



HIPAA CONSENT  
CONSENT TO LEAVE MESSAGE

Patient Name: \_\_\_\_\_  
(print)

Date: \_\_\_\_\_

I wish to be called at home  ; other  (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

\_\_\_\_\_ home

\_\_\_\_\_ other

I do  , I do not  give permission to leave relevant medical information on my answering machine or voice mail.

I do  , I do not  want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## Insurance Information

South Florida Interventional  
220 SW 84th Ave, Suite 105  
Plantation, FL 33324

phone: 954-693-0004

fax: 954-693-4345

**\*\*Please provide Staff with your insurance card(s) \*\***

### Primary Insurance

Company Name \_\_\_\_\_

Policyholder's name \_\_\_\_\_ Policy ID # \_\_\_\_\_

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

\*\*\*\*\*

### Secondary Insurance

Co Name \_\_\_\_\_

Policyholder's name \_\_\_\_\_ Policy ID # \_\_\_\_\_

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

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED BY ME IN THE OFFICE OF SOUTH FLORIDA INTERVENTIONAL. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO SOUTH FLORIDA INTERVENTIONAL FOR ALL SERVICES AND TREATMENT RENDERED TO ME. I HEREBY AUTHORIZE SOUTH FLORIDA INTERVENTIONAL TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION FOR THE CONTINUATION OF MY TREATMENT AND CARE. I AUTHORIZE ANY PHYSICIAN, HOSPITAL OR MEDICAL FACILITY TO PROVIDE ON MY BEHALF ALL INFORMATION ON MY MEDICAL HISTORY AND TREATMENT TO DR TODD SCHWARTZ. I HEREBY AUTHORIZE ANY PHOTOCOPIES OF THIS FORM TO BE AS VALID AS THE ORIGINAL.

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

PATIENT SIGNATURE (parent if patient is a minor) \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

**SOUTH FLORIDA INTERVENTIONAL INC.  
TODD D. SCHWARTZ, D.O.**

**954-893-0004**

Florida State Statute 458.320 requires the physician to prominently display a sign in his reception area stating "Your doctor has decided not to carry malpractice insurance."

As a patient of South Florida Interventional Inc., and Todd D. Schwartz, D.O., I acknowledge the display of this information in the reception area, and understand that my doctor does not carry malpractice insurance. Being fully informed of this fact, I choose to continue to receive medical services and/or consultations from South Florida Interventional Inc. and Todd D. Schwartz, D.O.

\_\_\_\_\_  
Pt Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian if Pt is a minor

\_\_\_\_\_  
Witness



## New Patient Information Sheet

South Florida Interventional  
220 SW 84th Ave, Suite 105  
Plantation, FL 33324

phone: 954-693-0004

fax: 954-693-4345

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Phone#: Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_

Marital Status (circle one) S M D W

Spouse Name \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Phone # \_\_\_\_\_

In case of emergency, please provide a name and phone number of your nearest relative other than spouse \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Physician (if other than PCP) \_\_\_\_\_

\*\*Reason for today's visit \_\_\_\_\_

Dialysis Center \_\_\_\_\_ Phone \_\_\_\_\_

Dialysis Days: MWF TTS

# South Florida Interventional PATIENT QUESTIONNAIRE MEDICAL HISTORY & REVIEW OF SYSTEMS

NAME: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

weight \_\_\_\_\_ pounds      height \_\_\_\_\_ feet \_\_\_\_\_ inches

None      1. List your ALLERGIES to medications or drugs:  
\_\_\_\_\_

None      2. List ALL medications you take at home (include over the counter meds):  
\_\_\_\_\_

- Yes No      3. Have you ever smoked? Average \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
 Yes No      4. Do you drink alcoholic beverages? Beer? Wine? Liquor? Amount per week? \_\_\_\_\_  
 Yes No      5. Have you used any recreational drug (marijuana, cocaine, LSD, etc.) within the past 14 days?  
 Yes No      6. Do you wear dentures? (Circle) Full set    Upper only                      Lower only  
 Yes No      7. Do you wear a dental bridge? (Circle) Partial    Fixed/Removable    Upper/Lower/Both  
 Yes No      8. Do you have any crowns, capped teeth, chipped teeth, or loose teeth?  
 Yes No      9. Have you ever had surgery or anesthesia? Please list below:

YEAR	OPERATION	TYPE OF ANESTHESIA				COMPLICATIONS (if any)
		GENERAL	LOCAL	SPINAL	EPIDURAL	

- Yes No      10. Has any blood relative ever had a complication related to anesthesia?  
 Yes No      11. Have you taken any of the following medications in the past week?  
                 Aspirin Products..... Anacin, Bufferin, Excedrin, Ecotrin, etc.  
                 Anti-Inflammatory Drugs.... Motrin, Advil, Nuprin, Ibuprofen, Naprosyn, etc.  
                 Blood Thinning Drugs..... Coumadin, Heparin, Persantine, Lovenox  
 Yes No      12. Have you taken any steroid medication (Prednisone, Cortisone) in the past 6 months?  
 Yes No      13. Do you require antibiotics before a dental procedure? Why? \_\_\_\_\_  
 Yes No      14. Have you ever been transfused with blood or blood products? \_\_\_\_\_  
 Yes No      15. Have you ever had an adverse reaction during or after transfusion of blood or blood products?  
                 Please describe: \_\_\_\_\_  
 Yes No      16. Do you have a religious objection to receiving blood products if deemed medically necessary  
 Yes No      17. Have you ever been treated for cancer with chemotherapy or radiation? Year: \_\_\_\_\_  
 Yes No      18. Have you had a cold, sore throat, runny nose, fever, cough, or flu in the past 2 weeks?  
 Yes No      19. Have you been treated for nervous or emotional problems (i.e., depression)?  
 Yes No      20. Have you ever had or been treated for HEART PROBLEMS?  
                 Yes No    Heart Attack Year \_\_\_\_\_                      Yes No    Rheumatic Fever  
                 Yes No    Chest pain or Angina                                      Yes No    Leg Swelling  
                 Yes No    Cardiac Arrest    Yes No    Fainting  
                 Yes No    Irregular Heartbeat or Atrial Fibrillation            Yes No    Peripheral Vascular Disease  
                 Yes No    Mitral Valve Prolapse                                      Yes No    Heart Murmur  
 Yes No      21. Have you ever had or been treated for HIGH BLOOD PRESSURE or LOW BLOOD PRESSURE?

- Yes No 22. Have you ever had or been treated for RESPIRATORY PROBLEMS?  
 Yes No Asthma Yes No Bronchitis  
 Yes No Wheezing Yes No Recent Pneumonia  
 Yes No Emphysema Yes No Tuberculosis  
 Yes No Chronic Cough or Shortness of Breath
- Yes No 23. Have you ever had or been treated for KIDNEY PROBLEMS?  
 Yes No Kidney Failure (Renal Failure)  
 Yes No Dialysis (Date Last Done: \_\_\_\_\_)  
 Yes No Kidney Stones
- Yes No 24. Have you ever had or been treated for DIGESTIVE TRACT PROBLEMS?  
 Yes No Liver Problems Yes No Peptic Ulcer or Gastritis  
 Yes No Hepatitis Yes No Hiatal Hernia or GE Reflux  
 Yes No Yellow Jaundice Yes No Pancreatitis  
 Yes No Cirrhosis of the Liver
- Yes No 25. Do you have any SKIN DISORDERS?  
 Yes No Open wound(s) or rash
- Yes No 26. Have you ever had or been treated for ENDOCRINE or METABOLIC DISEASES?  
 Yes No Diabetes  
 Yes No Low Blood Sugar  
 Yes No Thyroid Disease  
 Yes No Porphyra
- Yes No 27. Have you ever had a PROBLEM WITH COAGULATION or EASY BRUISING OR BLEEDING?  
 Yes No Hemophilia  
 Yes No Family history of bleeding problems  
 Yes No Sickle Cell Anemia or Trait  
 Yes No Other Blood Disorder
- Yes No 28. Have you ever had or been treated for NEUROLOGIC PROBLEMS?  
 Yes No Stroke Year \_\_\_\_\_ Yes No Herniated Disk or Spinal Stenosis  
 Yes No Mini-Stroke or TIA Year \_\_\_\_\_ Yes No Frequent Headaches or  
 Migraines  
 Yes No Seizure, Convulsion, or Epilepsy Yes No Pain in arms or legs  
 Yes No Paralysis or Spinal Cord Injury Yes No Numbness or tingling of  
 arms/legs
- Yes No 29. Have you ever had or been treated for MUSCLE, BONE, or JOINT PROBLEMS?  
 Yes No Trouble Opening Mouth (TMJ) Yes No Rheumatoid Arthritis  
 Yes No Back Pain or Sciatica Yes No Muscle Cramps or Weakness  
 Yes No Neck Problems Yes No Hoarseness (of your voice)  
 Yes No Degenerative (Osteo-) Arthritis
- Yes No 30. If you are a female, IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT NOW?  
 31. If you a female, WHAT IS THE DATE OF THE LAST DAY OF YOUR LAST NORMAL  
 MENSTRUAL PERIOD? \_\_\_\_\_  
 32. Please describe any medical problems not discussed above:  
 \_\_\_\_\_  
 33. PLEASE SIGN AND DATE: The information that I have provided is an accurate and current  
 profile of my medical history and review of systems. I have disclosed all of my medical history  
 known to me.

\_\_\_\_\_  
 Patient or Guardian Signature

\_\_\_\_\_  
 Date

M.D.'s Initials: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_



## **South Florida Interventional Inc.**

**Dr. Todd Schwartz**

220 SW 84th Ave Suite 105

Plantation, FL 33324

### **NOTICE OF PRIVACY PRACTICES – SHORT FORM**

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

**What is HIPAA and how does the Privacy Rule affect you?** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to comply with this regulation. Under the Privacy Rule, you are guaranteed access to your medical record, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

**What is Individually Identifiable Health Information?** Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment and/or that identifies you as an individual.

**What is the Notice of Privacy Practice?** Our official Notice of Privacy Practice is posted in our reception area and informs our patients about their rights surrounding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained or retained by our practice. We may update our Notice of Privacy Practices at any time. Our Notice of Privacy Practice will be posted in our reception area and you may ask for a copy at any time.

The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information:

Treatment	Appointment Reminders
Payment	Health Care Operations
Treatment Options	Disclosures required by law
Health-related benefits and services	Release of Information to Family/Friends

The following categories describe unique situations in which we may disclose your Individually Identifiable Health Information:

- |                                 |                                     |
|---------------------------------|-------------------------------------|
| Public Health Risks             | Health Oversight Committees         |
| Lawsuits and Similar Activities | Deceased Patients                   |
| Organ and Tissue Donation       | Serious Threats to Health or Safety |
| Military                        | National Security Inmates           |
| Worker's Compensation           | Law Enforcement                     |
| Research                        |                                     |

**What are your rights concerning your Individually Identifiable Health Information?**

You have rights regarding the Individually Identifiable Health Information that we maintain about you. The policies and procedures for the following circumstances are listed in our Notice of Privacy Practices:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

If you have any questions regarding this notice or our Privacy Practices please contact:

Elizabeth Vroman  
220 SW 84th Avenue, Suite 105  
Plantation FL 33324  
954-693-0004

I have read the short notice provided by South Florida Interventional, Inc. and have been informed of how to obtain more information regarding the practice's Notice of Privacy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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