JOSEPH KATTA, MD-PA

1900 NEBRASKA AVE STE. 4

FORT PIERCE, FL 34950

FOLLOWING CDC GUIDELINES FOR COVID-19:

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 2 WEEKS:

1) COUGH YES NO
2) SHORTNESS OF BREATH YES NO
3) FEVER YES NO
4) IN CONTACT WITH FLU YES NO
5) RESPIRATORY INFECTION YES NO
6) TRAVELED YES NO
7) CONTACT WITH FOREIGNERS YES NO
8) HAVE YOU BEEN TESTED FOR COVID-19? YES NO
   a. IF SO, WHEN WERE YOU TESTED AND WHAT WERE THE RESULTS?

   _____

9) ARE YOU WAITING FOR RESULTS OF COVID-19 TESTING? YES NO
10) IS ANYONE IN YOUR IMMEDIATE HOUSEHOLD WAITING FOR RESULTS OF COVID-19 TESTING YES NO

IF YOU HAVE ANSWERED YES TO ANY OF THESE QUESTIONS, PLEASE SEE YOUR PRIMARY CARE PHYSICIAN AS SOON AS POSSIBLE.

THANK YOU

Print name: _____ DOB: _____

Signature: _____ Date: _____

**********OFFICE USE ONLY**********

Has patient checked yes to any of the above questions? Yes_____ No_____

If yes, advise patient to contact primary care provider ASAP: Yes_____ No_____

Signature: _____ Date: _____

Patient Information Sheet

Patient Name _____
Address _____ **City** _____ **State** _____ **Zip Code** _____
Mailing Address *(if different)* _____
Primary Phone # _____ **Secondary Phone #** _____
Language Primary _____ **Email Address** _____@_____._____
Social Security # _____ **Date of Birth** _____ **Sex: Male / Female**

Relationship: Married / Single / Divorce /Widowed / Life Partner
Race: Caucasian / Black-African American / Hispanic / American Indian-Alaska Native / Asian / Native Hawaiian-Pacific Islander / Other _____ / Refuse to State *(as required by state law)*

Hispanic-Latino Ethnicity: ___YES ___NO ___Refuse to State*(as required by state law)*

Advance Care Planning and Advance Directives

___Care Giver (CG) / ___Living Will (LW) / ___Power of Attorney (PA)/ ___Surrogate Decision Maker Identified (S)/ ___Advance Directive Present (Y)/ ___Do Not Resuscitate (DNR)/ ___No Advance Directive Opted(None of the Above) (N)

Pharmacy Name _____ **Phone #** _____
Pharmacy Cross Roads _____ **and** _____
Primary Care Physician _____ **Phone #** _____
Referring Physician _____ **Phone #** _____

Insurance Information

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 CONTACT IN CASE OF AN EMERGENCY

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

Can we release medical information to this person? _____**YES** _____**NO**

Notice of HIPPA Privacy Practice

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 / Guardian Signature Date

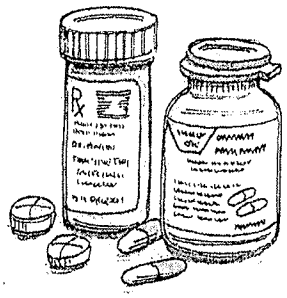
Questionnaire for Latex Sensitivity

Patient Name: _____

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:
   a. Seasonal hay fever? ☐ Yes ☐ No
   b. Asthma? ☐ Yes ☐ No
   c. Eczema? ☐ Yes ☐ No
   d. Auto immune disease? ☐ Yes ☐ No
6. Do you have an 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 any food allergies? ☐ Yes ☐ No
10. Are you allergic to:
    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
    a. If Yes, are the symptoms 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



Medication List

Patient Name: _____ Date: _____

Name of Medication	Strength	How many times daily
Example: Aspirin	*81 mg*	*Once a day*

JOSEPH J. KATTA, M.D., P.A.

1900 Nebraska Ave. * Suite 4-5 * Fort Peirce, FL 34950 *
Phone: 772-466-7200 Fax: 772-466-9513

□ JOSEPH J. KATTA, M.D., P.A.
□ JEAN HUBER, MSN, ARNP, FNP-BC
□ MANUEL DOMAGTOY, MSN, ARNP, FNP-BC
□ ROBERT EPSTEIN, MD
□ LISAMARIE SIMMONS, MSN, ARNP, FNP-BC

Records Request

TO: _____

PHONE #: _____ FAX #: _____

I hereby authorize you to release any information including the diagnosis and records of my treatment or examination _____ rendered to me during the period from: _____ to _____.

Patient Name: _____

Date of Birth: _____ S.S.# **XXX-XX-**_____

Patient Signature: _____ Date: _____

Witness: _____

Requesting Provider: Katta / Epstein / Huber / Domagtoy / Simmons

*Please return this form with records:

□ Fort Pierce
1900 Nebraska Ave.
Suite 4-5
Ft Pierce, FL 34950

□ St. Lucie West
306 N.W. Bethany Drive
Port St Lucie FL 34986

□ Port St. Lucie
1700 Hillmoor Drive
Suite 402
Port St Lucie, FL34952

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 early for your appointment. Patients who are late for any appointment may be asked to reschedule at the physician's discretion. Remember to bring all your prescriptions, over-the-counter medicines, vitamins and supplements to each visit. This will enable your doctor to review the mediation at each visit.

Cancellations

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

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment. Insurance will not cover charges for a no show/late cancellation fees. The $25 charge is in addition to any other charges you have incurred. No refunds will be given. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. We will offer 30 days of emergent care only and transfer your medical records when you find a new physician.

Payment

Payment is due in full at the time of service.

Patient Name	Signature	Date

JOSEPH J. KATTA M.D. P.A.

1900 Nebraska Ave., Ste 5
Ft. Pierce, FL 34950
Ph: 772-466-7200
Fax: 772-466-9513

306 S.W. Bethany Drive
Port St. Lucie, FL 34986
Ph: 772-878-1475
Fax: 772-878-1497

1700 Hillmoor Drive, Ste 402
Port St. Lucie, FL 34952
Ph: 772-236-5757
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 TO 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 Notice 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 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 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 authorization to use 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 notification of (including identifying or location) a family member, your personal representative 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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. PA
Robert Epstein, M.D.
Jean Huber, MSN, ARNP, FNP-BC
Manuel Domagtoy, MSN, ARNP, FNP-BC
LisaMarie Simmons, MSN, ARNP,FNP-BC
1900 Nebraska Ave., Suite 5 * Fort Pierce, FL 34950
Phone: 772-466-7200 Fax: 772-466-9513

Acknowledgement of Receipt of Notice of HIPPA Privacy Practices

Purpose: this form is used to obtain your acknowledgement of receipt of our Notice of Privacy Practices or to document good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement ****

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

_____/_____/_____
Patient's Signature Date Signed

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

_____
Full Name Relationship Phone Number

_____
Full Name Relationship Phone Number

May we leave results on answering machine or voice mail _____ Yes _____ NO

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
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

_____
_____