MARK A. LUPO, M.D.
THYROID & ENDOCRINE CENTER OF FLORIDA

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

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

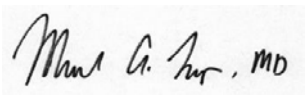
Please complete these forms prior to arriving at our office. In addition to these completed forms, please bring the following to your office visit:

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,

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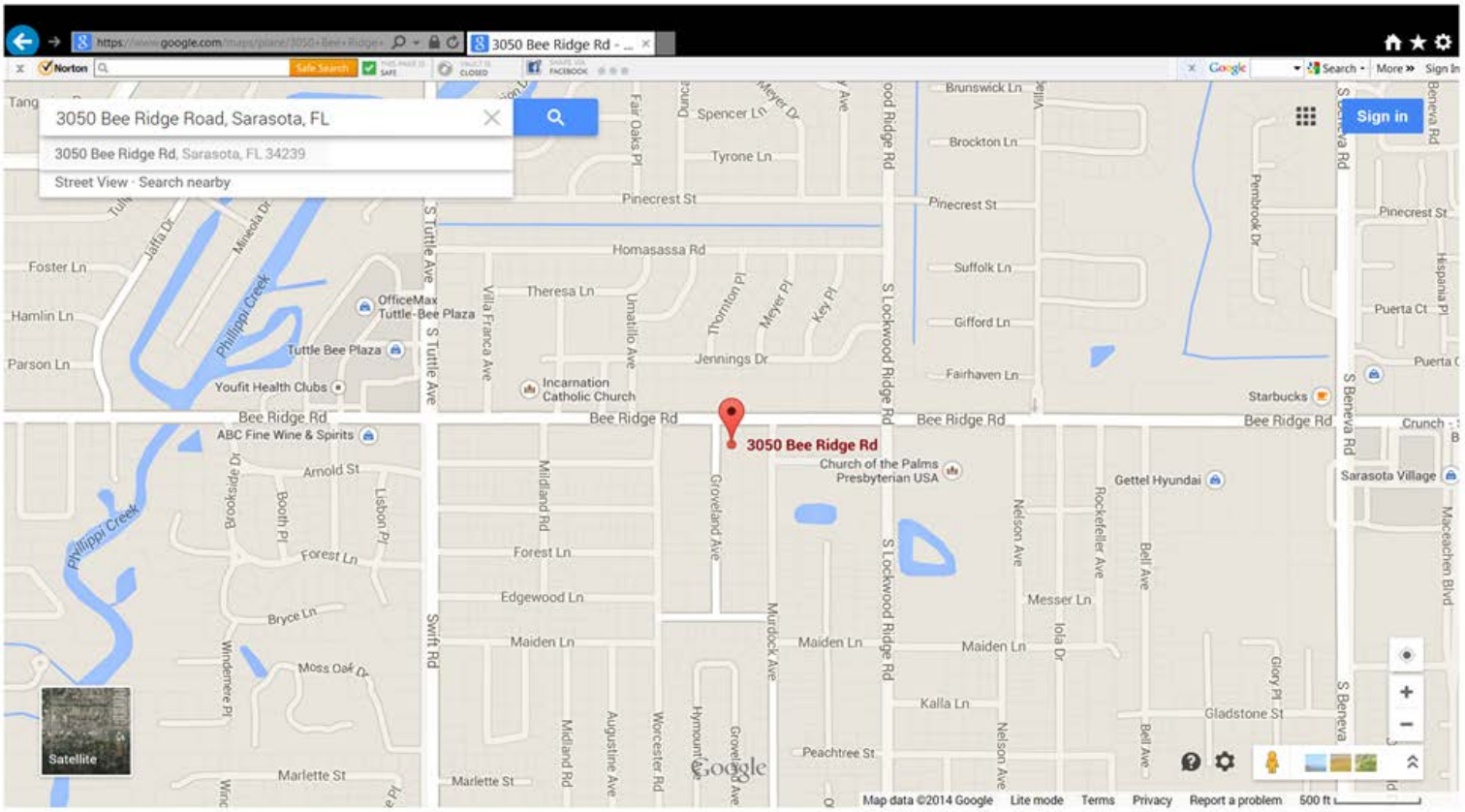
Thyroid & Endocrine Center of Florida
3050 Bee Ridge Road
Sarasota, Florida 34239
Telephone (941) 342-9750

*****Failure to arrive 30 minutes before your appointment time may result in your appointment being rescheduled.



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PATIENT HEALTH HISTORY

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

Patient Name: _____ Patient Age / Birth Date: _____

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). 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? _____
_____

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

Please list any other surgeries, including year: _____

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Page 2 – Patient Health History

Have you ever had a bone density test? If so, date: _____

Have you had a CT/MRI due to fracture? If so, list type and date: _____

Social and Family History

Are you… ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Do you use tobacco in any form? _____ Type _____ Amount_____ Start Date_____ Quit Date_____

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 <u>currently</u> 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*

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PATIENT INSURANCE INFORMATION

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

Primary Care Physician _____Physician's Telephone #_____

Full Name of Patient: _____ Primary Phone:_____

Address: _____Secondary Phone: _____

City: _____ State and Zip: _____

Gender: ___ Age: ____ Marital Status: M___ S___ D___ W___Birth date: _____

Patient Occupation: _____ Employer: _____

E-mail: _____

Pharmacy Name and Cross Streets: _____ Mail Order Pharmacy : _____

Emergency Contact Information: Whom should we notify in case of an emergency? _____

Phone number: _____ Relationship of emergency contact: _____

Are you a year-round resident of Florida? ____YES____NO If "No", please provide your out-of-state address

Address: _____City, State, Zip: _____ Telephone #:_____

Primary Insurance: Complete this section as it applies to the person who is the insurance account holder.

Insurance Company: _____

Name of Person Responsible for Account (Last, First, Middle): _____

Relationship of Insurance Account Holder to Patient: _____DOB: _____

Address: _____City, State, Zip: _____ Telephone #:_____

Occupation: _____Contract #: _____Group_____ Member ID#:_____

Secondary Insurance Company: _____

Name of Person Responsible for Account (Last, First, Middle): _____

Relationship of Insurance Account Holder to Patient: _____ Date of Birth:_____

Address: _____Home Phone: _____

City: _____ State and Zip: _____

Contract #: _____ Group _____ Member ID #: _____

Insurance Assignment of Benefits and Release of Information for Insurance Purposes

I, the undersigned, certify that I (or my dependent) have insurance coverage as outlined above. I assign directly to **Mark A. Lupo, M.D., P.A.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release all information needed to obtain benefit payment, and the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

MARK A. LUPO, M.D.
THYROID & ENDOCRINE CENTER OF FLORIDA

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Angela Boldo, M.D.

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, Discover, American Express or cash. Regrettably, we **do not** accept personal checks for new patient initial visits.
Established patients and return visits: We accept Visa, MasterCard, Discover, American Express, 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.

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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 The Thyroid & Endocrine Center of Florida 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, Dr. Katarzyna Piotrowska, and Dr. Angela Boldo. I understand that I have the right to decline seeing any physician. By signing below I AGREE to receiving treatment by Dr. Lupo and/or Dr. Geck and/or Dr. Piotrowska and/or Dr. Boldo.

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

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

Patient Name: _____ Date of Birth: _____

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)*

_____Thyroid and Endocrine Center of Florida_____

_____3050 Bee Ridge Road, Sarasota, FL 34239_____

_____Fax: 941-342-9788_____Phone: 941-342-9750_____

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 The Thyroid & Endocrine Center of Florida 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.

The Thyroid & Endocrine Center of Florida reserves 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.*

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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 # ( )_____-_____

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 e-mail? Yes_____No_____

Leave appointment information on your e-mail? Yes_____No_____

Leave billing information on your e-mail? Yes_____No_____

Please provide E-mail address: _____

By signing this consent you are giving our practice/staff permission to leave telephone messages, mail or email information to you and/or leave voice mail 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