Melanoma Center of Hope

David C. Ritter, M.D., F.A.C.S.

Melanoma, Cutaneous Oncology

9776 Bonita Beach Road SE, Suite 102, Bonita Springs, FL 34135

Office: (239) 949-1777 or (239) 948-7777

Fax: (239) 498-3777

Dear

Your appointment is scheduled for _____ _____ at. ____:____ arrival at: _____ :_____. Please fill out the paperwork and bring it with you for your appointment along with a photo ID and insurance card.

This appointment is a consultation. David C. Ritter, M.D., F.A.C.S.; and, his oncology nurse, Teresa Ritter, R.N., will review your pathology, physically assess you clinically, and set you up for surgery.

Bring all your M.D.'s full names, telephone and fax numbers *because Dr. Ritter dictates a letter immediately to your physicians.*

You will also have your surgery preoperative appointment on that same day with the scheduler.

Surgery is usually performed at the Lee Health Coconut Point (LHCP), an outpatient facility; or, minor procedures in our office.

We welcome a family member or friend to come to your first appointment. A pen and pad are helpful to write notes.

Office policies concerning patient care that you should know in advance of your first visit are:

1) Reports are communicated directly to you once they are reasonable available. This is usually by phone *five to seven* business days after the test is completed or given at the next office appointment. Pathology reports are communicated to you once they are available. This can take up to *two weeks* from the date of surgery.
2) Reports are forwarded to your physicians.
3) Patient and family education about Melanoma are discussed at the first visit.

Office policies that you should know in advance of the first visit are:

1) Your Financial Responsibility includes payment of co-pays or Medicare deductibles at the time of the visit. For those without insurance the payment is due at the time of service.
2) Dr. Ritter is on very few HMO's and patients with this type of insurance will sometimes be treated as those without insurance (self-pay).
3) Dr. Ritter accepts all insurances; however, Dr. Ritter may not be ***in-network.*** It is your responsibility to call your insurance and check to find out if Dr. Ritter is ***in-network.***
4) Dr. Ritter bills insurance companies as a courtesy to you. We can bill two companies, a primary and a secondary; however, third companies are not billed.
5) Patient will be responsible to pay in advance a $40.00 fee for completion of any Family Medical Leave Act (FMLA), Disability or insurance reimbursement paperwork.
6) Financial responsibility for other tests such as PET scans, MRI and CT exams is between you and the Radiology facility chosen.

7) Financial responsibility for surgical services at Lee Health Coconut Point (LHCP) is between you and that facility.
8) Minors: A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

All patients coming to this office have been treated for cancer. All are equally interested in expediency and timeliness to treatment, diagnostic testing, receiving reports, and additional physician consultation in pursuing a team approach to cancer management and strategy. Dr. Ritter assures you that timeliness is also his top priority and will work tirelessly to achieve that goal for you.

Most patients drive one or more hours for this visit because of the *sub-specialty* service that Dr. Ritter provides for this region of the state and for other countries. Please account for difficulty in travel. Dr. Ritter is board certified in general surgery, and Dr. Ritter has also completed sub-specialty training in cancer surgery (surgical oncology). Three physicians hold this level of expertise in Southwest Florida between Tampa and Miami; and, Dr. Ritter primarily manages patients with melanoma rather than all types of cancers such as those relating to the gut, breast, lung, and others.

Dr. Ritter places top priority on values from the Holy Bible and the office practices Biblical principles as Christians. Dr. Ritter will treat patients of all religious backgrounds.

We value the relational aspect with our patients. No follow-up should be made through e-mail with medical concerns. Any follow-up questions should be made with our staff by calling us at 239-949-1777 or answering service. We are here to support you 24 hours a day, 7 days a week. Either Dr. Ritter or Teresa Ritter, RN will personally return your call during the day or on the weekends.

Sincerely,

Melanoma Center of Hope

"I can do all things through Christ who strengthens me." - Philippians 4:13

PLEASE SIGN AND DATE

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Melanoma Center of Hope

David C. Ritter, MD, FACS

MELANOMA, CUTANEOUS ONCOLOGY

9776 Bonita Beach Rd. SE Suite 102
Bonita Springs, FL 34135

Tel: 239-949-1777 or 239-948-7777
Fax: 239-498-3777

HealthCare Center of Bonita Springs

On the corner of
Wisconsin St. and Bonita Beach Road

From I-75:

- Exit 116 West on Bonita Beach Road
- Just past the Baymont Wyndham Hotel turn Right onto Wisconsin St.
- Turn Right on Second driveway
- From the parking lot looking at the building, far left set of doors

From US 41:

- East on Bonita Beach Road
- Just past the First Presbyterian Church turn Left onto Wisconsin St. Turn
- Right on Second driveway
- From the parking lot looking at the building, far left set of doors

Please abstain from wearing any perfumes, colognes, or scented lotions to appointment.

Dr. and Teresa have sensitivities and allergies.

Thank you, Allan

..

Melanoma Center of Hope

David C. Ritter, MD FACS

Patient Information:

Date_____

Name_____ SS/HIC/Patient ID# _____
Last Name First Name Middle Initial

Address_____ Cell Phone (____)_____

City_____ Work Phone (____)_____
May we call work? □Yes □No

State_____ Zip_____ Home Phone (____)_____

Sex: ☐ M ☐ F Age_____ Birthdate_____

Patient Employer/School_____

Occupation_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____Phone (____)_____

Insurance: Please bring insurance cards with you at initial visit along with photo ID.

Is patient covered by additional Insurance? ☐ Yes ☐ No

Primary_____Subscriber_____ID#_____Group#_____

Secondary_____ID#_____Group#_____

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage with _____.
Name of Insurance Company(ies)

Assign directly to Dr. David C. Ritter all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Any pre-certifications or authorizations of Insurance is your responsibility; please call your Insurance prior to visit. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. If patient is under the age of 18 years old and unmarried, legal guardian must be present to sign consent before visit.

_____ _____
Signature of Patient, Parent Guardian Date

_____ _____
Please print name of Patient, Parent, Guardian Relationship to the Patient

_____ _____
Witness Date

INDIVIDUAL PATIENTS AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTITIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Name_____

Street Address_____

City_____ State_____ Zip_____

Telephone Number(s)_____

E-Mail address_____

Patient Account Number_____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information described above.

(Doctor)_____ **Phone #**_____ **Fax #**_____

(Doctor)_____ **Phone#**_____ **Fax#**_____

(Doctor)_____ **Phone#**_____ **Fax#**_____

(Doctor)_____ **Phone#**_____ **Fax#**_____

(Doctor_____ **Phone#**_____ **Fax#**_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

(Relatives)_____

_____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

_____ **(Health reasons)**_____

_____

3. ENDING THIS AUTHORIZATION

Select one of the following two choices:

☐ This authorization will end on the following date: _____

☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

_____

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. POSSIBILITY OF REDISCLOSURE

I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

Witness Signature: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to Individual Patient: _____

YOU HAVE THE RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Melanoma Center of Hope

David C. Ritter, MD FACS

Questionnaire

Name:_____

Genes and Inherited Susceptibility

What is your family origin/ancestry? (such as Irish, Scottish, German, etc.)

_____

Has anyone in your family been diagnosed with melanoma or pancreatic cancer? (Please note which relative, and the age at diagnosis).

_____

_____

Please complete the Fitzpatrick Skin Type Classification Questionnaire on the next page.

Intense-Intermittent Sun Exposure in the Past

Please describe any short periods of intense sun exposure, especially if you suffered from “sun poisoning” or severe, blistering burns. (Note that blistering burns are not peeling, but actual fluid filled bubbles resulting from sun exposure.)

_____

_____

_____

Cumulative Sun Exposure throughout your Life

Please describe any outdoor employment, and outdoor recreational activities, including the time periods involved.

_____

_____

_____

_____

Please discuss your tanning bed use, including the approximate number of sessions and the time period in which they took place.

_____

_____

Please describe your present sun exposure, such as which outdoor activities you participate in.

_____

_____

_____

Melanoma Center of Hope

David C. Ritter, MD FACS

Fitzpatrick Skin Type Classification

Instructions: For each of the questions below, please circle the answer that you feel best describes you.

Genetic Disposition

What are the color of your eyes?	Light Blue, Gray, Green	Blue, Gray Or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/ Dark Blonde	Dark Brown	Black
What is the color of your unexposed skin?	Reddish	Very Pale	Pale w/ Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Reaction to Sun Exposure

What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you tan within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem

Tanning Habits

When did you last expose your body to UV Radiation?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a months ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Melanoma Center of Hope

David C. Ritter, MD FACS

Family History of Cancer

Patient Name: _____

Your physician will ask you about any other family members that have developed cancer. There are many cancers that have genetic links. Take time to think about parents, grandparents, and siblings that may have had a diagnosis of cancer. Also note the approximate age at which these family members were diagnosed with cancer. This information may help your physician decide if genetic testing or counseling should be performed.

Name of Family Member	Relationship	Type of Cancer	Age of Diagnosis

Health History

Patient Name _____ **Today's Date** _____

Age _____ **Birthdate** _____ **Date of last physical examination** _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year

GENERAL
- ☐ Depression
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of weight

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arthritic Joints
- ☐ Neuropathy

Affected Area:

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat / A FIB
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision—Flashes
- ☐ Vision—Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Previous diagnosis of cancer
- ☐ Other

WOMEN only
- ☐ Abnormal Par Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last Menstrual period:
_____

Date of last Pap Smear:
_____

Have you had a mammogram?
_____

Are you pregnant? _____

Number of children_____

Conditions

Check (✓) symptoms you currently have or have had in the past year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Other:_____
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Stent's
- ☐ Polio
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Family History

Fill in health information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthmas, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Surgeries

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion/hospitalization?

☐Yes ☐No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Biological Children

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use:

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By: — Date

Melanoma Center of Hope

David C. Ritter, MD FACS

Prescription Medications

Name:_____ Date:_____

Allergies:_____

Please list prescription medicines as well as vitamins and aspirins.

Name of Medicine	Dose	Frequency	Physician who Prescribed	Date Started	Reason for Medicine

Pharmacy:_____

Address:_____

Phone:_____

SELF-ASSESSMENT FORM

NAME: _____ DATE: _____ D.O.B. _____ SEX: M __F__

CELL PHONE: _____ HOME PHONE: _____

SURGEON: David C. Ritter, M.D FAMILY PHYSCIAN _____ M.D. PHONE: _____

HEIGHT: _____ WEIGHT: _____ PERMISSION TO LEAVE MESSAGE: YES___NO ____

List all Allergies including drugs, tape, latex
Iodine, soy products, food and environmental _____ What reactions occur when you take? _____

_____ _____

History of Disease: Do you have any of the following:

RESPERATORY	Y	N	CARDIOVASCULAR	Y	N	NEUROMUSCULAR DISORDERS	Y	N	ENDOCRINE DISORDERS	Y	N
Asthma			High Blood Pressure			Epilepsy / Seizures			Thyroid Disease		
Seasonal Allergies			Mitral Valve			Paralysis / Weakness			Diabetes		
Emphysema			Pretreat for mitral valve prolapse?			Memory Loss / Unconsciousness			How often do you check your sugar?		
Chronic Lung Disease			Irregular Heartbeat			Migraines			Reading:		
Cough of 3 weeks			Palpitations			Neck Problems			Are you pregnant?		
Shortness of Breath			Chest Pain / Angina			Back Problems			Date of LMP:		
Tuberculosis			Endocarditis			Menopausal			Substance / Alcohol use:		
Pneumonia			Bleeding tendencies or bruising			Artificial Joints or Grafts			How many drinks/day?		
Do you smoke?			Stroke			Broken Jaw			How often do you use recreational drugs?		
Packs /day			TIA			Unsteady gait			Have you had breast surgery?		
Did you ever smoke?			Congestive Heart Failure			Arthritis			Implants		
Quit Date:			Previous Blood Clots			Use of assisted devices			Reconstruction		
Other			Pacemaker			What type?			Other Implants:		
Genitourinary / Gastrointestinal			Defibrillator			Do you have restless leg?			Do you have any implants?		
Kidney Disease			Anemia			Other:			Orthopedic		
Hepatitis / Jaundice			Heart Attack			Recent travel abroad?			Facial		
Peptic Ulcer Disease			Date:			Where:			Type:		
Hiatal Hernia / Reflux			Open heart or bypass surgery?			Have you or are you being treated for cancer?			Primary Language?		
Other:			Stent placement When?			What kind of cancer?			Do you have any caps, loose teeth?		
Do you have prostate issues?			Name of Cardiologist			Type of treatment:			Do you wear:		
Urinary retention or incontinence?			Are you on blood thinners?			Are you being treated for any other condition?			Contact Lenses		
			When was your last dose?			Treating physician:			Dentures		

Please list any major operations and approximate dates:
_____
_____
_____

Reaction to local or general anesthesia or blood relatives with problems
_____
_____

Explain: _____

PATIENT LABEL

NOTICE OF PRIVACY PRACTICES

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.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

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FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

_____

_____

_____

_____

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate_____

Signature _____Date _____

Melanoma Center of Hope

David C. Ritter, MD FACS

In case of emergency notify:_____

Phone:_____ Relationship:_____

THE INSURANCE INFORMATION FURNISHED HERE REPRESENTS A FULL DISCLOSURE OF THE INSURANCE BENEFITS TO WHICH I AM ENTITLED. I UNDERSTAND THAT FAILURE TO DISCLOSE PRECERTIFICATION/SECOND OPINION REQUIREMENTS FOR ANY AND ALL PLANS TO WHICH I SUBSCRIBE, MAY CAUSE ME TO INCUR FULL LIABILITY FOR PROFESSION CHARGES, AS A RESULT OF NON-PAYMENT BY ANY CARRIER.

FINANCIAL RESPONSIBILITY:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND ARE DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR PRACTICE FINANCIAL COUNSELOR. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. WE WILL FILE TO YOUR PRIMARY CARRIER. ONCE THIS PAYMENT HAS BEEN MADE, IF THE BALANCE HAS NOT ALREADY BEEN PAID IN FULL, WE WILL BILL THE PATIENT FOR AND EXPECT THIS PAYMENT OF BALANCE AS SOON AS POSSIBLE. THE PATIENT IS RESPONSIBLE FOR FILING OF ANY SECOND AND THIRD INSURANCE POLICIES. OUR PRACTICE ABIDES BY OUR CONTRACTS WITH MANAGED CARE PLANS. IF YOU HAVE CONTRACTED WITH A MANAGED CARE PLAN AND IT HAS A DEDUCTIBLE AND/OR CO-PAY, THESE AMOUNTS WILL BE EXPECTED IN FULL AT THE TIME OR PRIOR TO ANY PROCEDURE OR VISIT.

UNLESS PROHIBITED OR LIMITED BY APPLICABLE MANAGED CARE PLAN CONTRACT, YOU AGREE TO ALLOW US TO CHARGE INTEREST AT THE MAXIMUM RATE ALLOWED BY LAW ON ANY OUTSTANDING AMOUNT THAT YOU PERSONALLY OWE TO US IN EXCESS OF 30 DAYS AND TO ALLOW US TO RECOVER COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEYS' FEES AND EXPENSES, IF IT BECOMES NECESSARY TO PURSUE COLLECTION OF ANY OUTSTANDING AMOUNT THAT YOU PERSONALLY OWE TO US, REGARDLESS OF WHETHER SUIT IS BROUGHT. IN ADDITION, YOU AGREE THAT THE VENUE OF ANY COLLECTION ACTION SHALL BE IN A COURT OF COMPETENT JURISDICTION IN NAPLES, COLLIER COUNTY, FLORIDA.

ASSIGNMENT OF BENEFITS:

I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE AND ANY OTHER HEALTH/MEDICAL PLAN TO ISSUE PAYMENT CHECK(S) DIRECTLY TO DR. DAVID C. RITTER FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE DR. DAVID RITTER TO FURNISH AND/OR RELEASE ANY INFORMATION NECESSARY TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS TO PROCESS MY INSURANCE CLAIMS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT, TO ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS MY INSURANCE CLAIM FOR THE PERIOD OF LIFETIME. THIS ORDER WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

I HAVE REQUESTED MEDICAL SERVICES FROM DR. DAVID RITTER ON BEHALF OF MYSELF/OR MY DEPENDENTS AND UNDERSTAND THAT MY MAKING THIS REQUEST, I BECOME FULLY FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED IN THE COURSE OF THE TREATMENT AUTHORIZED. I FURTHER UNDERSTAND THAT FEES ARE DUE AND PAYABLE ON THE DATE THAT SERVICES ARE RENDERED AND AGREE TO PAY ALL SUCH CHARGES INCURRED IN FULL IMMEDIATELY UPON PRESENTATION OF THE APPROPRIATE STATEMENT. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT BY SIGNING THIS FORM, I AM RELEASING THE OFFICE OF DR. DAVID C. RITTER TO TRANSFER UPON WRITTEN NOTIFICATION FROM THE INSURANCE COMPANY, AUTHORIZATION TO TRANSFER REQUESTED INFORMATION REGARDING MY HEALTH, DIAGNOSIS AND TREATMENT.

_____ _____

PATIENT SIGNATURE DATE