PATIENT INFORMATION

Please Print CHART#_________________________ Today's Date_________________________ Marital Status: M S D W

Patient's Name (Last) ____ (First) ___________________________________ (M.I.) _______

Sex ___M / F___ Birthdate_______-_______-_______ SS#___________-_________-___________ Spouse's Name_________________________

Permanent Mailing Address: Street ____

City ____ State____________________ Zip___________________________________

Home # ( ) ____ Cell # ( ) ____

E-mail address ____@_________________________________.________________

2nd Address: Street ____

City ____ State ____________________ Zip__________________________________

Emergency Contact: (Name/Relationship) ____ (Phone) ___________________________

Employer: ____ (Phone) ___________________________

Primary Insurance (Plan) ____ (Policy number) ___________________________________

Secondary Insurance (Plan) ____ (Policy number) ___________________________________

Primary Care Physician (Name) ____ (Phone number) _____________________________

Previous history of Eyelid or Facial Plastic Surgery ____

What problems are you being seen for today? ____

What cosmetic concerns would you like to discuss? ____

Referred or Recommended by ____

DOCTOR-PATIENT ARBITRATION AGREEMENT
PLEASE READ CAREFULLY

This agreement is made between James C. Sanderson, M.D., and other medical physicians, physician assistants, their agents, employees, or any of the foregoing, referred to hereafter as "Doctor" and referred to hereafter as the "Patient". It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving claims through or on behalf of the patient.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under Rules 1.280 – 1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction in and for Pinellas County, Florida. Requests for arbitration by either party must be made within the time frame set forth in section 95.11 of the Florida Statutes dealing with the medical malpractice. All arbitration awards for all claims against any parties of James C. Sanderson, M.D. shall be limited to $100,000.00 total. This amount shall include all fees, awards, damage, and costs.

This agreement shall remain in effect for all treatment and/or surgery provided the patient presently and at any future date.
In witness whereof, I (we) have set our hands this date:

Doctor: James C. Sanderson, M.D. Patient Signature: ____

By: (Authorized Agent) ______________________________ Patient name: (Print): ____

Date: ____ Chart #: ____

Thank you for choosing Dr. James C. Sanderson, M.D.

MEDICAL HISTORY

NAME:____ **M / F (Circle) Age:**_________ **D.O.B.**________________

PRIMARY PHYSICIAN: ____ **PHONE: ( )** ______________________
PHYSICIAN: ____ **PHONE: ( )** ______________________
PHYSICIAN: ____ **PHONE: ( )** ______________________

PAST MEDICAL HISTORY: Please check if YES for each of the following: (Assumed no if not checked)

_____Rheumatic Fever	_____Angina	_____Kidney Disease
_____Pneumonia	_____Irregular Heartbeat	_____Hiatal Hernia
_____Tuberculosis	_____Heart Attack	_____Ulcers
_____Asthma	_____Congestive Heart Failure	_____Phlebitis
_____Emphysema	_____Stroke	_____Anemia
_____Bronchitis	_____Claustrophobia	_____Arthritis
_____High Blood Pressure	_____Psychiatric Disorder	_____Diverticulosis
_____Bleeding Problems	_____Memory Loss/Alzheimer's	_____None Apply
_____Carotid Artery Disease	_____Seizures	
_____Thyroid Disease	_____Diabetes	Other: ______________________
_____Radiation/Chemo Treatment	_____Liver Disease	Other: ______________________
_____Heart Disease	_____Hepatitis	

Please list ALL of your Prescription Medications, Over-the-Counter Medications and Vitamin Supplements:
____
____
____
____
____
____
____
____

ALLERGIES TO MEDICATIONS:

____
____

ADHESIVE/BANDAID SENSITIVITY: YES ☐ NO ☐

LATEX SENSITIVITY: YES ☐ NO: ☐ ***NO KNOWN ALLERGIES*** ☐

SOCIAL HISTORY: Occupation: ______________________
Do you smoke? ___________ How much? _______________
Do you drink alcohol? _______ How much? _______________
Substance abuse? _________ How often? _______________

FAMILY HISTORY: *How Related*
Diabetes____
High Blood Pressure_______________________________
Stroke____
Heart Disease_____________________________________
Eye Disease______________________________________
Other____

HOSPITALIZATIONS and SURGERIES:
Date Type
____
____
____
____
____
____

Review of Systems: Do you have these **now?** If yes, explain.

NO	YES		NO	YES		NO	YES	
___	___	Chest Pain________________	___	___	Leg Cramps________________	___	___	Blurry Vision___________
___	___	Cough____________________	___	___	Shortness of Breath/Wheezing____	___	___	Recent Weight Loss/Gain___
___	___	Dentures__________________	___	___	Skipped Beats/Palpitation________	___	___	Frequent Urination________
___	___	Difficulty Lying Flat__________	___	___	Swelling in Feet______________	___	___	Change in Energy_________
___	___	Dizziness/Fainting___________	___	___	Tremor____________________	___	___	Anxiety_______________
___	___	Hearing Loss_______________	___	___	Ulcers/Abdominal Pain__________	___	___	Easy Bruising___________

UPDATED BY

________	________	________	________	________	________	________
________	________	________	________	________	________	________
________	________	________	________	________	________	________
________	________	________	________	________	________	________

FILE NO:_________

LIFETIME AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL RECORDS FOR PAYMENT

I HEREBY AUTHORIZE JAMES C. SANDERSON, M.D. TO RELEASE TO THE INSURANCE CARRIER(S) (LIABLE FOR ALL OR PART OF THE CHARGES) ONLY SUCH DIAGNOSTIC AND THERAPEUTIC INFORMATION (INCLUDING ANY TREATMENT FOR PSYCHIATRIC, ALCOHOL, OR DRUG ABUSE) AS MAY BE NECESSARY TO DETERMINE BENEFITS ENTITLEMENT AND TO PROCESS PAYMENT CLAIMS FOR HEALTH CARE SERVICES PROVIDED TO ME, COMMENCING ON THIS DATE_____/_____/_____.

IN ADDITION, I AGREE TO HOLD AND SAVE JAMES C. SANDERSON, M.D. LLC, ITS OFFICERS, ITS EMPLOYEES, AND ANY PHYSICIANS WHO MAY HAVE EXAMINED ME HARMLESS FROM ANY COST, LOSS, DEMAND, OR LIABILITY RESULTING FROM SUCH DISCLOSURE.

I UNDERSTAND THAT THIS EXAMINATION AND/OR TREATMENT IS NOT COSMETIC. THIS EXAM AND/OR TREATMENT IS MEDICALLY NECESSARY AND MY INSURANCE WILL BE BILLED.

I ALSO AGREE THAT IF ALL OR ANY PART OF SUCH INSURANCE BENEFITS ARE DENIED, I AND/OR THE UNDERSIGNED WILL BE LIABLE FOR ALL CHARGES.

THIS AUTHORIZATION SHALL BE VALID FOR THE PERIOD OF TIME NECESSARY TO PROCESS & COLLECT PAYMENT CLAIMS PERTAINING TO MY TREATMENT.

<u>MEDICARE PATIENT CERTIFICATION…PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST</u>

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THE TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLD OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS RELATED MEDICARE OR INDEPENDENT INSURANCE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE OR INDEPENDENT INSURANCE COMPANY FOR PAYMENT TO ME.

THIS SIGNATURE IS FOR MEDIGAP ALSO.

<u>ASSIGNMENT OF INSURANCE BENEFITS/GUARANTEE OF PAYMENT</u>

I HEREBY AUTHORIZE, REQUEST, AND DIRECT ANY AND ALL ASSIGNED INSURANCE COMPANIES TO PAY DIRECTLY TO JAMES C. SANDERSON, M.D. LLC, OLDSMAR, FLORIDA THE AMOUNT DUE ME IN MY PENDING CLAIMS UNDER THE RESPECTIVE POLICIES. I AGREE THAT, SHOULD THE AMOUNT BE INSUFFICIENT TO COVER THE ENTIRE EXPENSE, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE, AND THAT IS THE NATURE OF THE DISABILITY BE SUCH THAT IT IS NOT COVERED BY SAID POLICY, I WILL BE RESPONSIBLE FOR PAYMENT OF THE ENTIRE BILL.

THIS OBLIGATION TO PAY ALL CHARGES IS UNCONDITIONAL AND ABSOLUTE.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, RECEIVED A COPY THEREOF, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT'S LEGAL REPRESENTATIVE, TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

WITNESS____

DATE____

THIS____________DAY OF___________20_____________

PATIENT____

SIGNATURE____
(PATIENT, PARENT OR MINOR AND/OR RESPONSIBLE PARTY)

PERSON UNABLE TO SIGN
REASON____

____
(NEXT OF KIN CO-SIGNATURE)

____
(PATIENT/PERSON AUTHORIZED TO CONSENT FOR PATIENT)

James C. Sanderson, M.D. Eyelid & Facial Plastic Surgery
Patient Consent for the Use and Disclosure of Health Information
For Treatment, Payment, or Health Care Operation

I,____ understand that as part of my health care, James C. Sanderson, M.D., originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine health care operations, such as assessing quality and reviewing the competence of staff.

I understand that I may request a *Notice of Patient Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *"Notice"* prior to signing this consent;
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation.

I further understand that James C. Sanderson, M.D. reserves the right to change their *"notice and practices"* in accordance with "45 Code of Federal Regulations, Section 164.520". Should James C. Sanderson, M.D. change the notice, I may request any revised notice be sent to the address I've provided via U.S. mail.

Restrictions:
I request the following restrictions to the use or disclosure of my health information:
____
____

Please tell us with whom we may discuss your treatment, payment or health care operation:
Example: spouse (name), children (names), other relatives (names), friends or care givers (names)
____
____

I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept/decline (**please circle one**) the information of this consent.

____ ____

Patient/Guardian Signature Print name of person signing

*If other than patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient's treatment, payment or health care operations? Yes [ ] No [ ]

Date______________________

____

FOR OFFICE USE ONLY
[ ] "Consent form" received and reviewed by_____________________________________on_______________________________
[ ] "Consent form" signature refused by patient [ ] Restrictions added by patient
[ ] "Consent form" placed in the patient's medical record on____