Shachner & Zaragoza, MD, PA
Mark S. Shachner, MD., F.A.C.S. * Bernard J. Zaragoza, MD., F.A.C.S.
Gabriel D. Glaun, MD * Megan Rodwell, PA-C
General, Foregut & Robotic Surgery

Date: _____ **DOB:** _____

Last Name: _____ **First Name**: _____ **M.I**._____

Reason for visit: _____

Medical problems:_____
_____
_____

Past Surgery:
Surgery name with the date (year): _____
_____
_____

Medications/vitamins/over-the-counter daily: _____
_____
_____
_____
_____

Drug Allergies: _____
_____
_____

Tobacco Use:
Did you ever smoke cigarettes YES____ NO_____ (If no, please skip to Alcohol use)
Current Every day Smoker? Yes____NO___ Current some day smoker? Yes___ NO____
Former Smoker? Yes___ NO___ When did you quit? _____ # of years smoking_____
Smoke Socially Yes___ NO_____Smokeless tobacco use? YES___ NO___

Alcohol Use:
Do you drink alcohol? YES___ NO____ If yes, how much? _____
Never Drinks alcohol? YES___ NO____ Quit drinking alcohol Yes___ NO If yes, when? _____

Vaccinations:
COVID-19 vaccination? YES__ NO__ If yes, When (Month & Year) _____

COLONOSCOPY: _____ (within the past 3years) please provide date
PAP SMEAR: _____ (within the past 3years) please provide date
MAMMOGRAM: (DATE)_____ **WHERE:** _____
RESULTS OF MAMMO: _____

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Please check the spaces below that pertain to you. Have you recently experienced:

Constitutional __weight changes, __ fever, __fatigue	__None of these
Eyes __ visual changes, __ pain	__None of these
Ears, Nose & Throat __sore throat, __sinus trouble, __ nose bleeds	__None of these
Cardiovascular __chest pain, __ palpitations, __ leg cramps	__ None of these
Respiratory __ cough, __shortness of breath, __ wheezing	__ None of these
Gastrointestinal __abdominal pain, __constipation, __ bloody or dark stools	__None of these
Genitourinary__pain with urination, __ frequent urination at night	__None of these
Musculoskeletal __arthritis, __limitation of movement	__None of these
Skin __rash, __lumps, __bruises	__None of these
Neurological __fainting, __headaches, __numbness	__None of these
Psychiatric __depression, __ panic attacks	__None of these
Endocrine __thyroid problems, __ hot flashes	__None of these
Hematological __ bleeding problems, __ anemia	__ None of these
Allergy/Immunology __ Steroid use, __hives, __ HIV	__ None of these

PLEASE CIRCLE ONE IF YOU ARE A NEW PATIENT TO THE PRACTICE. IF NOT, PLEASE IGNORE:

Race (circle one): Alaskan Native, American Indian, Asian, African American, Hispanic or Latino, Indian, Native Hawaiian, Caucasian, White Hispanic, refuse to report.

Ethnicity (circle one): Hispanic or Latino, Non-Hispanic or Latino, Refuse to Report

How did you hear about us? (Circle one): Referral from a doctor, friend/family member, social media, google search, website, insurance company, other _____

OFFICE USE ONLY (PLEASE DO NOT COMPLETE BELOW LINE)
****

Patient Weight: _____ Patient Height: _____Blood Pressure: _____/_____ (R/L)

Primary Care Physician: _____

Referring Physician: _____

Gastroenterologist: _____

OBGYN: _____

Other Physicians: _____

Doctor Reviewed Document
Physician Signature: _____

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Patient name: _____
Today's date: _____

Medical history in IMMEDIATE family (grandparents, parents, siblings, children)

- **Alcoholism?** YES___ NO____ Who? _____
- **Anemia?** YES___ NO____ Who? _____
- **Anxiety?** YES___ NO____ Who? _____
- **Arthritis?** YES___ NO____ Who? _____
- **Cancer?** YES___ NO____ Who? _____
- **Cataracts?** YES___ NO____ Who? _____
- **Diabetes? I or II** YES___ NO____ Who? _____
- **Hyperlipidemia** YES___ NO____ Who? _____
- **HTN?** YES___ NO____ Who? _____
- **Kidney Stones** YES___ NO____ Who? _____
- **Stroke** YES___ NO____ Who? _____

Doctor Reviewed Document
Physician Signature: _____

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Patient: _____
Last Name First Name M.I

Address: _____

_____
City State Zip Code

Home/Cell phone: _____ SS#: _____

Date of birth: _____ Age: _____

Patient's Employer: _____Occupation: _____

Spouse's Name: _____ Spouse's Phone #: _____

Nearest Relative: _____ Phone #: _____

Primary Physician: _____ Phone#: _____

Referred by: _____ Phone#: _____

Primary Insurance: _____ ID#: _____ Group: _____

Address: _____

******If you are NOT the primary policy cardholder, WE NEED the following information*******
Primary Cardholder name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____ ID#: _____ Group: _____

***I give permission to Mark S. Shachner, M.D., F.A.C.S, Bernard J. Zaragoza, M.D., F.A.C.S**
Gabriel Glaun, M.D or Megan Rodwell, PA-C, to administer medical treatment to me and authorize the release of all medical information necessary for my treatment.
Sign: _____ Date: _____
***I authorize the release of my medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to go directly to South Florida Surgical Specialists, LLC. I authorize photocopies of this form to be valid as the original.**
Sign: _____ Date: _____
***By signing below, you are giving permission to be contacted via the Internet by South Florida Surgical Specialists,**
Sign: _____ Email Address: _____
Payment is expected when services are rendered

*****PLEASE SUPPLY BELOW <u>emergency</u> phone numbers so that we may contact them in case of an emergency. These numbers are not to include home or work*****
1. _____ 2. _____

☐ **By checking this box, you agree to receive text messages at the number provided. Message frequency may vary. Standard message and data rates may apply. Text HELP for help. Text STOP to cancel.**

3001 Coral Hills Dr. Suite 320 Coral Springs, Florida 33065
Office 954-755-0111 Fax 954-755-2209

Shachner & Zaragoza, MD, PA
Mark S. Shachner, MD., F.A.C.S. * Bernard J. Zaragoza, MD., F.A.C.S.
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MEDICATION HISTORY CONSENT FORM

I, _____, hereby authorize the office of Shachner & Zaragoza, MD, PA, to E-Prescribe medications as well as view my medication history.

This authorization will last indefinitely unless this office is notified in writing about any changes.

Signature _____ Date_____

Print _____

Witness _____

PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW

PHARMACY NAME: _____

PHONE NUMBER OR LOCATION: _____

_____

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Consent to Treat

During your treatment with Shachner and Zaragoza, M.D., P.A., it may be necessary to contact you regarding your appointments, surgery, or medical condition.
Please list family members or friends you authorize us to speak with if we cannot contact you. ***Without this authorization, we are prohibited by law from answering any questions regarding your appointments, surgery, or medical condition.*** This rule applies to spouses, children, parents, and other immediate family members.

I, _____, hereby authorize the office of

Shachner & Zaragoza, MD, PA, Dr. Shachner, Dr. Zaragoza, Dr. Glaun, & Megan Rodwell, PA-C to contact

_____

_____

or to leave a message at my home or office. There are/are no exceptions to the above.

Exceptions: _____

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Signature _____ Date _____

Witness _____

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Office 954-755-0111 Fax 954-755-2209

Shachner & Zaragoza, MD, PA (the "Practice")
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Practice uses health information about you for treatment, to obtain payment for treatment, for operations and for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record, either electronic or paper, that is the physical property of the Practice. Your health information is referred to in this Notice as information or health information. This Notice is provided to tell you about our duties and practices with respect to your health information.

Practice Obligations:

The Practice is required by law to:

- maintain the privacy of protected health information;
- provide you with this Notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this Notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; and
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

The Practice reserves the right to change its privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. The Practice reserves the right to make the changes in its privacy practices and policies and the new terms of its Notice are effective for all health information that the Practice maintains, including health information the Practice created or received before the Practice made the changes. Before the Practice makes a significant change in its privacy practices, the Practice will change this Notice and make the new Notice available upon request.

Use or Disclosure of Your Health Information:

For Treatment: The Practice may use and disclose your health information to other health care providers, physicians, or facilities, involved in your care and treatment, in order to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment: The Practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may

contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: The Practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the Practice, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- conducting training programs;
- accreditation, certification, licensing, or credentialing activities;
- assess the quality of care and outcomes in your case and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

To Your Family and Friends: The Practice must disclose your health information to you, as described in the Patient Rights of this Notice. The Practice may disclose your health information to a family member, friend, or any person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that the Practice may do so.

Persons Involved in Care: The Practice may use and disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your general condition, or death. If you are present, then object to such uses or disclosures. In the event of your incapacity or emergency circumstances, the Practice will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. The Practice will also use its professional judgment and its experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Appointments: The Practice may use or disclose your information to provide appointment reminders, including telephone messages or voicemail messages, or emails, at telephone numbers or email addresses that you gave to the Practice.

Fund Raising: The Practice may use your information about you, including your name, address, telephone number, and dates of service, in order to contact you to raise funds for the Practice. If you do not want the Practice to contact you for this purpose, you must notify the COO of the Practice, in writing, and indicate that you do not want to be so contacted.

Required by Law: The Practice may use and disclose information about you as required by federal, state, and local law. For example, the Practice may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority.
- to report information related to a victim of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, reporting vital statistics such as death, or for other health oversight activities.

Abuse or Neglect: The Practice may use or disclose your health information to appropriate authorities if the Practice reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim in other crimes. The Practice may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: If you are an organ donor, your health information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: The Practice may use your health information for research purposes after an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety: Your health information may be used or disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be used or disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services including for national security purposes.

Workers Compensations: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Law Enforcement: As permitted or required by law, the Practice may disclose your health information to a law enforcement official for certain law enforcement purposes, such as reporting certain types of wounds and other physical injuries; pursuant to a court order, warrant, subpoena or summons; for identifying or locating a suspect, fugitive, material witness, or missing person; under certain limited circumstances if you are the victim of a crime; if we believe your death was the result of criminal conduct; and in an emergency to report a crime.

Your Authorization: In addition to the Practice's use of your health information for treatment, payment, or healthcare operations, you may give the Practice written authorization to use your health information or to disclose it to anyone for any purpose. Your written authorization is required to release your health information if it contains psychotherapy notes, is for marketing purposes, or is for the sale of your health information. Release of your health information for any reason not set forth in this Notice may only occur after you give written authorization. If you give the Practice authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give the Practice a written authorization, the Practice cannot use or disclose your health information for any reason except those in those Notice.

Marketing Health-Related Services: The Practice will not use your health information for marketing communications without your written authorization.

Other uses: Other uses and disclosure will be made only with your written authorization, and you may revoke the authorization except to the extent the practice has taken action in reliance on such.

Your Health Information Rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that the Practice provides copies in a format other than photocopies. The Practice will use the format you request unless the Practice cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain the authorization form to request access by using the contact information listed at the end of this Notice. The Practice may charge you a reasonable cost-based fee for expenses, such as copies, CDs, thumb drives, staff time, and postage. You may also request a copy by sending us a letter to the address at the end of this Notice. If you prefer, the Practice will prepare a summary or an explanation of your health information for a fee. Contact the Practice using the information listed at the end of this Notice for a full explanation of the Practice's fee structure.

Disclosure Accounting: You have the right to receive a list in which the Practice or its business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, the Practice may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that the Practice places additional restrictions on its use or disclosure of your health information. The Practice is not required to agree to these additional restrictions unless it is for disclosure of health information to a health plan or insure for purposes of payment or healthcare operations, is not otherwise required by law, and you or someone on your behalf other than the health plan or insurer has paid the Practice in full for its services.

Alternative Communication: You have the right to request that the Practice communicates with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that the Practice amend your health information. Your request must be in writing, and it must explain why the information should be amended. The Practice may deny your request under certain circumstances. If the Practice denies a request for an amendment, you or your representative has the right to file a statement of disagreement to the denial, and your request for amendment, the Practice's denial of the request, and your statement of disagreement, if any, shall be included in any future disclosures of such health information.

Electronic Notice: If you receive this Notice on the Practice's website or by electronic mail (e-mailed), you are entitled to receive this Notice in written form.

Questions and Complaints:

If you want more information about our privacy or have questions or concerns, please contact the Practice.

If you are concerned that we have violated your privacy rights, or you disagree with a decision the Practice has made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternate means it at alternative locations, you may complain to us by using the contact information listed at the end of this Notice, You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated and we will provide you with the address for such communication. You will not be retaliated against for filing a complaint.

Contact Information:

Contact:	Shachner & Zaragoza, MD, PA
Address:	3001 Coral Hills Dr, Suite 320
	Coral Springs, FL 33065
Telephone:	(954) 755-0111
Fax:	(954) 755-2209

Amended and Effective:

Shachner & Zaragoza, MD, PA
ACKNOWLEDGEMENT OF RECEIPT OF THE PRACTICE'S
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. You may refuse to sign this acknowledgment.

_____	_____	_____
Name (Print)	Signature	Date

The Practice Use Only_____

Date acknowledgement received: _____

Individual refused to sign: _____ (check if applicable)

An emergency situation prevented the Practice from obtaining acknowledgment: _____(check)

Another reason acknowledgment was not obtained: _____
_____

Practice Employee:

Signature: _____

Print Name: _____

Date: _____

MIPS 2025 Reporting

PATIENT NAME: _____ Date: _____

As part of our commitment to providing you with the best possible care and meeting the necessary requirements for MIPS 2025 reporting, we ask that you provide accurate information when completing the questions on this form. The data we collect helps us assess and improve the quality of care you receive while also ensuring that we meet healthcare standards set by Medicare. Your participation is important in helping us track your progress, address any gaps in care, and deliver the most effective treatment possible. We appreciate your cooperation and trust that the information you provide will be both accurate and helpful.

Please complete the following questions:

1. **CMS68:** Are you currently taking any medications? Please circle: Yes or No
2. **CMS138:** Do you currently smoke? Please circle: Yes or No
   If yes, our office will provide you with an appropriate educational handout to help you quit.
3. **CMS50:** Our provider will send your referring doctor the medical notes from today's visit.
4. **CMS139:** Are you over 65 and at risk of falling? Please circle: Yes or No
5. **CMS2v13:** Are you currently experiencing depression? Please circle: Yes or No
6. **CMS159V12:** Please complete the flow sheet below:

CMS 159v12: Depression Remission at 12 months (PHQ-9 Flowsheet)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping to much				
feeling tired or having little energy				
poor appetite or overeating				
feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
moving or speaking so slow that other people could have noticed? Or the opposite-being so fidgety or restless that you have been moving around a lot more than ususal				
Thoughts that you would be better off dead or hurting yourself in some way				
PHQ-9 SCORE				
Patient declined screening	☐ Done			

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OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that paying your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign before any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor; copayments, coinsurance, and deductibles are due at the time of service. We only accept cash, Visa, Master Card, Discover, or American Express. **We do NOT accept checks.**
Should your patient portion of the account not be paid timely, the patient assumes all costs of collection, including, but not limited to, court costs, interest, and legal fees we incur.

REGARDING INSURANCE

We will accept the assignment of insurance benefits; however, we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you provide a complete and accurate date. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. You will be responsible for the balance if your insurance company has not paid your account in full within 45 days. Please be aware that some services may be non-covered and not considered reasonable and necessary under the Medicare Program and other medical insurance.

Exceptions to the above policy are restricted to the plans for which Shachner & Dr. Zaragoza, MD, PA are contracted providers (e.g., certain HMOs & PPOs). You will be responsible for all required co-payments and deductibles at the time of service. You will also be responsible for payments for procedures not covered by your insurance company or procedures performed for pre-existing conditions if not covered by your policy. We will assist with obtaining authorizations for all procedures; however, pre-authorizations are not a guarantee of payment by your insurance company.
Your surgery may require a “surgical assistant” to be present. That surgical assistant may or may not be covered by your Insurance Company. You may receive a separate bill for the “surgical assistant” services based on your insurance coverage.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

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OUR FINANCIAL POLICY

MISSED APPOINTMENTS

Our policy is to charge for missed appointments at the rate of normal office visits unless canceled at least 24 hours in advance. Please help us serve you better by keeping the scheduled appointment.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I authorize direct payment of all benefits payable on my/the patient's behalf from any Insurance company or health plan directly to my physician(s).

I understand and acknowledge that all unpaid charges remain primarily and principally my obligation and agree to remain responsible for payment of all charges not covered or otherwise paid from my insurance or health plan, which charges my physician(s) are legally entitled to bill me for.

SURGERY

Once confirmed, surgery dates and times CAN NOT be rescheduled for any reason except failure to be medically cleared. A $250.00 rescheduling fee will be applied at the surgeon's discretion.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and understand and agree with this Financial Policy.

_____ _____

Signature of patient or responsible party Date

_____

Print Name of Patient or responsible party