Integrity Medical

1333 3rd Ave S Ste 506 Naples FL 34102 Website-INTEGRITYMEDICALPHYSICIANS.COM

Patient Registration Form

Patient Registration

First Name: _____ Middle Initial _____Last Name: _____

Sex: M or F Date of Birth: ____ / ____ / ____ SS#: _____

Race: American Indian/Alaska Native Black/African American White/Caucasian
Asian Hawaiian/Pacific Islander Other Declined

Ethnicity: Not Hispanic or Latino Hispanic or Latino Declined Other

Marital Status: Single Married Divorced Widowed

Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____ Home Phone#: _____ Cell Phone#: _____

Email: _____

Employer's Name: _____ Occupation. _____

Employers Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

How did you hear about us? Physician Self-referred internet

Other: _____

_____

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HIPAA/Communication Agreement

Do you give Integrity Medical permission to leave a voice mail regarding your health care on your preferred communication phone? Yes or No

Please list any family members or friends that Integrity Medical can release your medical information to:

Name_____ Relation_____ Contact#_____

Name_____ Relation_____ Contact#_____

Name_____ Relation_____ Contact#_____

By **signing this form,** you are granting Integrity Medical to use and disclose your protected health information for purposes of treatment, payment, and health care operations.

I authorize the release of my medical records to any physicians to whom I am referred.

I acknowledge that a copy of the Privacy Notice has been made available to me.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 331-3859. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information from original consent.

A copy of this form is to consider valid as an original.

Integrity Medical complies with applicable Federal civil right laws and does not discriminate on the basis of race, color, age, disability, or sex.

Patient or Responsible Party: _____ Date: _____

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Financial Policy

Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept most major credit cards. There will be a minimum charge of $25.00 for any returned checks.

There will be a $45.00 charge for no show appointments that do not provide 24 hr notice.

Please be advised that your insurance policy is a contract between you and your insurance company. As a service to our patients, we will file your insurance claim if you assign the benefits to the doctor. You agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 90 days, you will be responsible for payment in full. If the practice later receives payments from your insurance, we will refund any overpayment to you.

We are participating providers with many insurance companies and health plans and will submit claims to accept assignment of benefits. However, you are required to make your copayment or pay any deductibles at the time of service.

If we do not participate with your insurance carrier, you will be responsible for paying your charges at the time of service. We will, however, prepare and send a claim for you on an unassigned basis. Your insurance company will then pay you directly.

Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.

After 90 days your account will be turned over to our collection agency.

If you provide incorrect or false information, you will be responsible for any unpaid claims and/or all charges for services provided.

We will bill your insurance company for services that were provided to you in the hospital. If your insurance company does not pay, you are responsible for any balance due.

If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, included but not limited to, all collections fees or contingency fees added by a third party to the original or referral balance.

I have read and understand the Integrity Medical Financial Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Integrity Medical from time to time.

_____ _____

Patient Signature Date

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Medication List

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over the counter, herbal, vitamin, and diet supplement products.

Also list any medication you take only on occasion (like Viagra, albuterol, nitroglycerin)

If you have a medication list with you, please let the receptionist know and she will make a copy of it for you.

Medication Dose How and how often you take the Reason for Date Prescriber
(Brand & Generic medication taking started name)

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Personal and Family Medical History

	Mother	Father	Siblings	Moms Mom	Moms Dad	Dads Mom	Dads Dad
Alive							
Deceased							
Current age or at death							

The first two columns are for personal medical history. Under the parent, sibling, and grandparent columns please specify which relative such as mom (m), brother (b), maternal grandmother (mgm), etc…

Condition	Now	Past	Parent	Sibling	Grandparents	Comments
Hypertension						
Hyperlipidemia						
Heart Attack						
Diabetes Type 2						
Diabetes Type 1						
Cancer						
Osteoporosis						
Depression						
Alcoholism/Drug Abuse						
Alzheimer's						
Asthma						
Autoimmune Disease						
Bleeding/Clotting disorder						
Colon polyp						
Emphysema (COPD)						
Glaucoma						
Congestive Heart Failure						

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Condition	Now	Past	Parent	Sibling	Grandparents	Comments
Hip Fracture						
Hypothyroidism						
Kidney Disease						
Kidney Stones						
Macular Degeneration						
Stroke						
Sudden Cardiac Death						
Current Tobacco Use						# of years
Hepatitis						
Diverticulitis						
Depression						
Seizure/Epilepsy						
Migraines						
Skin condition						
Sleep apnea						
Stroke						
Stomach Ulcer						
IBS						
Thyroid Disease						
GERD						
Anemia						
Arthritis						
Gall bladder disease						

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Surgical & Procedure History

Surgical Procedure	NO	If Yes, please list year	Comments
Abdominal surgery			
Angiogram			
Appendectomy			
Back Surgery			
Biopsy			
Colonoscopy			
Coronary Bypass/Stent			
C Section			
EGD			
Cholecystectomy (Gallbladder removal)			
Hip Surgery			
Hysterectomy- Partial			
Hysterectomy- Total (includes Ovaries)			
Knee Surgery			
LEEP (Cervix surgery)			
Neck, Spine Surgery			
Sigmoidoscopy			
Stress test			
Sinus Surgery			
Tonsillectomy			
Vasectomy			
Hernia repair			
Carotid endarterectomy			
Other			

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Social History

Work Status-

1. Employment/ School
   Full Time Part Time Retired
2. Occupation: _____

Exercise- Do you exercise regularly? Yes No Type_____

On Average how many days per week do you exercise? _____

Alcohol Use- How many days per week do you drink beer, wine, or other alcoholic beverages?_____

Caffeine use- How much coffee or other caffeine containing beverages do you drink per day? _____

General Health Status- Excellent Good Fair Poor

Living Environment- With whom do you live?

Alone Spouse Spouse and Children Other relatives Group setting Other _____

In the past Month have you been feeling down, depressed, or hopeless? _____

Primary Language- English Spanish Creole Other_____

Are there any customs or religious beliefs that may affect your care? Yes No

If Yes - please explain_____