Michael G. Casagrande, MD
Family & Sleep Medicine

PATIENT DEMOGRAPHICS

Patient's Full Name: _____

Date of Birth: _____ Social Security Number: _____

Cell number: _____ Work/Other number: _____

E-mail for Health Portal: _____

Home Address: _____

_____

Gender: _____ Male _____ Female Marital Status: _____ Married ____ Single _____ Other

Spouse/SO name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Employer: _____ Phone: _____

INSURANCE INFORMATION

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

Guarantor's Name: _____ Gurantor's DOB: _____

Claims Address: _____

_____

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

Guarantor's Name: _____ Gurantor's DOB: _____

Claims Address: _____

_____

OTHER INFORMATION

Preferred Pharmacy: _____ Phone: _____

Address: _____

_____

How did you hear about us? *(please explain)* _____

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PATIENT MEDICAL HISTORY

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data. Please fill out ALL these pages to the best of your knowledge, this is an important part of your medical history and will help us understand the concerns you would like to talk to the doctor about. Please also give your primary and secondary insurance cards and ID/ Driver's License to copy for our records. Thank you!

Patient Name: _____

Patient Date of Birth: _____ **Today's Date:** _____

If patient has a guardian, please list guardian's name and date of birth: _____

_____

What would you like to talk to your doctor about today? _____

_____

MEDICAL HISTORY

Please list any medication allergies or reactions: _____

_____

Please check if you have ever had or currently have:

- ☐ Allergies
- ☐ Arthritis
- ☐ Blood Disorder
- ☐ Cholesterol disorder
- ☐ Diabetes
- ☐ Kidney disorder
- ☐ Stroke/ Paralysis
- ☐ Headaches/Dizziness
- ☐ Lung Disease
- ☐ High blood pressure
- ☐ HIV/ Hepatitis
- ☐ Depression
- ☐ Skin problems
- ☐ Asthma
- ☐ Anemia
- ☐ Breathing problems
- ☐ Hearing problems
- ☐ Heart Disease
- ☐ Seizures/ Tremors
- ☐ Digestive disorder
- ☐ Thyroid Disease (hypo or hyper): _____
- ☐ STD (type): _____
- ☐ Cancer (type): _____
- _____
- ☐ Eye problems (type): _____
- _____
- ☐ Other (explain): _____
- _____
- _____

Please list all medications and natural supplements you are currently taking, along with dosages if possible.
Medication Name: *Dosage:*

What pharmacy do you use for your prescriptions? *(list address and phone number)* _____

Are you currently being cared for by any other healthcare professionals? If yes, whom and what are they treating you for so we can coordinate your care.
Provider's name: *Condition being treated:*

Please list any surgeries or hospital stays and the approximate date/year. (You may write on the back for more room.)
Type of surgery/ reason for hospitalization/ location: *Date:*

If you have any other medical problems or injuries not listed, please describe: _____

When was your last physical? _____

Please note the dates of your recent immunizations:

Tetanus _____ Hepatitis A/B _____

Pneumonia _____ Prevnar 13 _____

Influenza _____ Shingles _____

If you have had the following tests, note when they were done and what the results were, if known.

Test:	*Approx date:*	*Result:*
Cholesterol		
Pap smear/ pelvic		
Mammogram		
Blood in stool		
HIV		
Colonoscopy		
Hepatitis		

FAMILY HISTORY

Please check any diseases that run in your family and note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Please note any relatives that are deceased or any other comments:

SOCIAL HISTORY

Do you smoke or use tobacco products *(what and how often)***?** _____

Do you drink alcohol *(what and how often)***?** _____

Have you used any other drugs *(what and how often)***?** _____

Are you currently married or living with a significant other? _____ **Yes** _____ **No**

Are you employed or a student? _____ **No** _____ **Yes:** *(specify)*_____

Do you exercise more than 2 times a week? _____ **Yes** _____ **No**

In the past year, has there been any major changes to your life? *(ex: marriage, divorce, death, illness or injury, or change in job situation)* _____ **No** _____ **Yes:** *(specify)*_____

SEXUAL HISTORY

Are you sexually active? _____ **Yes** _____ **No**

Do you feel at risk for HIV/AIDS? _____ **Yes** _____ **No**

Do you have any children? _____ **No** _____ **Yes:** *(how many?)*_____

Do you use any type of birth control? _____ **No** _____ **Yes:** *(specify)*_____

Have you ever been pregnant? _____ **No** _____ **Yes:** *(specify)*_____

Do you have menstrual periods? If so, are they regular? _____ **No** _____ **Yes:** *(specify)*_____

PREFERRED METHOD OF CONTACT

<u>You must leave contact information for all these categories, just check the box of your preferred.</u> I authorize the disclosure and use of my health information, and prefer the office to communicate information about my health by:

☐ **Phone number:** _____ _____ **Cell** _____ **Work/Home**

☐ **E-mail for Health Portal:** _____

☐ **Home Address:** _____

_____

You may send a detailed message about my health information; such as labs, test results, appointments, and or any personal health information. _____ **Yes** _____ **No**

Patient/guardian Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICE

I understand that under the Health Insurance Portability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information (PHI).

I understand that Dr. Michael G. Casagrande, MD may use or disclose my PHI for treatment, payment, or health care operations, which means providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of the information without my authorization.

Dr. Michael G. Casagrande, MD has a detailed document called the "Notice of Privacy Practices" which contains more complete description of my rights to privacy and how the office may use and disclose PHI.

I understand that I have the right to read the Notice and Dr. Michael G. Casagrande, MD will provide me with the most current Notice of Privacy Practices.

By signing below I understand I have been given the choice to review the Notice of Privacy Practices. I agree to allow Dr. Michael G. Casagrande, MD to use and disclose my PHI to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing, at any time, except to the extent that Dr. Michael G. Casagrande, MD has taken action relying on this consent.

Patient/guardian Signature: _____ **Date:** _____

Printed patient name: _____

Relationship of guardian to patient: _____

☐ I do not want a copy of the Notice of Privacy Practice.

☐ I do want a copy of the Notice of Privacy Practice.

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AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I hereby authorize and consent to the use or disclosure of information from the medical record of:

Patient Name: _____ **Date of Birth:** _____

For the purpose of: _____

I authorize the following individual(s) or organization(s) to disclose the patient's individual's health information:

_____ Address: _____

_____

This information may be disclosed TO and used by the following individual(s) or organization(s):

_____ Address: _____

_____

Please release the following:

- ☐ Entire Medical Record
- ☐ Problem List
- ☐ X-Ray/Imaging Reports: from (date) _____ to _____
- ☐ History/Physical Exam
- ☐ Laboratory Results: from (date) _____ to _____
- ☐ Medication List
- ☐ EKG Reports
- ☐ Immunization Record
- ☐ Genetic Testing Information
- ☐ List of Allergies
- ☐ Other (Specify) _____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at (281) 357-1934.

_____ _____

Patient or Guardian Signature Date

MEDICAL OFFICE ONLY

Date request completed_____ # pages copied_____ Reviewed only_____

Charges $_____ Cash_____ Check #_____ Initials_____

Please fax back to Dr. Casagrande MD at (281) 803-5298

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY

In accordance with the Health Insurance Portability Act of 1996 (HIPAA), we must know it there is anyone you do and do not want your physician/provider or our staff to disclose about your medical information to. However, in an emergency or critical situation these rules will be waived.

☐ I **DO** authorize the practice to release any and all information concerning my medical care to the following family members or guardians listed below.

Name: _____ **Phone:** _____
Relationship: _____
Information: *(circle one)* Billing Appointment Medical/Health

Name: _____ **Phone:** _____
Relationship: _____
Information: *(circle one)* Billing Appointment Medical/Health

☐ I **DO NOT** authorize the practice to release any and all information concerning my medical care to the following family members or guardians listed below.

Name: _____ **Phone:** _____
Relationship: _____
Information: *(circle one)* Billing Appointment Medical/Health

Name: _____ **Phone:** _____
Relationship: _____
Information: *(circle one)* Billing Appointment Medical/Health

I understand this request supersedes any prior request for communication of information I may have made.

Patient/guardian Signature: _____ **Date:** _____

Printed patient name: _____

Relationship of guardian to patient: _____

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FINANCIAL POLICIES

PAYMENT DUE AT TIME OF SERVICE
You are responsible for providing insurance, demographic and/or financial changes prior to being seen by physician or provider. If you fail to provide and inform the office with this information you will be responsible for all charges incurred.

As a courtesy, we file your claim to your insurance company. However, you are responsible for any portion not covered by your insurance; such as co-payments, deductibles or coinsurance. Payment is due at the time of service, unless financial arrangements have been made in advance. If prior financial arrangements have not been made, you will be asked to reschedule your appointment. Your insurance is a contract between you and your insurer. You are still responsible for payment of services regardless of the amount your insurance pays.

STATEMENT BALANCE REMAINING
Payment is due upon receipt of statement(s) from our billing office. Two statements will be sent for any balances. If we receive no response, our office will make one final attempt to reach you for unpaid balances. If we are unsuccessful in reaching you, your account will be referred to an outside collection agency. A fee of $50.00 or 40%, whichever is greater, will be charged to your account. This balance policy applies to family members within your immediate family. You will be discharged from our care unless balance is paid in full.

If you are unable to make payment in full for any balance(s) upon receipt of our statement, please contact our billing office immediately. We will make every effort to establish a mutually agreed-upon payment plan.

SELF PAY
If you choose not to use your insurance benefits, or have any out of network insurance plans, you will be charged the self-pay rate. You are not entitled to the contracted insurance rate. An estimated payment is required prior to being seen by physician or provider. We will estimate the charge of your visit based on information you provide. Any labs, testing, or ancillary services performed are an additional charge and will be due at check out. Dr. Casagrande, MD is NOT a network provider on any Affordable Care Act Plans.

FORMS
If you require a form to be filled out by our physician or NPs (i.e. FMLA, Disability, School, Camp, Handicap Placards, etc.) there is a $30 charge, per form. The fee must be paid prior to the completion of the form. Please allow up to 15 business days for completion of the form. We make every effort to complete the form as soon as possible.

FEES
A charge of $40 will be added to your account for any returned checks. If a check is returned, we will no longer accept this form of payment, we will accept cash, credit or debit card only. There is also a $40 charge for each medication requiring a prior authorization. If you wish to still use the medication, payment will be due before the authorization will be processed.

I authorize Michael G. Casagrande, MD to use and disclose and information needed to process my claim.

Patient/guardian Signature: _____ **Date:** _____