South Florida Surgical Specialists, LLC
General & Laparoscopic Surgery
Surgical Oncology

South Florida Surgical Specialists, LLC
General & Laparoscopic Surgery * Surgical Oncology
Diplomates American Board Of Surgery

Mark S. Shachner, MD., F. A. C. S. * Bernard J. Zaragoza, M. D., F. A. C. S.
Niranjan J. Shintre, M. D., F. A. C. S. * Melvin E. Pann, M. D., F. A. C. S

Patient: _____
Last Name **First** **M.I**

Address: _____

_____
City **State** **Zip Code**

Home phone: _____ **SS#:** _____

Date of birth: _____ **Age:** _____

Patient's Employer: _____ **Occupation:** _____

City of Employment: _____ **Phone #:** _____

Spouse's Name: _____ **Spouse's DOB:** _____

Spouse's Employer: _____ **Phone #:** _____

Nearest Relative: _____ **Phone #:** _____

Referred by: _____ **Primary Physician:** _____

Primary Insurance: _____ **ID#:** _____ **Group:** _____

Address: _____

******If you are NOT the primary policy cardholder, WE NEED the following information*******
Primary Cardholder name: _____ **DOB:** _____ **SSN:** _____

Secondary Insurance: _____ **ID#:** _____ **Group:** _____

***I give permission to Mark S. Shachner, M.D., F.A.C.S/ Bernard J. Zaragoza, M.D., F.A.C.S Niranjan N. Shintre, M.D., F.A.C.S or Melvin E. Pann, M.D., F.A.C.S to administer medical treatment to me and authorize the release of all medical information necessary for my treatment.**

Sign: _____

***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.**

Sign: _____ **Date:** _____

***By signing below you are giving permission to be contacted via Internet by South Florida Surgical Specialists,**

Sign: _____ **Email Address:** _____

Payment is expected when services are rendered

*****PLEASE SUPPLY BELOW <u>emergency</u> phone numbers so that we may contact in case of an emergency. These numbers are not to include home or work*****

1. _____ **2.** _____

3001 Coral Hills Dr. Suite 320 Coral Springs, Florida 33065
Office 954-755-0111 Fax 954-755-2209

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Melvin E. Pann, M.D., F.A.C.S.

Date: _____ DOB: _____

Last Name: _____ **First Name:** _____ **M.I.**_____

Reason for visit: _____

Medical problems:_____
_____
_____

Past Surgery:
Surgery name with date (year): _____
_____
_____

Medications/vitamins/over the counter daily: _____
_____
_____
_____
_____

Drug Allergies: _____
_____
_____

Tobacco Use:
Did you ever smoke cigarettes YES____ NO_____ (If no, please skip to Alcohol use)
Current Every Day Smoker? Yes____NO___ Current some day smoker? Yes___ NO____
Former Smoker? Yes___ NO___ When did you quit?_____ # of years smoking_____
Smoke Socially Yes___ NO_____Smokeless tobacco use? YES___ NO___

Alcohol Use:
Do you drink alcohol? YES___ NO____ If yes, how much?_____
Never Drinks alcohol? YES___ NO____ Quit drinking alcohol Yes___ NO If yes, when?_____

Vaccinations:
Influenza immunization? YES__ NO__ If yes, When (Month & Year) _____
Pneumonia vaccination? YES__ NO__ If yes, When (Month & Year) _____
COLONOSCOPY: _____(within the past 3years) please provide date
PAP SMEAR: _____ (within the past 3years) please provide date

MAMMOGRAM: (DATE)_____ **WHERE:**_____
RESULTS OF MAMMO:_____

Please check the spaces below that pertains to you. Have you recently experienced:

Constitutional __weight changes, __ fever, __fatigue	__None of these
Eyes __ visual changes, __ pain	__None of these
Ears, Nose & Throat __sore throat, __sinus trouble, __ nose bleeds	__None of these
Cardiovascular __chest pain, __ palpitations, __ leg cramps	__ None of these
Respiratory __ cough, __shortness of breath, __ wheezing	__ None of these
Gastrointestinal __abdominal pain, __constipation, __ bloody or dark stools	__None of these
Genitourinary__pain with urination, __ frequent urination at night	__None of these
Musculoskeletal __arthritis, __limitation of movement	__None of these
Skin __rash, __lumps, __bruises	__None of these
Neurological __fainting, __headaches, __numbness	__None of these
Psychiatric __depression, __ panic attacks	__None of these
Endocrine __thyroid problems, __ hot flashes	__None of these
Hematological __ bleeding problems, __ anemia	__ None of these
Allergy/Immunology __ Steroid use, __hives, __ HIV	__ None of these

PLEASE CIRCLE ONE IF YOU ARE A NEW PATIENT TO THE PRACTICE. IF NOT, PLEASE IGNORE:

Race (circle one): Alaskan Native, American Indian, Asian, African American, Hispanic or Latino, Indian, Native Hawaiian, Caucasian, White Hispanic, Refuse to report

Ethnicity (circle one): Hispanic or Latino, Non Hispanic or Latino, Refuse to Report

OFFICE USE ONLY (PLEASE DO NOT COMPLETE BELOW LINE)

****

Patient Weight:_____ Patient Height:_____Blood Pressure: _____/_____ (R/L)

Primary Care Physician:_____

Referring Physician:_____

OBGYN:_____

Other Physicians:_____

Doctor Reviewed Document

Physician Signature:_____

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Patient name:_____

Today's date:_____

Medical history in IMMEDIATE family (grandparents, parents, siblings, children)

- Alcoholism? YES___ NO___ Who? _____
- Anemia? YES___ NO___ Who? _____
- Anxiety? YES___ NO___ Who?_____
- Arthritis? YES___ NO___ Who?_____
- Cancer? YES___ NO___ Who?_____
- Cataracts? YES___ NO___ Who?_____
- Diabetes? I or II YES___ NO___ Who?_____
- Hyperlipidemia YES___ NO___ Who?_____
- HTN? YES___ NO___ Who?_____
- Kidney Stones YES___ NO___ Who?_____
- Stroke YES___ NO___ Who?_____

Doctor Reviewed Document
Physician Signature: _____

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SOUTH FLORIDA SURGICAL SPECIALISTS, LLC
Dr.'s Shachner, Zaragoza , Shintre and Pann
3001 Coral Hills Drive Suite 320
Coral Springs, Fl. 33065

Consent to Treat

In the course of your treatment with Shachner and Zaragoza, M. D., P. A., it may be necessary to contact you regarding your appointments, surgery or your medical condition. Please list family members or friends that you authorize us to speak with if we are unable to contact you. ***Without this authorization we are prohibited by law to answer any questions regarding your appointments, surgery or medical condition.*** This rule applies to spouses, children, parents and any other immediate family members.

I, _____, hereby authorize the office of

South Florida Surgical Specialists, LLC, Dr. Shachner, Dr. Zaragoza, Dr. Shintre, Dr. Pann to contact

_____

_____

or to leave a message at my home or office. There are / are not 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.'s Mark S. Shachner; Dr. Bernard J. Zaragoza; Dr. Niranjan J. Shintre, and Dr. Melvin E. Pann 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.'s Mark S. Shachner; Dr. Bernard J. Zaragoza; Dr Niranjan Shintre and Dr. Melvin E. Pann 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.

_____
Date

_____
Signature

_____
Please Print Your Name

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MEDICATION HISTORY CONSENT FORM

I, _____, hereby authorize the office of South Florida Surgical Specialists, LLC to E-Prescribe medications as well as view my medication history.

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

Signature _____ Date _____

Print _____

Witness _____

PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW

PHARMACY NAME: _____

PHONE NUMBER OR LOCATION: _____

_____

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor, Copayments, coinsurance and deductibles are due at the time of service. We only accept cash or Visa, Master card, Discover, or American Express. **We do NOT accept checks.**
Should the account not be paid, the patient assumes all cost of collection, including, but not limited to court costs, interest and legal fees.

REGARDING INSURANCE

We will accept assignment of insurance benefits; however we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you provide us with complete and accurate date. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. If your insurance company has not paid your account in full within 45 days you will be responsible for the balance. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurance.
Exceptions to the above policy are restricted to the plans for which Dr. Shachner/Dr. Zaragoza/ Dr. Shintre/ Dr. Pann are contracted providers (e.g. certain HMO's & PPO's). You will be responsible for all required co-payments and deductibles at the time of service. You will also be responsible for payments for procedures not covered by your insurance company, or procedures performed for pre-existing conditions if not covered by your policy. We will assist with obtaining authorizations for all procedures; however, pre-authorizations are not a guarantee of payment by your insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates

MISSES APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of normal office visits. Please help us serve you better by keeping scheduled appointment.

SURGERY

Once confirmed, surgery dates and times CANNOT be rescheduled for any reason except failure to be medically cleared. At the discretion of the surgeon a **$250.00** rescheduling fee will be applied.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and understand and agree to this Financial Policy.

_____ _____

Signature of patient or responsible party Date

SOUTH FLORIDA SURGICAL SPECIALISTS, LLC (the "Practice")
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

The Practice uses health information about you for treatment and to obtain payment for treatment for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the Practice. Your health information is referred to in this Notice as information or 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 discloses;
- 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 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 or physicians 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 medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- conducting training program;
- 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 indentifying 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 prior to use or disclosure of your health information, the Practice will provided you with an opportunity to 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 at telephone numbers which you gave to the Practice.

Fund Raising: The Practice may use your information to contact you to raise funds for the Practice.

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

- for judicial and administrative proceeding pursuant to legal authority;
- to report information related to 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, or for other health oversight activities.

Abuse or Neglect: The Practice may use or disclosed 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: 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 specializing 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.

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. If you give the Practice an 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 format to request access by using the contact information listed at the end of this Notice. The Practice will charge you a reasonable cost based fee for expenses, such as copies and staff time. You may also request address by sending us a letter to the address at the end of this Notice. If you request copies, the Practice will charge you $_____ For each page and $_____ per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request a alternate format, the Practice will charge a cost based fee for providing your health information in that format. 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 request.

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, but if the Practice does, it will abide by its agreement (except in an emergency).

Alternative Communication: You have the right to request that the Practice communicates with you about your health information by alternative means or to alternative location. You must make you request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation 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.

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.

You have the right to:

- request a restriction on certain uses and disclosures or your information as provide by 45 C.F.R. §164.522; however, the Practice is not required to agree to a requested restriction;
- obtain a paper copy of this Notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- request your health record be amended as provided in 45 C.F.R. §164.26;
- request communications of your health information by alternative means or at alternative locations; and
- receive a accounting of disclosure made of your health information as provided by 45 C.F.R. §164.258

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 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.

Contact Information:

Contact: South Florida Surgical Specialists, LLC
Address: 3001 Coral Hills Dr, Suite 320
Coral Springs, FL 33065
Telephone: (954) 755-0111
Fax: (954) 755-2209

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ACKNOWLEDGEMENT OF RECEIPT OF THE PRACTICE'S
NOTICE OF PRIVACY PRACTICES

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 acknowledgement.

_____	_____	_____
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 acknowledgement: _____(check)

Other reason acknowledgement was not obtained: _____

_____

Practice Employee:

Signature: _____

Print Name: _____

Date: _____