



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 _____

Patient Name _____ DOB _____ Age _____

ALLERGIES: _____

Pharmacy: _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, BELOW IN CHART:

Medications

Date	Medication	Dosage	Qty	Freq	Refills			Stop Date
					Date & Initial			

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	<u>FEMALE ONLY</u>	
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 2nd 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: _____