Barbara Ann Scherer, M.D., P.A.
2001 East Commercial Blvd., Ft. Lauderdale, FL 33308
954.771.3737 Fax 954.771.9980 www.**BASMD.com**

Please Print this Out

HMO, PPO & POS Patients

Please Read and Fill Out the Following Forms and Fax or bring with you on Your Appointment

FAX: 954.771.9980

Patient Authorization and Assignment of Benefits Form

Commercial Insurance And Managed Care Members Lifetime Authorization

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf, and I assign the benefits payable for physician services to Barbara Ann Scherer, MD, PA. I request that this authorization apply to all insurance claims, present and future. In consideration of the provision of medical services, I assume full responsibility for all physician charges for such medical services rendered to myself, derived from deductible and co-insurance amounts as well as any amounts not covered by my insurance carrier, from the actual physician charges. I have been advised that pursuant to 42 C.F.R., Section 405.420, the physician is authorized and obligated to undertake reasonable collection efforts, such as submitting follow-up letters, and engaging in personal and telephonic amounts due and owing pursuant to the rendering of medical services to myself. Further, I agree that, I will be responsible for all collection costs, attorney fees and court costs should this account be referred to an attorney or collection agency. In the event that I am unable to pay my bill, I will report in writing to the physician my inability to pay prior to services being rendered.
Initials:_____

HMO/PPO Acceptance: I certify that I am enrolled in_____
Health Maintenance Organization (HMO)/Preferred Provider Organization (PPO). I understand that if I change HMO/PPO enrollment I must notify Barbara Ann Scherer M.D., P.A. immediately. Subsequent rejection of a claim as a result of failure to notify us of this change will constitute responsibility for payment of claim on my part.
Initials:_____

HMO/PPO Disclaimer: I certify that I am not enrolled in any Health Maintenance Organization (HMO)/Preferred Provider Organization (PPO). Subsequent rejection of a claim due to current enrollment in a HMO will constitute responsibility for payment of claim on my part.
Initials:_____

_____ _____
Signature of Insured Print Patient/Insured's Name

_____
Today's Date

Barbara Scherer, M.D., P.A.
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Fort Lauderdale, Florida 33308

REGISTRATION FORM

Please Print

Today's Date_____ Home Phone (_____)_____

Name _____ Sex: Male Female
First Middle Last

Local Address_____

City _____ State _____ Zip Code_____

Work Phone (____)_____ Beeper/Cellular Number (_____)_____

Social Security Number_____-_____-_____ Date Of Birth____/____/_____ Age_____
Month Day Year

Marital Status: Single Married (Spouse's Name_____) Widowed Divorced

Place of Employment_____ Occupation_____

Address_____
Street City Zip Code

Primary Language Spoken_____ Secondary Language_____

Person To Contact in Case Of Emergency:_____

Phone (_____)_____ Relationship_____

How did you learn of our practice?_____

Primary Insurance Company_____

Please return this completed form (front and back), with your insurance card and your driver's license to the receptionist.

Thank You

Barbara Ann Scherer, M.D., P.A. *Internal Medicine*

Preventive Services Education Sheet

The promotion of healthy lifestyles and the early identification of potential health risks will benefit you and are important to us. In accordance with the current United States Preventative Services Task Force (USPSTF) guidelines, we have put together the following information for your guidance. Please read this preventative education sheet and feel free to discuss any of the topics with your physician, and/or Nurse Practitioner. Only **you** can take appropriate actions to maintain your health and well being.

1. Lifestyle changes:

- ***Diet and Exercise***
  A healthy diet and regular exercise are the most effective ways to maintain good health, longevity and increase your quality of life. Choose a diet low in saturated fat, cholesterol, sugar and salt; eat plenty of vegetables, fruits, grains which provide vitamins, minerals and fiber, lean meats, pastas, etc. Twenty minutes of exercise, three times a week (i.e., walking, swimming, etc.) will keep your heart and bones healthy.

- ***Substance Abuse***
  Use of tobacco is known to cause heart disease, strokes and lung cancer. Excessive alcohol intake is associated with many illnesses, including cancer, liver disease and impaired judgement (as in driving). Illicit drug use has many risks such as AIDS, hepatitis, heart problems, and mental and social disorders.

- ***Sexual Behavior***
  Certain sexual practices (i.e., promiscuity, unprotected sex) can expose you to potentially fatal diseases such as AIDS, STDs (sexually transmitted diseases) and other common infections.

- ***Excessive Sun Exposure***
  Causes skin cancer; always wear sunscreen when exposed to the sun. The higher the SPF (sun protection factor) you use, the higher the protection level against the ultraviolet rays.

- ***Injury Prevention***
  Take advantage of the many safety products that are important in preventing serious injury. These include seat belts, bicycle helmets and other protective gear, safe work habits (lifting, bending, etc), smoke detectors, firearm safety, water safety practices for adults and children, CPR training for household members, etc., poison prevention.

- ***Dental Health***
  Brush and floss regularly; see your dentist for routine visits every six months.

(Over)

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2. Physical Examination – Preventive Measures
(may vary according to age and specific needs):

Birth – 6 years:
- Newborn: hemoglobin, PKU, thyroid screening
- Childhood immunizations: check with your pediatrician
- Well child checkup

6 years – 18 years:
- Immunizations (booster shots)
- Well child and adolescent checkups (safe sexual practices, injury prevention, i.e., seat belts, bicycle helmets, substance abuse, smoking, etc.)

19 years – 39 years:
- Routine physicals every five years to include pap smears, blood pressure, testicular exam, cholesterol screening (if appropriate)
- Adoption of healthy lifestyle practices (i.e., diet, exercise, smoking cessation, etc.)
- Immunization boosters, (tetanus, diphtheria every 10 years)

40 years - 64 years:
- Routine physicals every three years to include mammograms, sigmoidoscopy, blood pressure cholesterol screening, bone density test, estrogen replacement therapy for post menopausal women, prostate exams, testicular exams, stool tests for occult blood and self breast exam instructions.
- Adult immunizations (tetanus, diphtheria boosters every 10 years).

65+ years:
- Routine physicals every one-two years to include as above (40 years-64 years) as well as influenza vaccine every year, pneumovax once in a lifetime and tetanus diphtheria booster every 10 years.

3. Advance Directives:

A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.
Have you prepared a living will? Yes_____ No_____

The foregoing recommendations are for healthy individuals without symptoms of illness. Special conditions may change the frequency and type of tests you desire, and/or need.

Please sign below to acknowledge that you have read and understand this information.

_____	_____	_____
Signature	Print Name	Date

Barbara Ann Scherer, M.D., P.A.

Diplomate, American Board of Internal Medicine

COMPREHENSIVE HISTORY QUESTIONNAIRE AND PHYSICAL EXAM

Name _____ Today's Date _____

CURRENT MEDICAL PROBLEMS

Please list the **current** medical problem(s) for which you came to see the doctor. About when did they begin?

Problems	Date Began

Doctor's notes on chief complaint and present illness:

DOCTOR USE ONLY

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements). List name, dosage, and times per day.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES

List anything that you are allergic to such as certain foods, medications, dust, chemicals, soaps, household items, pollens, bee stings, etc. and indicate how each affect you. _____

_____

RECENT TRAVEL AND IMMUNIZATIONS:

Write in the dates for the shots you had: Tetanus _____ Flu _____ Pneumococcal _____

Have you had a tuberculin (TB) skin test? _____ Date _____ ❑ Positive ❑ Negative Chest X-Ray Date _____

OTHER MEDICAL CARE:

If you are being treated for any other illness or medical problems by another physician or physical or mental health practitioner, please describe the problems and write the name of the physician, health practitioner or medical facility treating you. Use back page if more space is needed. Check if used ❑

Illness or Medical Problem	Physician or Medical Facility	Address

PAST SURGERIES:

None ❑ Blood Transfusions Yes ❑ No ❑

❑ List here any past surgeries with approximate age: _____

_____

SOCIAL:

Do you use drugs?_____ Which?_____

Hours of Sleep_____/day

Excercise Regulary? Yes ❑ No ❑

❑ Intake of Coffee/Tea_____cups/day/_____ years

❑ Smoke Cigarettes_____packs/day/_____ years

❑ Ex-Smoker_____pack day _____ years

❑ Alcohol (❑ Occasional, ❑ Social, ❑ Rare)_____drinks/day_____ years

PATIENT/PROVIDER CHECKLIST FOR MEDICAL HISTORY

PAST ILLNESSES: No serious past illnesses ❑

List any serious illnesses, with approximate age.

List childhood diseases:

Sexually Transmitted Diseases: ❑ No ❑ Yes Which ones:

❑ Hypertension ❑ Heart Attack
❑ Diabetes ❑ Asthma
❑ High Cholesterol ❑ COPD
❑ Others _____

FAMILY HISTORY: If any of the following have run in your family, check appropriate box, and in whom:

❑ Cancer _____ ❑ Hypertension _____
❑ Heart Disease _____ ❑ Strokes _____
❑ Diabetes _____ ❑ Alcoholism _____
❑ Thyroid Disease _____ ❑ High Cholesterol _____
❑ Others _____

REVIEW OF CURRENT SYMPTOMS: Place a checkmark in the appropriate boxes in the following list of **current** symptoms.

MD/Provider Notes

1. HEAD AND NECK

	Yes	No		Yes	No		Yes	No
Headaches	❑	❑	Ringing in ears	❑	❑	Chronic nose obstruction	❑	❑
Vision glasses	❑	❑	Pain in ears	❑	❑	Chronic sore tongue	❑	❑
Eye pain	❑	❑	Discharge from ear	❑	❑	Persistent sore gums	❑	❑
Double Vision	❑	❑	Repeated nosebleeds	❑	❑	Prolonged hoarseness	❑	❑
See "floating lights"	❑	❑	Teeth problems	❑	❑	Persistent neck regidity	❑	❑
Severe hearing loss	❑	❑	Frequent colds	❑	❑	Swellings in neck	❑	❑

2. HEART - CARDIOVASCULAR

	Yes	No		Yes	No		Yes	No
Heart problems	❑	❑	Chest pain on effort	❑	❑	Ankles swell	❑	❑
Hypertension	❑	❑	Skipping/irregular heartbeats	❑	❑	Difficult breathing	❑	❑

3. PULMONARY - LUNGS

	Yes	No		Yes	No		Yes	No
Sit up to breathe easier	❑	❑	Spit up blood	❑	❑	Wheezing	❑	❑
Have chronic cough	❑	❑	Frequent chest colds	❑	❑	Have night sweats	❑	❑

4. STOMACH AND INTESTINES

	Yes	No		Yes	No		Yes	No
Chronic abdominal pain	❑	❑	Vomit blood	❑	❑	Any blood from rectum	❑	❑
Persistent nausea	❑	❑	Skin turns yellow	❑	❑	Clay covered stools	❑	❑
Heartburn	❑	❑	Any chronic diarrhea	❑	❑	Habitual constipation	❑	❑
Appetite loss	❑	❑	Any black tarry stools	❑	❑	Have hemorrhoids	❑	❑
Bloating	❑	❑	Anal/Rectal itch	❑	❑	Change in bowel habits	❑	❑

5. URINARY TRACT - ETC.

OBGyn (For women only)

	Yes	No		Yes	No		Yes	No
Frequent urination	❑	❑	Pain with urination	❑	❑	Painful menstruation	❑	❑
Hard to start urinary flow	❑	❑	Any leakage of urine	❑	❑	Excess menstruation	❑	❑
Scanty urination	❑	❑	Passed any stones	❑	❑	Bleed between periods	❑	❑
Any blood in urine	❑	❑	Any bedwetting	❑	❑	Any missed periods	❑	❑
Frequent night urination	❑	❑	Any retention of urine	❑	❑	Last menstrual period_____		
			Men - Prostate problem	❑	❑	Number of pregnancies_____		
						Number of living children_____		

6. MUSCLES - JOINTS

	Yes	No		Yes	No		Yes	No
Phys. handicapped/limited	❑	❑	Any tingling sensations	❑	❑	Any paralysis	❑	❑
Joint or muscle problems	❑	❑	Any numbness	❑	❑	Any shaking	❑	❑
Shoulder pain	❑	❑	Disturbance in walking	❑	❑	Any strokes	❑	❑
Back pain	❑	❑	Any muscle jerking	❑	❑	Any seizures	❑	❑

7. NEUROPSYCHOLOGICAL

	Yes	No		Yes	No		Yes	No
Depression	❑	❑	Paralysis/weakness	❑	❑	Psychotherapy/counseling	❑	❑
Nervous breakdown	❑	❑	Any memory loss	❑	❑	Any alcohol problem	❑	❑
Any mental problems	❑	❑	Personality changes	❑	❑	Any drug problem	❑	❑
Dizzy spells	❑	❑	Speech disturbances	❑	❑	Serious mental problem	❑	❑

If there are any additional health factors in your history or if any of the above points need clarifying use this space for additional comments.

Barbara Ann Scherer, M.D., P.A.

Internal Medicine

MEDICAL RELEASE

1. I hereby authorize Barbara Ann Scherer, M. D., PA
   - ❑ TO RELEASE copies of my medical records to:
   - ❑ TO RECEIVE copies of my medical records from:

_____

_____

2. I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

_____ Signature _____ Date

3. Information to be released/requested: (Please Circle)

OFFICE NOTES	LAB	X-RAYS	EKG
D/C SUMMARY	DX	H&P	ALL

Date of Service(s) _____

4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.

5. This consent expires in 90 days.

6. Barbara Ann Scherer, M. D. PA is released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

Signed _____ Date _____

Print Patient Name _____

Patient SS# _____ Date of Birth _____

Patient Address _____

_____

Print name of person signing for the patient and their relationship to the patient: _____

_____

Witness _____ Date _____

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Barbara Ann Scherer, M.D., P.A

Diplomate, American Board of Internal Medicine
Proctology

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. (effective April 14, 2003)

This is a Federal Law that we are required to have patient's sign.

Once you sign Barbara Scherer, MD, PA's consent form, we may use and disclose your medical information to treat you, to obtain payment and to operate this practice. The law requires this practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices. The law requires us to abide by the terms of this notice and to provide individuals with notice revisions.

Examples of uses and disclosures for treatment: ▪If we refer you for a cardiac stress test and need to call the cardiologist for results, we may give your name and the reason for ordering the stress test to the cardiologist's office. ▪We may call you to advise you of treatment alternatives.

Examples of uses and disclosures to obtain payment: ▪Our billing department may submit a claim form that contains your name, address, social security number, diagnosis and procedures performed in our office to your insurance company.

Examples of uses and disclosures to operate the practice: ▪We may audit (read and comment upon) your chart to track and improve our performance in assuring that we perform screening tests and immunizations on time. ▪We may call you to remind you of upcoming appointments. ▪We may leave messages on your telephone and ask you to return our call.

The practice may use or disclose your protected health information about you for other purposes, and without your consent, if the law requires us to disclose information to government authorities. Examples of such uses or disclosures include suspected abuse and infectious diseases.

You have the following rights regarding your protected health information, and the practice must act on your request within 60 days: ▪You may request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction. ▪You may request that you receive confidential communication of protected health information. ▪You may request to inspect, amend and receive copies (at a charge of $1/per page) of your protected medical information. ▪You may request a paper copy of this notice.

You may complain to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with the practice by writing to our Office Manager. No one will retaliate against you for filing a complaint. For more information about this notice, contact our Office Manager at (954)771-3737.

▪I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
▪I understand that if I withhold consent for the use of my information for the purposes of treatment, payment, or operations, Barbara Ann Scherer, MD, PA may refuse to undertake my care.

_____	_____	_____
Signature	Printed Name	Date

Please turn page over

Barbara Ann Scherer, M.D., P.A

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Proctology

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule (A Federal Law) gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office
- ☐ O.K. to fax to _____

☐ Other _____

Family Members I authorize you to speak to regarding my medical care:

Due to confidentiality rules, we will not be allowed to discuss your medical care or PHI with anyone that you do not authorize below.

- ☐ Spouse/Significant Other (Name)_____
- ☐ Child (Name)_____
- ☐ Sibling (Name)_____
- ☐ Other (Name)_____

_____ _____
Patient Signature Date

_____
Print Name

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address/Fax Number	Patient O.K.	Description of Disclosure/Purpose	By Whom Disclosed

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