ALDO CICCOTELLI, M.D., P.C.

PREPARING FOR YOUR VISIT

❑ PLEASE ARRIVE 15 MINUTES EARLY
❑ ALL PAPERWORK MUST BE FILLED OUT BEFORE YOUR APPOINTMENT
❑ IF YOU HAVE AN HMO INSURANCE PLAN THAT REQUIRES YOU TO SELECT A PROVIDER, PLEASE MAKE SURE **ALDO CICCOTELLI, MD, PC** IS SELECTED PRIOR TO YOUR VISIT OR YOUR APPOINTMENT WILL BE RESCHEDULED. USE OUR OFFICE NPI 1649266313 OR 1972046977

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE

PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other___________

PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT) RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

PHARMACY INFORMATION

PHARMACY	ADDRESS	
CITY, STATE	ZIP	PHONE
MAIL ORDER PHARMACY		

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

Allergies
❑ NONE/No Known Allergies
❑ Yes, I have the following allergies:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER/FATHER	SIBLING (Brother/Sister)	GRANDPARENT/AUNT/UNCLE
Cancer (describe type)			
Diabetes			
Heart Disease			
High Blood Pressure			
Stroke			
Mental Disease (anxiety/depression, etc.)			

SOCIAL HISTORY
☐**Yes** ☐**No -** Do you drink alcohol?☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (____ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures, or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Check all conditions you currently have or have had in the past:

❑ NONE of the problems listed
❑ Abdominal discomfort
❑ Anemia
❑ Anxiety
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ Bronchitis
❑ CAD (coronary artery disease)
❑ Cancer ______________
❑ Change in bowels
❑ Chest pain
❑ CHF (congestive heart failure)
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Gout
❑ High blood pressure
❑ Hemorrhoids
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney disease
❑ Migraines/headaches
❑ Nausea/vomiting
❑ Osteoporosis
❑ Pneumonia
❑ Shortness of breath
❑ Skin disease
❑ Stroke
❑ Thyroid problems
❑ Tuberculosis
❑ Ulcers
❑ Unexplained weight loss/gain

Medications

PLEASE BRING MEDICATION BOTTLES TO YOUR FIRST VISIT TO ENSURE EVERYTHING IS RECORDED INTO YOUR CHART ACCURATELY. PLEASE NOTE WE WILL NOT REFILL ANY PRESCRIPTIONS UNLESS WE HAVE THE PREVIOUS PRESCRIPTION BOTTLE.

*****PLEASE BE AWARE THAT OUR OFFICE WILL NOT FILL PRESCRIPTIONS FOR CHRONIC PAIN AND/OR CHRONIC ANXIETY MEDICATIONS*****

ALDO CICCOTELLI, M.D., P.C.

Patient Financial Policy

It is the policy of Aldo Ciccotelli, MD, PC to provide you with information related to our billing processes and your financial responsibilities as our patient. This policy helps us in our mission to provide you with exceptional medical care in the most cost-effective manner.

Things to bring with you each visit:

1) Current insurance card(s)
2) Your preferred method of payment for any cost shares due at the time of service

Insurance Companies: Participation and Billing

1) While Aldo Ciccotelli, MD, PC participates with the majority of third-party insurance plans available in our area; it is **your** responsibility to verify that we are currently participating with your plan. You are responsible to designate your physician as your PCP with your insurance plan. Failure to do so may results in your responsibility for any incurred charges.
2) You may be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have on file is correct, and that your plan is current.
3) Except where my plan provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise payable to me, for services rendered by Aldo Ciccotelli, MD, PC. I understand that I am ultimately responsible to the provider for charges not covered by my benefit plan.
4) Due to the wide range of insurance plans, we are unable to quote specific benefit plan benefits. To fully understand your individual insurance plan, please contact your insurance company directly to discuss your plan's benefits.
5) Your first visit as a new patient will be to establish care with our practice, review medical history, order labs you may be due for and address any medical concerns you may have at that time. This is not a preventative visit; therefore you will be responsible for any co-payment, deductible, or coinsurance for that visit.

Time of Service Payments

1) Co-payments, deductibles, and coinsurances are part of the contractual agreement between you and your insurance company. Your insurance company requires us to collect your co-payment in full at the time of service. If your plan also has a deductible and/or coinsurance that hasn't been met, we will collect a deposit of $50 (since we can only estimate the future amount due) at the time of service. Co-payments and deductible deposits are due at time of service unless previous arrangements have been made with the office.
2) All account balances must be in good standing prior to receiving additional services. You must contact the office if unable to pay your balance.

Collections

1) The practice reserves the right to consider delinquent patient accounts for external collection in accordance with state and federal regulations. Delinquent accounts are those in which no payment towards balance has been made in 90 days, or no payment plan with the office has been made.
2) If your account is sent to collections, you will be discharged from the practice.

By signing below, I acknowledge that I have read, understand, and accept the policy.

Print Name: ______________________________ Date of Birth: ____________________

Signature: ______________________________ Date: ____________________

ALDO CICCOTELLI, M.D., P.C.

Consent for Treatment Authorization Form

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Aldo Ciccotelli, MD, PC, its providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the Aldo Ciccotelli, MD, PC provider of service(s) furnished to me. I authorized Aldo Ciccotelli, MD, PC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of m private, group employer's or group health insurance plan, directly to Aldo Ciccotelli, MD, PC. I hereby authorize that photocopies of this form to be valid as the original.

ELECTRONIC PRESCRIBING: I understand that Aldo Ciccotelli, MD, PC may use an electronic prescription system which allows prescriptions and related information to be electronically sent between Aldo Ciccotelli, MD, PC and my pharmacy. I have been informed and understand that Aldo Ciccotelli, MD, PC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent for Aldo Ciccotelli, MD, PC to see this health information.

CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location.

I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include poor video and data quality experience, or lack of access o my complete medical record by the remote physician. I understand that all information will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

CELL PHONES/EMAIL: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), and email address(es), so that representatives from Aldo Ciccotelli, MD, PC, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but no limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

NOTICE OF PRIVACY PRACTICES: I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services. This will include all of my protected health information generated during hospitalizations and/or outpatient treatments.

I, or my legal representative, certify that I have read this document and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

Print Name: ____ Date of Birth: ___________________

Signature: ____ Date: __________________________