

# Medical Information Sheet

Fill in each response bubble completely - a check mark, a line or two lines through the response bubble or other partial fillers will not register with the reader.

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_ Reason for Today's visit \_\_\_\_\_

Date of Injury or length of symptom \_\_\_\_\_ Have you ever had a similar problem or injury? \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

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**History of Previous Surgeries:**     Yes (see list below)     No Previous Surgeries

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**Past Medical History:**     Yes, see the list below.     No Past Medical Problems

- |                                      |  |                                     |  |
|--------------------------------------|--|-------------------------------------|--|
| <input type="radio"/> Stroke         | <input type="radio"/> Heart attack     | <input type="radio"/> Lung disease  | <input type="radio"/> Heart disease          |
| <input type="radio"/> Kidney disease | <input type="radio"/> Vascular disease | <input type="radio"/> Ulcers        | <input type="radio"/> Neurological disorders |
| <input type="radio"/> Diabetes       | <input type="radio"/> Hypertension     | <input type="radio"/> Liver disease | <input type="radio"/> Cancer                 |

Other medical problems \_\_\_\_\_

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**Family Medical History:**     Yes, see the list below.     No History of Family Medical Problems

- |          |                              |                                |                                    |                                 |                              |
|----------|------------------------------|--------------------------------|------------------------------------|---------------------------------|------------------------------|
| Mother   | <input type="radio"/> Cancer | <input type="radio"/> Diabetes | <input type="radio"/> Hypertension | <input type="radio"/> Arthritis | <input type="radio"/> Stroke |
| Father   | <input type="radio"/> Cancer | <input type="radio"/> Diabetes | <input type="radio"/> Hypertension | <input type="radio"/> Arthritis | <input type="radio"/> Stroke |
| Siblings | <input type="radio"/> Cancer | <input type="radio"/> Diabetes | <input type="radio"/> Hypertension | <input type="radio"/> Arthritis | <input type="radio"/> Stroke |

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## Social History

- |              |                            |                                 |                                   |                                 |
|--------------|----------------------------|---------------------------------|-----------------------------------|---------------------------------|
| Smoking      | <input type="radio"/> Yes  | <input type="radio"/> No        |                                   |                                 |
| Alcohol      | <input type="radio"/> None | <input type="radio"/> 1 per day | <input type="radio"/> 2-3 per day | <input type="radio"/> 4 or more |
| Special diet | <input type="radio"/> Yes  | <input type="radio"/> No        |                                   |                                 |
| Exercise     | <input type="radio"/> Yes  | <input type="radio"/> No        |                                   |                                 |

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**Do You Have any Allergies?**     Yes, see list below.     No Known Drug Allergies

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**List any medications you are currently taking:** \_\_\_\_\_

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**Do you currently have any problems related to the following systems?**

**Please color in appropriate bubble.**

**Constitutional**

- Fever
- Chills
- Headache

**ENT**

- Ear infection
- Sore throat
- Sinus problem

**Ophthalmology**

- Blurring of vision
- Double vision
- Pain

**Urology**

- Urine retention
- Painful urination
- Frequent urination

**Allergy**

- Hay fever
- Drug allergies

**Respiratory**

- Wheezing
- Cough
- Shortness of breath

**Neurology**

- Tremor
- Dizziness
- Tingling numbness

**Hematology/Lymph**

- Swollen glands
- Blood clotting problems

**Endocrinology**

- Excessive thirst
- Heat intolerance
- Cold intolerance
- Fatigue

**Psychology**

- Generally satisfied with life  Yes  No
- Suicidal ideation  Yes  No

**Gastroenterology**

- Abdominal pain
- Nausea
- Vomiting
- Heartburn

**Cardiology**

- Chest pain
- Varicose veins
- High blood pressure

**Dermatology**

- Rash
- Boils
- Itch

**Musculoskeletal**

- Joint pain
- Joint stiffness
- Joint swelling

## PATIENT INFORMATION

Today's date:						
Patient's last name:		First name:		Middle initial:		
Mailing Address:			City:		State	Zip:
Street Address, City, State, Zip: <i>(if different than mailing)</i>						
Email address: <i>(We will <b>not share</b> this with any other entities. We will <b>not</b> send any confidential information via email)</i>						
Home phone:		Mobile phone:		Work phone and extension:		
Patient DOB		Age:	Sex:	Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> other:		
Social Security No.		Occupation:		Employer Name and Address:		
Primary Care Physician and Phone No.				Referring Provider and Phone No.		
<b>IN CASE OF EMERGENCY</b>						
Name of emergency contact person:			Relationship to patient	Home phone:		Work or Cell phone: (    )    -
Mailing Address <i>(if different than patient)</i> :			City:		State	Zip:
<b>RESPONSIBLE PARTY (GUARANTOR)</b> <i>(if different from patient)</i>						
Guarantor's last name:		First name:			Middle name:	
Mailing Address:			City:		State	Zip:
Guarantor's phone number: (    )    -		Relationship to patient:		Guarantor's DOB	Guarantor's Social Security No.: -    -	
Guarantor's employer and address:						
<b>INSURANCE INFORMATION</b> <i>(Please present new insurance card to our office staff)</i>						
<input type="checkbox"/> Self-Pay / No Insurance <input type="checkbox"/> Patient is the Insured Subscriber		Policy subscriber's name <i>(if not patient)</i> :			Policy subscriber's DOB <i>(if not patient)</i> :	
Name of primary insurance:		Primary insurance address:			Insurance Phone Number:	
Patient's relation to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:						
Subscriber Number:			Group Number:		Specialist Co-Pay Amount	
<b>PHARMACY INFORMATION</b>						
Pharmacy name:		Pharmacy location (address or intersection is okay)			Pharmacy phone number (if known)	

## **FINANCIAL POLICY**

*Thank you for choosing us as your health care provider. We are committed to serving you to the best of our ability. In order to bring you the quality of service, which you expect, we need to reach a mutual understanding about our payment policies. We therefore ask you to read and accept the following statement of our financial policy prior to treatment.*

I. **PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.** We accept cash, checks, and Visa, MasterCard, and American Express.

### **PRIVATE INSURANCE**

Your insurance policy is a contract between you and your carrier. We are not a party to that contract. You are responsible to know the policy of the company that insures you. This includes obtaining any referrals from your primary care provider before coming to see our physicians. Your bill with the physician is your responsibility whether or not your insurance company pays for the services rendered. You will be asked to pay only the co-pay and your unmet deductible at the time of your visit. If your insurance company has not paid your account within 90 (ninety) days, the balance will automatically become due from you. We stress that the correct insurance policy information be provided for billing. Claims denied due to terminated policies, unidentifiable policy numbers, or wrong billing addresses will become the patient's responsibility. This is due to the limited amount of time required by insurance companies to file a claim.

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. We assure you that what we charge you is usual and customary for our area. If your insurance company refuses to accept the level of our charge, unfortunately, we must still hold you primarily responsible for payment in full.

### **MANAGED CARE CONTRACTS**

We currently participate in some "managed care" insurance programs. If you are covered by one of these identified programs, you will be required to pay any co-pay, unmet deductible or non-covered service at the time of each visit. Make sure you present your identification card to the receptionist and advised that you are covered under a managed care program. As with any other insurance policy, if your managed care administrator has not paid your account within 90 (ninety) days, the balance will automatically become due from you.

### **MEDICARE PATIENTS**

We are participating physicians with Medicare. This means that you will only be responsible for 20% of the approved Medicare fee, the \$155 yearly deductible and full payment of any non-covered services. Non-covered services include but are not limited to complete annual physicals, immunizations and diagnostic tests done for screening purposes.

Supplemental insurance is available to cover all charges that Medicare does not pay. Medicare submits claims directly to some supplemental insurance carriers including those connected to their Medica program. We will file claims with other supplemental insurance carriers that pay the physician directly. Otherwise, you will be required to pay the 20% co-payment, unmet deductible or non-covered service at the time of each visit and then file your claim with your supplemental carrier. Medicare HMO participants need to obtain a referral when out of network or denied services will become your responsibility.

### **MEDICAID**

Medicaid patients over 18 are required to pay a \$2.00 co-pay at the time of their office visit (\$3.00 with diagnostic testing). If you have a Medipass provider, your service will need to be verified with that provider prior to treatment. If we cannot obtain an authorization from your Medipass provider, you will be responsible in full when service is rendered.

### **PATIENTS UNDER THE AGE OF 18**

A parent or guardian must accompany the child who will be responsible for payment of the bill at the time of service. We cannot be bound by any divorce or other family relationship contracts. Any account 90 days past due will be turned over to an outside collection agency and you will be responsible for ALL costs of collection in addition to unpaid charges. A typical collection fee is 40% of the charges.

### **ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

### **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

# HIPAA Notice of Privacy Practices

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**Michael T. Havig, M.D.**  
**1350 Tamiami Trail N. #202**  
**Naples, FL 34102**  
**Phone: 239-325-1135 Fax:239-262-3843**

**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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_