ELIAS A. FEANNY, M.D., P.A.

CORAL REEF MEDICAL BUILDING PARK 2

9275 SW 152ND STREET #101 MIAMI, FL. 33157

PHONE (305)2538869 FAX (305)2339726

DATE: _____

ALLERGIES: _____

NEW PATIENT INFORMATION

Name: _____

(First) (Middle) (Last)

Date of Birth: _____/_____/_____ *Age:* _____ *Marital Status:* _____

(MM) (DD) (YYYY) (S/M/D/W)

Permanent Address: _____

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

Telephone Number: HOME: (_____) _____ *CELL (____)* _____

**Email:*_____

Race (circle all that apply): -American Indian/Alaska Native -Asian -Black/African-American -White -Native Hawaiian/Pacific Islander -Hispanic/Latino -Other

Occupation: _____ *Employer/School* _____

Business Address: _____

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

RELATIVE INFORMATION / EMERGENCY CONTACT

(**Please give a different phone number than above, if possible!!)

Relative Name: _____ *Relation:* _____

Address: _____

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

Telephone Number: HOME: (_____) _____ *CELL (____)* _____

INSURANCE INFORMATION (**Only fill out if no card provided)

Name of Insurance Co: _____ *Phone: (____)* _____-_____

Contract, Policy, or ID NO: _____ *Group #* _____

Is this Insurance an HMO or PPO? Yes _____ NO _____

Do you have other Insurance? Yes _____ NO _____

X_____

PLEASE SIGN HERE

- *What is your current height? _____ft. ____in.*
- *What is your current weight? _____ Lbs.*
- *Have you had any serious illness or operations in the past? □ yes □ no*

  If yes, please list dates: _____
- *Has there been a change in your general health with in the past year? □ yes □ no*
- *Are you under any treatment by your previous physician? □ yes □ no*

  If yes, please explain: _____
- ***Please check any of the following that you have or have had in the past:***
  - *Rheumatic fever, valvular heart disease, heart murmur, or congenital heart disease*
  - *Heart attack or angina*
  - *High blood pressure or stroke*
  - *Heart failure, irregular heart beat or other heart conditions or surgery*
  - *Chest pain, shortness of breath, or ankle welling*
  - *Asthma, bronchitis, emphysema, pneumonia, TB, or chronic cough*
  - *Seizures, fainting spells, or blackouts*
  - *Gastrointestinal disease, ulcers, colitis, or other G.I. disease*
  - *Hepatitis or liver disease*
  - *Hemophilia or other bleeding abnormality*
  - *Anemia, sickle cell disease, or other blood disorder*
  - *Nose bleeds, or ease bruising*
  - *Diabetes, thyroid, kidney, or adrenal disease*
  - *Arthritis, rheumatism, muscular dystrophy, or other muscle disorder*
  - *Venereal disease*
  - *Immunologic problems, organ transplants, or HIV infections*
  - *Cancer*
  - *Glaucoma*
  - *Alcohol or drug abuse*
- ***Please check any of the following medications that you have taken in the past:***
  - *Cortisone*
  - *Prednisone*
  - *Thyroids pills*
  - *Coumadin*
  - *Warfarin*
  - *Blood thinners*
  - *Diuretics*
  - *Digozin*
  - *Inderal*
  - *Aminophyline*
  - *Theo-Dur*
  - *Insulin*
  - *Other diabetic medications*
  - *Tranquilizers*
  - *Nerve pills*
  - *Other breathing pills*
  - *Inhalers*
  - *Other heart pills*
  - *Ventolin*
- ***Please list all the medications that you are currently taking:***

_____

_____

_____

- *Are you allergic to anything? □ yes □ no*

  If yes, please list: _____
- *Do you smoke? □ yes □ no*

  If yes, how much? _____
- *Do you wear contact lenses? □ yes □ no*
- *Have you had general anesthetic before? □ yes □ no*

  If yes, please explain: _____
- *Have you or any member of your family had any adverse reaction to an anesthetic?*
- ***Women:*** *Are you pregnant? □ yes □ no*
- *Do you have any disease, conditions, or problem not listed above that the doctor should know about? □ yes □ no*

  If yes, please explain: _____

X_____ _____

Patient or Guardian Signature ***Date***

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CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION TO FAMILY MEMBERS OR FRIENDS

I hereby allow and give consent for the following family member(s), personal friend(s) or health care surrogates to accompany me in the exam room during my visit. I also consent the release of Medical Records or discussions of my health information with the physician.

	FULL NAME	***RELATION***	***PHONE #***
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

X_____ _____

Patient or Guardian Signature ***Date***

X_____ _____

Witness Signature ***Date***

Living Will

(Optional)

Declaration made this _____ day of _____

(Day) (Month) (Year)

I, _____ voluntarily make know my desire that my dying not artificially prolonged under the circumstances set forth below and I do hereby declare that if at any time I am both mentally and physically incapacitated,

- *_____ and I have a terminal condition or*
  (Initials)
- *_____ I have an end-stage condition or*
  (Initials)
- *_____ I am in a persistent vegetative state*
  (Initials)

and if my attending or treating physician and another consulting physician have determined that there are medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedure would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication deemed necessary to provide me with comfort care to alleviate pain.

It is my intention that this declaration be honored by my family and my physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate as my surrogate to carry the provisions of this declaration:

Full Name: _____

Address: _____

_____

Phone # (___) ____-_____ Cell # (___) ____-_____

X_____ _____

Patient or Guardian Signature ***Date***

X_____ _____

Witness Signature ***Date***

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and rights concerning your health information. We must follow the privacy practice that are described in this Notice while it is in effect. This Notice takes effect January 1, 2012 and will remain in effect until we replace it.

We reserve the right to change our privacy practice and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our practices, or for additional copies of this Notice, please contact us using the information listed at the end for this Notice.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment payment and healthcare operations. For example:

Treatment: *We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.*

Payment: *We may use and disclose your health information to obtain payment for services we provide to you.*

Healthcare Operations: *We may use and disclose your health information in connection with our health care operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs accreditation, certification, licensing or credentialing activities.*

Your Authorization: *In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information for to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use o disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.*

To your family and friends: *We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.*

Persons involved in care: *We may use or 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 location, you general condition, or death. If you are present the prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of you incapacity or emergency circumstances, we 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. We will also use our professional judgment and dour 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.*

Marketing health-related services: *We will not use your health information for marketing communications without your authorization.*

Required by law: *We may use or disclose your health information when we are required to do so by law.*

Abuse or Neglect: *We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We 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 other.*

National Security: *We may disclose your health information to provide you with appointment reminders (such as voicemail messages).*

Patient Rights:

Access: *You have the right to look at or get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-base fee for expenses such as copies. You may also request access by sending us a letter to the address at the top of this Notice. If you request copies, we will charge you $1.00 for each page.*

Contact us using the information listed at the top of this Notice for a full explanation of our fee structure.

Alternative Communication: *You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location or request.*

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended) We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practice or have questions or concerns, please contact us or if you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend to restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative location, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services and Human Services upon request. We support you right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health Services.

Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have read the (Notice of Privacy Practice)
(PRINT FULL NAME) and can request a copy upon request at any time.

X_____ _____
Patient or Guardian Signature *Date*

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Summary of the Florida's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full ext of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- ✓ *A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.*
- ✓ *A patient has the right to prompt and reasonable response to questions and requests.*
- ✓ *A patient has the right to know who is providing medical services and who is responsible for his or her care.*
- ✓ *A patient has the right to know what patient support services are available, including whether and interpreter is available if he or she does not speak English.*
- ✓ *A patient has the right to know what rules and regulations apply to his or her conduct.*
- ✓ *A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.*
- ✓ *A patient has the right to refuse any treatment, except as otherwise provided by law.*
- ✓ *A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.*
- ✓ *A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.*
- ✓ *A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charge for medical care.*
- ✓ *A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.*
- ✓ *A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.*
- ✓ *A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.*
- ✓ *A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.*
- ✓ *A patient has the right to express grievances regarding any violation of his or her rights as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her to the appropriated state licensing agency.*
- ✓ *A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete in formation about present complaints, past illnesses, hospitalizations, medications, and other matters relating to this or her health.*
- ✓ *A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.*
- ✓ *A patient is responsible to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.*
- ✓ *A patient is responsible for following the treatment plan recommended by the health care provider.*
- ✓ *A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.*
- ✓ *A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.*
- ✓ *A patient is responsible for assuring that the financial obligation of his or her health care are fulfilled as promptly as possible.*
- ✓ *A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.*

***X*_____ _____**

Patient or Guardian Signature ***Date***

***X*_____ _____**

Witness Signature ***Date***

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

(For hospitals and specialists to send records to your primary physician)

Date: _____

To: _____

Phone: _____ Fax: _____

I hereby authorize you to release records to:

ELIAS A. FEANNY, M.D., P.A.
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9275 SW 152ND STREET #101 MIAMI, FL. 33157
PHONE (305)2538869 FAX (305)2339726

Copies of my medical records in you possession, concerning my illness and / or my treatment, as indicated below:

_____

Dates of Service: _____

Please indicate if the records (MAY INCLUDE) the following:

YES ____ NO ____ Psychiatric or mental health illness
YES ____ NO ____ Drug and alcohol abuse records
YES ____ NO ____ HIV, AIDS Test/Diagnosis, or related conditions
YES ____ NO ____ (Women) Abortion records

I release Dr. Elias A. Feanny M.D., P.A. of all responsibility for loss of confidentiality access and / or copies of records released in compliance with this authorization.

Patient Name: _____
Address: _____
Date of Birth: _____

Patient Signature: _____ ***Date:*** _____

Witness Signature: _____ ***Date:*** _____

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Authorization to Send Your Records to Specialists or Other Companies Upon Request

Patient Name: _____ *Date: _____*
Previous Name: _____

1. ***My Authorization***

You may use or disclose the following health care information (check all that applies):

- *All my health information maintained by the above-named practice*
- *My health information relating to the following treatment or condition: _____*
- *My health information for the date(s): _____*
- *Other: _____*

You may disclose this health information to:

Name (or title) and organization: _____
Address: _____ City _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- *At my request*
- *Other (specify) _____*

This authorization ends:

- *On (date) _____*
- *When the following event occurs _____*

2. ***My Rights***

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- *Fill out a revocation form. The form is available from the office.*

~ or ~

- *Write a letter to the office.*

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature: _____ ***Date: _____***

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E-SCRIPTS

Please help us send your prescription electronically.

Please fill out your pharmacy information.

Patient's Name: _____ *DOB:* _____

*Pharmacy Name*_____

*Pharmacy Phone Number (if known):*_____

Pharmacy Address (crossroad estimate is fine):

_____