Marco Island Medical Center
Patient Demographic Form

Patient Information

Name: _____
Last First Middle

Date of Birth_____ Age _____ SSN:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ E-Mail: _____

Florida Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Northern Address: _____ Apt #: _____

City _____ State: _____ Zip Code: _____

Sex: [ ] M [ ] F **Marital Status** [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Other

Emergency Contact/Relation: _____Phone: _____

Reason for Visit: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Were you injured at work? ____Yes ____No If yes , date of Injury_____

Insurance Information

If under the age of 65, are you on Medicare Disability? _____

- Primary Insurance: _____

Name of Insured: _____

Policy #: _____ Group#: _____ Relation to Patient: _____

Date of Birth of Insured: _____

- Secondary Insurance: _____

Name of Insured: _____

Policy #: _____ Group#: _____ Relation to Patient:_____

Date of Birth of Insured: _____

Insurance Authorization, Treatment, and Financial Responsibility

For Medicare Patients:

I authorize the physician and/or staff of Joseph Vickaryous D.O., PA (DBA Marco Island Medical Center) to release to the Social Security Administration, Health Care Financing Administration of its intermediaries or carriers and/or the above named Medigap insurer any information needed for this or any Medicare, and/or Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurances either to myself or to the party who accepts Regulation pertaining to Medicare assignment of benefits apply. I understand signing this authorization may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare. I also understand that I am responsible for any balance deemed my responsibility by supplemental insurer if applicable

Signature: _____ Date: _____

Signature of patient, parent, guardian, or personal representative: _____

For PPO/POS/ HMO Patients:

I authorize the physician and/or staff of Joseph Vickaryous DO, PA (DBA: Marco Island Medical Center) to release to my insurance company or its representatives any information including the diagnosis and records of any treatment or examination rendered to me during medical and surgical care. I authorize and request my above named insurance company to pay directly to Joseph Vickaryous DO, PA (DBA: Marco Island Medical Center) the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Signature: _____ Date: _____

For all Patients:

I understand that I am financially responsible for all services rendered in the office and issued refunds will be returned to the same credit card used and/ or check provided from the office.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

Patient Name: _____ Date:_____
Date of Birth: _____Current Age: _____Referred By: _____
If under the age of 65, are you on Medicare Disability? _____
Reason for Today's Visit: _____
Preferred Pharmacy: _____ Phone: _____
Social History:
Do you smoke or chew tobacco? [ ] Yes [ ] No If yes, how many packs per day_____
Former smoker? [ ] Yes [ ] No If yes, for how many years_____
Do you drink alcohol, beer or wine? [ ]Yes [ ] No If yes, how much per day_____
Do you use recreational drugs? [ ] Yes [ ] No If yes, list the names and quantity_____
Marco Island Resident? [ ]Full Time [ ] Part Time [ ]Other: _____
Family History:

	Living	Age	Serious illness
Mother	[ ] Yes [ ] No	_____	_____
Father	[ ] Yes [ ] No	_____	_____
Brothers	[ ] Yes [ ] No	_____	_____
Sisters	[ ] Yes [ ] No	_____	_____

Personal Medical History

1. Have you ever been a patient in a hospital during the past two years? [ ] Yes [ ] No
   If yes, for what reason? _____
2. Are you allergic to penicillin or any drugs or medicines? [ ] Yes [ ] No
   If yes, what allergies? _____
3. Have you ever been under the care of a physician in the last 2 years? [ ] Yes [ ] No
   Name of Physician _____ Date of last Exam: _____
4. Have you ever been pregnant, if yes how many times? _____
   Vaginal? _____C-Section? _____Hysterectomy? _____Tubal Ligation? _____

Do you have or have you had any of the following- PLEASE CIRCLE YES OR NO:

Yes/No	Allergies (Seasonal)	Yes/No	Diabetes	Yes/No	Low Blood Pressure
Yes/No	Anemia	Yes/No	Epilepsy	Yes/No	Migraine/Headache
Yes/No	Anxiety	Yes/No	GERD	Yes/No	Neurologic Problems
Yes/No	Arthritis	Yes/No	Glaucoma	Yes/No	Pacemaker
Yes/No	Asthma	Yes/No	Hearing Loss	Yes/No	Psychiatric Problems
Yes/No	Back Problems	Yes/No	Heart Attack	Yes/No	Sinus Issues
Yes/No	Cancer: _____	Yes/No	Hepatitis	Yes/No	SOB (Shortness of Breath)
Yes/No	Cholesterol High	Yes/No	High Blood Pressure	Yes/No	Swollen Ankles
Yes/No	COPD	Yes/No	HIV/AIDS	Yes/No	Thyroid Disease
Yes/No	Dementia	Yes/No	Kidney Disease	Yes/No	Tuberculosis
Yes/No	Depression	Yes/No	Liver Problems	Yes/No	Urinary Issues

Surgical History; please list below or mark NONE:
_____
_____
_____

Please List all Medications you are currently using, ATTACH A LIST or MARK NONE:

Name	Dosage	Times per Day

Vaccines(Immunizations) please write in DATE or MARK N/A:

PNEUMONIA:_____FLU: _____ TETANUS:_____ SHINGLES:_____

DATE DATE DATE DATE

Marco Island Medical Center

Acknowledgement of Receipt Of HIPPA Notice of Privacy Practices

_____
Printed Patient Name

_____ _____ _____
Signature of Patient Signature Of Representative Date

If the patients' representative's signature appears above, please describe relationship to the patient:

_____

Marco Island Medical Center

Office Policy

Missed Appointment Policy

Marco Island Medical Center has to put into effect a $**45.00 fee for patients who do not show** for scheduled appointments. Our practice requests that you call and provide us with **at least 24 Hrs in advanced to cancel an appointment** and avoid this charge. Appointment times are very important to our patients as well as our providers. When a patient fails to keep their appointment, this time goes unused. Even on a relatively short notice another patients could have made use of your appointment time. By implementing the **"NO SHOW**" fee, it is our goal to make as many appointments available to our patients as possible, by encouraging all patients to keep their appointments

Insurance:

It is the patient's responsibility to verify that their insurance is current and in-network with Marco Island Medical Center and its providers. Patients are responsible to keep their insurance information current with the administrative staff of Marco Island Medical Center. **If the failure to do so results in the rejection of a filed-claim, Marco Island Medical Center will charge the patients a billing fee of $60.00.**

In any case the private insurance/ PIP insurance carrier rejects a claim the patient will be held responsible for the full charge amount of incurred expenses.

Payment Methods

- Credit Cards/Debit Cards
- Visa MasterCard Discover AMEX
- Checks
  - **No Travlers Checks**
  - **No Checks accepted in Office as form of payment , ONLY for outstanding account balance payments**
  - **We charge a $35.00 fee for each returned check and all incurred bank NSF fee.**
  - ***ALL COPAY'S, DED, AND CO-INS ARE DUE BEFORE SERVICES ARE RENDERED***

Prescription Refills:

For your convenience we take the request for prescription refills over the phone through **Monday-Thursday**.

Please allow for 24 hours for prescription refill request to be processed.

Prescription refill requests made on Friday will be processed on the following Monday.

Procedure Consent:
While under the care of Dr. Vickaryous and Marco Island Medical Center, I consent to biopsy, cryosurgical procedures, and injections as recommended by the providers and verbal consent will be obtained prior to performing any of the above procedures.

Patient Name: _____

Patient Signature: _____ Date: _____

Marco Island Medical Center
Authorization for Use of Disclosure of Information
I request and authorize Joseph Vickaryous DO (DBA Marco Island Medical Center) located at 531 Bald Eagle Drive Marco Island, FL 34145
Phone (239)393-2000 Fax (239)393-0355

[ ] Receive the following information from (Doctor's Name/ Clinic/ Hospital/Other/City, State, Zip):
_____ Phone No: _____
_____ Fax No: _____

Specifically describe the information to be used or disclosed, including but not limited to, meaningful descriptors such as date of service provided, level of detail to be released origin of information, etc.

_____

_____

This is the protected health information and is being used or disclosed for the following purposes: (List specific purposes here, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)

[ ] Insurance [ ] Attorney [ ] Personal Review [ ] Continued Care by other health care provider
[ ] School [ ] Disability [ ] Other: _____

I understand and agree that the information I am authorizing to be released may include:

1. AIDS/ HIV test results, diagnosis, treatment and related information
2. Drug screening results and information about drug and alcohol use and treatment
3. Mental health information and/or
4. Genetic testing

Unless otherwise requested: _____

This authorization shall be forced and in effect until further notification by patient or patients representative. I understand that, as set forth in the Marco Island Medical Center Notice of Privacy Practice, I have the right to revoke this authorization, in writing, at any time by sending the written notification to Marco Island Medical Center. I understand that revocation is not effective to the extent that the clinic has relied on the use or disclosure of protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that the clinic will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that I have the right to:

1. Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
2. Refuse to sign this authorization

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

_____	_____	_____
Print Patient Name	Date of Birth	Patient SSN
_____	_____	_____
Signature of Patient	Print Name of Patient Representative	Date

PLEASE NOTE OUR OFFICE DOES NOT PAY FOR ANY MEDICAL RECORDS