



PATIENT INFORMATION

PATIENT NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

STATUS (PLEASE CIRCLE): Single Married

ETHNICITY (PLEASE CIRCLE): Caucasian Afro-American Native American Hispanic Asian Middle Eastern

How did you hear about our office? Doctor \_\_\_ Another patient \_\_\_ Relative \_\_\_ Friend \_\_\_ Other \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALL FINANCIAL ARRANGMENTS FOR PAYMENT SHOULD BE MADE PRIOR TO YOUR TREATMENT.
INSURANCE: PLEASE PRESENT YOUR INSURANCE CARD ALONG WITH IDENTIFICATION TO THE RECEPTIONIST. THANK YOU!

Primary Insurance Co.
\_\_\_\_\_

Claims Address
\_\_\_\_\_

Insured's Name
\_\_\_\_\_

Group # or Name
\_\_\_\_\_

Primary Insurance Co.
\_\_\_\_\_

Claims Address
\_\_\_\_\_

Insured's Name
\_\_\_\_\_

Group # or Name
\_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to the physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



Mark any of the following conditions you or a family member has EVER experienced?

| Condition                   | No                       | Self                     | Family                   | Please Explain |
|-----------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Sinusitis                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Hypothyroidism              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Skin cancer                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Abnormal moles              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Psoriasis                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Eczema                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Hives                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Asthma                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| COPD                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Lung cancer                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Pneumonia                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Atrial fibrillation         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Murmur                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Angina (chest pain)         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Ankle swelling              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Heart attack                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| High blood pressure         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Rheumatic/Scarlet fever     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Gastric reflux (GERD)       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Gastric bleeding            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Colon cancer                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Prostate/cancer enlargement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Testicular cancer           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Pinched nerve               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Spinal stenosis             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Stroke/seizures/TIA         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Diabetes (type)             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Breast cancer               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| Anemia                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____          |

**Surgeries & Dates:**

\_\_\_\_\_

Are you pregnant? \_\_\_\_Yes\_\_\_\_No    Number of pregnancies\_\_\_\_    Number of Births\_\_\_\_

Please  next to the symptoms that apply to you:

|                       |  |                        |  |                           |  |
|-----------------------|--|------------------------|--|---------------------------|--|
| Decreased appetite    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Anxiety                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cough                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Change in weight      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Confusion              | <input type="checkbox"/> No <input type="checkbox"/> Yes | Respiratory pain          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| High blood pressure   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Depression             | <input type="checkbox"/> No <input type="checkbox"/> Yes | COPD                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| High cholesterol      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Delusions              | <input type="checkbox"/> No <input type="checkbox"/> Yes | Prod. of sputum           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Fatigue               | <input type="checkbox"/> No <input type="checkbox"/> Yes | Easy bruising          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Coughing blood            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Fevers                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Anemia                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Apnea                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cancer                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Clotting disorder      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Wheezing                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Decreased vision      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bleeding disorder      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bronchitis                | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Double vision         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pain in leg at rest    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pneumonia                 | <input type="checkbox"/> No <input type="checkbox"/>     |
| Temporary blindness   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Leg pain when walking  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone/joint deformity      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Blurred vision        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Slow healing leg wound | <input type="checkbox"/> No <input type="checkbox"/> Yes | Joint swelling            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Detached retina       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sensitivity to cold    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Back pain                 | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Temporal arteritis    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arterial disease       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Muscle aches              | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Paralysis             | <input type="checkbox"/> No <input type="checkbox"/> Yes | History of aneurysm    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Limited motion            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Weakness              | <input type="checkbox"/> No <input type="checkbox"/> Yes | Change in moles        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Knee replacement          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Seizure               | <input type="checkbox"/> No <input type="checkbox"/> Yes | Itching                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hip replacement           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Fainting              | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rash                   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Spinal problems           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Headache              | <input type="checkbox"/> No <input type="checkbox"/> Yes | Dry skin               | <input type="checkbox"/> No <input type="checkbox"/> Yes | Thyroid disorder          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Migraine              | <input type="checkbox"/> No <input type="checkbox"/> Yes | Chronic skin problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes w/ insulin       | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Stroke                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sore throat            | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes -no insulin      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Numbness in limbs     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sinus drainage         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Extreme appetite          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Slurred speech        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hoarseness             | <input type="checkbox"/> No <input type="checkbox"/> Yes | Extreme thirst            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Decreased memory      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Discharge from ears    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Lupus                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ankle swelling        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nose bleeds            | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatoid arthritis      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Atrial fibrillation   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hearing loss           | <input type="checkbox"/> No <input type="checkbox"/> Yes | <b><u>FEMALE ONLY</u></b> |  |
| Labored breathing     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Ringling in ears       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Irregular periods         | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dizziness             | <input type="checkbox"/> No <input type="checkbox"/> Yes | Painful swallowing     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Breast problems           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital heart dis. | <input type="checkbox"/> No <input type="checkbox"/> Yes | Indigestion            | <input type="checkbox"/> No <input type="checkbox"/> Yes | Menopause                 | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic heart dis.  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Vomiting               | <input type="checkbox"/> No <input type="checkbox"/> Yes | Last pelvic exam          | _____ / year   |
| Murmur                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Vomiting blood         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Last period               | _____ year   |
| Loss of consciousness | <input type="checkbox"/> No <input type="checkbox"/> Yes | Gall bladder problems  | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Palpitations          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver disease          | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Chest pain            | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hemorrhoids            | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Chest discomfort      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diarrhea               | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Unable to urinate     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Jaundice               | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Painful urination     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Constipation           | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Prostate problems     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Abdominal pain         | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Kidney/bladder dis.   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bloody stools          | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Decr. urine stream    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Change in stool color  | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Kidney failure        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Change in bowel habits | <input type="checkbox"/> No <input type="checkbox"/> Yes |                           |  |
| Blood in urine        | <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |  |                           |  |
| Excessive urination   | <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |  |                           |  |

**OFFICE USE ONLY**

## Habits

Do you drink alcoholic beverages? No Yes (#/week \_\_\_\_\_) Exercise? No Yes (#of days / week \_\_\_\_\_)  
Do you now or have you ever used tobacco? No Yes (Packs/week \_\_\_\_\_)Quit Date, if applicable \_\_\_\_\_

**ACKNOWLEDGEMENT:** The following services may require 3 or more treatments: Aura Laser, Lyra Laser, Sclerotherapy injections. Depending on your individual needs, the length of time in which you will see results can vary. Please discuss the possible number of treatments and costs when scheduling your treatments.

I, \_\_\_\_\_, verify that the above is true.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



### NOTICE OF PRIVACY PRACTICES

This notice defines Erasers' Privacy Policy. It describes how healthcare information about you may be used and disclosed and how you can get access to this information.

Please review it carefully:

This office uses and discloses your protected healthcare information (PHI) for the following reasons:

- To share with other treating healthcare providers regarding your health care.
- To submit to insurance companies, Workers' Compensation, or other Third Party Administrators claim information to verify treatment has been rendered.
- To determine patient's benefits in a healthcare plan.
- Releasing information required by State of Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- *Any other uses or disclosures will only be made with your specific written prior authorization.*

You have the right to:

- Revoke authorization, in writing, at any time by specifying what you want restricted and to whom you want it restricted.
- Speak to our privacy office manager, who can be reached at **(941) 907-3400** regarding privacy issues.
- Inspect, copy, and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health & Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy of our policy, upon request, at any time simply by requesting it from a staff member.

I acknowledge that I have received and reviewed this notice with full understanding.

\_\_\_\_\_  
Patient/Guardian Name (Print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

### NOTICE OF ULTRASOUND LABORATORIES

Federico Richter, MD has a vascular ultrasound lab located at Vein Center at Erasers. We are required by law to inform you there are other vascular ultrasound testing labs, such as: *Manatee Diagnostic Center (300 Riverside Dr. E, Bradenton, FL 34208)* & *Manatee Memorial Hospital (206 2<sup>nd</sup> St. E, Bradenton, FL 34208)*.

However, these centers' tests are not as complete as the ones performed by Erasers' Registered Vascular Technologist. Vital information can be left out which is needed for an accurate evaluation for your plan of care.

Medicare, or any other insurance company will only pay for services deemed to be "reasonable and necessary" under section 1862(a)(1) of Medicare law. Medicare or any other insurance company will deny payment for services that are considered cosmetic procedures. Cosmetic procedures performed at Erasers are not considered to be medically necessary by your insurance company. They consider these services to be strictly cosmetic. As a provider of these services, we are informing you these will not be filed with your insurance. Only services that are medically necessary will be billed to your insurance company.

\_\_\_\_\_  
Patient /Guardian Name (Print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name(Print)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR RELEASE  
OF MEDICAL RECORDS AND INSURANCE INFORMATION

In consideration of services rendered or to be rendered, I hereby assign to the provider Federico Richter, MD of such services my major medical insurance benefits and rights attendant thereto as shall equal the full amount of the bill for such services, and the provider or his assigns may secure same in my name.

I further understand if said sum is not collected, I will remain liable therefore.

Kindly furnish my insurance company or its representatives all information you may have regarding my condition while under your treatment or observation. You are authorized to provide this information in accordance with applicable laws.

Kindly furnish the provider, or his representatives, all information relating to the status or extent of my applicable insurance benefits.

A photocopy of this assignment and authorization shall be valid and accepted as the original.

DATE: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE (IF MINOR PARENT OR GUARDIAN)

PRINT NAME: \_\_\_\_\_