

Welcome to our practice!

Thank you for choosing the Thyroid & Endocrine Center of Florida for your medical care.

Our goal is to provide exemplary care in an efficient and courteous office environment. To that end, we have put together a New Patient Packet that includes information about our office as well as medical and insurance forms that will assist in your initial visit. The New Patient Packet includes the following forms and information:

Patient Health History
Patient Insurance Information
Clinical Financial Policy & Notice of Privacy Policy
Authorization for Release of Medical Records
Patient Consent to Receive Mail and/or Telephone Messages
Map to our office

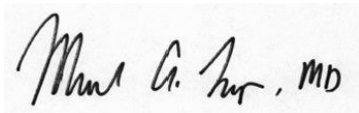
Please complete these forms prior to arriving at our office. In addition to these completed forms, please bring the following to your office visit:

Driver's License or other photo identification
Insurance cards (including Medicare card if applicable)
Visa, MasterCard, or cash for applicable copays and/or deductibles
List of all medications and supplements which you are currently taking


Should you have any questions regarding your upcoming appointment, please contact our office. We can be reached by telephone at (941) 342-9750.

We look forward to meeting you.

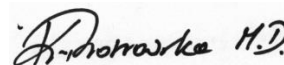
Sincerely,



Mark A. Lupo, M.D.



Zsofia Geck, M.D.



Katarzyna Piotrowska, M.D.

PATIENT HEALTH HISTORY

☺ **Please print clearly so information is legible.**

Patient Name: _____ Patient Age / Birth Date: _____

Primary Care Physician: _____

Whom may we thank for your visit? _____

For what health concerns are you coming to see us? _____

Please list Thyroid medications currently taking (with dose): _____

Please list any **prior** Thyroid medications (dose not needed): _____

List of medications (including prescriptions, over-the-counter, nutritional supplements, and vitamins)

Please attach a separate sheet for 5 or more medications: _____

Please list medication allergies: _____

Please check if you have ever had any of these conditions:

- Underactive Thyroid Overactive Thyroid Enlarged Thyroid Thyroid Nodules Thyroid Cancer
- Heart Attack Heart Failure High Cholesterol Stroke Heart Rhythm Problem Heart Valve Problem Hypertension
- Parathyroid Disease Abnormal Blood Calcium Bone Fracture Kidney Stones Osteopenia/Osteoporosis
- Depression Anxiety Sleep Apnea Blood Disorder or Anemia Kidney Disease
- Fibromyalgia Arthritis Sjogren's Syndrome Lupus Infertility Pituitary/Adrenal Disease
- Liver Disease Acid Reflux Stomach Ulcer Lung Disease Diabetes

Cancer & type: _____ Treatments: _____

Other Conditions: _____

Reproductive History (women only): Regular Cycles? - yes no Number of Pregnancies _____

Number of Miscarriages _____ Number of Live Deliveries _____ Last Menstrual Period _____ Age of Menopause _____

Have you ever had a thyroid biopsy (FNA)? If so, when/where and what were results? _____

Have you had x-rays of your thyroid or neck (including ultrasound, nuclear scans and CT scans)? If so, when and where? _____

Have you ever had radiation treatment involving your neck or been given radioactive iodine treatment for your thyroid? _____

Page 2 – Patient Health History

Have you ever had any surgery on your neck? If so, list type and date:

Please list any other surgeries, including year: _____

Social and Family History

Are you... Single Married Separated Divorced Widowed

Do you use tobacco in any form? _____ Type _____ Amount _____ If Quit, When? _____

Do you drink alcohol? _____ Type _____ Amount _____

Do you exercise? _____ Type _____ Amount _____ min Frequency _____ times per week.

Occupation (Present or former if retired) _____

Please tell us about your family's health history (include age or age at death, diseases or cause of death).

Father: _____ Mother: _____

Siblings: _____ Children: _____

Do any of the following run in your family? Thyroid Problems Thyroid Cancer Parathyroid Disease Heart Attacks

Osteoporosis Stroke Diabetes Auto-Immune Disease (such as Lupus) Pituitary or Adrenal Disease Kidney Stones

Please check symptoms which you are currently experiencing:

General: Chills Fatigue Fever Weight loss (amount : _____) Drenching night sweats

Tight rings/shoes Easy bruising Loss of height Weight gain (amount _____)

ENT: Headache that is out of ordinary for you Snoring Hoarseness

Eyes: Aching Watery Swollen Dry Redness Double vision Vision problems

Skin: Itching Dryness Rashes Hives Unwanted hair Brittle nails Hair Loss

Respiratory: Cough Shortness of breath Wheeze Choking sensation

Cardiac: Chest pain High blood pressure Irregular heart beat Fainting

Intestinal: Vomiting Constipation Diarrhea Indigestion Nausea Abdominal pain Trouble swallowing

Endocrine: Excessive thirst Significant sensitivity to heat Significant sensitivity to cold Shakiness

Muscle-Joint: Joint pain Ankle or leg swelling Muscle pain Muscle weakness Exercise intolerance

Neurological: Numbness/Tingling Seizures Dizziness Vertigo Flushing sensations Tremor

Women only: Irregular periods Pregnant Trying to get pregnant

Psychological: Insomnia Depression Nervousness Difficulty concentrating Mood Swings

Is there any other information that you would like for us to know? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of Patient Date

 Signature of Staff Reviewer / Physician Date

CLINIC FINANCIAL POLICY & NOTICE OF PRIVACY POLICY

Thank you for choosing the Thyroid & Endocrine Center of Florida for your medical needs. Our practice specializes in thyroid and parathyroid disorders. We do not practice general medicine or general endocrinology. We recommend that all our patients have a primary care provider to address and coordinate care for their medical matters beyond the scope of our practice.

If you are not in complete agreement with our recommendations, we will help facilitate a second opinion or make a referral to a provider who can work with you.

At the time of your initial appointment, we reserve the right to *not* establish a doctor-patient relationship if we feel that our practice is not able to address your medical issues. In this case there will be no charge to you or your insurance carrier.

Courtesy Insurance Filing Service

As a courtesy and convenience to you, we will file claims for all services and procedures to insurance companies with whom we are contracted. Secondary insurance will be filed one time only by our billing department. Sometimes your policy will not pay for services, testing or medications that we, your physicians, may feel are medically recommended. Since coverage rules change often, it is not possible for us to always know what your particular coverage may be. Please acquaint yourself with your policy and call your insurer regarding any coverage questions.

For patients who have insurance from companies with which we are not contracted, we will supply you with the necessary paperwork so that you can submit your reimbursement request directly to your insurance company.

For Insurance Assignment Situations

You are responsible for applicable deductibles/co-payments when we accept fee assignment from your insurer. Please have your insurance card with you at the time of your appointment.

Payment at Time of Service

Please provide payment at the time the service or procedure is performed.

New patients: New patients are required to pay co-pays, co-insurance fees, and deductibles with Visa, MasterCard, or cash. Regrettably, we **do not** accept personal checks for new patient initial visits.

Established patients and return visits: We accept Visa, MasterCard, cash, or personal checks.

For patients without insurance or for those who have insurance from companies with whom we are not contracted, we offer reasonably priced cash rates.

Missed New Patient & Re-Visit Patient Appointments

You must notify the office 24 hours prior to your scheduled New Patient or Return Patient appointment if you need to re-schedule or cannot keep your appointment. There will be a \$150.00 fee for missed New Patient appointments and \$75.00 fee for missed Return Patient visits without 24 hours notice, except in case of emergency. This fee must be paid with cash or a credit card before a new appointment will be scheduled.

Fee for Returned Checks

Checks returned to our office by the bank for insufficient funds on your account will be charged back you. The amount of the check and the return check processing fee of \$25.00 will be due prior to rescheduling your appointment. Please contact the office to arrange payment.

Questions

Should you have any questions regarding your financial responsibilities or our payment policies, please do not hesitate to ask.

Page 2 - CLINIC FINANCIAL POLICY & NOTICE OF PRIVACY POLICY

Medicare & Medical Insurance Signature on File

I, the undersigned, have insurance with the carrier named on the insurance information document prepared by me today. I will notify the office immediately of any changes to my insurance coverage. I authorize payment of medical benefits directly to the physician for professional services rendered. I am financially responsible for all charges for such services rendered to me, including the balance remaining after the payment of any insurance benefits. I permit a copy of this authorization to be used in place of the original, and authorize the release of any medical or other information necessary to process a claim on my behalf. If I am a Medicare patient I understand that I am responsible for the Medicare Part B deductible for the beginning of each calendar year and the remaining 20% of charges not covered by Medicare.

Permission to Treat

I hereby give Dr. Mark A. Lupo, and/or Dr. Zsofia Geck, and/or Dr. Katarzyna Piotrowska permission to treat me as a patient. I shall comply with their recommendations for treatment, tests and/or referrals to other specialists as may be necessary for my care. Non-compliance of their plan of treatment may result in discharge from the practice.

Release of Medical Information

I authorize the release of any and all medical information necessary to process this claim.

Assignment of Benefits

I authorize the payment of medical benefits for professional services rendered are made directly to Mark A. Lupo, M.D., P.A.

Fax Clearance

I give my permission to fax any and all records with the understanding that there is a possibility that this information may be misdirected.

Exclusions

We never share your confidential information with unauthorized persons. As an added measure of security, if there is a specific individual or company that you specifically **do not want** us to discuss and/or disclose any part of your medical or health information with, please list the person or company: _____

Florida Patient's Bill Of Rights and Responsibilities

I acknowledge that I have received or can request a copy of the Florida Patient's Bill of Rights and Responsibilities.

Notice of Privacy Policy Acknowledgement

I hereby acknowledge that I have seen/reviewed the Notice of Privacy Policy for Mark A. Lupo, M.D., P.A. displayed in the waiting room and available on our website. I have been given an opportunity to ask questions concerning the Notice of Privacy Policy. I understand that I may have a paper copy should I so desire. A copy of this policy will be made available upon request.

Financial Agreement

I understand that I am directly responsible for my account, the payment of this account and hereby assume and guarantee payment of expenses incurred by myself and/or my dependants. Should legal action be required to secure payment of this account I agree to pay a reasonable collection expenses, all court costs and a reasonable attorney's fee incurred thereby.

I am aware that Dr. Mark A. Lupo practices with Dr. Zsofia Geck, and Dr. Katarzyna Piotrowska. I understand that I have the right to decline seeing either physician. By signing below I AGREE to receiving treatment by Dr. Lupo and/or Dr. Geck and/or Dr. Piotrowska.

COMPLIANCE STATEMENT

I have read and understand the above financial, office and privacy policies and I agree to abide by them.

Patient or Responsible Party

Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

☺ **Please print clearly so information is legible.**

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

I hereby authorize _____
(Name of Facility or Physician)

to disclose records obtained in the course of my evaluation and/or treatment to: *(complete address please)*

I understand that I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for Dr. Mark A. Lupo and/or Dr. Zsofia Geck, and/or Dr. Katarzyna Piotrowska to inform the requestor that portions of the record have been withheld.

Unless otherwise indicated below, my signature authorizes the release of all medical records without exception, including any information concerning AIDS or AIDS testing, psychological or psychiatric treatment, and/or alcohol or drug abuse.

This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

Dr. Mark A. Lupo, and/or Dr. Zsofia Geck, and/or Dr. Katarzyna Piotrowska reserve the right to charge a \$1 per page fee for copying of medical records (i.e., in cases of extensive medical records). If a fee is to be assessed, the patient will be informed of the total cost before medical records copies are made.

Signature of Patient*: _____ Date: _____

Signature of Witness: _____ Date: _____

If signed by other than the patient, indicate relationship: _____

**Legal representatives must submit copies of legal documents supporting assignments of this authority.*

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

☺ *Please print clearly so information is legible.*

Patient's Last name, First name and Middle initial
(Please print)

Patient's Date of Birth
(Please print)

Primary Telephone # () _____ - _____ Secondary Telephone # () _____ - _____

E-mail address: _____

Do we have your permission to do the following?

Mail test results and/or appointment reminders to your home? Yes _____ No _____

Leave medical information/results on your primary or secondary phone? Yes _____ No _____

Leave appointment information on your primary or secondary phone? Yes _____ No _____

Leave billing information on your primary or secondary phone? Yes _____ No _____

Please list names of those with whom we can leave the above information: _____

Leave medical information on your work phone? Yes _____ No _____

Leave appointment information on your work phone? Yes _____ No _____

Leave billing information on your work phone? Yes _____ No _____

If "Yes", please provide: Work Telephone # () _____ - _____ Extension: _____

By signing this consent you are giving our practice/staff permission to leave telephone messages, mail information to you and/or leave voicemail messages pertaining to your appointment information, medical information and/or billing information as indicated by you on this consent form.

Signature of Patient (Parent or Guardian if patient is a minor)

If signed by Parent or Guardian – please print name

Date

*Mark A. Lupo, M.D., FACE, ECNU
Zsofia Geck, M.D., FACE, ECNU
Katarzyna Piotrowska, M.D.*

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