☐ Hepatitis	☐ Psoriasis
☐ Cataracts	☐ High blood pressure	☐ Rheumatic fever
☐ Colitis	☐ High cholesterol	☐ Stomach/peptic ulcer
☐ Crohn's disease	☐ HIV/AIDS	☐ Stroke
☐ Diabetes	☐ Jaundice	☐ Thyroid Disease
☐ Emphysema	☐ Kidney disease	☐ Tuberculosis
☐ Other:		

Surgical History List all surgeries and dates:

Prior Hospitalizations List reasons for hospitalization and dates:

Allergies	
Drug Allergies:	
Food Allergies:	
Environmental Allergies:	

Systems Review		
General	**Stomach & Intestines**	**Psychiatric**
☐ Recent weight gain. how much:	☐ Nausea	☐ Depression
☐ Recent weight loss. how much:	☐ Heartburn	☐ Excessive worries
☐ Fatigue	☐ Stomach pain	☐ Difficulty falling asleep
☐ Weakness	☐ Vomiting	☐ Difficulty staying asleep
☐ Fever	☐ Yellow jaundice	☐ Difficulties with sexual arousal
☐ Night sweats	☐ Increasing constipation	☐ Poor appetite
Muscle/Joint/Bones	☐ Persistent diarrhea	☐ Food cravings
☐ Numbness	☐ Blood in stools	☐ Frequent crying
☐ Joint pain	☐ Black stools	☐ Sensitivity
☐ Muscle weakness	**Skin**	☐ Thoughts of suicide/attempts
☐ Joint swelling	☐ Redness	☐ Stress
Where?	☐ Rash	☐ Irritability
Ears	☐ Nodules/bumps	☐ Poor concentration
☐ Ringing in ears	☐ Hair loss	☐ Racing thoughts
☐ Loss of hearing	☐ Color changes of hands or feet	☐ Paranoia
Eyes	**Blood**	☐ Mood swings
☐ Pain	☐ Anemia	☐ Anxiety
☐ Redness	☐ Clots	☐ Risky behavior
☐ Loss of vision	**Kidney/Urine/Bladder**	
☐ Double or blurred vision	☐ Frequent or painful urination	**Heart and Lungs**
☐ Dryness	☐ Blood in urine	☐ Chest Pain
Throat	**Women Only**	☐ Palpitations
☐ Frequent sore throats	☐ Abnormal pap smear	☐ Shortness of Breath
☐ Hoarseness	☐ Irregular periods	☐ Fainting
☐ Difficulty in swallowing	☐ Bleeding between periods	☐ Swollen legs or feet
☐ Pain in jaw	☐ PMS	☐ Cough
Nervous System		
☐ Headaches		
☐ Dizziness		
☐ Fainting or loss of consciousness		
☐ Numbness or tingling		
☐ Memory loss		

Personal History			
Where were you born and raised?			
Highest level of education?	☐ High school ☐ Some college ☐ College graduate ☐ Advanced degree		
Marital status?	☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/Signif. other		
Spiritual/Religion:			
What is your current or past occupation?			
Have you ever served in the military?	☐ Yes ☐ No	Branch:	Role:
Are you currently working?	☐ Yes ☐ No	Hours/Week:	If Not: ☐ Retired ☐ Disabled ☐ Sick leave
Do you receive disability or SSI?	☐ Yes ☐ No	If yes, for what disability, how long?	

Social History					
Alcohol use:	☐ Yes ☐ No	Drinks per day:	Tobacco use:	☐ Yes ☐ No	Amount per day:

Family History	**If Living**		**If Deceased**	
	Age	**Health & Psychiatric**	**Age(s) at Death**	**Cause**
Father				
Mother				
Siblings				
Siblings				

Extended Family Problems Past & Present	
Maternal Relatives:	
Paternal Relatives:	

Preventatives and Vaccines				
Vaccines	Yes	No	Date	Notes
Flu	☐	☐		
COVID	☐	☐		
Tdap	☐	☐		
Shingles	☐	☐		
Pneumonia	☐	☐		
RSV	☐	☐		
Preventatives	Yes	No	Date	Notes
Colonoscopy	☐	☐		

Females Only						
Reproductive History						
Age of first period:		# Miscarriages:		# Abortions:		
# Children (including step)		Have you reached menopause?	☐ Yes ☐ No	At what age?		
Do you have regular periods?		Yes No				
Preventatives	Yes	No		Date	Notes	
Mammogram	☐	☐				
Pap	☐	☐				