PATIENT INFORMATION SHEET

Patient Name: _____
Address: _____**City**:_____**State:** _____**Zip Code:**_____
Mailing Address: (If different): _____
Primary Phone: _____ **Secondary Phone:** _____
Primary Language: _____ **Email Address:** _____
Social Security Number: _____ **Date of Birth**: _____**Sex:** □ Male / □ Female
Primary Care Physician: _____
Pharmacy: _____

Relationship Status: □ Single / □ Married / □ Divorced / □ Widowed / □ Life Partner
Race: □ White / □ African American / □ Asian / □ American Indian Alaska Native / □ Hawaiian Native Pacific Islander / □ Other _____ / □ REFUSE TO STATE (As Required By The Law)

Hispanic – Latino Ethnicity: _____ Yes _____No / _____ Refuse To State (As Required By The Law)

ADVANCE CARE PLANNING AND ADVANCE DIRECTIVES

_____ Caregiver (CG) / _____ Living Will (LW) /_____ Power Of Attorney (POA) / _____ Surrogate Decision Maker Identified (S) / _____ Advanced Directive Present (Y) / _____ Do Not Resuscitate (DNR) /) No Advance Directive Opted (None Of The Above) (N)

INSURANCE INFOMATION

Primary Insurance _____**Primary Policy Holder:** Self / Spouse / Child
Card Holder Name _____ **Date of Birth:** _____
Secondary Insurance _____**Primary Policy Holder:** Self / Spouse / Child
Card Holder Name _____**Date of Birth:** _____

PERSON TO CONTACTR IN CASE OF EMERGENCY

Name: _____ **Phone:** _____ **Relationship:** _____

Can we release medical information to this person? _____**Yes** _____ **No**

NOTICE OF HIPPA PRIVACY PRACTIVE

A copy of this office Notices of Privacy Practices has been provided to me.
Signature: _____ **Date**: _____

To whom may we disclose your medical information (pathology, labs, instructions, or post-procedure results?)

Full name: _____**Phone Number:** _____

Full name: _____**Phone Number:** _____

The above information is true to the best of my knowledge. I understand that if you participate with my insurance, I am responsible to pay my copayment and any unpaid balance as your patient. Insurance Prior Authorization approval certification for office visit and/or procedure does not guarantee of payment. If you do not participate with my insurance, I will be required to pay the entire visit charge ($150 first visit, and $50 each follow-up visit.) I understand that you accept cash, check, MasterCard, Visa, American Express and Discover as a form of payment.

Patient Signature: _____ **Date**: _____

MEDICATION LIST

Patient Signature: _____ **Date:** _____

NAME OF MEDICATION	STRENGTH	HOW MANY TIMES DAILY
Example: **ASPIRIN**	**81mg**	**Once a day**

Questionnaire for Latex Sensitivity

1. Sex: ☐ Male ☐ Female

2. Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other: _____

3. Have you ever been told by a doctor that you are allergic to latex? ☐ Yes ☐ No

4. How many surgeries have you had in the past? _____

5. Do you suffer from any of the following?

a) Seasonal hay fever ☐ Yes ☐ No
b) Asthma ☐ Yes ☐ No
c) Eczema ☐ Yes ☐ No
d) Autoimmune disease ☐ Yes ☐ No

6. Do you have on-the-job exposure to latex? ☐ Yes ☐ No

7. Were you born with problems involving your spinal cord? ☐ Yes ☐ No

8. Do you catheterize yourself to urinate? ☐ Yes ☐ No

9. Do you have food allergies? ☐ Yes ☐ No

10. Are you allergic to any of the following?

a) Bananas ☐ Yes ☐ No
b) Avocados ☐ Yes ☐ No
c) Guacamole ☐ Yes ☐ No
d) Chestnuts ☐ Yes ☐ No

11. Are you allergic to latex or products containing rubber? ☐ Yes ☐ No

If yes, are your symptoms any of the following?

a) Rash ☐ Yes ☐ No
b) Hives ☐ Yes ☐ No
c) Itching ☐ Yes ☐ No
d) Wheezing ☐ Yes ☐ No
e) Difficulty breathing ☐ Yes ☐ No
f) Watery eyes ☐ Yes ☐ No
g) Anaphylaxis ☐ Yes ☐ No

12. Do you have allergic symptoms while:

a) Blowing up balloons? ☐ Yes ☐ No
b) During dental examinations? ☐ Yes ☐ No
c) On Contact with diaphragms/condoms? ☐ Yes ☐ No
d) During vaginal or rectal exams? ☐ Yes ☐ No
e) While wearing rubber gloves? ☐ Yes ☐ No

_____ _____

Signature of Patient Date

JOSEPH J. KATTA M.D. P.A

GASTROENTEROLOGY

1900 NEBRASKA AVE STE #4 - #5, FORT PIERCE, FL 34950

PHONE: (772) 466-7200 **FAX: (772) 466-0218**

□ JOSEPH J. KATTA, M.D.
□ ROBERT S. EPSTEIN, M.D.
□ JESSICA SADLEY, MSN, APRN, AGACNP-BC
□ JACQUELINE NURSE, MSN, APRN, FNP-BC
□ VALERIA NIETO-GONZALEZ, MSN, APRN, FNP-BC

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

TO: _____

PHONE: _____ FAX: _____

I HEREBY AUTHORIZE YOU TO RELEASE MY INFORMATION INCLUDING DIAGNOSIS AND RECORDS OF MY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD

FROM _____ TO _____.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____

REQUESTING PROVIDER: KATTA **/** SADLEY **/** NIETO GONZALEZ **/** NURSE **/** EPSTEIN

PLEASE RETURN THIS FORM WITH RECORDS REQUESTED

OFFICE LOCATIONS:

FORT PIERCE 1900 NEBRASKA AVE STE 4-5 FORT PIERCE, FL 34950 PHONE : (772) 466-7200 **FAX : (772) 466-0218**	**ST LUCIE WEST** 306 NW BETHANY DR PORT ST. LUCIE, FL 34952 **PHONE:** (772) 878-1475 **FAX : (772) 878-1497**	**PORT ST LUCIE** 1700 HILLMOOR DR SUITE 402 PORT ST. LUCIE, FL 34986 PHONE : (772) 236-5757 **FAX : (772) 236-5758**

JOSEPH J. KATTA M.D. P.A

GASTROENTEROLOGY

Appointment/Cancellation/No Show Policy

Appointments:

Office visits are by appointment only, please call (772) 466-7200. The receptionist may ask about the reason for your visit. This helps us schedule the doctors' time more efficiently. Please arrive 10 minutes before your appointment. Patients who arrive late for any appointment may be asked to reschedule at the physician's discretion. Remember to bring all your prescriptions, over-the-counter medications, vitamins, and supplements to every visit. This will enable your doctor to review the medication at each visit.

Cancellations:

We would like to thank you for being a patient at our practice. We value all of our patients and strive to provide the best possible care in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your specific needs. We kindly ask that if you need to change your appointment, give us at least a 24 hours' notice. This courtesy allows us to offer your reserved time to another patient who may need it. We know your time is valuable. When you schedule an appointment, a room is reserved for you and your records are prepared for the visit. Except in cases of emergency treatment for another patient, you can expect us to run on schedule. If this is not possible, please call as soon as you can so that another patient may be given your appointment time.

Missed appointments (Non-Cancelled)

We understand that appointments may occasionally be missed for various reasons. However, when you miss an appointment without canceling, another person could have used that time, and your spot goes unused unnecessarily. We keep track of missed (non-canceled) appointments. A "No-Show/Late Cancellation" is defined as missing an appointment without canceling at least 24 hours before the scheduled time. There will be a charge for missed or non-canceled appointments. Insurance does not cover no-show or late cancellation fees. The $25 fee is in addition to any other charges incurred. Refunds will not be given. Repeated missed appointments may result in your doctor sending you a "discharging you from the practice letter". We will provide 30 days of emergency-only care and will transfer your medical records once you have established care with a new provider.

Payment:

Payment is due in full at the time of service. No exceptions.

_____ _____

Patient Signature: Date:

JOSEPH J. KATTA M.D. P.A

FORT PIERCE	ST LUCIE WEST	PORT ST LUCIE
1900 NEBRASKA AVE STE 4-5	306 NW BETHANY DR	1700 HILLMOOR DR SUITE 402
FORT PIERCE, FL 34950	PORT ST. LUCIE, FL 34952	PORT ST. LUCIE, FL 34986
PHONE : (772) 466-7200	**PHONE:** (772) 878-1475	PHONE : (772) 236-5757
FAX : (772) 466-0218	**FAX : (772) 878-1497**	**FAX : (772) 236-5758**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TI THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable 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 your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notices takes effect (04-14-03), and will remain in effect until we replace It.

We reserve the right to change our privacy practices 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 practices 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 privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES 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 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 healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification 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 authorizations in use of your health information or 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 or 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 notifications of (including Identifying or location) a family member, your personal representatives or another person responsible for your care, of your location, your general condition, or death. If you are present, then 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 your 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 persons involvement in your healthcare. We will also use our professional judgment and our 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.

JOSEPH J. KATTA M.D. P.A

□ **JOSEPH J. KATTA, M.D.**
□ **ROBERT EPSTEIN, M.D.**
□ **JESSICA SADLEY, MSN, APRN, AGACNP-B**
□ **JACQUELINE NURSE, MSN, APRN, FNP-BC**
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GASTROENTEROLOGY

1900 NEBRASKA AVE STE #4 - # 5, FORT PIERCE, FL 34950
PHONE : (772) 466-7200 FAX : (772) 466-0218

Acknowledgement of Receipt of Notice of HIPPA Privacy Practices

PURPOSE: This form is used to obtain your acknowledgment of receipt of our *Notice of Privacy Practices* or to document our good-faith effort to obtain that acknowledgment.

***** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT ******

I, _____, have received a copy of this office's *Notice of Privacy Practices*.

Patient Signature: _____ Date: _____

To whom may we disclose your medical information to (pathology, instructions, or post-procedure results)?

_____

Name: Relationship: Phone:

_____

Name: Relationship: Phone:

May we leave results on your answering machine or voicemail? ☐ Yes ☐ No

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our *Notice of Privacy Practices*, but

acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify): _____

_____

_____

JOSEPH J. KATTA M.D. P.A

FORT PIERCE 1900 NEBRASKA AVE STE 4-5 FORT PIERCE, FL 34950 **PHONE** : (772) 466-7200 **FAX : (772) 466-0218**	**ST LUCIE WEST** 306 NW BETHANY DR PORT ST. LUCIE, FL 34952 **PHONE:** (772) 878-1475 **FAX : (772) 878-1497**	**PORT ST LUCIE** 1700 HILLMOOR DR SUITE 402 PORT ST. LUCIE, FL 34986 **PHONE** : (772) 236-5757 **FAX : (772) 236-5758**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

☐ JOSEPH J. KATTA, M.D. ☐ ROBERT S. EPSTEIN, M.D.

☐ JESSICA SADLEY, MSN, APRN, AGACNP-B ☐ JACQUELINE NURSE, MSN, APRN, FNP-BC

☐ VALERIA NIETO-GONZALEZ, MSN, APRN, FNP-BC

to release my medical records to include all progress notes, diagnostic studies and consult notes to:

Doctor / Facility / Company: _____

Address: _____

Fax: _____ Phone #: _____

Other: _____

Patients Name: _____ DOB: _____

_____ _____

Patients Signature / Power of Attorney: Date:

JOSEPH J. KATTA M.D. P.A

☐ JOSEPH J. KATTA, M.D.

☐ ROBERT S. EPSTEIN, M.D.

☐ JESSICA SADLEY, MSN, APRN, AGACNP-B

☐ JACQUELINE NURSE, MSN, APRN, FNP-BC

☐ VALERIA NIETO-GONZALEZ, MSN, APRN, FNP-BC

MEDICAL RECORDS REQUEST

I, _____, acknowledge and understand that if I request a copy of my complete medical records, the information that will be provided to me will be limited to records from the providers/locations listed above, as well as any providers who have previously worked at or for Joseph J. Katta, M.D., P.A.

PATIENTS NAME: _____ DATE OF BIRTH: _____

PATIENTS SIGNATURE : _____ DATE : _____

FORT PIERCE 1900 NEBRASKA AVE STE 4-5 FORT PIERCE, FL 34950 PHONE : (772) 466-7200 **FAX : (772) 466-0218**	**ST LUCIE WEST** 306 NW BETHANY DR PORT ST. LUCIE, FL 34952 **PHONE:** (772) 878-1475 **FAX : (772) 878-1497**	**PORT ST LUCIE** 1700 HILLMOOR DR SUITE 402 PORT ST. LUCIE, FL 34986 PHONE : (772) 236-5757 **FAX : (772) 236-5758**

Patient Financial Responsibility Agreement

Patient Information:

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

(If patient is a minor) **Responsible Party Name:** _____

Insurance Information:

Insurance Company**:** _____

Policy Holder Name**:** _____

Providing insurance information does not guarantee payment.

Financial Responsibility:

I understand and agree that I am financially responsible for **all charges not paid by my insurance**. This includes, but is not limited to:

- Deductibles
- Copayments
- Coinsurance
- Non-covered or denied services
- Charges due to incomplete or incorrect insurance information

I understand that insurance coverage is a contract between me and my insurance company, not the provider.

Insurance Claims

I authorize Joseph J. Katta M.D P.A to bill my insurance on my behalf. I understand that **any balance not paid by insurance is my responsibility**.

Payment & Collections

Payment is due upon receipt of a bill. Unpaid balances may be sent to collections, and I may be responsible for collection costs as allowed by law.

Acknowledgment

I have read and understand this Financial Responsibility Agreement and agree to its terms.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party: Date: