ZAMPOGNA HEALTHCARE

NEW PATIENT REGISTRATION

□ Mr. □ Mrs. □ Ms. □ Dr. □ Other: _____

First Name: _____ MI: _____ Gender: □ Male □ Female

Last Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____ Home Phone: _____

Cell Phone: _____ OK to TEXT appt reminder? □ YES □ NO

Email: _____ Contact Preference: □ Home □ Work □ Cell □ Email

I give permission to leave messages regarding my medical care/appointment confirmation □ YES □ NO

Address: _____City: _____ State:_____ Zip: _____

Secondary Address: _____City: _____ State: _____ Zip: _____

Race/Ethnicity: □ White □ Black/African Amer. □ Hispanic/Latino □ Asian □ Amer. Indian
□ Native Hawaiian/Other Pacific Islander □ Decline □ Other_____

Preferred Language: □ English □ Italian
□ Other _____

Occupation: □ Employed □ Student
□ Retired □ Other _____

Marital Status: □ Single □ Married □ Divorced
□ Widowed □ Other

Education Level: □ High School □ College
□ Post Grad □ Other: _____

Employer/School Name: _____ Title: _____

Phone: _____ Address: _____

Emergency Contact

Name _____ Phone: _____ Relationship: _____

Preferred Pharmacy

Name: _____ Address: _____ Phone: _____

Primary Insurance: _____

Member ID: _____ Group ID: _____

Secondary Insurance: _____

Member ID: _____ Group ID: _____

If you are not the primary policy holder, please fill out the following information:

Policy Holder Name: _____ DOB (of subscriber): _____/_____/_____

Relationship to policy holder: _____ Insurance card number: _____

Policy Holder Address: _____ Policy Holder SS#: _____ - _____ - _____

SIGN HERE _____ Date _____
(Patient or Legal Guardian)

Please provide the following to our office, if applicable:
☐ Power of Attorney ☐ Living Will ☐ Do Not Resuscitate Order (DNR) ☐ Medication List (dosage/frequency)
☐ Emergency Contacts *(We have DNR and Medication list templates to provide, if needed.)*

PAYMENT POLICY

INSURANCE. We are in network with most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **CO-PAYMENTS & DEDUCTIBLES**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. **MEDICARE & SECONDARY INSURANCE**. Whether or not your secondary payer is a crossover, you are expected to pay the 20% co-payment at the time of service. Upon receiving payment from your secondary insurance company, we will refund you the payment. **NON-COVERED SERVICES**. Please be aware that some, & perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. **PROOF OF INSURANCE.** All patients must complete our patient forms before the visit. We must obtain a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance info in a timely manner, you may be responsible for the balance of a claim. **CLAIMS SUBMISSION**. We will submit your claims and assist you to get your claims paid. Your insurance company may need you to supply certain info directly. It is your responsibility to comply with their request. Please know the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your benefits are a contract between you and your insurance company; we are not party to that contract. I authorize the release of any medical or other information necessary to process claims on my behalf. **COVERAGE CHANGES.** Please notify us of insurance changes before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be billed and payment expected.

NON-PAYMENT. Accounts over 90 days past due will receive a letter stating that you have 20 days to pay your account in full and a monthly interest rate will accrue for non-paid services. Partial payments will not be accepted unless otherwise agreed upon. We will refer delinquent accounts to a collection agency and you and your immediate family members may be discharged from this practice. You will be notified by regular and certified mail that you have 30 days to find alternative medical care. Our providers will then only be able to treat you on an emergency basis. I agree to be fully responsible for all lawful debts incurred by myself for services.

MISSED APPOINTMENTS. If you fail to show up or cancel your appointment with less than a 24 hour advance notice, you will be charged a fee of $25, ($50 for a physical). As a courtesy, a reminder call is made by our staff a day prior to your appointment, but in no way does this relieve the patient of the responsibility to fulfill their scheduled appointment.

PAYMENTS ACCEPTED. Cash or check. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of $35.00 to your account.

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

• Conduct, plan & direct my treatment & follow-up among multiple health providers who may be involved in the treatment directly or indirectly. • Obtain payment from third-party payers (your insurance company). • Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received and reviewed a copy of the Notice of Privacy Practices (in office or printed out from website) containing a more complete description of the uses and disclosure of my health information. I understand that Zampogna Healthcare has the right to change its privacy notice and that I may contact Zampogna Healthcare any time to obtain a current copy of the Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Zampogna Healthcare Privacy Officer, 1350 Tamiami Trail N. Suite 205 Naples, FL 34102.

I hereby give my consent for Zampogna Healthcare to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). With this consent, Zampogna Healthcare may call, mail, or email my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I authorize the following persons to be contacted regarding my appointments, billing, or medical care.

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

By signing this form, I am consenting to allow Zampogna Healthcare to use and disclose my PHI to carry out TPO. I have read and understand the payment policy and agree to abide by its guidelines.

SIGN HERE _____(Date)_____
(Signature of Patient or Legal Guardian)

PRINT
Patient Name _____Legal Guardian Name (If Applicable) _____

ZAMPOGNA HEALTHCARE

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital, Health Care Provider) to release medical records:

» FROM (Name of Health Care Provider Office Releasing Records):

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Approximate dates of service: _____ to _____

OFFICE USE ONLY

□ Abstract Summary (2 yrs. office visits/labs/imaging/hospitalizations)

□ Office Visits: _____ □ Diagnostic Tests: _____ □ Medication List

□ Lab Results: _____ □ History & Physical □ Immunization Record

□ Hospital Records: _____

» TO (Name of Requesting Party):

□ Zampogna Healthcare
1350 Tamiami Trl. N. Ste. 205
Naples, Florida 34102

Tel (239) 263-1910
Fax (239) 263-5424
info@zampognahealthcare.com

PURPOSE OF RELEASE OF MEDICAL RECORDS

□ Change in primary doctor □ Other (specify): _____

The Undersigned hereby releases Zampogna Healthcare from any and all legal responsibility or liability that could occur from this action.

PATIENT SIGNATURE _____ Date _____

Name:	DOB:	Birth Place:
Chief Complaint:	List Places Lived:	
Current Health Concerns:		
Past Medical History:		
Allergies:		

Medications/Supplements:	Dose/Frequency:	Medications/Supplements:	Dose/Frequency:

Surgeries/Hospitalizations:	Date:	Women's Health	
		Last Pap date:	Result:
		Last Mammo date:	Result:
		# of Children:	# of Pregnancies:
		# of Abortions:	Of Miscarriages:

Preventative Health History (approx. date- i.e. month/year)			Vaccines: (approx. date)
Last Physical:	Bone Density:	Stress Test:	Flu:
Blood Draw:	Hearing Exam:	Heart Echo:	Pneumonia:
Colonoscopy:	Eye Exam:	EKG:	Shingles:
Chest X-Ray:	Foot Exam:	Pulmonary Test:	Tetanus:
		Covid19 Vaccine:	Manufacturer:

Social History		(circle one)
Current/Past Occupation:	Exposure: Fumes Dust Solvents Noise	
Hobbies:	Exercise (type):	
Sexually Active: Yes No	Birth Control/Protection? Yes No	Type:
Tobacco? Never Past Current	Quit Date: / Cigarettes? Pack/day:	Smokeless Tobacco? Yes No
Alcohol? Never Past Current	Type:	Frequency:
Caffeine? Never Past Current	Type:	Frequency:
Drug Use? Never Rare Moderate Daily	Type:	Frequency:

Family History	Cancer (type)	Diabetes	Mental Illness	Stroke	Heart Disease	HTN	Birth Defects	Deceased?
Father								
Mother								
Sister								
Brother								
Grandparent								

Other Physicians:

PATIENT SIGNATURE _____ Date _____