MICHAEL FUNK, MD, FACP, FACC
CARDIOLOGY

Patient: _____

Last Name **First Name** **M.I**

Address: _____

_____

City **State** **Zip Code**

Home phone: _____ **SocialSecurityNumber:** _____

Date of Birth:

_____ **Age**: _____

Patient's Employer: _____ **Occupation**: _____

City of Employment: _____ **Phone#**: _____

Spouse's Name: _____ **Spouse's DOB** _____

Spouse's Employer: _____ **Phone #**: _____

Nearest Relative: _____ **Phone #**: _____

Referred by: _____ **Primary: Physician**: _____

Insurance Information:

Primary Insurance: _____ ID #: _____ Group#: _____

Address: _____

Primary Cardholder'sName: _____ DOB: _____ SSN: _____

Secondary Insurance: _____ ID#: _____ Group: _____

_____

Reason for Visit: _____

Medical Problems: _____

_____

Past Surgery:

Surgery name with date (year): _____

_____

Medications/Vitamins/Over the counter daily: _____

_____

Phone: 954.840.0530 • Fax: 954.840.3570
3001 Coral Hills Drive • Suite 340 • Coral Springs, FL 33065

South Florida Surgical Specialists, LLC

Drug Allergies: _____

_____

Tobacco Use:

Did you ever smoke cigarettes Yes_____N0_____ _ (If no, please skip to Alcohol use)

Current Every Day Smoker? Yes _____No _____Current some day smoker? Yes _____No_____

Former Smoker? Yes _____No _____When did you quit? _____Number of years smoking_____

Smoke Socially Yes _____No _____Smokeless tobacco use? Yes _____No_____

Alcohol Use:

Do you drink alcohol? Yes _____No_____ if yes how much? _____

Never Drinks alcohol? Yes _____ No_____ Quit drinking alcohol YES_____No If yes, when? _____

Vaccinations:

Influenza Immunization? Ye s ____ No____ Pneumonia Vaccination? Yes _____No_____

Please check below what pertains to you. Have you recently experienced?

Constitutional _____weight changes, _____fever, _____fatigue _____none of these

Eyes: _____visual changes, _____pain: _____ _____none of these

Ears, Nose & Throat _____sore throat, _____sinus trouble, _____nose bleeds_____ _____none of these

Cardiovascular _____chest pain, _____palpitations, _____leg cramps_____ _____none of these

Respiratory _____cough, _____shortness of breath, _____wheezing_____ _____none of these

Genitourinary_____ pain with urination _____frequent urination at night_____ _____none of these

Musculoskeletal _____Arthritis_____, limitation of movement_____ _____ none of these

Skin _____rash, _____lumps, and _____bruises_____ _____ none of these

Neurological _____fainting, _____headaches, _____numbness _____none of these

Psychiatric _____depression, _____ panic attacks_____ _____ none of these

Endocrine _____thyroid problems _____hot flashes _____ _____ none of these

Hematological _____bleeding problems, anemia_____ _____none of these

Allergy/Immunology _____Steroid use _____hives _____HIV_____ _____none of these

Gastrointestinal _____abdominal pain, _____ constipation, _____bloody or dark stools_____ _____none of these

Have you ever had a Colonoscopy? Yes_____ No _____ what is the date of your most recent colonoscopy? _____

Medical history in IMMEDIATE family (grandparents, parents, siblings, children)

- Alcoholism YES___ NO____ Who? _____
- Anemia YES___ NO____ Who? _____

- Anxiety YES___ NO____ Who? _____
- Arthritis YES___ NO____ Who? _____
- Cancer? YES___ NO____ Who? _____
- Cataracts YES___ NO____ Who? _____
- Diabetes I or II YES___ NO____ Who? _____
- Hyperlipidemia YES___ NO____ Who? _____
- HTN YES___ NO____ Who? _____
- Kidney Stones YES___ NO____ Who? _____
- Stroke YES___ NO____ Who? _____

PLEASE CIRCLE ONE IF YOU ARE A NEW PATIENT TO THE PRACTICE. IF NOT, PLEASE DISREGARD

Race (circle one): Alaskan Native, American Indian, Asian, African American, Hispanic or Latino, Indian, Native Hawaiian, Caucasian, White Hispanic, Refuse to report.

Ethnicity (circle one): Hispanic or Latino, Non Hispanic or Latino, Refuse to Report

PLEASE READ AND SIGN

I authorize the release of my medical records or any other information necessary to process an insurance claim. I authorize payment of medical benefits to go directly to MultiSpecialty Healthcare, LLC. the office of Dr. Michael Funk MD, FACP, FACC.

By signing below you are giving your permission to be contacted via Internet or voicemail by MultiSpecialty Healthcare LLC, the office of Dr. Michael Funk MD, FACP, FACC

Our office has a policy regarding "**No Show**" visits. There will be an automatic **$75.00 dollar** charge applied to your account if we have no record of the appointment being **rescheduled or cancel**. The cancelation has to occur 24 hours prior to your appointment.

Patient Signature: _____Date:_____

OUR OFFICE DOES NOT ACCEPT PERSONAL CHECKS

Internal Use only _____

Doctor Reviewed Document:

Physician Signature: _____

Date: _____

CONSENT TO TREAT

In the course of your treatment as a patient of Multispecialty Healthcare LLC, the office of Michael Funk MD, FACP, FACC there will medical treatment plans, diagnostic test and possibly minor proceeds recommended or administered by the office physician or staff member. The doctors and staff will ensure that you have a complete understanding of your care and recommend that you ask questions. By signing below you are granting your permission for this office to proceed with providing the appropriate care.

Patient Signature: _____

Print Name: _____

Date: _____

CONSENT TO NOTIFY

In the course of your treatment as a patient of MultiSpecialty Healthcare, LLC with Dr. Michael Funk MD, FACP, FACC it may be necessary to contact you regarding your appointments, surgery or your medical condition. Please list family member or friends that you authorize us to speak with if we are unable to contact you.

Without this authorization we are prohibited by law to answer any questions regarding your appointments, surgery or medical condition. This rule applies to spouses, children, parents and any other immediate family members.

I, _____, hereby authorize the office of

MultiSpecialty Healthcare LLC, the office of Dr. Michael Funk MD., FACP, FACC to contact;

Name: _____Telephone:_____

Name: _____Telephone:_____

Name: _____Telephone:_____

Name: _____Telephone:_____

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Signature: _____ Date: _____

PHARMACY CONSENT

PLEASE PROVIDER YOUR PHARMACY INFORMATION BELOW

Pharmacy Name: _____

Phone Number: _____

Location: _____

MEDICATION CONSENT FORM

I, _____hereby authorize the office of MultiSpecialty Healthcare, LLC the office of Michael Funk MD, FACP, FACC to E-Prescribe medications as well view my medication history. This authorization will last indefinitely unless this office is notified in writing about any changes.

Signature: _____ **Date**: _____

Print Name: _____

Witness: _____

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your care by providing the best treatment available. Our charges are usual and customary for our area. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor, Co-payments, co-insurance and deductibles are due at the time of service. We only accept cash, Visa, Master Care, Discover or American Express.

WE DO NOT ACCEPT PERSONAL CHECKS.

Should the account not be paid and a financial agreement is not in place the account will be turned over to collections. You the patient will assume all cost of collection, including but not limited to court costs, interest and legal fee.

If you have a balance on your account you should expect to receive a billing statement from the office's billing company in the name of South Florida Surgical Specialists, LLC.

Regarding Insurance

We will accept assignment of insurance benefits; however we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not you r insurance company pays. We cannot bill your insurance company unless you provide us with complete and accurate date. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. If you're insurance company has not paid your account in full within 45 days you will be responsible for the balance. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurance.

Referral/ Authorizations

This is primarily the patient responsibility to obtain and provide to the office prior to services being provided. My office will assist obtaining authorizations for procedures. This is not a guarantee of payment by your insurance company.

Missed Appointments

Our office has a policy regarding "**No Show**" visits. There will be an automatic **$75.00 dollar** charge applied to your account if we have no record of the appointment being **rescheduled or cancel**. The cancelation has to occur 24 hours prior to your appointment.

Procedures

Once a date is set, the office requires that all cancellations are "prior to 24 hours" of the procedure. Failure to cancel within the appropriate amount of time will result in a $150.00 dollar fee be applied to your account.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns, I have read the Financial Policy and understand and agree to this Financial Policy.

_____ _____

Signature of patient or responsible party Date

REMINDER OUR OFFICE DOES NOT ACCEPT PERSONAL CHECKS

Internal Use only _____

Doctor Reviewed Document:

Physician Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF THE PRACTICE'S

NOTICE OF PRIVACY PRACTICES

_____

Date:

_____

Name (Print)

_____

Signature

The Practice Use Only

Date acknowledgement received: _____

Individual refused to sign: _____ (check if applicable)

An Emergency situation prevented the Practice form obtaining acknowledgement :_____(check)

Other reason acknowledgment was not obtained: _____

_____

Practice Employee:

Signature: _____

Print Name: _____

Date: _____

MICHAEL FUNK, MD, FACP, FACC
CARDIOLOGY

AUTHORIZATION FOR RELEASE OF

CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____ **Telephone:** _____

Address: _____

Date of Birth: _____ Social Security Number: _____

I, _____ authorize the office

Of _____ to release a copy of my health information to the following party:

MultiSpecialty Healthcare, LCC

Michael Funk, MD, FACP, FACC

3001 Coral Hill Drive, Ste: 340

Coral Springs, FL. 33065

Telephone: 954 840-0530 Fax: 954 840-3570

I, _____ authorize the office of MultiSpecialty Healthcare LLC, the office of Dr. Michael Funk to release a copy of my medical records to:

_____

_____

_____

Patient/Personal Representative

Signature: _____

Print Name: _____

Date: _____

Witness: _____

Date: _____

PLEASE REVIEW IT CAREFULLY

The Practice uses health information about you for treatment and to obtain payment for treatment for administrative purposes and to evaluation the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the Practice. Your health information is referred to in this Notice as information or health information.

Practice Obligations:

The Practice is required by law to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information issued or discloses;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;

The Practice reserves the right to change its privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. The Practice reserves the right to make the changes in its privacy practices and policies and the new terms of it s Notice effective for all health information that the Practice maintains, including health information the Practice created or received before the Practice made the changes. Before the Practice makes a significant change in its privacy practices, the Practice will change this Notice and make the new Notice available upon request.

Use of Disclosure of Your Health Information:

For Treatment: The Practice may use and disclose your health information to other health care providers or physicians in order to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in you record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment: The Practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: The Practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- conducting training program;
- accreditation, certification, licensing or credentialing activities;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

To your Family and Friends: The Practice must disclose your health information to you, as described in the Patient Rights of this Notice. The Practice may disclose your health information to a family member, friend or any person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that the Practice may do so.

Persons involved in Care: The Practice may use and disclose health information to notify, or assist in the notification of (including indentifying or locating) a family member, your personal representative or another person responsible for your care, of your general condition, or death. If you are present, then prior to use of disclosure of your health information, the Practice will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, the Practice will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. The Practice will also use its professional judgment and its experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filed prescriptions, medical supplies, x-rays or other similar forms of health information.

Appointments: The Practice may use or disclose your information to provide appointment reminders, including telephone messages or voicemail messages at telephone numbers which you gave to the Practice.

Fund Raising: The Practice may use your information to contact you to raise funds for the Practice.

Required by law: The practice may use and disclose information about you as required by law. For example, the Practice may disclose information for the following purposes:

- for judicial and administrative proceeding pursuant to legal authority;
- to report information related to victim of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Abuse or Neglect: The Practice may use or disclose your health information to appropriate authorities if the Practice reasonably believes that you are a possible victim of abuse, neglect or domestic violence or the possible victim in other crimes. The Practice may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Decedents: health information may be disclosed to funeral directors or coroners to enable them to care out their lawful duties.

Organ/Tissue Donations: Your health information may be used to disclose the cadaveric organ, eye or tissue donation purposes.

Research: The Practice may use your health information for research purposes after an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety: Your health information may be used or disclosed t avert a serious threat to the health or safety or you or any other person pursuant to applicable law.

Government Functions: Your health information may be used or disclosed for specializing government functions such as protection of public officials or reporting to various branches of the armed services including for national security purposes.

Workers Compensations: Your health information may be used or disclosed in order to comply with laws and regulations related to workers' Compensation.

Your Authorization: In addition to the Practice's use of your health information for treatment, payment or healthcare operations, you may give the Practice written authorization t use your health information or to disclose it to anyone for any purpose. If you give the Practice an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was it was in effect. Unless you give the Practice a written authorization the Practice cannot use or disclose your health information of r any reason except those in those Notice.

Marketing Health –Related Services: The Practice will not use your health information for marketing communications without your written authorization.

Other uses: Other uses and disclosure will be made only with your written authorization and you may revoke the authorization except to the extent the Practice has taken action in reliance on such.

Your health Information Rights:

Access: you have the right to look at or get copies of your health information, with limited exceptions. You may request that the Practice provides copies in a format other than photocopies the practice will use the format you request unless the Practice cannot practicably do so. You must make a request in writing to obtain access to your health information YO may obtain format to request access by using the contact information listed at the end of this Notice. The Practice will charge you a reasonable cost based fee for expenses, such as copies an staff time. You may also request address by sending us a letter to the address at the end of this Notice. If you request copies, the Practice will charge you $__ for each page $_ per hour of staff time t locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, the Practice will charge a cost based fee for providing your health information in that format. If you prefer, the Practice will prepare a summary or an explanation of your health information for a fee. Contact the Practice using the information listed at the end of this Notice for a full explanation of the Practice's fee structure.

Disclosure Accounting: You have the right to receive a list in which the Practice or its business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14 2003. If you request this accounting more than once in a twelve (12) month period the Practice may charge you a reasonable cost based fee for responding to these additional request.

Restrictions: You have the right to request that the Practice places additional restrictions on its use or disclosure of your health information. The Practice is not required to agree to these additional restrictions but if the Practice does, it will abide by its agreement (except in an emergency).

Alternative Communication: you have the right to request that the Practice communicates with you about your health information by alternative means or to alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that the Practice amend your health information. Your request must be n writing and it must explain why the information should be amended. The Practice may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on the Practice's website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

You have the right to:

- request a restriction on certain uses and disclosures on your information as provide by 45 C.F.R. 164.522; however, the Practice is not required to agree to a requested restriction;
- obtain paper copy of this Notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R. 164.524
- request our health record be amended as provided in 45 C.F.R. 164.26
- request communications of your health information by alternative means or at alternative locations; and
- Receive a accounting of disclosure made of your health information as provided by 45 C.F.R. 164.258

Questions and Complaints:

If you want more information about our privacy or have questions or concerns please contact the Practice.

If you are concerned that we have violated your privacy rights, or you disagree with a decision the Practice has made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternate means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice, You may also submit a written complaint to the U. S.

Department of Health and Human Services if you believe your privacy rights have been violated and we will provide you with the address for such communication. You will not be retaliated against for filing a complaint.

Contact Information:

Contact: MultiSpecialty Healthcare, LLC

3001 Coral Hills Dr, Suite 340

Coral Springs, FL. 33065

Telephone: (954) 840-0530

Fax: (954) 840-3570