Matthew S. Fine M.D.
Amanda Bibbings PA-C
10650 West State Road 84, Suite 204
Davie, FL 33324
786.563.3463 office 888.972.5618 fax
www.fineurology.com

PATIENT INFORMATION

LAST NAME	FIRST NAME	M	SEX
			□ Male □ Female

DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS
_ _ / _ _ / _ _ _ _	_ _ _ - _ _ - _ _ _ _	□ Single □ Married □ Divorced □ Widowed

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

E-MAIL	PREFERRED METHOD OF CONTACT
	Call Home Call Cell Send E-mail Send Text

EMPLOYER	OCCUPATION	EMPLOYER PHONE

RACE	ETHNICITY	PREFERRED LANGUAGE

PRIMARY CARE PHYSICIAN (PCP) & PHONE NUMBER	HOW DID YOU FIND DR. FINE?
	□ PCP □ Insurance □ Family/Friend _____ □ Website □ Zoc Doc □ Other: _____

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NUMBER

PATIENT INSURANCE INFORMATION

INSURANCE	ID NUMBER	GROUP NUMBER

POLICY HOLDER'S NAME	RELATIOSHIP TO PATIENT	POLICY HOLDER'S DATE OF BIRTH
	□ Self □ Spouse □ Dependent	_ _ / _ _ / _ _ _ _

MEDICAL HISTORY

WHAT IS YOUR REASON FOR TODAY'S VISIT?

PHARMACY NAME: _____ **PHONE:** _____

LIST CURRENT MEDICATIONS

Name of Medication	Dose	Frequency

PAST AND CURRENT MEDICAL CONDITIONS (Check all that apply)

□ Diabetes □ High Blood Pressure □ Heart attack □ Coronary Disease

□ Kidney Failure/ Disease □ Kidney Stones

□ High Cholesterol □ Organ Transplant – type_____ □ Cancer - _____

□ Hepatitis □ Liver Failure □ Irritable Bowel Disease (IBS) □ Inflammatory Bowel Disease (Chron's/UC)

□ Stroke □ Parkinson's Disease □ Spinal Cord Injury

□ Acid Reflux □ COPD □ Asthma □ Lung Infections

Please provide any details to further explain your past and current medical conditions:

*I give permission to Matthew S. Fine M.D. or Amanda Bibbings PA-C, to administer medical treatment to me and authorize the release of all medical information necessary for my treatment.

*I authorize the release of my medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to go directly to South Florida Surgical Specialists, LLC. I authorize photocopies of this form to be valid as the original.

*By signing below, you are giving permission to be contacted via the Internet by South Florida Surgical Specialists and to receive text messages at the number provided.

*Payment is expected when services are rendered.

Name: _____Sign: _____ Date: _____

PAST SURGICAL HISTORY	
Type of Surgery	**Hospital and Date**

FAMILY HISTORY (Check all that apply)

Has anyone in your family had:

□ Cancer? – _____

□ Stroke? – If yes, who? _____ □ Diabetes? – If yes, who? _____

□ Heart disease? – If yes, who? _____ □ High blood pressure? – If yes, who? _____

□ Kidney failure - If yes, who? _____ □ Kidney stones? – If yes, who?

□ Other? – please explain: _____

SOCIAL HISTORY (Check all that apply)

What is your occupation?

What is your marital status? Married Single Divorced Widowed

ALCOHOL: Do you drink alcohol? Never Occasionally Everyday
If every day how many? _____

TOBACCO: Do you smoke? Never Used to, quit Current Smoker
If Yes, how many packs per day? _____ Since when? ____
If you are a former smoker, when did you quit? _____
Use any non-smoking tobacco products (gum, chew) _____

DRUGS: Any previous drug or alcohol dependence? □ No □ Yes

REVIEW OF SYSTEMS

Constitutional	**Eyes**	**Ears/Nose/Throat/Mouth**
Chills □ Yes	Blurred vision □ Yes	Ear infection □ Yes
Fevers □ Yes	Vision Loss □ Yes	Hearing loss □ Yes
Fatigue □ Yes	Glaucoma □ Yes	Sore throat □ Yes
Weight loss □ Yes	Cataracts □ Yes	Sinus problems □ Yes
Other:	Other:	Other:
Cardiovascular	**Pulmonary**	**Gastrointestinal**
Heart trouble □ Yes	Wheezing □ Yes	Abdominal pain □ Yes
Chest pain □ Yes	Cough □ Yes	Nausea/vomiting □ Yes
Ankle swelling □ Yes	Shortness of breath □ Yes	Indigestion/heartburn □ Yes
Fainting □ Yes	Coughing up blood □ Yes	Rectal bleeding □ Yes
Other:	Other:	Other:
Genitourinary	**Musculoskeletal**	**Integumentary**
Incomplete emptying □ Yes	Arthritis □ Yes	Skin rash □ Yes
Leakage of urine with coughing, sneezing, or laughing □ Yes	Neck pain □ Yes	Changes to moles □ Yes
	Back pain □ Yes	Itchy Skin □ Yes
Leakage of urine with severe urge to urinate □ Yes		Hives □ Yes
Other:	Other:	Other:
Neurological	**Psychological**	**Endocrine**
Severe headaches □ Yes	Are you depressed? □ Yes	Too cold □ Yes
Numbness □ Yes	Have severe anxiety? □ Yes	Hot flashes □ Yes
Nerve tingling □ Yes		Too thirsty □ Yes
Dizziness/Vertigo □ Yes	Have you ever considered suicide?	Steroid use □ Yes
Weakness □ Yes	□ Yes	Thyroid condition □ Yes
Other:	Other:	Other:

Hematologic/Lymphatic	**Allergic/Immunologic**
Bruising Easily □ Yes	Hay fever □ Yes
Bleeding problems □ Yes	HIV exposure □ Yes
Blood clotting □ Yes	Seasonal allergies □ Yes
Swollen glands □ Yes	Drug/food allergies □ Yes

Allergies to medications:	If yes, what happened?

Is there anything else that you would like to discuss today?

_____

_____

_____

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Consent to Treat

During your treatment with Matthew S. Fine M.D. or Amanda Bibbings PA-C it may be necessary to contact you regarding your appointments, surgery, or medical condition.

Please list family members or friends you authorize us to speak with if we cannot contact you. *Without this authorization, we are prohibited by law from answering any questions regarding your appointments, surgery, or medical condition*. This rule applies to spouses, children, parents, and other immediate family members.

I, _____, hereby authorize the office of

Matthew S. Fine M.D. and Amanda Bibbings PA-C to contact

_____

_____

or to leave a message at my home or office. There are/are no exceptions to the above.

Exceptions: _____

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Signature _____ Date _____

Witness _____

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CONSENT FOR PARTICIPATION

BY RESIDENTS AND/OR MEDICAL STUDENTS

I have been informed that Dr. Matthew Fine and Amanda Bibbings PA-C, have been appointed to the clinical faculty of the Broward Health – Nova Southeastern University, College of Osteopathic Medicine and have the rank of Clinical Instructor to Professor Dr. Matthew Fine and Amanda Bibbings PA-C; may, from time to time, request that the resident's and or medical students under his supervision participate in my care.

Please Check Below:

_____ **I hereby** consent to such participation by residents or medical students in my care.

_____ I **do not** consent to such participation by residents or medical students in my care and treatment.

Please Print Your Name: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Practice uses health information about you for treatment, to obtain payment for treatment, for operations and for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record, either electronic or paper, that is the physical property of the Practice. Your health information is referred to in this Notice as information or health information. This Notice is provided to tell you about our duties and practices with respect to your health information.

Practice Obligations:

The Practice is required by law to:

- maintain the privacy of protected health information;
- provide you with this Notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this Notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; and
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

The Practice reserves the right to change its privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. The Practice reserves the right to make the changes in its privacy practices and policies and the new terms of its Notice are effective for all health information that the Practice maintains, including health information the Practice created or received before the Practice made the changes. Before the Practice makes a significant change in its privacy practices, the Practice will change this Notice and make the new Notice available upon request.

Use or Disclosure of Your Health Information:

For Treatment: The Practice may use and disclose your health information to other health care providers, physicians, or facilities, involved in your care and treatment, in order to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment: The Practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: The Practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the Practice, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- conducting training programs;
- accreditation, certification, licensing, or credentialing activities;
- assess the quality of care and outcomes in your case and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

To Your Family and Friends: The Practice must disclose your health information to you, as described in the Patient Rights of this Notice. The Practice may disclose your health information to a family member, friend, or any person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that the Practice may do so.

Persons Involved in Care: The Practice may use and disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your general condition, or death. If you are present, then object to such uses or disclosures. In the event of your incapacity or emergency circumstances, the Practice will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. The Practice will also use its professional judgment and its experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Appointments: The Practice may use or disclose your information to provide appointment reminders, including telephone messages or voicemail messages, or emails, at telephone numbers or email addresses that you gave to the Practice.

Fund Raising: The Practice may use your information about you, including your name, address, telephone number, and dates of service, in order to contact you to raise funds for the Practice. If you do not want the Practice to contact you for this purpose, you must notify the COO of the Practice, in writing, and indicate that you do not want to be so contacted.

Required by Law: The Practice may use and disclose information about you as required by federal, state, and local law. For example, the Practice may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority.
- to report information related to a victim of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, reporting vital statistics such as death, or for other health oversight activities.

Abuse or Neglect: The Practice may use or disclose your health information to appropriate authorities if the Practice reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim in other crimes. The Practice may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: If you are an organ donor, your health information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: The Practice may use your health information for research purposes after an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety: Your health information may be used or disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be used or disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services including for national security purposes.

Workers Compensations: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Law Enforcement: As permitted or required by law, the Practice may disclose your health information to a law enforcement official for certain law enforcement purposes, such as reporting certain types of wounds and other physical injuries; pursuant to a court order, warrant, subpoena or summons; for identifying or locating a suspect, fugitive, material witness, or missing person; under certain limited circumstances if you are the victim of a crime; if we believe your death was the result of criminal conduct; and in an emergency to report a crime.

Your Authorization: In addition to the Practice's use of your health information for treatment, payment, or healthcare operations, you may give the Practice written authorization to use your health information or to disclose it to anyone for any purpose. Your written authorization is required to release your health information if it contains psychotherapy notes, is for marketing purposes, or is for the sale of your health information. Release of your health information for any reason not set forth in this Notice may only occur after you give written authorization. If you give the Practice authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give the Practice a written authorization, the Practice cannot use or disclose your health information for any reason except those in those Notice.

Marketing Health-Related Services: The Practice will not use your health information for marketing communications without your written authorization.

Other uses: Other uses and disclosure will be made only with your written authorization, and you may revoke the authorization except to the extent the practice has taken action in reliance on such.

Your Health Information Rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that the Practice provides copies in a format other than photocopies. The Practice will use the format you request unless the Practice cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain the authorization form to request access by using the contact information listed at the end of this Notice. The Practice may charge you a reasonable cost-based fee for expenses, such as copies, CDs, thumb drives, staff time, and postage. You may also request a copy by sending us a letter to the address at the end of this Notice. If you prefer, the Practice will prepare a summary or an explanation of your health information for a fee. Contact the Practice using the information listed at the end of this Notice for a full explanation of the Practice's fee structure.

Disclosure Accounting: You have the right to receive a list in which the Practice or its business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, the Practice may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that the Practice places additional restrictions on its use or disclosure of your health information. The Practice is not required to agree to these additional restrictions unless it is for disclosure of health information to a health plan or insure for purposes of payment or healthcare operations, is not otherwise required by law, and you or someone on your behalf other than the health plan or insurer has paid the Practice in full for its services.

Alternative Communication: You have the right to request that the Practice communicates with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that the Practice amend your health information. Your request must be in writing, and it must explain why the information should be amended. The Practice may deny your request under certain circumstances. If the Practice denies a request for an amendment, you or your representative has the right to file a

statement of disagreement to the denial, and your request for amendment, the Practice's denial of the request, and your statement of disagreement, if any, shall be included in any future disclosures of such health information.

Electronic Notice: If you receive this Notice on the Practice's website or by electronic mail (e-mailed), you are entitled to receive this Notice in written form.

Questions and Complaints:

If you want more information about our privacy or have questions or concerns, please contact the Practice.

If you are concerned that we have violated your privacy rights, or you disagree with a decision the Practice has made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternate means it at alternative locations, you may complain to us by using the contact information listed at the end of this Notice, You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated and we will provide you with the address for such communication. You will not be retaliated against for filing a complaint.

By signing this document, I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. You may refuse to sign this acknowledgment.

_____	_____	_____
Name (Print)	Signature	Date

The Practice Use Only

Date acknowledgement received: _____

Individual refused to sign: _____ (check if applicable)

An emergency situation prevented the Practice from obtaining acknowledgment: _____(check)

Other reason acknowledgement was not obtained: _____
_____

Practice Employee:

Signature: _____

Print Name: _____

Date: _____