Andrew P. Cassidenti, M.D.

Patient Information Form

This information is confidential. We appreciate your cooperation in filling out this form in its entirety.

PLEASE PRINT IN BLACK INK

Your Full Name: **Date:**

Home Address: **City/State/Zip:**

Phone: (Home) **Work:** **Cell:**

Birthdate: **Age:** **Birthplace:**

Married: Single: Widowed: **Divorced:** Separated: **Email:**

Maiden Name: **Social Security#:** **Driver's License #:**

Who referred you to us?

Your Employer: **Occupation:** **Retired (circle one): Yes or No**

Your Work Address: City/State/Zip:

Spouse/Responsible Party Information:

Name: **Relationship:**

Home Address: City/State/Zip:

Birthdate: Social Security#: Employer:

Person to contact in case of **an emergency:**

Relationship: Phone:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR BILLING COSTS, WE REQUEST THAT YOUR PATIENT RESPONSIBILITY BE PAID ATTHE CONCLUSION OF EACH VISIT. If you cannot pay at time of service, you must discuss other payment arrangements PRIOR to your visit, with our Billing Department. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records. I/We hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: **CASSIDENTI & ASSOCIATES**.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I'm financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (by Patient): _____ **Date:**_____

Signed (by Responsible Party): _____ **Date:** _____

HEALTH HISTORY

NAME	AGE	RACE	S M W D	SEP.

Family History	Living		Deceased		Has any relative ever had	NO	YES	Who
	Age	Health	Age	Cause				
Father					Cancer	☐	☐	
Mother					Tuberculosis	☐	☐	
Brother or sister 1					Diabetes	☐	☐	
2					Heart trouble	☐	☐	
3					High blood pressure	☐	☐	
4					Stroke	☐	☐	
5					Epilepsy	☐	☐	
Husband					Suicide	☐	☐	
Son or daughter 1					Mental illness	☐	☐	
2					Hysterectomy	☐	☐	
3					Caesarean section	☐	☐	
4					Kidney trouble	☐	☐	

Menstrual History

Age at onset _____

Regular ☐ Yes ☐ No

Cycle_____days (from start to start)

Usual duration _____days

Flow ☐ Light ☐ Mod ☐ Heavy

Pain or cramps ☐ Yes ☐ No

Date of last period _____

List Pregnancies (include miscarriages)

Year	Weight	Sex	Hours of labor	Anesthesia	Complications

Personal History

Weight Now _____ 1 year ago_____ Highest _____ When _____

Have you ever had	NO	YES
Anemia	☐	☐
Cancer	☐	☐
Chicken pox	☐	☐
Deep Vein Thrombosis	☐	☐
Diabetes	☐	☐
Diphtheria	☐	☐
Epilepsy	☐	☐
Gallbladder disease	☐	☐
German measles	☐	☐
Gonorrhea or syphilis	☐	☐
Heart disease	☐	☐
Heart murmur	☐	☐
Hepatitis	☐	☐
Herpes	☐	☐
High or low blood pressure	☐	☐
HIV/AIDS	☐	☐
Hypoglycemia	☐	☐
Jaundice	☐	☐
Kidney infections	☐	☐
Migraine headaches	☐	☐
Mumps	☐	☐
Nervous breakdown	☐	☐
Pneumonia	☐	☐
Pulmonary Embolism	☐	☐
Polio or meningitis	☐	☐
Rheumatic fever	☐	☐
Scarlet Fever	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐
Tuberculosis	☐	☐
Valley fever	☐	☐

Do you now have or have you ever had	NO	YES
Any eye disease, injury, impaired sight	☐	☐
Any ear disease, injury, impaired hearing	☐	☐
Any trouble with nose, sinuses, mouth, throat	☐	☐
Any head injury, fainting spells, convulsions	☐	☐
Frequent or severe headaches	☐	☐
Skin disease	☐	☐
Chronic or frequent cough	☐	☐
Chest pain, or spitting up of blood	☐	☐
Night sweats	☐	☐
Shortness of breath	☐	☐
Swelling of hands, feet, or ankles	☐	☐
Varicose veins	☐	☐
Kidney or bladder disease	☐	☐
Indigestion, stomach trouble or ulcer	☐	☐
Rectal bleeding, constipation or diarrhea	☐	☐
Loss of urine with cough or sneeze	☐	☐

Alcoholic beverages ☐ Never ☐ Moderate ☐ Daily

Cigarettes_____ packs per day

Surgery—what, when, where

_____

_____

Allergies _____

Drug sensitivity _____

Transfusions No Yes Number

What medicine are you now on: _____

PATIENT FINANCIAL POLICY

Our Primary Goal is to provide you with the best possible medical care and your clear understanding of our financial policy is important in order to sustain a professional relationship.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. A copy of the current insurance card and complete billing information is required and must be presented before services are rendered. We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement. If adequate information is not available at the time of service, payment in full is required. Insurance companies require us to collect deductibles and co-pays from patients which is payable at the time of service. Non-covered services and patient responsibility amounts are due upon receipt of statement from our office.

We expect to receive payment in full at the time services are rendered unless other arrangements have been made in advance. We accept cash and personal checks(PAYABLE TO: CASSIDENTI & ASSOCIATES)

If your insurance requires you have lab, radiology and other services at a specific facility it is the patient's responsibility to notify our staff at the time testing is ordered. It is also the patient's responsibility to insure that necessary authorizations are received prior to services being rendered.

We do not assume responsibility for verification of insurance benefits or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan before services are rendered. This also applies to any facility or provider that your doctor may refer you to.

HMOs, EPOs, and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self-referrals and unauthorized services require payment at the time of service.

Any portion of the balance not paid within sixty days by the insurance company due to patient co-pays or deductible amounts, non-covered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation, request for additional information from the patient, incorrect billing information or any other reason for nonpayment, reduced or delayed payment is the responsibility of the patient or responsible party.

Please be certain the billing and insurance information we have on file is accurate. Otherwise, you will be billed directly and responsible for payment in full. You will be reimbursed if your insurance company pays us after you have paid in full_____.
Initial

A statement of charges will be sent to the patient or responsible party showing the balance due. Balances older than sixty days will be subject to late fees. Delinquent balances may be referred to an outside agency for collection.

I have read the above financial policy and agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party Date

Patient Consent for Use and Disclosure of Protected Health Information

_____ Initial With your consent, our physicians may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 1140 West La Veta, Suite 560, Orange, CA 92868.

_____ Initial With your consent, our physicians may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

_____ Initial With your consent, our physicians may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

_____ Initial I give my consent to electronically send or fax my records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve your physicians of all liability.

_____ Initial You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

_____ Initial By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. <u>If you decline to sign this consent, we may decline to provide treatment for you.</u>

Signature of Patient or Legal Guardian _____ Date _____
This Authorization Will Remain Standing Until Revoked in Writing.

Patient's Name _____ Date of Birth _____

Print Name of Patient or Legal Guardian _____ Date _____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my PHI to carry out treatment, payment, and health care operations.

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. 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 contacting our Privacy Officer at 1140 W. La Veta, Ste. 560, Orange, CA 92868, 714-835-0101.

I acknowledge receipt of the ***Notice of Privacy Practices***.

Signature:_____ Date:_____
(parent/patient/conservator/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative:_____ Date:_____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

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