ALVARO R. BADA, M.D.

LAST NAME ________________ FIRST____________ MI__________

ADDRESS____

CITY ________________________ STATE__________ ZIP__________

PHONE NUMBERS

HOME ____

CELL____

WORK ____

RACE ___________ LANGUAGE______________ HISPANIC_____

EMAIL ADDRESS ______________________ NON HISPANIC ______

REFERRING PHYSICIAN__________________________________

DATE OF BIRTH____________ SS#__________________ M____ F_____

WORK ADDRESS____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

NAME_____________________________ PHONE_________________

INSURANCE GUARANTOR _________________________________

NAME___________________________________ DOB___________

*******IMPORTANT NOTICE!!*********

I FULLY UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN A REFERRAL/ AUTHORIZATION FOR THIS VISIT IF IT IS REQUIRED BY MY INSURANCE COMPANY. IF A REFERRAL/ AUTHORIZATION IS NOT OBTAINED, I UNDERSTAND THAT I MAY BE NECESSARY TO RESCHEDULE THIS APPOINTMENT OR I WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR SERVICES RENDERED.

I AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION THAT MAHY BE NECESSARY TO OBTAIN REIMBURSMENT FROM MY INSURANCE CARRIER(S). I REQUEST THAT PAYMENT OF BENEFITS BE MADE TO THE PART WHO ACCPTS ASSIGNMENT.

PATIENT SIGNATURE_____________________________

Name:

PATIENT PHARMACY DESIGNATION FORM

NAME OF PHARMACY ______________________________

CITY WHERE PHARMACY IS LOCATED__________________

STREET WHERE PHARMACY IS LOCATED

____

ALL LINES MUST HAVE AN ANSWER

ALVARO R. BADA, M.D., F.A.C.S.

PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. THIS INFORMATION WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

TODAY"S DATE____/____/____ DATE OF LAST PHYSICAL EXAM___/____/____

LAST NAME______________________FIRST NAME____________________MI____

SOCIAL SECURITY______-______-_______ DATE OF BIRTH_____/_____/_____

WHAT IS THE REASON FOR YOUR VISIT TODAY? PLEASE DESCRIBE:

HISTORY OF PRESENT ILLNESS:

LOCATION OF THE PROBLEM____

ON A SCALE OF 1 TO 10, WITH 10 BEING THE MOST SEVERE, PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PROBLEM 1 2 3 4 5 6 7 8 9 10

WHEN DID YOU FIRST NOTICE THE PROBLEM? ____________________________

HOW LONG DOES THE PROBLEM LAST? __________________________________

IS THE PROBLEM CONSTANT OR VARIABLE? ______________________________

IS ANY THING ELSE OCCURRING AT THE SAME TIME?

NAUSEA RASH HEADACHES OTHER ___________________________________

DOES ANYTHING MAKE THE PROBLEM WORSE?

MOVING AROUND STANDING LYING ON YOUR SIDE OTHER_________________

HAVE YOU HAD A COLONOSCOPY? _________ DATE:___________

HAVE YOU HAD A MAMMOGRAM? __________ DATE:___________

HAVE YOU HAD YOUR BLOOD WORK DONE RECENTLY? ____________________

____

Name:

PAST MEDICAL & SOCIAL HISTORY

1. LIST ANY PAST ILLNESSES AND DATES THEY OCCURRED:

____

____

____

2. LIST ANY PAST SURGERIES AND DATES THEY OCCURRED:

____

____

____

3. DO YOU SMOKE? YES___ NO___

CURRENT EVERY DAY _______ HOW MUCH? ____________

CURRENT SOME DAY _______ HOW MUCH? ____________

FORMER _______ NEVER ____________

4. DO YOU DRINK ALCOHOL? YES___ NO___

IF YES: SOCIAL___________OCCASIONAL________RARE_______

5. PLEASE LIST ALL SERIOUS ILLNESSES/DISEASES IN YOUR IMMEDIATE FAMILY: (EXAMPLE: CANCER, DIABETES, HEART DISEASE ETC.)

____

____

____

6. ARE YOU ON ANY MEDICATIONS? PLEASE INCLUDE ANY OVER THE COUNTER MEDICATIONS/VITAMINS AS WELL:

____

____

____

DO YOU HAVE ANY ALLERGIES?

____

____

Name:

REVIEW OF SYMPTOMS

DO YOU NOW HAVE ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS:

FEVER	Y	N
CHILLS	Y	N
HEADACHE	Y	N

EYES:

BLURRED VISION	Y	N
DOUBLE VISION	Y	N
EYE PAIN	Y	N

OTHER______________________

ALLERGIC/IMMUNOLOGIC:

HAY FEVER	Y	N
DRUG ALLERGY	Y	N

OTHER______________________

NEUROLOGICAL:

TREMORS	Y	N
DIZZY SPELLS	Y	N
NUMB/TINGLING	Y	N

OTHER______________________

ENDOCRINE:

EXCESSIVE THIRST	Y	N
TOO HOT/COLD	Y	N

GASTROINTESTINAL :

ABDOMINAL PAIN	Y	N
NAUSEA/VOMITING	Y	N
INDIGESTION/HEARTBURN	Y	N

OTHER ______________________

CARDIOVASCULAR :

CHEST PAIN	Y	N
VARICOSE VEINS	Y	N

INTEGUMENTARY:

SKIN RASH	Y	N
BOILS	Y	N
PERSISTENT ITCH	Y	N

OTHER______________________

MUSCULOSKELETAL :

JOINT PAIN	Y	N
NECK PAIN	Y	N
BACK PAIN	Y	N

EAR/NOSE/THROAT/MOUTH:

EAR INFECTIONS	Y	N
SORE THROAT	Y	N
SINUS PROBLEMS	Y	N

OTHER ______________________

GENITOURINARY:

URINE RETENTION	Y	N
PAINFUL URINATION	Y	N
URINARY FREQUENCY	Y	N

RESPIRATORY:

WHEEZING	Y	N
SHORTNESS OF BREATH	Y	N
FREQUENT COUGH	Y	N

HEMATOLOGICAL/LYMPHATIC:

SWOLLEN GLANDS	Y	N
BLOOD CLOTTING	Y	N

OTHER ______________________

PSYCHOLOGIC:

SEVERE DEPRESSION	Y	N
SATISFIED WITH LIFE	Y	N
SUICIDAL THOUGHTS	Y	N

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ______________________________ have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

Person/s you wish to receive any or all your medical records

______________________________ Date ______

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other dis closures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 2.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Most sharing of psychotherapy notes '
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
We typically use or share your health information in the following ways.
We can use your health information and share it with other professionals who are treating you.
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. We do not share your information via any Electric Exchanges.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting suspected abuse, neglect, or domestic violence

Do research
Comply with the law
Respond to organ and tissue donation requests
Work with a medical examiner or funeral director
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Alvaro Bada, M.D.
HIPAA Compliance Officer: Beverly Bada (Office Manager)
941-255-0069

Effective Date: July 1, 2014

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Alvaro R. Bada, M.D., P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alvaro R. Bada, M.D., P.A., provides at no cost aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters, written information in other formats (large print, audio, accessible elec. formats, other formats). Provides at no cost language services to people whose primary language is not English, such as: qualified interpreters; information written in other languages. If you need these services please tell our front desk or any staff member.

If you believe our practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator: Beverly Bada, 18308 Murdock Circle, Suite 101, Port Charlotte, Florida 33948, 941-255-0069. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

Proficiency of Language Assistance Services

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, are available to you.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

ه الصم والبكم: .رقم برقم اتصل .لمجانبا لك تتوافر ةىاللغو المساعدة خدمات فإن ،اللغة اذكر تتحدث كنت إذا :ملحوظة

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod Numer.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

تم دیریبگ. شما یبرا گانیرا بصورت یزبان لاتیتسه ،دیکن یم گفتگو یفارس زبان به اگر :توجه

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche.