Zoran Potparic M.D., P.A.

A Good Result
depends on
Experience and Skill

PATIENT INFORMATION

Patient Name: _____ Home Phone: _____

May we send appointment reminders via text message? ❑ Yes ❑ No Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____ Age:_____ Sex: ❑ M ❑ F

Marital Status: ❑ S ❑ M ❑ W ❑ D Email Address: _____

Employer:_____ Occupation:_____ Phone:_____

Spouse's Name: _____ Phone:_____

Additional/Emergency Contact: _____ Relationship:_____

Phone: _____

How Did You Hear About Dr. **Zoran**? _____ Reason for Visit: _____

RESPONSIBLE PARTY *(ONLY fill out if the patient is a minor)*

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____

State: _____ Zip:_____ Relationship:_____

INSURANCE INFORMATION (HOSPITAL OR RECONSTRUCTIVE PATIENTS)

Insurance Name:_____ Member ID# _____ Group # _____

_____ Worker's Compensation _____ Auto Insurance _____ Other: _____

Date of Injury:_____ Nature of Accident:_____

Employer Name:_____ Employer Phone Number: _____

Attorney Name:_____ Attorney Phone Number:_____

AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS

Medical photographs may be taken before, during and after a surgical procedure or treatment. Consent is required to take such images. These images are used only for the education of other patients and physicians.

Patient Signature:_____ Date:_____

MEDICAL HISTORY

Name_____ Date of Birth: _____

Primary Care Physician_____ Telephone: _____

Primary Care Physician's Address _____ Last Seen: _____

Other physicians you have seen in the last year: _____

_____

Previous Operations:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Have you had:

Tonsillectomy/Adenoidectomy	Yes_____	No_____
Cholecystectomy (gallbladder)	Yes_____	No_____
Appendectomy	Yes_____	No_____
Hysterectomy	Yes_____	No_____
C-Section	Yes_____	No_____

Medical Illnesses you are being treated for:

1. _____ 4._____ 7._____
2. _____ 5._____ 8._____
3. _____ 6._____ 9._____

Have you ever had problems with anesthesia? ❑ Yes ❑ No If so, which type of anesthesia? ❑ Local ❑ General

What was the nature of the problem? _____

Has anyone in your family had a reaction to anesthesia? ❑ Yes ❑ No

Drug Allergies: _____

List All Other Allergies: _____

Prescription Medications:

1. _____ Dose: _____ 2. _____ Dose:_____
3. _____ Dose: _____ 4. _____ Dose:_____
5. _____ Dose: _____ 6. _____ Dose:_____
7. _____ Dose: _____ 8. _____ Dose:_____

List all other medications are you taking (aspirin, vitamins, birth control pills, etc.)?

_____

What vitamins, herbs or supplements are you taking?

_____

Are you taking any diet or weight loss pills? ❑ Yes ❑ No If so, which ones? _____

Do you smoke? ❑ Yes ❑ No How much? _____ How many years? _____

If you used to smoke, when did you quit? _____

Do you drink alcohol? ❑ Yes ❑ No How much and what type? _____

Have you ever had an Exercise Tolerance Test (Stress Test)? ❑ Yes ❑ No When?_____

Name: _____ Date of Birth: _____

Family History - Have any immediate family members had the following? If yes, please indicate how you're related:

❑ Breast Cancer_____
❑ Melanoma _____
❑ Stroke _____
❑ Emphysema_____
❑ Diabetes _____
❑ High Blood Pressure _____
❑ Heart Disease _____
❑ Cancer_____
❑ Bleeding Problems _____
❑ Blood Clots in the Veins of the Legs_____
Type?_____

Past Medical History – Have YOU ever had any of the following?

❑ Heart Disease
❑ Rheumatic Fever
❑ High Blood Pressure
❑ Mitral Valve Prolapse
❑ Diabetes
❑ Stroke
❑ Anemia
❑ Bleeding Disorders
❑ Asthma
❑ Tuberculosis
❑ Arthritis
❑ Cancer Type? _____
❑ Hepatitis or Liver Disease
❑ Gastro Esophageal Disease
❑ Psychiatric Disease
❑ HIV+
❑ MRSA Infections
❑ Kidney Disease
❑ Blood Clots in your legs
❑ Hernias
❑ Other: _____

Review of Symptoms – Have YOU had any of the following symptoms in the past five years?

❑ Weight Change
❑ Dry eyes
❑ Chronic Cough
❑ Shortness of Breath
❑ Wheezing
❑ Chest Pain
❑ Irregular Heart Beat
❑ Low Blood Pressure
❑ Bleeding Problems
❑ Easy Bruising
❑ Swelling of Feet or Ankles
❑ Skin Rash
❑ Skin Infections
❑ Chronic Constipation
❑ Heart Burn
❑ Problems with Urination
❑ Jaundice
❑ Depression
❑ Passing out or Fainting
❑ Seizures
❑ Swollen Lymph Nodes (glands)
❑ Joint or Muscle Pain
❑ Anxiety
❑ Other: _____

I attest that the health history as noted above is complete and accurate. All prescribed medicines and over the counter supplements and vitamins are listed. I understand that omissions or misrepresentations may affect my personal health, safety and/or the outcome of any of my procedures.

Signature:_____ Date: _____

PATIENT INFORMATION SHEET
Zoran Potparic, M.D. 1116 E. Broward Blvd, Ft. Lauderdale, FL 33301, For billing/collection please call: (954) 527-2677

FINANCIAL AGREEMENT

THE UNDERSIGNED agrees whether s/he signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, s/he herby individually Obligates himself/herself to pay the account. THE UNDERSIGNED UNDERSTANDS THOSE UNPAID ACCOUNTS WILL BE CONSIDERED IN DEFAULT AFTER ONE HUNDRED TWENTY DAYS (120), AFTER WHICH TIME INTERESTS WILL BE CHARGED AT THE RATE OF 1% PER MONTH ON THE UNPAID BALANCE. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. Dr. Potparic does NOT accept insurance. Patients are responsible for payment of all services rendered at the time of service. However, as a courtesy to patients, this office will assist patients by submitting bills to their insurance companies.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL AND/OR PROFESSIONAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING PRIVATE INSURANCE AND ALL OTHER HEALTH PLANS TO ZORAN POTPARIC, M.D. THIS STATEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORGINAL.

I hereby authorize Zoran Potparic, M.D., to release my records to my insurance company, or company with any request from my insurance company to release my records to them.

I fully understand that any payment that I or my attorney receives made by my insurance company was solely intended for services rendered by Dr. Potparic. These checks must be sent to this office upon receipt. Failure to do so will immediately result in a 1% interest on the outstanding balance plus legal fees.

I understand that the information I am providing, including any phone numbers listed, may be used as a means of contacting me in the event that I do not pay for the services as agreed. I further understand that this permission extends to an outside collection agency or attorney if the account reaches 120 days or more past due.

I understand that in the event my account is referred for outside collections and /or to an attorney, that it may be reported to one or all of the National Credit Reporting Agencies.

Patient's Name (Print): _____ Date: _____

Patient's Signature: _____ Date: _____

PARENT/SPOUSE/GUARANTOR:

Print Name: _____ Date: _____

Signature: _____ Date: _____

FOR MEDICARE PATIENTS ONLY:
Medicare will only pay for services that it determines are "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. I understand that there is a $162.00 Medicare deductible every year that is solely my responsibility.

Patient's or Authorized Signature: _____ Date: _____

PATIENT INFORMATION SHEET

PATIENT CONSENT FORM

List names that you authorize Dr. Potparic and staff to speak to regarding your medical condition.

_____

_____

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes for treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Date:_____

Signature: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients: The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly Thank you for being one of our highly valued patients.