Dr. Craig Amshel – Dr. Randell Sehres – Joan Amshel, PA-C,MHS

Date: ______________

Patient Name: ________________________________ DOB: ____________ Age: ___________

Reason for visit: ___________________________ Primary Care Physician: ___________________

Height: _____ Weight: _____ Allergic to any medications? __________ Reaction: ____________

MEDICATIONS:

1. _______________
2. _______________
3. _______________
4. _______________
5. _______________
6. Are you taking any weight-loss Meds or Anticoagulants? **YES or NO**

Dr's Notes:

PAST MEDICAL HISTORY

___ A-Fib	___ Sleep Apnea	___ Heart Disease	___Heart Attack
___Diabetes T1/T2	___High Blood Pressure	___Pneumonia	___HIV
___Asthma	___Bronchitis/Emphysema	___History of Cancer	___Hard of Hearing
___Hypo/Hyper Thyroid	___Arthritis	(What type? _______)	___Blood Clots
___High Cholesterol	___Crohn's Disease	___BPH	___GERD
___ Colon Polyps	___ Diverticulosis	___ Hepatitis A, B, C	___Depression
___ Migraines	___ COVID	___ Ulcerative Colitis	___Anxiety

PAST SURGICAL HISTORY

___________Last PAP	___Appendectomy	___Hernia	___Bariatric
________ Last Mammo	___Back Surgery	___Heart Bypass	___ Neck
___________Last PSA	___Tubal Ligation	___Knee Scope L or R	______ Last Endoscopy
_________ PSA Level	___Breast Surgery L or R	___Gallbladder	_____Last Colonoscopy
___ C-Section	___ Hysterectomy	___ Prostate	_____ Never had a colonoscopy
___ Heart Stents	___ Vasectomy	___ Hemorrhoid	

FAMILY MEDICAL HISTORY	SOCIAL HISTORY
Family History of Colon Cancer: Yes ____ No ____	Marital Status: Married/Divorced/Single/Widowed
Family Medical Illness: ____________________	Smoke: Yes: ____ No: ____
Mother: Alive: ________ Deceased: ________	How Many Packs: ________ How Long: ________
Father: Alive: ________ Deceased: ________	Alcohol: Yes: ____ No: _____
	How Much per week: ______________________

HISTORY OF PRESENT ILLNESS

Cardiovascular	**Musculoskeletal**	**Psychologic**	**Neurological**	**Gastroenterology**
Chest Pain Y N	Joint Pain Y N	Memory Loss Y N	Tremors Y N	Abdominal Pain Y N
Irregular HB Y N	Back Pain Y N	Bipolar Disorder Y N	Numbness Y N	Constipation Y N
CHF Y N	Neck Pain Y N	Sleeping Problems Y N	Headache Y N	Diarrhea Y N
Integumentary	**Respiratory**	**Hematologic**	**Urology**	Nausea Y N
Boils Y N	SOB Y N	Swollen Glands Y N	Incontinence Y N	Rectal Bleeding Y N
Itch Y N	Wheezing Y N	Blood Clots Y N	Retention Y N	Difficulty Swallowing Y N
Rash Y N	Cough Y N	Anemia Y N	Nocturia Y N	Fecal Incontinence Y N
			Hematuria Y N	

Dr. Craig Amshel – Dr. Randell Sehres - Joan Amshel, PA-C, MHS
1046 Cypress Village Blvd, Sun City Center, Florida 33573

Date: ____________

Patient Name: ____ DOB _____________

Female _____ Male ______ Social Security _______________________________

Address:

____

Home Phone: ____________________ Cell: _______________ Wk. ______________

OK to leave a message? Yes ______ No _______

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: ____

Authorization to disclose medical information with the following:

Person's Name: ___________________________ Relationship: __________________

Patient signature: ____

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

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 /Tom 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:____________________

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

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 a 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 of **20%**, 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 during 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 **$50.00** fee. This charge is not covered by insurance. **Credit Card processing fee of $5.00 - FMLA or any other forms filled out fee $25-$50.00 - Method of payments accepted credit card, Money Orders, Cash or Cashier Checks.**

CANCELLATION POLICY

We charge $50.00 for office no- show and $ 200.00 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:** ________________

Medical Photography Consent Form

Patient Consent:

Patient Name: ________________________ **Date of Birth:** ______________

Consent to medical images and/or video being made of me or/dependent. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:

Please Circle Yes or No

Placed in my medical record for future treatment: Yes No

Electronically emailed to my treating health professional: Yes No

Used by health professionals for education and training: Yes No

Used in paper or electronic health publications: Yes No

Used in commercial broadcast: Yes No

Used in marketing materials: Yes No

By signing below, I confirm that I understand this consent form.

______________________________ ______________

Signature of Patient/Parent of Guardian Date

______________________________ ______________

Signature of Doctor/Staff 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

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HIPAA Compliance Program