Welcome! Thank you for selecting our healthcare team. We will strive to provide you with the best possible healthcare. To help us meet your entire healthcare needs, please fill out this form completely in ink. If you have any questions or need further assistance please ask us. We are happy to help.

PATIENT INFORMATION

(*Please Print Patient's Complete Legal Name*)

PATIENT NAME: _____ MI ____ LAST_____

ADDRESS: _____ UNIT# _____

CITY/STATE/ZIP: _____

HOME PHONE # (include area code): _____ CELL: _____

EMAIL ADDRESS: _____

NORTHERN ADDRESS

ADDRESS: _____ UNIT# _____

CITY/STATE/ZIP: _____

HOME PHONE # (include area code): _____ CELL: _____

SOCIAL SECURITY: _____ GENDER: MALE / FEMALE

BIRTHDATE: _____/_____/_____ RACE: _____ ETHNICITY: HISPANIC ____

NON-HISPANIC_____ PRIMARY LANGUAGE: _____

MARITAL STATUS: DIVORCED _____ MARRIED _____ SINGLE _____ WIDOWED _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP _____

EMERGENCY PHONE NUMBER (include area code): _____

LOCAL PRIMARY CARE PROVIDER: _____

REFERRING PHYSICIAN: _____

PATIENT EMPLOYER/SCHOOL INFORMATION

NAME OF EMPLOYER/SCHOOL: _____

(Circle one) Full-time Part-Time Self-employed Unemployed

INSURANCE INFORMATION

**** PLEASE COMPLETE THE FOLLOWING IF THE POLICY HOLDER IS NOT THE PATIENT ****

*** Medicare Patients: Please complete if the patient is not the holder of secondary insurance ***

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO POLICY HOLDER: (Check One) Self _____ Spouse _____ Child _____

DATE OF BIRTH: _____ / _____ / _____ GENDER: MALE _____ FEMALE _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

SOCIAL SECURITY #: _____ EMPLOYER NAME: _____

By signing below, I acknowledge the following:

1. I hereby authorize this provider to treat me.
2. I hereby attest that the personal and financial information given show is true and that my personal identification or insurance information has not been falsified.
3. I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the provider(s) and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of my medical information to release to the centers for Medicare and its agents, or any other third party liability or insurance center, any information needed to determine these benefits or the benefits payable for the related services.
4. I have received and understand all the information as the second page of this document, including the HIPPA notice of Privacy of Practice Statement as indicated with my signature and date below.

Signature: _____ Date: _____

RESPONSIBLE PARTY:

Who is responsible for the account?

Name: _____

Relationship to patient: _____

Birthdate: _____ / _____ / _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Home Number: _____ Work Number: _____

Cell Number: _____ Fax Number: _____

AUTHORIZE AND RELEASE:

I authorize the release of any information including the diagnosis and records of any treatment or examination on my child or me during the periods of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits due and payable for my care. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all co-pays and deductible for all services rendered on my behalf.

Signature of Patient and/or Parent of Minor:

X _____ Date: _____

Minor's name _____

FINANCIAL ARRANGEMENTS:

For your convenience we offer the following methods of payment. Please check the option of payment you prefer. Payment is due in full at each appointment.

CASH: ____ PERSONAL CHECK: ____ VISA or MASTERCARD: ____

I wish to discuss the office's payment policy: _____

LATE CHARGES:
If I do not pay the entire balance within 25 days of the monthly-billed date, a late charge of 15% of the balance of the unpaid and owed will be assessed each month (allowed by law). I realize that failure to keep this account current may result in me being unable to obtain additional services except for emergencies or where there is prepayment for additional services. In case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in an attempt to collect on this amount or any future outstanding account balance.

THANK YOU for your cooperation. The information you have provided will help us to serve your healthcare needs.

Joseph G. Spano, M.D., P.A.
Internal Medicine, Gastroenterology
130 Tamiami-Trail North, Suite 130
Naples, Florida

HIPPA Notice of Privacy Practices Acknowledgement & Authorization

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to provide you with our Notice of Privacy Practice which explains our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask that you authorize when, and to whom, your protected health information can be released.

May we leave a detailed message on your home answering machine? YES _ NO _

May we phone you at work and leave a message to call our office back? YES _ NO _

Do we have your permission to talk to family members or other individuals? YES _ NO _

If ***YES***, please provide the names, phone numbers, and relation to you:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

ALL RESULTS ARE COMMUNICATED TO THE PATIENT VIA PHONE UNLESS OTHERWISE SPECIFIED.

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices of Joseph G. Spano, M.D., P.A. and have been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

Signature: _____ Date: _____

Joseph G. Spano, M.D., P.A.
Internal Medicine, Gastroenterology
130 Tamiami Trail North, Suite 130, Naples, Florida
(239) 263-4470

Please review the Financial Policy and separate Notice of Privacy Practices documents carefully. To avoid any misunderstanding regarding either policy, it is necessary for you to read both pages and sign before treatment is rendered. Please ask us any questions you may have regarding either document and take this copy herein for future reference if necessary.

Our Financial Policy

Insurance: Patients will be asked to present their insurance with driver's license to the receptionist for copying upon check-in at the office each time you are seen at the office. Please bring insurance card with you each time you visit the office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans in which we ARE participating providers, all co-payments are due at the time of service. We will file the insurance claim with the insurance company. For those patients covered by insurance plans in which we ARE NOT participating providers, or patients without insurance coverage, we require payment in full at time of service and we will file the insurance claim with your insurance company as a courtesy.

Any charges that are not paid by your insurance company are your responsibility. Your insurance policy is a contract between YOU and the insurance company. Any pre-certification of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

Medicare Patients: We are participating providers with Medicare. This means that you will be responsible for the 10% of the Medicare fee for covered services, the current yearly deductible and full payment of any non-covered services.

Payment/Co-payment is due at time of service. Payment is due in full at the time of service, unless you are covered by Medicare or an insurance company with which we participate. You will be charged a $30 service fee for any returned checks.

Acknowledgement of Notice of Privacy Practices Statement

I have been given the opportunity to review Joseph G. Spano, M.D.'s Notice of Privacy Practices prior to signing this acknowledgement. The office of Joseph G. Spano M.D. reserves the right to revise its Notice of Privacy Practices at any time.

By signing the following pages, I hereby acknowledge that Joseph G. Spano M.D. may use and disclose my protected health information to carry out treatment, payment, and healthcare operations. The office's Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization. Joseph G. Spano, M.D. is authorized to use my personal information to secure payment for services rendered and will comply with all reasonable measures to follow the FTC guidelines regarding identify theft.

I may make restrictions to the use and disclosure of my protected healthcare information or revoke a previous request for restrictions at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both requests for Restriction and Revocations must be in writing. By signing these pages of this document I am acknowledging that I have received the office's Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If Joseph G. Spano, M.D. determines that my restrictions make it impossible to for them to carry out my treatment, payment, and healthcare operations, they may refuse to accept me as a patient.

Joseph G. Spano, M.D., P.A.
130 Tamiami Trail North, Suite 130
Naples, Florida 3102-6233
Telephone: (239) 263-4470 * Fax: (239) 403-1655
INTERNAL MEDICINE * GASTROENTEROLOGY
DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE

CONSENT FOR RELEASE OF MEDICAL RECORDS

Date: _____

Dear Dr. _____:

_____ has recently seen me in consultation.

I would appreciate it very much if you would send me his/her medical history and any information you think may be useful to me. If you have any questions concerning this request, please contact my office at (239) 263-4470. You will find a signed consent form below.

I hereby authorize:

Doctor of Facility Name: _____

Address: _____

City: _____State: _____ Zip: _____

To release to Dr. Joseph G. Spano, M.D. my medical history, laboratory reports, and other materials regarding medical consultations and treatment I received. My records should be under the following name:

First: _____ **Middle:** _____ Maiden: _____

Last: _____ **Date of Birth:** _____ / _____ / _____

Patient Signature: _____

Consent is valid for one year from the date of signature.

Yours truly,

Joseph G. Spano, M.D.