ABSOLUTE SURGICAL SPECIALISTS

Dr. Craig Amshel
1046 Cypress Village Blvd, Sun City Center Blvd, FL 33573 813-633-0081

Insurance_____

PCP:_____ Date: _____

Patient:_____Age: _____

DOB:_____ Height:_____ Weight_____ Pharmacy: _____

Reason for Visit:_____ BP _____ P _____ **Notes:**

MEDICATIONS:

1. _____ 4._____
2. _____ 5. _____
3. _____ 6. _____

Are you allergic to any medications? Yes ___ No ___ If so what _____ Reaction: _____

PAST MEDICAL HISTORY

__ Diabetes T1 T2
__Asthma
__Hypo/Hyper Thyroid
__High Cholesterol
__Colon Polyps
__High Blood Pressure
__ Bronchitis /emphysema
__ Arthritis
__ Crohn's Disease
__Diverticulitis / osis
__Heart disease
__Pneumonia
__History of Cancer
__IBS
__BPH
__Heart Attack
__ Hard of Hearing
__Blood Clots
__GERD
__ Depression / Anxiety

PAST SURGICAL HISTORY

__Appendectomy
__Back Surgery
__Tubal ligation
__ Colonoscopy date___
__Breast Surgery R /L
__Hysterectomy
__Vasectomy
__ EGD date
__Hernia R/L
__Heart Bypass
__Never had a colonoscopy
__ Knee scope R/L
__Gallbladder
__Prostate
__ Other:_____

Family Medical History

Family Colon Cancer __Y ___N Who?_____
Family Heart Disease Yes __ No___
Family Adverse reaction to anesthesia Y ___ N__
Family medical illness _____ Mother A D _____ Father A D _____ Siblings _____

Social History

Marital Status M D S W
Smoke Y____ N____ Packs____ How Long ___
Alcohol Y____ N____ Sometimes ___ How Much__

HISTORY OF PRESENT ILLNESS

Cardiovascular
Chest pain Y N
Irregular HB Y N
Stroke Y N

Musculoskeletal
Joint pain Y N
Back pain Y N
Neck pain Y N

Neurological
Tremors Y N
Numbness Y N
Headache Y N

Hematologic
Swollen glands Y N
Blood clots/ bleeding issues Y N
Anemia Y N

Integumentary
Skin Rash Y N
Boils Y N
Itch Y N
Psoriasis Y N

Respiratory
SOB Y N
wheezing Y N
Cough Y N
Asthma Y N

Psychologic
History of depression Y N
Hx of Biopolar disorder Y N
Sleeping Problems Y N

Urology
Incontinence Y N
Retention Y N
Nocturia Y N
Hematuria Y N

Gastroenterology
Abdominal pain Y N Constipation Y N Diarrhea Y N Difficulty Swallowing Y N
Fecal Incontinence Y N How many / often accidents ____ Rectal Bleeding Y N Nausea Y N

ABSOLUTE
SURGICAL
SPECIALISTS

Dr. Craig Amshel
1046 Cypress Village Blvd, Sun City Center, Florida 33573 813-633-0081

Date: _____

Patient Name:_____ DOB _____

Female _____ Male _____ Social Security _____

Address:_____

_____

Home Phone:_____ Cell : _____ Wk _____

OK to leave message? _____ Home _____Cell ____ Both _____

Primary Care Physician _____

Referring Physician_____

Referring patient or family member:_____

Responsible Party Name: _____Relationship _____

Primary Insurance_____ Group _____

Subscriber Id:_____ DOB_____

Secondary Insurance _____Subscriber _____ Group ____

Emergency Contact _____Phone:_____

Pharmacy: _____ Address: _____

Email: _____

- ☐ I have received a written copy of my patient rights and responsibilities
- ☐ I have received a copy of the office privacy practice

ABSOLUTE SURGICAL SPECIALISTS

1046 Cypress Village Blvd, Sun City Center Fl, 33573
www.absolutesurg.com
813-633-0081

FINANCIAL CONSENT

Patient Name: _____ DOB: _____ Date: _____

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan (s) is correct. I authorize any medical holder or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit claim to the above insurance company for payment to me.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductible and co-pays, and that the payments are due at the time service rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency's fee for collection, court costs, and/or reasonable attorney's fee that might incurred in the collection of any outstanding balance. I authorize the physician to release any information necessary to allow payment of any claim or any information acquired in the course of my examination or treatment to my referring physician. I understand and agree if I do not keep my appointment or fail to give **24 hour notice** of appointment change I will be charged **$25.00 fee**. This charge is not covered by insurance. **Credit Card processing fee of $3.00 to charges less than $30.00.**

CANCELLATION POLICY

We charge $25.00 for office no- show and $ 100.00 for procedure no show. Due to the increased time and work required by some insurance companies to obtain authorization for a procedure, if you cancel an appointment after our office has obtained your authorization **(usually a week prior) there will be a 50.00 cancellation fee.**

Patient Signature: _____ **Date:** _____

CONSENT FOR TREATMENT

I hereby voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and /or surgical procedures. I understand that I am under the care of the attending physician and it is the responsibility of the staff to carry out the instructions of the physician(s).

Patient Signature: _____ Date: _____

MEDICATION, PATIENT REFERRAL AND COMMUNITY EXCHANGE

I hereby voluntarily consent to the rendering care physician, to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years. Electronic referrals and the capability to electronically exchange your health information

Patient Signature: _____ Date: _____

Absolute Surgical Specialists
1046 Cypress Village Blvd
Sun City Center, Fl 33573

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Absolute Surgical Specialists may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Absolute Surgical Specialists has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Absolute Surgical Specialists will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Absolute Surgical Specialists to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Absoulte Surgical Specialists has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Absolute Surgical Specialists,1046 Cypress Village Blvd, Sun City Center,FL 33584 813-633-0081 .

FORM Us

Absolute Surgical Specialists
1046 Cypress Village Blvd
Sun City Center,FL,33573
Phone 813-633-0081
Fax 813-633-0082

Authorization to Disclose Protected Health Information

This form is for all record requests.

RELEASE INFORMATION FROM:
Specify Provider/Organization Name and Facility Address

Organization Name: _____

Address: _____

_____

_____

RELEASE INFORMATION TO:
Specify Provider/Organization Name and Facility Address

Organization Name: Absolute Surgical Specialists

Address: 1046 Cypress Village Blvd Sun City Center, Florida 33573

Phone: 813-633-0081 Fax 813-633-0082

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH ____/____/_____ **SSN/MEDICAL RECORD #** _____

ADDRESS _____
Mailing Address, City, State, Zip

_____

Covering the period(s) of health care:

FROM (Date) ____/____/_____ **TO** (Date) ____/____/_____

1. **Information authorized for disclosure**, *if included in my records*:
   - ☐ Complete Health Record
   - ☐ Visit/Discharge Summary
   - ☐ Clinical Documentation of Physical
   - ☐ Documentation of Consultation
   - ☐ Immunization Records
   - ☐ Progress Reports
   - ☐ Radiology and Diagnostic Imaging Reports
   - ☐ Photographs, Videos, Digital or Other Images
   - ☐ Pathology Reports

FORM Js

☐ Laboratory tests *(please specify)*

☐ Other *(please specify)*

2. ***If applicable,* I also give permission** for the following "Sensitive Protected Health Information" to be disclosed ***(please initial below):***

   ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)

   ☐ Behavioral Health Services / Psychiatric Care

   ☐ Treatment for Alcohol and/or Drug Abuse

   ☐ Sexually Transmitted Diseases (STD)

   ☐ Genetic Counseling / Testing

   _____ Initial **I understand** that the information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. **The purpose for which disclosure is authorized** *(check where applicable)*:
   ☐ Medical Care ☐ Insurance ☐ Benefit eligibility ☐ Immunization

   Other: _____

4. **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 the provider(s) of care. **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 review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   (Date) / / . **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such,** (Initial here _____) **it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

5. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signed: Patient – (or Legal Representative, Parent or Legal Guardian) *(Relationship if not Patient)*

ID Provided _____ Date ____/____/_____

_____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or court.

Official Use Only

Name/Title of Person Releasing Information: _____

Date ____/____/_____

FORM Js

Craig E. Amshel, M.D.ABSOLUTE SURGICAL SPECIALISTS, PLLC
1046 Cypress Village Boulevard Sun City Center, FL 33573 Tel: 813-633-0081

Physician-Patient Arbitration Agreement

Under this practice, this Arbitration Agreement ("Agreement") should be read carefully and fully understood. If you have any questions before or after reading and signing this statement please ask the staff or my office manager. Please read this document clearly. Thank you for
your consideration.

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary, authorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by the Florida Arbitration Code, Chapter 682, and not by a lawsuit except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Article 2: AU Claims Must Be Arbitrated: It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee /or the patient shall not waive the right to compel arbitration of any mal practice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties and must be made within the time /Tame set forth in F.S. 95.11 dealing with medical malpractice. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness
fees, or other expenses incurred by a party for such party's own benefit Arbitration shall take place within 30 days after the completion of discovery as provided in the Florida Rules of Civil Procedure (Rules 1.2801.390) and the decision of the arbitration panel shall be binding upon all parties for all purposes. The time for responding to discovery requests shall be 10 days. All discovery shall be completed within 2 months after the appointment of the panel of arbitrators, unless the time for discovery is extended for good cause by the panel. The arbitration panel shall decide any disputes regarding discovery. The arbitration panel is expressly authorized to award all reasonable fees and costs, including attorney's fees, to the prevailing party against any party who has violated this Agreement. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law provisions. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and join in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and join any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (I) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Florida Rules of Civil Procedure provisions relating to arbitration.

Article 5: Retroactive Effect: If patient intends this Agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below;

Effective as of the date of first medical services
Patient's or Patient's Representative's Initials

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Arbitration Agreement.

Signature _____ Date_____