

2068 Hawthorne Street

Sarasota, FL 34239

941-953-5050

|  |  |  |
| --- | --- | --- |
| Patient Name:  | Date of Birth: | Social Sec #: |
| Home Phone: | Cell Phone: | Preferred Contact Number: |
| Primary Address: | City : | State: | Zip Code: |
| Summer Address: | City : | State: | Zip Code: |
| If Minor, Legal Guardians Name: | Relationship to Patient: |
| Emergency Contact:  | Relationship to Patient: | Preferred Phone: |
| Race: * White
* African American
* Latino
* Other
 | Sex:* Male
* Female
 | Marital Status:* Single
* Married
* Widowed
* Other
 | Ethnicity: |
| Language: |
| Height: | Weight: |
| E-mail Address: | Employer: |

|  |  |
| --- | --- |
| Primary Care Physician: | Referring Physician: |
| Preferred Pharmacy: | Address & Phone Number: |

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| --- |
| **How did you hear about our practice?** |
| * Friend
 | * Observer
 | * Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Herald Tribune
 | * Sarasota Magazine
 | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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I assign to Hawthorne Clinic and Research Center all insurance benefits paid to me on my behalf. I understand that insurance may not pay all or part of the charges for services provided and that I bear full responsibility for any balance due. I hereby authorize the release of all Protected Health Information necessary for insurance and for my care to insurers and other healthcare providers.

Signature of Patient or Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Family History** | **Afflicted Family Member** | **Notes** |
| * Adopted
 |  |  |
| * Asthma
 |  |  |
| * Autoimmune Disorders
 |  |  |
| * Bleeding/Clotting
 |  |  |
| * Brain Tumor
 |  |  |
| * Breast Cancer
 |  |  |
| * Diabetes
 |  |  |
| * Endocrine Disease
 |  |  |
| * Hearing Loss
 |  |  |
| * Heart Disease
 |  |  |
| * Hemophilia
 |  |  |
| * High Blood Pressure
 |  |  |
| * Kidney Disease
 |  |  |
| * Liver Disease
 |  |  |
| * Lung Cancer
 |  |  |
| * Malignant Melanoma
 |  |  |
| * Other Cancer
 |  |  |
| * Ovarian Cancer
 |  |  |
| * Prostate Cancer
 |  |  |
| * Seasonal/Year Round Allergies
 |  |  |
| * Skin Cancer
 |  |  |
| * von Willebrand
 |  |  |

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| **Skin History** | **Treatments** | **Treating Physician** | **Notes** |
| Actinic Keratosis |  |  |  |
| Acne |  |  |  |
| Basal Cell Carcinoma |  |  |  |
| Dysplastic Nevus |  |  |  |
| Eczema |  |  |  |
| Malignant Melanoma |  |  |  |
| Non-Melanoma Skin Cancer |  |  |  |
| Other Suspicious Lesion |  |  |  |
| Psoriasis |  |  |  |
| Squamous Cell Carcinoma |  |  |  |
| Urticaria |  |  |  |

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| **Past Medical History:**  | **Details** |  | **Details** |
| * Anemia/Blood Disorder
 |  | * Heart Murmur
 |  |
| * Anxiety
 |  | * Heartburn/Reflux
 |  |
| * Arthritis
 |  | * Hepatitis C
 |  |
| * Asthma
 |  | * High Blood Pressure
 |  |
| * Back Problems
 |  | * HIV/ AIDS
 |  |
| * Breast Cancer
 |  | * Hives
 |  |
| * Cancer
 |  | * Kidney Stones
 |  |
| * Cataracts
 |  | * Loss of Hearing
 |  |
| * Chest Pain/Tightness
 |  | * Other
 |  |
| * Depression
 |  | * Radiology
 |  |
| * Diabetes
 |  | * Stroke
 |  |
| * Emphysema
 |  | * Thyroid Disorder
 |  |
| * Glaucoma
 |  | * Tuberculosis
 |  |
| * Gynecological Problems
 |  | * Ulcers
 |  |
| * Heart Disease
 |  |

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| **Surgical History** | **Date**  | **Notes** |
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| **Drug Allergies** | **Reaction** | **Notes** |
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| **Medication/Drug** | **Dosage** | **Prescribed By** |
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**Female Questions**

Are you pregnant or lactating (circle one)? Yes No

**Immunizations**

|  |
| --- |
| Pneumonia Yes / No If **“YES”** when |
| Influenza Yes / No If **“YES”** when |

**Social History**

|  |
| --- |
| **Alcohol Use:** |
| * Did you have a drink containing alcohol in the past year? (circle one)? Yes No
 |
| * If “**YES**” how often did you have 6 or more drinks on one occasion?
 |
| **How often:** | **How many drinks:** |
| * Never
 | * 1 - 2
 |
| * Monthly or less
 | * 3 - 4
 |
| * 2-4 times a month
 | * 5 - 6
 |
| * 2-3 times a week
 | * 7 - 9
 |
| * 4 or more times a week
 | * 10 or more
 |

|  |
| --- |
| **Smoking History:** |
| * Never smoked
 |
| * Current tobacco smoker
 |
| * Current smokeless tobacco user (chew, snuff)
 |
| * Former smoker - If former, when did you stop smoking ?
 |

|  |  |  |
| --- | --- | --- |
| **Current Smokers**: Packs per day | **Current Smokers**: Duration | **Former Smokers:** how long ago did you quit? |
| * < 1 pack per day
 | * For < 5 years
 | * <1 year ago
 |
| * 2 packs per day
 | * For 5-10 years
 | * 1-5 years ago
 |
| * 3 packs per day
 | * For 10-15 years
 | * 5-10 years ago
 |
| * 4 packs per day
 | * For 15+ years
 | * 10-15 years ago
 |
| * 4 or more packs per day
 |  | * 15+ years ago
 |

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| * Do you use illegal drugs (circle one)? Yes No
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Sarasota, FL 34239

**Confidential Communications**

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| --- | --- | --- |
| May we leave personal medical information on your answering machine at home? | * Yes
 | * No
 |
| May we leave personal medical information on your cell phone voicemail? | * Yes
 | * No
 |
| Do you give our office permission to discuss your medical information with family members? | * Yes
 | * No
 |

If yes, please provide information of your friend/family member that we may discuss your medical information with:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Relationship: |  | Phone: |  |
| Name: |  | Relationship: |  | Phone: |  |

**Acknowledgment of our Notice of Privacy Practices**

Our notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). It discusses your rights as a patient and our offices duties with respect to your PHI. Our Notice of Privacy Practices is available on our website and you will be furnished with a printed copy upon request. If we change our Notice, you may obtain a revised copy by contacting our office or downloading it from our website: [www.hawthorneclinic.com](http://www.hawthorneclinic.com)

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Print Name Date of Birth

**Acknowledgement of Administrative, Clinical and Financial Policies**

Hawthorne Clinic and Research Center is dedicated to providing you with the best possible care and service while keeping the charges at a reasonable level. As a patient in our practice, it is important that you are aware of our policies. We ask that you carefully read this notice in its entirety and have any questions answered by our staff.

**INSURANCE:**  We participate with most medical insurances. It is important to understand that insurance is an agreement between you and your insurance carrier and that your physician’s bill for services provided is an agreement between you and your physician. If we do participate with your insurance, all services will be submitted to your carrier for you, unless we have received prior notification of non-coverage services. **However, we must collect all applicable co-pays, deductibles, co-insurances and fees for non-covered services at the time of the visit.**

Some insurance plans, including HMO’s, may require an authorization from your referring physician for medical services. It is your responsibility to obtain the authorization prior to the time of service. If the required authorization is not presented at the time of service you may do one of the following:

* Reschedule the appointment and obtain the authorization prior.
* Contact your referring physician to authorize the visit by using our courtesy phone.
* Pay the charge for your services and seek insurance payment.

If we do not participate with your insurance, payment is required at the time of service. We will file your insurance as a courtesy.

We accept Visa, MasterCard, Discover, American Express credit cards as well as cash or check. Your account is not satisfied until your check clears the bank. Should your check be returned, you will be liable for any bank fees levied and an additional fee of $20 for administration. Some procedures performed by us are considered “cosmetic” in nature and are not covered by insurance carriers. Full payment for cosmetic services is required prior to the procedure. We accept the Carecredit plan should you need additional financial assistance.

**CANCELLATIONS:** Please provide 48 hours notice if you must cancel an appointment, otherwise a $25 cancellation fee may be assessed.

**COLLECTIONS:** If your account becomes delinquent, it will be sent to a collection agency. In that event, you will be financially responsible for all collection fees incurred unless contractually prohibited. This means you will owe both the original balance and any fee incurred by using the collection agency to secure payment. Payment for current services and payment in full of any past due balance is expected prior to being seen again in our office.

**MEDICAL RECORDS AND FORMS**: if you require a copy of your medical records, a fee may be charged to offset our costs. All fees are payable prior to the release of records. Government regulation limits, but allows for these fees and requires us to obtain a Medical Records Release Authorization form prior to the release of your records. If you require FMLA, disability, or forms to be completed, a fee of $25 will be charged.

**PHOTOGRAPHY RELEASE**: I understand that the photographs may be taken in connections with the medical services I receive and that such photographs will be retained in my medical records that may be shared with others, including, but not limited to, my insurance carrier. I give permission for these photos and information relative to them and/or relating to my case to be published and republished for the purpose of medical research, education, or science and I specify that such publication of the photographs will not include my name. I understand that this release remains valid unless I revoke myself.

**MEDICARE & MEDICAL INSURANCE SIGNATURE ON FILE**: I have provided insurance information documents that may provide payments for services. I authorize payment of medical benefits directly to the physician for professional services rendered. I am financially responsible for all charges for such services rendered to me, including the balance remaining after the payment of any insurance benefits.

**PERMISSION TO TREAT**: I hereby give the physician and those under the supervision of the physician permission to treat me as a patient. I will comply with their recommendations for treatment, tests, and/or referrals to other specialists that may be necessary for my care.

**NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT**: I hereby acknowledge that I have seen/reviewed that “Notice of Privacy Policy” displayed in the waiting room and that I may have a paper copy should I so desire.

**FINANCIAL AGREEMENT**: I understand that I am directly responsible for my account, the payment of this account and hereby assume and guarantee payment of expenses incurred by myself and/or my dependents. Should legal action be required to secure payment of this account I agree to pay a reasonable collection expenses, all court costs and a reasonable attorney’s fee incurred thereby.

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 **Records Release Form**

**Last name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the following entity to release/receive my (PHI) Protected Health Information:

**To / From To / From**

Hawthorne Clinic and Research Center Individual, Facility, Organization and address

2068 Hawthorne Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suite 201 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sarasota, Florida 34239 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **□ Disclose to self**

**Purpose of Disclosure:**

□ Continuing Care □ Payment of claim □ School □ Legal □ Personal use □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released:**

□ Progress Notes □ Lab work □ Pathology Results □ Operative Notes □ Allergy testing □ Other testing

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Understanding:**

* I understand the expiration date of this request is 1 year from date signed.
* I understand I may revoke this authorization at any time by providing the Hawthorne Clinic and Research Center in writing, and it will be in effect the date notified, except to extent of action already been taken.
* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer be protected by Federal privacy regulations.
* I understand that I may be required to pay and administrative fee for retrieval and photocopying of records.

 *(Cost: $1.00 a page for the first 25 pages and .25 for every page thereafter)*

* I understand that my medical information may include information related to sexually transmitted disease, AIDS, HIV status, mental health and drug or alcohol use.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_