ASPI BIOLOGICS

5808 W. Cypress St. Tampa, FL 33607

Patient Information

Today's Date _____Home Phone _____

Name _____ SS# _____

Address _____Cell Phone _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Married ☐ Widow ☐ Single ☐ Divorced/Separated ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Emergency Contact _____ Phone _____

Family/Referring Dr _____Phone _____Fax _____

Email Address _____

Medications

1._____	2._____	3._____
4._____	5._____	6._____
7._____	8._____	9._____
10._____	11._____	12._____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO If so what_____

_____

Medical History

Check all that apply

_Diabetes	_High Blood Pressure	_Heart Disease	_Heart Attack
_Asthma	_Bronchitis or Emphysema	_Pneumonia	_Ulcers
_Hypo/Hyper Thyroid	_Rheumatoid Arthritis	_History of Cancer	_Blood Clots
_High Cholesterol	_Other:_____	type: _____	

Family Medical History

Has anyone in your immediate family died of heart disease: Yes No

Has anyone in your family had an adverse reaction to anesthesia: Yes No

List any medical illnesses that run in your family: _____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____

Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years

Do you drink alcohol? YES NO How much? _____ drinks per day How long? _____ years

PATIENT / PHYSICIAN AGREEMENT

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to ASPI Biologics to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from ASPI Biologics a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me ASPI Biologics may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information.

_____

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to ASPI Biologics sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect ASPI Biologics. If applicable, I also authorize my attorney to **release any and all information** without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of ASPI Biologics unpaid sum.

I fully understand that I am directly and fully responsible to ASPI Biologics for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is **not** contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby further give my authorization to ASPI Biologics to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the tortfeaser. I have read, understand, and agree with the above.

I hereby, intending to be legally bound for myself, my heirs and assignees, executors or administrators specifically agree that the ASPI Biologics, its officers, directors, owners and/or employees and agents shall not be liable for any claim, demand, cause of action of any kind whatsoever for, or on account of death, personal injury, property damage, or loss of any kind resulting from or related to my use of the facilities and/or participation in any intravenous therapy. I hereby waive all claims for any and all injuries I may suffer under any circumstances, including but not limited to those claims arising from the negligence of the ASPI Biologics, its employees, agents, servants, invitees, co-members, contractors, or sub-contractors, or otherwise.

Patient/Guardian Signature:_____ Date:_____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS ARE ACCURATE.

Patient/Guardian Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At ASPI Biologics, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act that requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

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Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date