PATIENT REGISTRATION

DANIEL BENDETOWICZ, M.D., P.A.

PLEASE COMPLETE ALL INFORMATION:

Date: _____

Last Name: _____ Home Phone #: _____

First Name: _____ M.I.: _____ Work Phone #: _____

If year round resident with only one address, please check here: ❑ Cell Phone #: _____

LOCAL ADDRESS

Street Address: _____ Apartment #: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Spouse Name: _____

Zip Code: _____ Sex: ❑ Male ❑ Female Spouse DOB: _____

Social Sec. #: _____ Date of Birth: _____ Spouse Social Sec. #: _____

Employer: _____ Spouse Cell Phone #: _____

UP NORTH ADDRESS

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

INFORMATION RELEASE

LIFETIME MEDICARE B signature authorization for services beginning _____. I authorize any hold of medical or other information about me, including the results of any HIV (human immunodeficiency virus) test, to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carriers, or to my insurance company or any organization or authority, or to the billing agent for Daniel Bendetowicz, M.D., P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment.

PATIENT'S SIGNATURE: _____ MEDICARE #: _____ DATE: _____

If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:

AUTHORIZED SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZED SIGNATURE'S NAME: _____ DATE: _____

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I authorize treatment of the patient named herein and agree to pay all fees and charges promptly, unless advance credit arrangements are agreed in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

PATIENT'S SIGNATURE: _____ DATE: _____

IF PATIENT IS A MINOR

I, _____, the _____, of _____,
hereby personally accept financial responsibility for professional services by Daniel Bendetowicz, M.D. P.A., upon the aforementioned child.

SIGNED: _____ DATE: _____

ASSIGNMENT AND RELEASE

I/We hereby authorize my insurance benefits, including Medicare Gap Fillers, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I/We authorize the physician to release any information required by my insurance, including HIV (AIDS) testing/notes, mental health, alcohol and/or substance abuse. Financial information can be released if the Patient's account number is provided by the person making the request.

PATIENT'S SIGNATURE: _____ DATE: _____

If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:

AUTHORIZED SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____ DATE: _____

AUTHORIZED SIGNATURE'S NAME: _____ DATE: _____

NAME _____ **DATE OF BIRTH** _____

CONTACT INFORMATION

DANIEL BENDETOWICZ, M.D., P.A.

EMERGENCY CONTACT:

Name: _____

Relation to the patient: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____ Cellular Phone Number: _____

NON-EMERGENCY CONTACT:

You may be contacted to remind you of appointments, questions regarding insurance, discuss results of your tests or to talk about your medical conditions. Is there someone else to whom Daniel Bendetowicz, M.D., P.A is authorized to disclose the above information? If yes, provide this person's name and contact information below.

❑ _____ **If same as above, it is not necessary to repeat all the information. Please check here and initial.**

Name: _____

Relation to the patient: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____ Cellular Phone Number: _____

This authorization will remain in effect until I cancel it in writing.

By signing this form, I authorize the disclosure of the information as above. I acknowledge I have reviewed and understand this authorization form.

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITIES

DANIEL BENDETOWICZ, M.D., P.A.

We would like to let you know your financial responsibilities as a patient.

Please be informed of the coverage and limitations of your insurance plan. Due to the number of different plans it is not always easy for us to know all the details and coverage of your particular plan. This is particularly important for complete physical exams. Although important and recommended, sometimes they are not covered by your insurance. The same situation could occur with testing and vaccines that although necessary could be not payable under a given plan.

We suggest you check with your insurance before any testing is done to find out what is your financial responsibility on it. It is also important that you will find out what testing facilities are approved by your insurer for outpatient testing (laboratory, radiology).

For any billing questions, please contact our billing service.

PATIENT FINANCIAL RESPONSIBILITIES ALSO INCLUDE:

- Payment of all co-payments, co-insurance, and deductibles.
- Payment at the time of service.
  (Please note: As a courtesy, we will try to bill your secondary insurance. After your secondary insurance has paid the co-payments a refund will be made to you, if applicable.)
- Payment of any final, outstanding balance.
- Providing us with current and complete patient and insurance information.
- Remembering to bring your insurance card to each office visit.

PAYMENT METHODS:

- Cash
- Personal checks
- Visa
- Master Card
- Traveler checks

Signature: _____ Date: _____

NAME _____ DATE OF BIRTH _____

ADULT HEALTH HISTORY

DANIEL BENDETOWICZ, M.D., P.A.

1. ALLERGIES: LIST ALLERGIES TO MEDICATIONS, LATEX, DYE, ETC.

1. _____ 2. _____ 3. _____

PLEASE INDICATE BELOW THE REACTION IT CAUSES:

1. _____ 2. _____ 3. _____

2. MEDICATIONS

LIST ALL CURRENT MEDICATIONS INCLUDING OVER-THE-COUNTER DRUGS, HERBS, SUPPLEMENTS.

NAME	STRENGTH	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

NAME	STRENGTH	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

3. PATIENT PAST MEDICAL HISTORY

CHECK ALL YOUR MEDICAL CONDITIONS

Alcohol Problem ❑ YES ❑ NO	Chronic Bronchitis/ Emphysema ❑ YES ❑ NO	High Cholesterol ❑ YES ❑ NO	Stroke ❑ YES ❑ NO
Drug Problem ❑ YES ❑ NO	Diabetes ❑ YES ❑ NO	Kidney Disease ❑ YES ❑ NO	Thyroid Disease ❑ YES ❑ NO
Anemia ❑ YES ❑ NO	Glaucoma ❑ YES ❑ NO	Mental Problems ❑ YES ❑ NO	Tuberculosis ❑ YES ❑ NO
Arthritis ❑ YES ❑ NO	Gout ❑ YES ❑ NO	Migraines ❑ YES ❑ NO	Stomach Problems ❑ YES ❑ NO
Asthma ❑ YES ❑ NO	Heart Disease ❑ YES ❑ NO	Seizures ❑ YES ❑ NO	Intestinal Problems: ❑ YES ❑ NO
Cancer ❑ YES ❑ NO	High Blood Pressure ❑ YES ❑ NO		OTHER:
If YES to cancer, where:			
_____			_____

4. SURGERIES

LIST ALL THE SURGERIES YOU EVER HAD

1. _____	Date: _____	5. _____	Date: _____	9. _____	Date: _____
2. _____	Date: _____	6. _____	Date: _____	10. _____	Date: _____
3. _____	Date: _____	7. _____	Date: _____	11. _____	Date: _____
4. _____	Date: _____	8. _____	Date: _____	12. _____	Date: _____

5. SOCIAL HISTORY

MARITAL STATUS: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

NUMBER OF CHILDREN: _____

OCCUPATION: _____

LAST GRADE COMPLETED: _____

HIGHEST DEGREE RECEIVED: _____

DO YOU HAVE EITHER OF THE FOLLOWING: ❑ Living Will ❑ Healthcare Power of Attorney

DO YOU DRINK ALCOHOL: ❑ Yes ❑ No

IF YES ABOVE: Amount per week: _____ Type: _____

DO YOU CURRENTLY SMOKE? ❑ Yes ❑ No

IF YES ABOVE: Packs per day: _____ # of years: _____

DID YOU EVER SMOKE? ❑ Yes ❑ No

IF YES ABOVE: When stopped: _____ Amount: _____

HAVE YOU EVER USED RECREATIONAL DRUGS? ❑ Yes ❑ No

IF YES ABOVE: Type: _____

PLEASE TURN THE PAGE AND COMPLETE THE BACK ▶

NAME _____ DATE OF BIRTH _____

REVIEWED BY _____ DATE FORM COMPLETED _____

6. FAMILY MEDICAL HISTORY

	AGE	NAME	DISEASES	IF DECEASED, CAUSE OF DEATH
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Spouse	_____	_____	_____	_____

ANY FAMILY HISTORY OF:

Coronary artery disease (heart attack, angioplasty, heart surgery): ❑ Yes ❑ No Whom:_____

High blood pressure: ❑ Yes ❑ No Whom:_____

Diabetes (blood sugar): ❑ Yes ❑ No Whom:_____

Cancer: ❑ Yes ❑ No Whom and What type:_____

7. IMMUNIZATION HISTORY

PLEASE INDICATE THE MOST RECENT YEAR

Flu Vaccine (Date): _____ Pneumovax Vaccine (Date): _____

Last Tetanus (Date): _____ Hepatitis Vaccine (Date): _____

FOR PATIENTS WITH DIABETES ONLY:

Last visit to the podiatrist (Date): _____

Last visit to the ophthalmologist (Date): _____

8. PREVENTATIVE

Colon Cancer Screening ❑ Yes ❑ No

IF YES ABOVE: When _____; What type of screen test: _____

Date of last Bone Density Scan _____

MALES ONLY:

Date of last Rectal Exam _____

Date of last PSA Level _____

FEMALES ONLY:

Date of last Pap Smear/Pelvic Exam _____ Number of pregnancies _____

Date of last Mammogram _____ Number of miscarriages _____

Date of Last menstrual period _____ Birth control method _____

HOW DID YOU HEAR ABOUT US?

_____

NAME _____ **DATE OF BIRTH** _____

REVIEWED BY _____ **DATE FORM COMPLETED** _____

DANIEL BENDETOWICZ, M.D., P.A.

TELL US ABOUT YOUR OTHER DOCTORS

PRIMARY CARE PHYSICIAN:

NAME:_____

PHONE NUMBER: _____

ADDRESS:_____

CITY:_____ST:_____

CARDIOLOGIST:

NAME:_____

PHONE NUMBER: _____

ADDRESS:_____

CITY:_____ST:_____

GASTROENTEROLOGIST:

NAME:_____

PHONE NUMBER: _____

ADDRESS:_____

CITY:_____ST:_____

NAME: _____ DOB: _____

REQUEST TO OBTAIN MEDICAL INFORMATION

DANIEL BENDETOWICZ, MD, PA
INTERNAL MEDICINE

I do hereby authorize:

PRACTICE NAME

ADDRESS

CITY STATE ZIP

PHONE NUMBER FAX NUMBER

to release to: DANIEL BENDETOWICZ, M.D., P.A.
6840 INTERNATIONAL CENTER BLVD.
FORT MYERS, FL 33912

PHONE: (239) 985-1050
FAX: (239) 985-1060

the following medical information, including sexually transmitted diseases, HIV/Aids, psychiatric, psychological, alcohol and drug abuse:

- ❑ ALL RECORDS
- ❑ HISTORY & PHYSICAL
- ❑ PROGRESS NOTES
- ❑ CONSULTATION
- ❑ LABORATORY RESULTS
- ❑ RADIOLOGY TEST
- ❑ OTHER: _____

for the purpose of: ❑ CONTINUITY OF CARE ❑ UPDATE ON PATIENT MEDICAL CONDITION ❑ OTHER: _____

From: _____ To: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Daniel Bendetowicz, M.D., P.A. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Daniel Bendetowicz, M.D., P.A.

PATIENT NAME DATE OF BIRTH

SOCIAL SECURITY NUMBER PHONE NUMBER

PATIENT SIGNATURE OR LEGAL REPRESENTATIVE SIGNATURE DATE

IF SIGNED BY LEGAL REPRESENTATIVE, STATE THE RELATIONSHIP TO THE PATIENT

WITNESS SIGNATURE

ACKNOWLEDGEMENT OF OFFICE POLICIES

LATE CANCELLATIONS – NO SHOW APPOINTMENTS

1) I understand and I have been notified that I will be charged a fee in the event that I do not give a minimum of 24 hours cancellation/reschedule notice by phone to Dr. Bendetowicz's office.

The notification should be done during regular working hours. A message left on the answering machine or to the on call physician is not considered a 24 hour notice.

There may be exceptions that will be considered in exceptional situations.

2) I acknowledge that I have been notified that in case that my account goes to a collection agency due to lack of payment, I will be responsible for the collection agency's fees. This is 25% of the debt amount.

Initials_____

AUTHORIZATION TO RETRIEVE EXTERNAL MEDICATION HISTORY

I authorize Daniel Bendetowicz, MD, PA to retrieve my external medication history. I understand that this may include medication history prior to getting established as a patient of Daniel Bendetowicz MD PA. This medication history may include substance-controlled medication, psychiatric drugs, antiviral drugs (for example those ones used in the treatment of HIV/AIDS) and medications used in the treatment of pain.

Initials_____

AUTHORIZATION TO RETRIEVE MEDICAL RECORDS THROUGH WEB SITE PORTALS AND BY ELECTRONIC MEANS (INTERNET)

I authorize Daniel Bendetowicz, MD, PA to retrieve my medical history through website portals and by electronic means, including patient data exchanges with different networks. I understand that this may include history prior to getting established as a patient of Daniel Bendetowicz MDPA. This history may include substance-controlled medication, psychiatric drugs, antiviral drugs (for example those ones used in the treatment of HIV/AIDS).

Initials_____

NON-COVERED SERVICES

There is a charge for non-covered services, payable out of pocket and not billable to insurances. For example a phone consultation.

Initials_____

Signature _____

Name_____

Date_____

V10/2021

DANIEL BENDETOWICZ, MD, PA
INTERNAL MEDICINE

Consent Form

Patient: _____

Physician: Dr. Daniel Bendetowicz

In connection with the medical services that I am receiving from Daniel Bendetowicz, M.D., P.A., and its medical staff, I hereby authorize Daniel Bendetowicz, M.D., P.A., the above-named physician, and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples or analyses, or other such information), including copies of applicable hospital and medical records to:

A. any third-party payor covering the medical services of the patient;
B. other health care professionals and institutions involved in the delivery of health care to the patient.
C. The proponent of any legally sufficient subpoena, or in response to a court order.
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies; and
F. As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.

2. The photographs shall be taken by my physician or by a photographer approved by my physician.

3. The photographs shall be used for medical records and, if, in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he may deem proper in the interest of medical education, knowledge, or research. In such instances, however, it is specifically understood that in any such publication or use I shall not be identified by name and reasonable steps shall be taken to preserve my identity.

4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

___ Telephone messages on an answering machine
___ Messages to the following family members or friends:
_____

___ E-mail to the following address: _____

5. I also consent to the release of Protected Health Information to the following individual(s):

_____

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed: _____

Date: _____

Witness: _____

DANIEL BENDETOWICZ, MD, PA
INTERNAL MEDICINE

Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act, patients of Daniel Bendetowicz, M.D., P.A. (DBPA) are entitled to and afforded the rights to privacy regarding their health-related information as set forth under applicable law, and a patient's Protected Health Information ("PHI") may only be released as authorized by this law. DBPA will strive to ensure that patient information is used only for purposes authorized by the patient, including but not limited to patient treatment and payment operations, lawful subpoenas, fundraising (unless the patient objects) and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies.

Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice. In addition, patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

Moreover, patients have the right:

*to be informed of any breach of their unprotected PHI;
*to have marketing communications made to them only if authorized by the patient;
*to decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim.

Should you ever have a concern or complaint, you may contact Daniel Bendetowicz, M.D., the DBPA HIPAA Compliance Officer, at (239) 985-1050.

Patient Signature: _____

Date: _____

PATIENT'S NAME: _____ DOB:_____