Zinni Family Practice

Luis Villaplana, M.D.

Elizabeth Zinni, N.P.

Joey Annichine, N.P.

540 East Main Street
Canfield, Ohio 44406
P: 330-533-3351
F: 330-533-8966

Dear _____,

Time has been reserved for your appointment with Elizabeth Zinni, NP or Joey Annichine, NP _____ at _____.

Please arrive 15 minutes early for this appointment. Please bring a copy of your insurance card, your medication list, as well as any records you may have and all the enclosed forms ***completed.***

If you are a self-pay patient, all services must be paid for at the time services are rendered. You are also responsible for your co-payment at the time of service if covered by your insurance.

If for any reason you are unable to keep your appointment, please give our office at least a 24-hour notice so that we may fill your appointment time with another patient. If you do not call to cancel, you may be subject to charge and will not be rescheduled at our office.

Thank you for your cooperation and we very much look forward to seeing you at the time of your visit.

PATIENT REGISTRATION

Elizabeth A. Zinni, NP Joey Annichine, NP

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: M F

Home Phone: _____ Cell Phone: _____

SS#: _____ - _____ - _____ Marital Status: S M W D

Employment Information

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Responsible Party If Other Than Patient OR Spouse Information

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#: _____ - _____ - _____ Marital Status: S M W D

In Case of Emergency Please Contact (Not at the same address)

Name: _____ Phone: _____

Name: _____ Phone: _____

I, _____, give to the following people authorization to any of my medical records, results, or any information about my health permission to review my records at any time:

_____

_____

Signed: _____ Date: _____

Please do not turn into front desk unless COMPLETELY filled out. Thank You.

MEDICAL HISTORY

Elizabeth Zinni, NP Joey Annichine, NP

Allergies to Medication, X-Ray Dyes, or Other Substances: ____

_____

_____

Current Medications:

_____

_____

Please circle if **YOU** have had any problems with or are presently experiencing any of the following and check if any family member has had any of the following:

___ High Blood Pressure	___ Bronchitis	___ Arthritis	___ Diabetes
___ Pneumonia	___ Low Back Pain	___ Cancer	___ Persistent Cough
___ Skin Diseases	___ Heart Disease	___ T.B.	___ Hemorrhoids
___ Blood Disorder	___ Chest Pain	___ Hay Fever	___ Venereal Disease
___ Anxiety	___ Abdominal Pain	___ Colitis	___ Indigestion
___ Depression	___ Hepatitis/Jaundice	___ Depression	___ Nausea
___ Alcohol Abuse	___ Head/Neck Radiation	___ Lightheadedness	___Constipation
___ Headache	___ Drug Abuse	___ Gout	___ Diarrhea
___ Kidney Disease	___ Difficulty Urinating	___Rheumatic Fever	___ Blood in Stool
___ Kidney Stones	___ Sexual Dysfunction	___ Frequent Urination	___ Ulcers
___ Asthma	___ Shortness of Breath	___ Change in Bowels	___ Weight Gain/Loss

Other: _____

Gynecologic and Obstetric History:

Age at onset of periods: _____ Frequency: _____ Length: _____ Pregnancies: _____

Births: _____ Miscarriages: _____ Prolonged or abnormal Bleeding: Y N Leakage of Urine: Y N

Pelvic Pain: Y N Abnormal Discharge: Y N History of Abnormal Pap: Y N

When was your last: Pap Smear_____ Mammogram _____

Please List and Supply the Dates of the Following:

Operations: _____

_____

Hospitalizations other than the above: _____

_____

Immunization History —

Hepatitis B: N Y When? _____ Flu Vaccine: N Y When? _____

Pneumovax: N Y When? _____ Tetanus: N Y When? _____

Our Responsibilities

We are required by the Federal Privacy Rules to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to health information we collect and maintain about you
- When required by state law
- To state and federal public health authorities, including state medical officers, the "Food and Drug Administration (FDA), and other agencies charged with preventing or controlling disease.
- To government authorities, including protective service agencies, authorized to receive reports of abuse, neglect or domestic violence.
- To government health oversight agencies, such as the state and federal Departments of Health and Human Services, Medicare/Medicaid PRO's, state boards of Medicine, Nursing, and Pharmacy, and other licensing authorities
- When required or court order in a judicial or administrative proceeding
- To law enforcement officials for certain law enforcement purposes, including the reporting of certain types of wounds or injuries, or pursuant to a warrant, subpoena, or other legal process, or for the purpose of identifying or locating a subject, fugitive, material witness, missing person, or victim, provided that the conditions to the rule are met..
- To coroners, medical examiners or funeral directors for purposes of identifying a deceased person or carrying out their duties as required by law
- To organ procurement organizations for purposes of organ or tissue donation and transplantation, consistent with applicable law
- For research approved by and Institutional Review Board (IRB) or Privacy Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- When required to avert a serious threat to health or safety.
- When requested for certain specialized government functions authorized by law, including military and similar situations.
- As authorized by law in connection with workers compensation programs.

Uses and Disclosures Specifically Authorized by You

We expect to make other uses and disclosures of your protected health information only on the basis of specific writer authorization forms signed by you. You have the right to revoke any such authorization at any time, except to the extent we have already relied on it making an authorization use or disclosure.

For More Information or to Report a Problem:

If you have any questions, you may contact the privacy office at your practice location/ if you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or the Privacy Officer at your practice location or with the secretary of health and human services. There will be no retaliation for filing a complaint. Effective Date April 14th, 2003.

FINANCIAL POLICY

We are doing everything possible to reduce the cost of medical care. You can help a great deal by eliminating the need for us to bill you.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Gregory S. Zinni, M.D., Inc. accepts cash, personal checks, VISA, MasterCard, Discover and American Express. There is a $30.00 fee for all returned checks.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

We do not accept any form of Medicaid as secondary insurance.

Please be sure to check your coverage before your appointment.

If you need assistance or have questions, please contact Helen at 330-533-3351 Monday through Friday.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

REFERRALS

If you are enrolled in a managed care-insurance plan, you must receive a referral from our office before seeing a specialist. NO retroactive referrals will be given.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointment. Excessive abuse of scheduled appointments may result in a discharge from the practice.

I understand that I am fully responsible for all appointments that are made. If I no show for an appointment, I am aware that I will be charged for a visit. I also understand that this fee must be paid before my next appointment.

Signature _____

I have read and understand Gregory S. Zinni, M.D., Inc.'s financial policy. I agree to assign insurance benefits to Gregory S. Zinni, M.D. whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections and that I will then have 30 days to find a new physician.

Signature of insured or authorized representative: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND TO ACCEPT BENEFITS PAID TO PHYSICIAN

l, the undersigned, assign directly to Gregory S. Zinni, M.D. all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Gregory S. Zinni, M.D. or his office to release all information necessary to secure payments of benefits.

Signature: _____ Printed Name: _____

Date: _____ Witnessed: _____

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT. (MEDICARE PATIENTS ONLY)

I certify that the information given to me in applying for payment under the title XVII of the social security act is correct. I authorize a holder or medical or other information about me to release to the carriers any information needed for this or related MEDICARE behalf. I assign the benefits payable for covered MEDICARE services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to MEDICARE for payment to me. I request that the payment under the medical insurance program be made to Gregory S. Zinni, M.D. or any bills for services furnished by Gregory S. Zinni, M.D.

Signature: _____ Printed Name: _____

Date: _____ Witnessed: _____

Communication Preferences

Patient Name: _____

Current Phone Number to contact for details: _____

Would you like us to leave a detailed message? _____

Would you like us to leave a message just to return the call? _____

Would you like us to leave no message? _____

Please list people that we may share your results with (Example: Spouse, parent, roommate, etc.)

_____

_____

Alternate Phone Number to contact for results: _____

Alternate Phone Number to contact for results: _____

Signed: _____ Date: _____

Zinni Family Practice Privacy Agreement

Notice of Health Information Practices:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment, this information, which we refer to as your health or medical record is an essential part of the health care we provide for you. It serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were provided..
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged with improving the health of the nation.
- Source of data for facility planning and marketing.
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Your health record contains personal health information, the confidentiality of which is protected under both state and federal law. Understanding we expect to use and disclose your health information helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why your health care providers and others my access your health information
- Make more informed decisions When authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner of the facility that you complied with, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164 you have a right to:

- Receive notice of the uses and disclosures we expect to make of your health information, including a paper copy of the notice if requested, as provided in Rule 520.
- Request additional restriction on uses and disclosures of your health information (though we are not required to agree to any such request), or request that we send you confidential communications by alternative means or at alternative locations, as provided'45 CFR 164.523.
- Inspect and obtain a copy of your health record as provided in Rule 524.
- Request that your health record be amended as provided in Rule 526.
- Obtain an accounting of disclosures of your health information made after April 14th 2003, for the purposes other than treatment, payment, or health care operations, as provided in Rule 528.

540 East Main Street
Canfield, Ohio 44406
P: 330-533-3351
F: 330-533-8966

Elizabeth Zinni NP
Joey Annichine NP

Date: _____

Name: _____

Address: _____

_____

SS#: _____-_____-_____ DOB: _____/_____/_____

I Authorize (Previous Physician):

_____

_____

_____

To Release ALL of My Medical Records to:

Elizabeth Zinni NP
Joey Annichine NP
540 East Main Street
Canfield, Ohio 44406
Fax: 330-533-8966

Signature: _____

Relationship: _____

Date Sent: _____

Initials: _____