Arturo Castro M.D., F.A.C.E.
3585 Murrell Road, Suite B, Rockledge FL 32955
Phone: (321) 301-1692 Fax: (321) 301-1691

PATIENT REGISTRATION SHEET

Patient Information:

Legal Name: _____Date: _____

Address #1: _____

City: _____ State: _____ Zip code: _____

Address #2:_____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

DOB: ____ /____ / ____ SS# _____ Male: ___ Female: ___

Marital Status: _____ Spouse Name: _____ Spouse DOB: ____ /____ / ____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Primary Care Physician: _____Who referred you: _____

Designated Relative:

I authorize the discussion of my general medical condition and diagnosis (including treatment, payment,

and health care operations with: ( ) Spouse ( ) Children ( ) Other_____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Guarantor Information: (Person Financially Responsible for Bill)

Name: _____ Relationship to Patient: _____

Mailing Address: _____

Home Phone: _____ DOB: ____ /____ / ____ SS#_____

Employer: _____ Employer Phone: _____

Employer Address: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____

Insurance ID#:_____

Secondary Insurance

Insurance Company: _____

Insurance ID#:_____

Assignment and Release:

Authorization to treat and release information to insurance carrier for direct payment to the provider: I authorize treatment and the release of medical information (acquired in my treatment) to process claims to my insurance company. I authorize direct payment from my insurance company to my provider. At any time If I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.

Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we contact you by cell phone or email about appointments and other matters that do not include specific information regarding your care? YES___ NO___

Privacy Notice:

I have received a copy of Dr. Arturo Castro's Office Privacy Notice as required by HIPPA.

Signature: _____ **Date:** _____

Patient Name (Print): _____

Statement of Financial Policy

It is our firm belief that all patients who come to this office expect and deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies. Therefore, we are asking that you read and sign the following important information:

1. We are "providers" for many insurance plans. If we are a participating provider in your plan, we will be listed in your group's "provider list" or "preferred provider" directory. We will bill your insurance company directly and receive payment from them directly. Most plans require a "co-payment" per visit and/or have yearly "deductibles". Some plans require you to pay a co-payment when diagnostic tests are provided. We require that co-payments, co-insurance and/or deductible amounts are paid at the time you receive services.

2. If your insurance requires referral/authorization approval, necessary documentation is your responsibility. You must give your referral form and/or number to the receptionist when you check in to see the doctor. Referral information is required before you see the doctor. If your insurance company does not pay our bill, you will be responsible for the full bill.

3. If your insurance information is up-to-date, we will file up to two separate insurance claim forms for services you receive. It is your responsibility to tell us about changes in your insurance plan. These forms are processed on a daily basis and are sent to your insurance company. We are happy to help you by submitting insurance claims. It is important to remember that your insurance coverage is a contract between you and your insurance company. Although we file claims for you, you are still responsible for your bill, regardless of the amount your insurance company pays, except in cases of pre-negotiated insurance agreements and where legally prohibited.

4. **If you do not have insurance, or we are not a participating provider with your insurance, payment is expected at the time you receive services. Payments will be accepted in cash, by check, or credit card. We accept most major credit cards. If payment in full is not possible at time of service, arrangements must be made through our billing office.**

5. Please remember when you receive your statement, you have already received health care from our physicians and we have initiated your insurance claim. We ask that you promptly pay in full your portion of the balance due.

We hope this Statement of Financial Policy helps you understand the importance of prompt payment of your bill. Please feel free to call our billing office at 1-888-612-7222 ext 701 if you have any questions.

Patient's Name _____ SS# _____
(Print Clearly)

Patient's Signature _____ Date _____

Coastal Endocrinology Office Policies

The following are guidelines for the Patients of this Practice:

As a Patient, you have the right to:

1. Be treated with respect, courtesy, and privacy.
2. Be informed and take an active part in the course of your treatment and to decline treatment and understand the consequences.
3. To have your privacy protected and to receive our Notice of Privacy Practices.

It is your responsibility to:

1. Follow through on physician referrals and scheduled laboratory tests.
2. Keep scheduled appointments, and to telephone the office in a timely manner (24 hours notice) if you are unable to keep your appointment.
3. Keep track of your insurance, make sure it is current, and obtain referrals from your primary care provider.
4. Inform the office if your address, phone number, or insurance changes.
5. Make payments of co-pays and shared costs in a timely manner.
6. Be considerate of the rights and confidentiality of others.
7. Act in a manner that is respectful of other patients, staff, and clinic property.
8. To give your health care provider correct and complete information about your present medical condition, past illnesses, hospitalizations, medications, including over-the counter drugs, herbal supplements, and other health matters.
9. Accept responsibility for your actions if you decline treatment or do not follow your practitioner's instructions.
10. **Please bring your driver's license** or a government issued photo ID with you to your appointment.
11. **Bring copies of any recent lab tests results, X-ray reports, etc. if applicable.**

Cancellation Policy:
In the event that it is necessary for you to cancel or reschedule an appointment, we request that you provide our office with **24 HOUR NOTICE PHONED IN DURING OFFICE HOURS**. This is to allow time to make the opening available to another patient. **THERE IS NO CHARGE FOR APPOINTMENTS CANCELED AT LEAST 24 HOURS IN ADVANCE.**

IF 24 HOURS NOTICE IS NOT RECEIVED OR YOU MISS YOUR APPOINTMENT, YOU WILL BE EXPECTED TO PAY A $40.00 NO CANCELLATION/MISSED APPOINTMENT FEE.

Return Checks:
Any returned check will be subject to an **ADDITIONAL COLLECTION FEE OF $40.00.**

Phone Hours:
Phone lines open from 9:00am-12:00pm and 1:00pm-4:30pm, Monday through Friday. For medical emergencies please call 911. For non-urgent calls, please leave a message and allow us **3 business days** to return all non urgent messages. Prescription refills are processed during normal business hours only (allow **3 business days** for this request).

Any information of a confidential nature regarding patients and/or this office, including medical information and personal life may not be talked about in the community.

Breach of this confidentiality or no-show appointments will result in dismissal from this practice.

By signing below, I understand that I may place my patient eligibility in jeopardy by not following the above statements regarding my responsibilities. Dr. Arturo Castro or a member of his staff has discussed the above rights and responsibilities with me.

Patient Signature: _____ **Date:** _____

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Authorization to Use or Disclose Protected Health Information

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient Name: _____Date of Birth: ____ /____ / ____

Social Security Number: _____

Address: _____

Phone Number: _____

___ Information may be released to Arturo Castro M.D., F.A.C.E. (address above)
___ Information may be released by Arturo Castro M.D., F.A.C.E (address above)

___ Information may be released to the following individual or organization:
___ Information may be released by the following individual or organization:

Name: _____ Phone: _____

Address: _____

Purpose of Request: ___Medical Treatment ___ Other: _____

Dates of Service to be Released: ___ All Records (or) ___ From ____/____/____ To ____/____/____

The type of information to be used or disclosed (check appropriate boxes):

( ) All Medical Records
( ) Consult Reports
( ) Discharge Summary
( ) Other (please describe) _____
( ) Lab reports/ X-ray and other imaging
( ) Operative Report
( ) Emergency Room Records

_____

I understand this may include medical, mental, alcohol and/or drug abuse. HIV (Human Immunodeficiency Virus) testing, AIDS, eating disorders, or any other medical information of a sensitive nature.
I understand that if the individual or organization authorized to receive the information is not a health plan or healthcare provider the released information may no longer be protected by Federal Privacy Regulations. I understand that I need not sign this authorization to ensure treatment.
This authorization shall remain valid for one year.
I understand that I have the 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 department or facility listed on the authorization. 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.

Signature of patient or legal representative _____Date_____

If signed by legal representative, relationship to patient: _____

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Patient Forms

Today's Date: ____ / ____ / ____

Patient Name: _____

Race (circle one)

American Indian or Alaska Native Asian Black or African American White Not Given/Specified

Ethnicity (circle one)

Hispanic or Latino Not Hispanic or Latino Not Given/Specified

Sexual Orientation (circle one)

Straight Homosexual Bisexual Choose not to Disclose

Gender Identity (circle one)

Male Female Transgender Decline to Answer

Preferred Language: _____

What problems are you here for today?

_____

_____

Pharmacy: _____ Phone: _____ Address: _____

Allergies: □ **No Known Allergy**

Please list any ALLERGIES and REACTIONS TO MEDICATIONS:

Name of Allergen	Reaction caused
1.	
2.	
3.	
4.	
5.	

Current Medications: □ **No Current Medications**

Please list any Current Medications, Vitamins, Supplements (amounts, times per day):

1._____ 8. _____

2. _____ 9._____

3. _____ 10._____

4. _____ 11._____

5. _____ 12._____

6._____ 13._____

7._____ 14._____

Past Medical History: □ No Known Past Medical History

Please checkmark or circle ailments listed below. In case, you don't find any ailment listed then please enter the details in the area provided for 'Other'.

□ Diabetes

□ Eye Diseases such as:
__ retinopathy
__glaucoma
__cataracts
__legally blind

□ Neuropathy

□ Feet ulcers

□ Thyroid disease

□ Heart or Vascular Diseases such as:
__coronary artery disease or previous heart attack
__congestive heart failure
__arrhythmias
__peripheral vascular disease or claudication
__carotid artery stenosis

□ Cholesterol problems

□ Hypertension

□ Respiratory diseases

□ Sleep Apnea

□ Gastrointestinal problems such as:
__stomach problems
__ intestinal problems
__ liver disease

□ Genitourinary problems such as:
__kidney failure
__kidney stones
__erectile dysfunction
__prostate enlargement

□ Neurological problems, including Stroke

□ Cancer

□ Psychiatric problems such as:
__depression
__psychosis

□ Adrenal Gland problems such as:
__adrenal insufficiency
__adrenal mass

□ Osteoporosis

□ Fractures

□ Other Endocrine Diseases such as:
__hyperparathyroidism
__hypercalcemia
__hypoparathyroidism
__hypocalcemia
__pituitary disorders
__polycystic ovary syndrome
__hirsutism (abnormal hair growth)

□ Head trauma (ever)

□ Infertility

Other:
_____
_____

Surgical History: □ **No Known Surgical History**

Please list any operations (and dates) you have ever had:

Name of Surgery/ Date

1._____ 6. _____

2. _____ 7._____

3. _____ 8._____

4. _____ 9._____

5. _____ 10._____

Family History: □ **No known family history**

Please check each ailment in your immediate family and include relationship:

□ Diabetes _____

□ Thyroid Disease _____

□ Cholesterol problems _____

□ Hypertension _____

□ Heart Problems _____

□ Respiratory problems _____

□ Stomach/Intestinal _____

□ Kidney diseases _____

□ Stroke _____

□ Osteoporosis _____

□ Hip Fracture _____

□ Parathyroid/Calcium problems_____

□ Pituitary tumors _____

□ Infertility _____

□ Abnormal hair growth _____

□ Cancer _____

□ Other: _____

Social History:

Tobacco:

☐ Current everyday smoker
☐ Current someday smoker
☐ Former smoker
☐ Never smoker

Alcohol:

☐ Current everyday drinker
☐ Current someday drinker
☐ Former drinker
☐ Never drinker

Coastal Endocrinology

Review of Systems:

Although many of the following symptoms may not pertain to you, please address each symptom and provide any other symptoms under "other".

General

fever	□ No □ Yes
fatigue	□ No □ Yes
weight gain	□ No □ Yes
weight loss	□ No □ Yes

Eyes

blurred vision	□ No □ Yes
double vision	□ No □ Yes
bulging eyes	□ No □ Yes

Ears/Nose/Mouth/Throat

hearing loss	□ No □ Yes
ear ringing	□ No □ Yes
loss of smell	□ No □ Yes
anterior neck pain	□ No □ Yes
enlarged thyroid (goiter)	□ No □ Yes
neck mass	□ No □ Yes

Cardiovascular

chest pain	□ No □ Yes
palpitations	□ No □ Yes
leg swelling	□ No □ Yes

Respiratory

cough	□ No □ Yes
shortness of breath	□ No □ Yes
snoring	□ No □ Yes

Endocrine

excessive thirst	□ No □ Yes
frequent urination	□ No □ Yes
cold intolerance	□ No □ Yes
heat intolerance	□ No □ Yes
excessive sweating	□ No □ Yes
nipple discharge	□ No □ Yes

Gastrointestinal

abdominal pain	□ No □ Yes
bloating	□ No □ Yes
constipation	□ No □ Yes
diarrhea	□ No □ Yes
difficulty swallowing	□ No □ Yes
indigestion	□ No □ Yes
nausea	□ No □ Yes
vomiting	□ No □ Yes

Hematologic/Lymphatic

anemia	□ No □ Yes
easy bruising/bleeding	□ No □ Yes
lymph node enlargement	□ No □ Yes

GU

hot flashes	□ No □ Yes
decreased sex drive	□ No □ Yes
infertility	□ No □ Yes
difficult erections (male only)	□ No □ Yes
irregular periods (female only)	□ No □ Yes

Skin

acne	□ No □ Yes
change in skin color	□ No □ Yes
dryness	□ No □ Yes
itching	□ No □ Yes
feet wounds	□ No □ Yes

Musculoskeletal

muscle cramps	□ No □ Yes
muscle pains	□ No □ Yes

Neurological

unusual headaches	□ No □ Yes
numbness or tingling in feet	□ No □ Yes
tremors	□ No □ Yes
head injury (ever)	□ No □ Yes

Psychiatric

depression	□ No □ Yes
anxiety	□ No □ Yes
insomnia	□ No □ Yes

Other

_____

_____

Notice of Privacy Practices for Protected Health Information (HIPAA)

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information".
Please Review It Carefully!

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for which you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals, surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect , domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster Relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You Have The Right To:

- Inspect and copy medical information from you chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years, starting March 15, 2018**.** You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our <u>Privacy Officer</u> at our office.

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If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.