Mario E. Carbonell, MD

17912 Toledo Blade Blvd. Ste A
Port Charlotte, Florida
941-766-1001

New Patient Paperwork

Appointment Date:_____ Appointment Time:_____

Patient Name: _____ Date of Birth: _____

Florida address: _____

City, State, Zip Code: _____

Northern address: _____

City, State, Zip code _____

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security Number: _____

Sex: ___ Male ___ Female Retired? ___ Yes ___ No

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Optional: Preferred language _____ Race? _____ Hispanic? ___ Yes ___ No

Do you have a Power of Attorney? ___Yes ___No Do you have a Living Will? ___ Yes ___ No

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Referred by: _____

Insurance Information

Co-pays and Deductible Payments are due at the time of service. Please refer to the Financial Agreement. If you are unable to make these payments, your appointment will be rescheduled unless otherwise determined by Dr. Carbonell.

Primary Insurance
Subscriber_____
Policy Number_____

Secondary Insurance
Subscriber_____
Policy Number_____

Medications

****DISCLAIMER: New patients will be referred out to a specialty provider to supply ANY narcotics (pain, sleep & *most* psychiatric medications) at Dr. Carbonell's discretion. Please sign below stating that you agree to this condition.****

Signature: _____ **Date:** _____

Medication	Dose	Frequency

****Please allow a 24/48 hour turn around time for refill requests. Please monitor your medications and request your refill at least 1 week prior to running out of your medication to prevent any delays.****

Generic Allergies: _____

Medication Allergies: _____

Preferred Local Pharmacy:(include street)_____

Preferred Mail-away Pharmacy: _____

Please list all MEDICAL providers so we can obtain past medical records:

PROVIDER NAME	SPECIALITY	CITY, STATE	OFFICE PHONE#	OFFICE FAX#

Preferred Lab: Quest:_____ LabCorp:_____ Other:_____

Medical History

___	Asthma	___	Epilepsy	___	Kidney Stones
___	Chest pain	___	Fractures/Type	___	Migraines
___	Anemia	___	Glaucoma	___	Polyps/Type
___	Arthritis	___	GERD	___	Rheumatic Fever
___	Cancer/Type	___	Heart Attack	___	Stroke
___	Chronic Bronchitis	___	Heart Murmur	___	Thrombophlebitis
___	Cirrhosis	___	Headaches	___	Thyroid Disease
___	Clotting Disorder	___	Hepatitis	___	Ulcers
___	CHF	___	High Blood Pressure	___	**Other – Please list below**
___	COPD	___	High Cholesterol		
___	Diabetes/Type	___	HIV & Aids		_____
___	Diverticulitis	___	Incontinence		_____
___	Emphysema	___	Kidney Disease		_____

Family History

If any blood relative has ever had any of the following, please check box and indicate relationship.

L = Living

D = Deceased

Age

___	Blood Disorder	_____	Father	_____
___	Cancer	_____	Mother	_____
___	Diabetes	_____	Siblings	_____
___	Heart Attack	_____		_____
___	Heart Disease	_____		_____
___	High Blood Pressure	_____		_____
___	Kidney Disease	_____		_____
___	Liver Disease	_____		_____
___	Migraine / Headaches	_____		_____
___	Stroke	_____		_____
___	Tuberculosis	_____		_____

Operations and / or Hospitalizations

Reason	Date	Reason	Date

Review of Symptoms

General
- __Weight Gain
- __Weight Loss
- __Loss of Appetite
- __Fevers
- __Weakness
- __Fatigue

Neurology / Ophthalmology
- __Headaches
- __Tingling
- __Fainting
- __Dizziness
- __Difficulty Walking
- __Memory Loss
- __Hearing Loss
- __Diminished Vision
- __Blurring of Vision
- __Loss of Vision
- __Vision Floaters
- __Macular Degeneration

Cardiology
- __Chest Pain
- __Palpitations
- __Varicose Veins
- __Sweating
- __ Swelling
- __Fluttering sensations

Respiratory
- __Shortness of Breath
- __Congestion
- __Cough
- __ Short of Breath on Exertion
- __Sinus Problem

Gastroenterology
- __Nausea
- __Heartburn
- __Constipation
- __Diarrhea
- __Difficulty Swallowing
- __Indigestion
- __Abdominal Pain

Male Reproductive
- __Difficulty with Erection
- __Frequent Urination
- __Difficult / Painful Urination
- __Blood in Urine

Musculoskeletal
- __Cramps
- __ Joint Pain
- __ Back Pain
- __Arm Pain
- __Neck Pain
- __Leg Pain

Endocrine
- __Cold intolerance
- __Heat Intolerance
- __Increased Thirst

Female Reproductive
- __ Pregnant
- __Menopause

Hematology
- __Easy Bruising
- __ Bleeding

Dermatology
- __Rash
- __Flushing
- __Wound
- __Dry Skin

Psychology
- __Depression
- __Anxiety
- __High Stress

Other

_____
_____
_____
_____

Habits

Do you exercise routinely? ___ Yes ___ No

What do you do for exercise? _____

Do you smoke? ___ Yes ___ No

How much do you smoke? _____

If you quit, when did you quit? _____

How long did you smoke? _____

Do you drink alcohol? ___ Yes ___ No

How often? _____

Sleep: Snoring ___ Yes ___ No

Daytime drowsiness? ___ Yes ___ No

Early morning waking? ___ Yes ___ No

Difficulty falling asleep? ___ Yes ___ No

Patient Consent Form Treatment
Privacy

With this consent, Dr. Mario Carbonell or his staff may call or speak with (check all that apply):

___Call my home or alternative location to speak with me directly in reference to any items that assist the practice in carrying out treatment, payment, health care operation, appointment reminders, insurance items and calls pertaining to my clinical care including labs / other results.

___ May leave a message at my home or alternate location as listed on my demographic sheet.

___ Has authority to speak with the following persons about my medical care and test results. ***It is the patient's responsibility to notify Dr. Carbonell's office of any changes below.***

Name	***Relationship***	***Phone Number***

The above may be revised by forwarding in writing the change to our office except to the extent that the office may already have made disclosures to the above prior to the revision.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I have received a copy of the Notice of Privacy Practice for Mario E. Carbonell, MD.
(Please request one if not provided to you)

Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

MARIO E. CARBONELL, M.D.
Diplomate of the American Board of Internal Medicine
Fellow in Geriatric Medicine

FINANCIAL POLICY

Thank you for choosing the office of Dr. Mario Carbonell for your primary care. We are committed to providing you with the highest quality care possible. We are contracted with most insurance companies, but please contact your insurance to verify that we are in network.

In order to provide the best care in the most cost-effective way, we have devised the followingfinancial policies to keep you current on your medical fees. You must inform us on any and allchanges in insurance while under our care as this will facilitate the claims process and will reduce the number of claims being denied. In the event that a claim is denied by your insurance, you (the patient) are responsible for all fees accrued for services rendered.

INSURED - Commercial Insurances/ Medicare Replacement

I understand and agree that health insurance coverage is an agreement between my insurance carrier and me. I agree that all services are charged directly to my insurance and that I am personally responsible for any balance that comes back. ***All co-pays (and deductibles if not met) are due at the time of my appointment.*** I acknowledge that if my deductible amount is more than my payment per my insurance, I am also responsible for the remaining balance. If I cannot pay my co-pay or deductible payment, my appointment may be rescheduled unless otherwise determined by Dr. Carbonell.

MEDICARE

I understand that Medicare is a federal insurance program. I acknowledge that Medicare has an annual deductible and if my appointment fee is applied to this deductible, then I, the patient, am responsible for the balance. I understand that if I have a secondary insurance or supplemental policy to my Medicare plan and fail to provide the plan information, then my secondary or supplement will not be billed and I will be responsible for any balances that comeback as coinsurances.

No Show/Late Cancellation Fee: I understand that if I do not show for my scheduled appointment, or cancel without providing a 24-hour notice, I will be charged a $75.00 No Show/Late Cancellation Fee.

Signature:_____ Date: _____

Responsible Party Signature:_____ Date:_____

17912 Toledo Blade Blvd., Suite A, Port Charlotte, FL 33948 | P: 941.766.1001 | F: 941.766.1830

MARIO E. CARBONELL, M.D.
Diplomate of the American Board of Internal Medicine
Fellow in Geriatric Medicine

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.

Uses and Disclosures:

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, dispensing medications, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. Additionally, we may disclose information to a friend or family member in the event of an emergency or when deemed necessary by our medical staff.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of Dr. Mario Carbonell. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders Your health information may be used by our staff to remind you of appointments or request a return call.

Information about treatments Your health information may be used to send you information thatyou may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Information will be released to our management firm, Complete Physician Billing, in order to receive payment from your insurance company or directly from you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected healthinformation
- the right to receive confidential communications concerning your medical conditionand treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of nonroutine disclosures
- the right to receive a printed copy of this notice

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices.These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide a revised notice on your next office visit.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Practice
Manager
17912 Toledo Blade Blvd.
Port Charlotte, Florida
33948

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This Notice is effective on or after July 14, 2003