Patient Information Sheet

Patient Name _____
Address _____ **City** _____ **State** _____ **Zip Code** _____
Mailing Address *(if different)* _____
Primary Phone # _____ **Secondary Phone #** _____
Language Primary _____ **Email Address** _____@_____._____
Social Security # _____ **Date of Birth** _____ **Sex: Male / Female**

Relationship: Married / Single / Divorce /Widowed / Life Partner
Race: Caucasian / Black-African American / Hispanic / American Indian-Alaska Native / Asian / Native Hawaiian-Pacific Islander / Other _____ / Refuse to State *(as required by state law)*

Hispanic-Latino Ethnicity: ___YES ___NO ___Refuse to State*(as required by state law)*

Advance Care Planning and Advance Directives

___Care Giver (CG) / ___Living Will (LW) / ___Power of Attorney (PA)/ ___Surrogate Decision Maker Identified (S)/ ___Advance Directive Present (Y)/ ___Do Not Resuscitate (DNR)/ ___No Advance Directive Opted(None of the Above) (N)

Pharmacy Name _____ **Phone #** _____
Pharmacy Cross Roads _____ **and** _____
Primary Care Physician _____ **Phone #** _____
Referring Physician _____ **Phone #** _____

Insurance Information

Primary Insurance _____ **Primary Policy Holder: Self / Spouse / Child**
Card Holder Name _____ **Date of Birth** _____
Secondary Insurance _____ **Primary Policy Holder: Self / Spouse / Child**
Card Holder Name _____ **Date of Birth** _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name: _____ **Phone #:** _____ **Relationship** _____

Can we release medical information to this person? _____**YES** _____**NO**

Notice of HIPPA Privacy Practice

A copy of this office Notices of Privacy Practices has been provided to me.
Signature _____ **Date** _____

To whom may we disclose your medical information (pathology, labs, instructions, or post-procedure results?)
Full Name _____ **Phone Number** _____
Full Name _____ **Phone Number** _____

The above information is true to the best of my knowledge. I understand that if you participate with my insurance, I am responsible to pay my copayment and any unpaid balance as your patient. Insurance Prior-Authorization approval certification for office visit and/or procedure does not guarantee of payment. If you do not participate with my insurance, I will be required to pay the entire visit charge ($150 first visit, and $50 each follow up visit.) I understand that you accept cash, check, MasterCard, Visa, American Express and Discover as a form of payment.

_____ _____
Patient / Guardian Signature Date

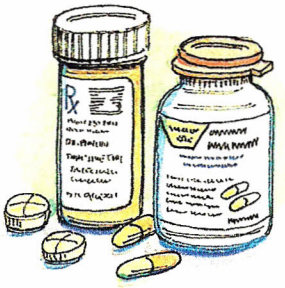
Questionnaire for Latex Sensitivity

Patient Name: _____ DOB: _____

1. Sex: ☐ Male ☐ Female
2. Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other: _____
3. Have you ever been told by a doctor that you are allergic to latex? ☐ Yes ☐ No
4. How many surgeries have you had in the past? _____
5. Do you suffer from:
   a. Seasonal hay fever? ☐ Yes ☐ No
   b. Asthma? ☐ Yes ☐ No
   c. Eczema? ☐ Yes ☐ No
   d. Auto immune disease? ☐ Yes ☐ No
6. Do you have an on-the-job exposure to latex? ☐ Yes ☐ No
7. Were you born with problems involving your spinal cord? ☐ Yes ☐ No
8. Do you catheterize yourself to urinate? ☐ Yes ☐ No
9. Do you have any food allergies? ☐ Yes ☐ No
10. Are you allergic to:
    a. Bananas? ☐ Yes ☐ No
    b. Avocados? ☐ Yes ☐ No
    c. Guacamole? ☐ Yes ☐ No
    d. Chestnuts? ☐ Yes ☐ No
11. Are you allergic to latex or products containing rubber? ☐ Yes ☐ No
    a. If Yes, are the symptoms a rash? ☐ Yes ☐ No
    b. Hives? ☐ Yes ☐ No
    c. Itching? ☐ Yes ☐ No
    d. Wheezing? ☐ Yes ☐ No
    e. Difficulty breathing? ☐ Yes ☐ No
    f. Watery eyes? ☐ Yes ☐ No
    g. Anaphylaxis? ☐ Yes ☐ No
12. Do you have allergic symptoms while:
    a. Blowing up balloons? ☐ Yes ☐ No
    b. During dental examinations? ☐ Yes ☐ No
    c. On Contact with diaphragms/condoms? ☐ Yes ☐ No
    d. During vaginal or rectal exams? ☐ Yes ☐ No
    e. While wearing rubber gloves? ☐ Yes ☐ No

_____ _____

Signature of Patient Date



Medication List

Patient Name: _____ Date: _____

DOB: _____

Name of Medication	Strength	How many times daily
Example: Aspirin	*81 mg*	*Once a day*

JOSEPH J. KATTA M.D. P.A.

1900 Nebraska Ave., Ste 5
Ft. Pierce, FL 34950
Ph: 772-466-7200
Fax: 772-466-9513

306 S.W. Bethany Drive
Port St. Lucie, FL 34986
Ph: 772-878-1475
Fax: 772-878-1497

1700 Hillmoor Drive, Ste 402
Port St. Lucie, FL 34952
Ph: 772-236-5757
Fax: 772-236-5758

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04-14-03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time, For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures, In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, or neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will us the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.____ for each page,
$ _____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations **(You must make your request in writing).** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.