Please Circle One:

Ethnicity:
Hispanic or Latino
American/White
Not Hispanic or Latino
Unknown

Race:
American Indian or Alaska Native
Asian/Black or African
Other __________________ Unknown

Smoking Status:
*Current every day Smoker
*Current some day Smoker
Former Smoker
Never Smoker
Smoker, current status unknown
Unknown if ever smoker

Preferred Language _________________

*If patient is a smoker use procedure code 99406

Preferred Pharmacy List:

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Reminder Communication Preference: (Circle One)
- Home Phone
- Mobile Phone
- Email
- Mailed Letter

*Advanced Directive  Yes / No  
* Living Will  Yes/No
PATIENT INFORMATION

(Please Print)

Today’s Date______________ □ Male

Patient Name_________________________ Date of Birth_________ Age_________ □ Female

□ Single  □ Married

□ Divorced  □ Widow

Street________________________ City & State________________________ Zip_________

Home Phone________________________ Work Phone________________________ Cell Phone_________________

Social Security Number_________________________ Spouse or Guardian Name_________________________

Employer____________________________________ Occupation________________________________

Employer Addresss________________________________________

Spouse Employer________________________________________

Do you have and Advance Directive (Living Will)   □ No   □ Yes   (If Yes, please provide a copy.)

PERSON TO CONTACT IN CASE OF EMERGENCY

___________________________________________________________________________________________

TELEPHONE NUMBERS

___________________________________________________________________________________________

REASON FOR VISIT

What is your surgical problem? _________________________________________________________________

What are your symptoms? __________________________________________When did they start?_________

Primary Care Physician (Family Doctor)___________________________

Referring Physician_________________________________________Other Physicians you are seeing________________

ASSIGNMENT OF BENEFITS

I assign insurance or other medical coverage benefits directly to Surgical Associates of Central Florida, PA. I understand that I am financially responsible for any services not covered by my third party coverage. All balances are due and payable on demand. I authorize the release of my medical records as necessary to complete my care.

_________________________________________ _________________________________________

Signature of Patient or Representative Date

Printed Name
Today’s Date ____________________________

Patient Name __________________________________________         Date of Birth _________________________
(First)                     (Middle)                   (Last)

### MEDICAL HISTORY

<table>
<thead>
<tr>
<th>List Operations (Include Date)</th>
<th>Other Medical Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ___________________________</td>
<td>1) ______________________</td>
</tr>
<tr>
<td>2) ___________________________</td>
<td>2) ______________________</td>
</tr>
<tr>
<td>3) ___________________________</td>
<td>3) ______________________</td>
</tr>
<tr>
<td>4) ___________________________</td>
<td>4) ______________________</td>
</tr>
</tbody>
</table>

### MEDICATIONS

<table>
<thead>
<tr>
<th>Medications (State amount taken daily)</th>
<th>Allergies (Please list below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Aspirin, Advil, Arthritis Medication</td>
<td>Smoke □ No □ Yes Packs/Day</td>
</tr>
<tr>
<td>2) ____________________________</td>
<td>Alcohol □ No □ Occasional □ Moderate</td>
</tr>
<tr>
<td>3) ____________________________</td>
<td>Drugs (recreational) □ No □ Occasional □ Moderate</td>
</tr>
<tr>
<td>4) ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

### HEALTH HISTORY

<table>
<thead>
<tr>
<th>Reactions to Anesthesia</th>
<th>AIDS</th>
<th>Constipation</th>
<th>Headaches</th>
<th>HIV Positive</th>
<th>Hemorrhoids</th>
<th>Lung Disease</th>
<th>Hepatitis C</th>
<th>Sleep Apnea</th>
<th>Depression</th>
<th>Arthritis</th>
<th>Kidney Problems</th>
<th>Hearing Loss</th>
<th>Alcoholism</th>
<th>Frequent Uration</th>
<th>Heart Trouble</th>
<th>Thyroid Trouble</th>
<th>Varicose Veins</th>
<th>Chest Pain</th>
<th>Stomach Ulcers</th>
<th>Phlebitis</th>
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<tbody>
<tr>
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<td>□ No □ Yes</td>
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<td>□ No □ Yes</td>
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</table>
Please Explain ALL Yes answers ____________________________________________________________

______________________________________________________________________________________________

______________________________________________________________

______________________________________________________________________________________________

FAMILY HISTORY

<table>
<thead>
<tr>
<th></th>
<th>Living</th>
<th>Deceased</th>
<th>Age at Death</th>
<th>Stroke</th>
<th>High Blood Pressure</th>
<th>Diabetes</th>
<th>Cancer</th>
<th>Type</th>
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<tbody>
<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Brother/Sister</td>
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<tr>
<td>Other</td>
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</table>

Date of last Chest X-Ray ______________________________ Where Done ________________________________

Date of last Electrocardiogram (EKG) ___________________ Where Done ________________________________

Patient Notes: ________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Physician Notes: ________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________
Consent for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Surgical Associates of Central Florida, P.A. (hereafter referred to as Surgical Associates) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations. I understand that diagnosis or treatment of me by the doctors of Surgical Associates may be rendered based on upon my consent, as evidenced by my signature below.

The Notice of Privacy Practices has been made available to me and I understand that I have the right to review it prior to signing this consent. Surgical Associates reserves the right to modify the Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for additional information regarding your privacy rights.

I ____________________________, am also giving Surgical Associates of Central Florida, PA permission to involve the below listed people in my complete medical care.

I understand and give my permission to Surgical Associates of Central Florida, PA to discuss testing, treatment, and any results with the below people for the purpose of my medical care and wellbeing.

This permission also includes any and all financial issues involving my account and further care.

I understand that this permission will remain in place until I request a change.

<table>
<thead>
<tr>
<th>Persons Name:</th>
<th>Relationship:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<table>
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<tr>
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<th>Relationship:</th>
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<table>
<thead>
<tr>
<th>Patient Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Print Patient Name:</th>
</tr>
</thead>
</table>
Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully and then sign the HIPAA consent.

If you have any questions about this notice, please contact our Privacy Officer at the address listed at the end of this notice.

Who will follow this notice: This notice describes information about privacy practices followed by Doctors, Employees and Business Associates of Surgical Associates of Central Florida, P.A.

Your Health Information: This notice applies to the information and records we have about your health, health status and the healthcare and services you will receive from this medical practice. This information is known as Protected Health Information (PHI).

How we may use and disclose health information about you: We must have your written, signed Consent to use or disclose PHI for the following purposes:

For Treatment: We may use PHI about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care who may or may not be employed by us.

For example, your doctor may be treating you for a condition that requires other specialists to be involved. We may share your records with other doctors and healthcare providers. We may also verbally or in writing, exchange or disclose facts about your healthcare.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you.

For Payment: We may use and disclose PHI about you so that treatment and services you received may be filed with and payment collected from your insurance company or third party payor. For example, we may need to provide your health plan with demographic or clinical information about a service you received from us in order to received payment for those services.

For Healthcare Operations: We may use and disclose PHI about you in order to operate the medical practice and make sure that you and our other patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you at home or work as a reminder that you have an appointment for treatment or additional medical services.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Family and Friends: We may disclose your PHI to your family members, friends or your personal representative if we obtain verbal agreement to do so. You have the right and obligation to object if you do not agree. We will only do this when we believe you would not object. For example, we may disclose your information to your spouse when they have been with you at your office visit or other treatment and care.

In emergencies or situations where you are not able to give consent or to object to disclosures of your information, we may deem it necessary, in our professional judgment, to disclose portions of your PHI relevant to the person’s involvement in your care. For example, we may provide discharge instructions or prescriptions, etc to a friend that is with you at the time of surgery or treatment.

We will disclose only the minimally necessary information and will do so only when your best interest is served.

Revocation of Consent: You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but will not apply to any uses or disclosures that occurred before that time. Your written revocation should be provided to the Privacy Officer at the address listed below.

If you revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.
**Uses and Disclosures without your consent:** Your PHI may be used or disclosed without your written consent in the following special situations:

a.) Public health activities including the prevention or control of communicable diseases, injury or disability; reporting of deaths, non-accidental physical injuries, reactions to medications
b.) Required reporting for victims of abuse, neglect or domestic violence.
c.) Health oversight activities for audits, investigations, inspections or for licensing purposes. Disclosures may be made to state or federal agencies for the monitoring of healthcare systems, government programs and compliance with civil rights laws.
d.) Legal proceedings in conjunction with subpoenas, discovery requests or other lawful requests
e.) Legal requests and cooperation with law enforcement, Coroners, Funeral Directors and organ donation programs
f.) Compliance with Workers Compensation laws or if you are an inmate of a correctional facility
g.) Research projects where your specific permission will be obtained if your PHI is to be released to a researcher
h.) Disclosures to avert any serious threat to health or safety of you or another party.
i.) As required by any local, state or federal law.

**Other uses and disclosures of health information:** We will not use or disclose your PHI for any purposes other than those mentioned above. We must obtain your Authorization, separate from any Consent we may have obtained from you already. Any Authorization you have given us may be revoked at any time. When your written revocation is received, we will no longer use or disclose the identified items and cannot take back any uses or disclosures already made with your permission.

**Your individual rights regarding health information about you:**

You may place restrictions on certain uses and disclosures of your protected health information. For example, you may restrict us from releasing any information to a certain family member or friend. Your instructions must be in writing and provided to the Privacy Officer. **NOTE:** We are not required to agree or to comply with your request.

You have the right to receive confidential communications. You may restrict or direct the manner in which we communicate with you. For example, you may ask us not to contact you at your place of employment. Your instructions must be in writing and provided to the Privacy Officer.

You may inspect and copy your records. You have the right to inspect and receive a copy of your records. You must make a written request in advance to the privacy officer listed at the bottom of this privacy notice. You may be charged a fee for the cost of copying the records.

You may request an amendment to your protected health information. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. The request will be made in writing and will include the incorrect information and the amended information. The request will be provided to the Privacy Officer. **NOTE:** We are not required to agree or to comply with your request but will include it with your records.

You may request an accounting of disclosures made of your protected health information. Upon your written request to the Privacy Officer, we will provide an accounting of all disclosures of your protected health information except for those made for treatment, payment and healthcare operations. This will include all disclosures back six (6) years or April 14th, 2003, which ever is later. The accounting will be provided within 60 days of request and will include the date of each disclosure, name of recipient and a description of the information disclosed.

You have the right to a paper copy of this notice. A paper copy of this notice is available from the Privacy Officer at the address listed below.

**Our duties under HIPAA and this notice:**

a) Surgical Associates of Central Florida, P.A. is required by HIPAA and Florida state law to maintain the privacy of your PHI and to provide you with written notice of our legal duties under the law.

b) We reserve the right to change the terms of this Notice at any time.

c) We are required to abide by the terms of this Notice. The terms of this notice will remain in effect indefinitely unless you are notified of modifications. Modifications to the Privacy policy will not be back dated.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with us, provide your detailed written complaint to the attention of the Privacy Officer at the address listed below. You will not be penalized for filing a complaint.

**Privacy Officer:** To contact the Privacy Officer of Surgical Associates of Central Florida, P.A. please address all correspondence to:

Surgical Associates of Central Florida, P.A.
Attention: Privacy Officer
1181 Orange Avenue
Winter Park, Florida 32789
(407) 647-1331
AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I _____________________________________ hereby authorize Surgical Associates of Central Florida, P.A. to:

☐ obtain records on my behalf from:
________________________________________________________________________________________

☐ release medical records on my behalf to:
________________________________________________________________________________________

Please release my complete medical records including medical, drug or alcohol abuse, mental health, and HIV testing.

Any portion of the medical record may be withheld according to additional instructions indicated on this release. This release is valid for one year and may be revoked at any time upon written notification from the patient.

Use or disclosure of Protected Health Information made according to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule 45 CFR Part 164.

_________________________________________  ________________________________
Date                                              Signature of Patient or Personal Representative

_________________________________________
Date of Birth                                   Printed Name

_________________________________________
Social Security                                Address
Patients that require *FMLA, Disability, or any other forms* filled out by our office will need to allow our office 7 – 10 business days to complete.

The charge/fee for completing forms is $25.00 for one form and $35 for two forms. The charge/fee must be paid at the time you pick up the form. If the form is being mailed or faxed; the charge/fee must be paid when you drop off the form to be completed.

This is not an insurance billable or reimbursable charge/fee

Thank you. Surgical Associates of Central Florida, PA
Practice Administrator