Name:
Date of Birth:

Fast Form: Adult Male

(Please check any corresponding issues)

Constitutional

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain (Unintentional)
- ☐ Weight Loss (Unintentional)

Eyes

- ☐ Blurred Vision
- ☐ Eye Drainage
- ☐ Eye Pain
- ☐ Glasses/Contacts
- ☐ Sensitivity to Light

Ears/Nose/Throat

- ☐ Ear Pain
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Thrush

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Pedal Edema

Respiratory

- ☐ Cough (acute)
- ☐ Cough (chronic)
- ☐ Dyspnea
- ☐ Wheezing

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Anorexia
- ☐ Bloating
- ☐ Dysphagia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary

- ☐ Hematuria
- ☐ Hx Frequent UTI's
- ☐ Impotence
- ☐ Urinary Incontinence
- ☐ Urinary Stream Change

Musculoskeletal

- ☐ Joint Stiffness
- ☐ Back Pain
- ☐ Arthralgias
- ☐ Limp Pain
- ☐ Myalgias

Integumentary

- ☐ Pruritis
- ☐ Rashes

Neurological

- ☐ Dizziness
- ☐ Headaches
- ☐ Memory problems
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Speech Disorder
- ☐ Tremor
- ☐ Weakness

Hematologic/Lymphatic

- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Hx of Blood Transfusions
- ☐ Lymphadenopathy

Endocrine

- ☐ Heat/Cold Intolerance
- ☐ Excessive Sweating

Allergic/Immunologic

- ☐ Seasonal Allergies/"hayfever"

Psychiatric

- ☐ Anxiety
- ☐ Crying Spells
- ☐ Depression
- ☐ Feeling Stressed
- ☐ Personality Change
- ☐ Poor Concentration
- ☐ Recreational Drug Use
- ☐ Sadness
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts
- ☐ Personality Change
- ☐ Loss of Interest in pleasurable activities

KORUNDA MEDICAL INSTITUTE

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Last Name: _____ First: _____ Middle: _____
Date of Birth: _____ Sex: Female/Male
Occupation: _____ Employer's Name: _____
Do you have any Religious or Cultural Practices That may affect your healthcare or treatment? YES/NO
If yes, in what way? _____
List other physicians you see: _____
Reason for visit/chief complaint:

Do you have a living will? YES/NO Have you designated a health care surrogate? YES/NO
Name and phone number of surrogate: _____
Have you completed a Do Not Resuscitate Form? YES/NO Are you an organ donor? YES/NO

MEDICAL HISTORY

Have you previously had or been suspected to have had: Please Check and include the year Diagnosed.

NEUROLOGIC/PSYCHIATRIC	YEAR	EYES	YEAR
☐ Stroke		☐ Glaucoma	
☐ Sleeping Problems		☐ Other Eye Disorder/Disease	
☐ Epilepsy		☐ Macular Degeneration	
☐ TIA (stroke symptoms<24hrs)			
☐ Depression			
EARS/NOSE/MOUTH/THROAT		**LUNG/PULMONARY**	
☐ Disorders of Ears/Hearing or Balance		☐ Asthma	
☐ Problems with Nasal Allergies, Obstruction or Bleeding		☐ Recurring Bronchitis	
☐ Mouth, Throat or Swallowing Problems		☐ Chronic Lung Disease	
		☐ Emphysema	
		☐ Penumonia	
CARDIAC			
☐ Heart Attack/MI		☐ Heart Catherization	
☐ Angina/Chest pain		☐ Murmur	
☐ High Blood Pressure		☐ Abnormal Heart Tracing	
GASTRO			
☐ Gastritis		☐ Esophagitis	
☐ Reflux		☐ Ulcer Disease	
☐ Upper/Lower GI bleeding		☐ Diverticulitis	
☐ Colon Disease/Polyps		☐ Hepatitis	
☐ Liver Disease/Jaundice			
GU/GYN			
☐ Kidney Disease		☐ Prostate Cancer	
☐ Uterine/Ovarian Problem		☐ Prostate Infection	
☐ Difficulty Controlling Bladder		☐ Prostate Enlargement	
When was your last Menstrual Flow?		Any Sexually Transmitted Disease?	
☐ Breast Issues? If yes, please explain:			

MUSCULOSKELETAL	YEAR		YEAR
☐ Abnormal Muscle Function		☐ Loss of Joint Function	
☐ Arthritis Pain		☐ Bothersome Spine/Joint	
☐ Bone/Joint Replacement? Which joint?		☐ Pain, where?	
SKIN			
☐ History of skin Disease		☐ History of Cancer, what kind?	
☐ Current Skin Problems			
ENDOCRINOLOGY			
☐ Diabetes/High Sugar		☐ Recent Steroid Use (cortisone/prednisone)	
☐ Other Hormonal Problems? What kind?		☐ Thyroid Disorder (high/low) what kind?	
HEMATOLOGY			
☐ Bleeding Disorder/Sickle Cell		☐ Anemia	
☐ Immune Problems/AIDS/HIV		☐ Prolonged Bleeding from Cuts	
☐ Phlebitis/Blood clots in Legs		☐ Blood Transfusion	

SERIOUS INJURIES/ACCIDENTS: _____

_____

SURGICAL AND PROCEDURE HISTORY

Have you had any of the following surgeries and when?

	YEAR		YEAR		YEAR
☐ Hernia		☐ Heart Surgery		☐ Colonoscopy	
☐ Appendectomy		☐ Sinus Surgery		☐ Polyps	
☐ Gastrointestinal Surgery		☐ Lung/Pulmonary Surgery		☐ EGD (gastroscopy)	
☐ Gallbladder		☐ Hysterectomy		☐ Mammogram	
☐ Tonsillectomy		☐ Joint Replacement		☐ DEXA	
☐ Arthroscopy		☐ ENT Surgery		☐ Stress Test	
Other:					

PLEASE INCLUDE MEDICATIONS- Including non-prescription medications dosage and when taken:

_____

_____

_____

_____

VACCINATIONS

Last tetanus shot: _____ Last Pneumococcal Vaccine: _____ Last Influenza Vaccine: _____

DRUG ALLERGIES/SENSITIVITIES: _____

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SOCIAL HISTORY:
Marital Status: MARRIED/ SINGLE/ DIVORCED/ WIDOWED

Do you have any Children? YES/ NO **How many? _____ Ages: _____**

Seasonal Resident in _____ or; Full Time resident in _____

Are you currently employed? YES/ NO/ RETIRED/ DISABLED

If yes; where are you employed? _____

If retired; where were you employed? _____

Past employment_____

PERSONAL HABITS (PLEASE CIRCLE)

Do you smoke or have you ever smoked? NO/YES Cigarettes ____ Pipes ____ Cigars ____
How many years? _____ How much per day: _____ Quit date: _____

Do you usually drink over six cups of coffee a day? NO / YES

Do you drink alcohol? YES/NO/PAST HISTORY OF ABUSE
If yes; how often? REGULAR/SOCIAL/RARE
What type of alcohol? HARD LIQUOR/WHITE WINE/RED WINE/BEER

Do you do any Recreational Drugs? YES/NO/PAST HISTORY
If yes; how often? REGULAR/SOCIAL/RARE What types of Drugs? _____

Are you sexually active? YES/NO

History of any of the following: (Please circle) Anxiety (Panic Attacks, acute stress, anxiety due to medication) Major Depression, Bipolar, Suicidal Thoughts, Borderline Personality Disorder, Schizophrenia, NONE, Other: _____

FAMILY HISTORY
Father: Alive/ Deceased at age _____
Mother: Alive/ Deceased at age _____
Siblings:
Brother/s: # Alive_____ # Deceased _____
Sister/s: # Alive_____ # Deceased _____

PLEASE CHECK IF AN IMMEDIATE FAMILY MEMBER HAS BEEN AFFECTED WITH ANY OF THE FOLLOWING: (EXAMPLE: PARENTS, SIBLINGS, AND CHILDREN)

□ Cancer	□ Diabetes	□ Leukemia	□ Liver Disease
□ Stroke	□ Circulation Problems	□ Heart Disease	□ Bleeding Problems
□ Angina	□ Thyroid Disease	□ Lung Disease	□ Rheumatic Fever/Heart
□ Asthma	□ Colitis	□ Blood Disorders	□ Kidney Disease
□ Allergies	□ Depression	□ Heart Attack	□ Mental Illness
□ Glaucoma	□ Hypertension	□ Kidney Stones	□ Suicide
□ Ulcers	□ Neuromuscular Disease	□ Arthritis	□
□ Migraines	□ Epilepsy/Seizures	□ Tuberculosis	□

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Name: _____ Date of Birth: _____ Date: _____

Over the **last 2 weeks**, how often you have been bothered by any of the following problems?
(Please circle your answer)

Please answer the questions below using the following scale:

0= Not at all, 1= Several days, 2= More than half the days, 3= Nearly every day

1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING **0+_____+_____+_____**

=TOTAL SCORE: _____

If you circles any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
[ ]	[ ]	[ ]	[ ]

Name: _____ Date of Birth: _____ Date: _____

The Alcohol Use Disorders Identification Test: Self-Report Version

Patient: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. **Circle** that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking	1-2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 6 or more drinks in one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total:	

Korunda Medical LLC

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Patient Registration

Patient Name: _____ DOB: _____ SSN: _____

Gender: Male [ ] Female [ ] Marital Status: Married [ ] Single [ ] Divorced [ ]

Home Phone: _____ Cell Phone: _____

Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

If your billing address is the same as your mailing address please check here [ ]

Billing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____

Patient Demographics

Due to new government regulations, we are required to obtain additional demographic information from our patients. Please fill in the questions below. If you do not wish to disclose this information Please select "declined" from the list of options.

Preferred Language:

- ☐ _____
- ☐ Declined

Race:

- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino
- ☐ Refuse to Report

How did you hear about Korunda Medical? _____

KORUNDA MEDICAL, LLC

4513 Executive Dr, Naples, FL 34119
(239) 431-6464

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have received a copy of this Practice's **Notice of Privacy Practices.**

Print Name: _____ Telephone # _____

Signature: _____ Date: _____

If not signed by the patient, please indicate:

Relationship: (please check)

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For office use only:

Signed form received by: _____ Date: _____

Acknowledgment refused:

- ☐ Yes
- ☐ No

Efforts to obtain: _____

Reason for refusal: _____

KORUNDA MEDICAL, LLC (F-2)

Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Korunda Medical, LLC. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Korunda Medical LLC.

I understand that diagnosing or treatment of me by Korunda Medical, LLC may be conditioned upon my consent as evidence by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Korunda Medical, LLC agrees to a restriction that I request, the restriction is binding on the practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance on this Consent.

My "Protected Health Information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Korunda Medical, LLC's Notice of Privacy Practices prior signing this document.

Korunda Medical, LLC Notice of Privacy Practices has been provided to me:

The Notice of Privacy Practices for Korunda Medical, LLC describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of heath care operations.

A summary of the Notice of Privacy Practices for Korunda Medical, LLC I also posted in the waiting room.

The Notice of Privacy Practices also describes my rights and duties of Korunda Medical, LLC with respect to my protected health information.

Korunda Medical, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting Korunda Medical, LLC at 4513 Executive Drive Naples, FL 34119.

_____ _____

Patient Name (please print) **Date**

_____

Signature of Patient or Representative

_____ _____

Name of Patient or Representative (please print) **Employee Initial**

Korunda Medical, LLC.

FINANCIAL POLICY

Thank you for choosing Korunda Medical as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Part of this good practice is to provide you with a clear understanding of our financial policy.

CO-PAYS/DEDUCTIBLES/ CO-INSURANCE

Payments are due at time of check-in unless previous arrangements have been made with the billing department. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. Payments include all co-pays, deductibles, co-insurance and non-covered charges along with any past due balances. In addition, payment in full must be made if you do not have insurance, or if your coverage is currently under a pre-existing condition clause.

MEDICARE PART B

All Physicians/Providers at Korunda Medical, LLC are participating providers with Medicare Part B. Please be aware that Medicare has an annual deductible at the beginning of every year. After your deductible has been met, Medicare only pays for 80% of allowed charges. You will be responsible for the deductible and for the remaining 20% co-insurance. If you have supplemental insurance, it is your responsibility to provide us with that information. **Any remaining balance after payment from Medicare and the supplement insurance will be your responsibility.**

INSURANCE

Insurance is a contract between you and your insurance company. As a courtesy to you we will bill your primary insurance company. We are required to collect all co-pays, deductibles and coinsurance due to our contracts with your insurance. It is your responsibility to provide us with all your insurance information both primary and secondary or any changes made to your insurance. Failure to do so may result in patient responsibility in full.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by your insurance.

WORKER'S COMPENSATION

If you have a worker compensation claim, it is your responsibility to provide us with any/all necessary billing information prior to your first visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Once the worker's compensation carrier has released you from its financial responsibility or if benefits are denied, you will be responsible to pay in full for services rendered. Please understand that worker's compensation requires prior authorization for each office visit and/or procedure.

PERSONAL INJURY OR MOTOR VEHICLE ACCIDENT

As a courtesy, this facility will bill your MVA Insurance once you have provided us with all the necessary billing information for your claim. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Due to extreme delays of payment associated with such cases, Korunda Medical LLC., regrets to inform you that we do not accept letters of protection.

FORMS/MEDICAL RECORDS FEES

There will be a fee for all forms, copies of medical records, notarizing and for extra written communication by the doctor. If you are requesting copies of medical records a request must be made and our billing department will contact you with the fee. We require pre-payment for these services. The charge is determined by the complexity of the form, letter or communication. Please keep in mind completing these tasks require office staff time and time away from patient care for our doctors.

RETURNED CHECKS/CREDIT CARD PAYMENTS

Returned checks will incur a service charge. You will be asked to bring cash for any future visits if this occurs. All bad checks written to this office are subject to collections. Stopped payments for either checks or credit card constitute a breach of payment and are subject to a service fee and collections action.

ACCOUNTING PRINCIPALS

Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

COLLECTION FEES

In the event that your account is placed in a collections status, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of up to 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts. You may also be responsible for up to 1.5% interest per month. Please understand that these additional fees will be your personal responsibility to pay in full.

PATIENT NO-SHOW/CANCELLATION POLICY

Korunda Medical, LLC., requires a minimum of 24-hour notice for any canceled appointment. Failure to give proper notice in advance or not keeping your appointment for any reason resulting as a "no show" will be assessed a $25.00 fee. This fee will not be paid by your insurance company. You are responsible to pay this fee immediately. Thank you for your cooperation.

I have read and understood the practices financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Print Patient Name

Signature of Patient and/or Responsible Party Date

KORUNDA MEDICAL INSTITUTE

4513 Executive Dr, Naples, FL 34119
Phone: (239) 431-6464
Fax: (239) 594-5637

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient: _____ Date of Birth: _____

☐ **I DENY THE AUTHORITY TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF.**

I authorize the following people to speak freely with both Doctor and nurse about my medical conditions. Authorization includes the following information:

- Medication
- Past medical history
- Present care
- Future plan of care
- Appointments
- Billing and payments

Contact person: _____ Relationship: _____

Contact number: _____

Contact person: _____ Relationship: _____

Contact number: _____

Contact person: _____ Relationship: _____

Contact number: _____

Please sign below if you refused OR authorized others.

Signature: _____ Date: _____

Witness: _____ Date: _____

Korunda Medical Institute

4513 Executive Dr, Naples, FL 34119 Phone: 239-431-6464 Fax: 239-594-5637

Authorization to Release or Obtain Medical Records

Patient Name:

_____

From:
- ☐ Korunda Medical Institute
- ☐ _____ Fax: _____
- _____ Fax: _____
- _____ Fax: _____

To:
- ☐ Korunda Medical Institute
- ☐ _____ Fax: _____

- ☐ Complete Medical Record
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation/Operative Report
- ☐ X-Ray and Imaging Reports
- ☐ Laboratory Test Results
- ☐ Immunization Records
- ☐ Demographic Information
- ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services, and treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law. I understand according to Florida Statutes, there will be a charge for medical records copied and released to patients. There is no charge for copies to physicians for continuation of care. This may be disclosed to and used by the above facilities for purpose of:

- ☐ Further Medical Care
- ☐ Legal Investigation or Action
- ☐ Changing Physicians
- ☐ Insurance Eligibility/Benefits
- ☐ Personal
- ☐ Other: _____

I understand I have the right to inspect and obtain a copy of my protected health information in the designated sets you or your business maintain. In understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use or for any civil, criminal , or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 USC section 263a), and certain other records. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy and information used or disclosed under this authorization as described above. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization. I release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance with this authorization. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires with 3 years unless otherwise specified.

Signature of Patient: _____ Date: _____

(If signed by person other than patient, state relationship and authority to do so.)

Patient is: ( ) Minor ( ) Incompetent ( ) Disabled ( ) Deceased

Legal Authority is: ( ) Parent ( ) Legal Guardian ( ) Executor of Estate of Deceased ( ) Power of Attorney ( ) Legal Rep.

Signature of Witness: _____ Date: _____