SAL A. FARRUGGIO, M.D., FACS
2 Medical Park Dr, Suite 4
West Nyack, New York 10994
845-639-7546

REASON FOR THIS VISIT_____ DATE_____

WHO REFERRED YOU? _____

PATIENT INFORMATION

LAST NAME_____FIRST_____ MIDDLE INITIAL_____

HOME ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE #_____CELL PHONE #_____WORK PHONE #_____

E-MAIL_____SS#_____

SEX____M____F AGE_____ BIRTHDATE_____ MARITAL STATUS_____

CAN WE MAIL INFORMATION TO YOUR HOME: YES_____ NO_____

INSURED PARTY (IF OTHER THAN PATIENT)

NAME_____ (H)TELEPHONE#_____

ADDRESS_____ (W)TELEPHONE#_____

_____ EMPLOYER_____

RELATIONSHIP_____BIRTHDATE_____ SS#_____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY_____ ID#_____

ADDRESS_____ TELEPHONE#_____

_____

I hereby authorize Salvatore A. Farruggio, MD to furnish information to insurance carriers regarding my medical care and I hereby assign to him all payments for medical/surgical services rendered to myself or dependents. A copy of this signature shall be considered an original. I understand that I am responsible for all fees, regardless of insurance reimbursement, including deductible amount, coinsurance, or any unpaid balance. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and not a substitute for payment. I further understand that payment is required at the time that services are rendered unless other arrangements are made in writing. Services that are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise. I agree that this noncredit challenge agreement is irrevocable.

I also acknowledge that I have received notification of Dr. Farruggio's credentials, training and experience.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient Name or Legal Guardian

Medical History

Are you being treated or have you been treated for any of the following medical problems?

High Blood Pressure	_____	Chest Pain	_____	Heart Attack	_____
Vascular Disease	_____	Asthma	_____	Bronchitis	_____
Abnormal Heart Rhythm	_____	Depression	_____	Vertigo	_____
Thyroid Disease	_____	Anxiety	_____	Diabetes	_____
Kidney Problems	_____	Glaucoma	_____	Cataracts	_____
Ulcers/Gastritis	_____	Tuberculosis	_____	Hepatitis	_____
Diverticulitis/Hiatal Hernia	_____	Epilepsy	_____	Heart Murmur	_____
Persistent cough	_____				

Do you stop bleeding normally? Yes No
Do you have any bad scars? Yes No
Have you ever taken steroids? Yes No
Do you heal normally? Yes No
Have you ever had radiation treatments? Yes No

Please list all current medications with dosages: None: _____

_____

_____

_____

_____

Height: _____ Weight: _____

Females: Are you pregnant? _____ If no, last menstrual period? _____

Do you smoke? Yes___ #Packs/day_____
No____ Have you recently quit? _____When? _____

Do you drink alcohol on a regular basis? Yes_____ No_____ Occasionally_____

Recreational drug use Yes_____ No_____

Name of local internist/physician: _____ Phone _____

Emergency Contact: _____ Phone: _____

Name of Pharmacy: _____ Phone: _____
Address of Pharmacy: _____

Please list all previous surgeries:

Type of Surgery	Place	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all allergies to medications: None: _____

_____

_____

_____

Please list any other medical problems or conditions which you are, or have been treated for:

_____

_____

_____

The above information is accurate to the best of my knowledge:

Signature: _____ Print Name: _____

PATIENT HIPAA AWARENESS

With my permission, Dr. Salvatore Farruggio may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Salvatore Farruggio's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Salvatore Farruggio reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Salvatore Farruggio may call my home or other designated locations 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 call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Salvatore Farruggio may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my permission, the office of Dr. Salvatore Farruggio may e-mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Salvatore Farruggio restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

In addition, by signing this form, I am irrevocably consenting to allow Dr. Salvatore Farruggio, to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment.

By signing this form, I am allowing Dr. Salvatore Farruggio to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of our Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

FOR PRACTICE USE ONLY:

Our facility has made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:

-

_____

_____

_____

_____

_____

_____

_____ _____
Signature of Staff Member **Date**

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.
Examples:

- **Patient was asked to sign upon check-in but refused to do so**
- **Because of medical condition, Patient physically unable to sign acknowledgement**
- **etc.**