THE WOODRUFF INSTITUTE

Dear New Client:

We are pleased to welcome you to our practice! Thank you for allowing us to serve your health care needs. We are enclosing with this letter our new patient information forms. Please complete the forms and bring them to your first appointment. **Please plan to arrive 15 minutes prior to your appointment time**.

LOCATION AND HOURS:

Please visit our website for door-to-door directions: **www.thewoodruffinstitute.com**

Our **NORTH NAPLES** office is located at 2235 Venetian Court, Suite 1, in the Venetian Plaza located at the south west corner of the intersection at Vanderbilt Beach Road and Airport-Pulling Road.

Our **DOWNTOWN NAPLES** office is located at 1333 3rd Avenue South, Suite 201, in the Bayfront Professional Center, just off of Goodlette Frank Road.

Our **BONITA SPRINGS / ESTERO** office is located at 23471 Walden Center Drive, Suite 300, on the third floor of the US Trust building, located on the west side of US 41, just south of Coconut Road, across from the Bonita Community Health Center.

Our **FORT MYERS** office is located at 14440 Metropolis Avenue, Suite 102, just north of the intersection of Six Mile Cypress Parkway and Metro Parkway.

We have office hours **Monday through Friday from 8:00am until 5:00pm**. We do not close for lunch. We request that you give us at least 24-hour notice if you are unable to keep a scheduled appointment. This will give us time to schedule someone else who may have an urgent need for care.

FINANCIAL: If you have medical insurance, please bring all of your current insurance identification cards with you to the appointment. **Please contact your insurance company prior to your appointment to verify that our office is contracted with your plan. You may do this by calling the 800 telephone number on the back of your card and giving them our Tax ID# 200113558. If your insurance plan requires a referral / authorization from a Primary Care Physician, please obtain prior to your appointment.** Please check to make sure that your cards are not expired. You will also need to bring a valid photo identification card.

All co-payments, coinsurance, and/or deductible monies will be collected at time of check-in. For self-pay patients, payment in full at the time of service is required. We accept cash, checks, and Mastercard, VISA or America Express. There is a $25.00 insufficient (bounced check) fee if your check does not clear the bank, in addition to the amount of your check.

We look forward to meeting you soon!

THE WOODRUFF INSTITUTE

PATIENT INFORMATION (Please print)

Name_____ **Today's Date**_____

Date of Birth_____ **Social Security** _____ **Gender** M or F

Local Mailing Address_____

Alternative/Seasonal Address _____

Home Phone _____ **Cell Phone** _____ **Work Phone**_____

Primary Care Physician _____

Employer_____ **Occupation** _____

Preferred Contact Number: ❑ Home ❑ Cell ❑ Work ***Ok to leave detailed message?*** ❑ Yes ❑ No

Preferred Language ❑ English ❑ Spanish Other: _____

Race ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Caucasian/White
❑ Native Hawaiian/Pacific Islander ❑ Unknown ❑ Decline to specify

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to specify

Email address: _____

❑ Yes ❑ No ***Please add my e-mail address to your mailing list to receive e-mail updates/ specials***

How did you hear about the Woodruff Institute?

❑ Physician referral, please specify: _____
❑ Newspaper / magazine, please specify: _____
❑ Family / friend, please specify: _____
❑ Website / social media, please specify: _____
❑ Other: _____

Have you verified In-Network Coverage? ❑ Yes ❑ No
If not, I understand that I am responsible for **all payments, copayments, and deductibles** specified by the insurance company if these services are deemed **Out-of-Network** by my insurance company.

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance _____ **Secondary Insurance** _____

Name of Insured_____ **Name of Insured**_____

Insured's SSN # _____ **Insured's SSN #** _____

Insured's Date of Birth _____ **Insured's Date of Birth**_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ **Date** _____

PATIENT NAME: _____ **DATE:** _____

PREFERRED PHARMACY: _____ **Phone:** _____

City & Intersection: _____

Seasonal Pharmacy & Phone: _____

PAST MEDICAL HISTORY: (please check all that apply)

- ❑ **NONE**
- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ BPH (enlarged prostate)
- ❑ Cerebrovascular accident (stroke)
- ❑ COPD
- ❑ Coronary artery disease
- ❑ Depressive disorder
- ❑ Diabetes
- ❑ Elevated blood pressure
- ❑ End stage renal disease
- ❑ Epilepsy
- ❑ GERD (reflux)
- ❑ Hearing loss
- ❑ HIV/ AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Inflammatory liver disease
- ❑ Leukemia
- ❑ Malignant lymphoma
- ❑ Malignant tumor of lung
- ❑ Malignant tumor of breast
- ❑ Malignant tumor of colon
- ❑ Malignant tumor of prostate
- ❑ Radiation treatment
- ❑ Transplantation of bone marrow

Other:_____

PAST SURGICAL HISTORY: (please check all that apply)

- ❑ **NONE**
- ❑ Abdominoperineal resection
- ❑ Bilateral replacement knee joints
- ❑ Biopsy of breast
- ❑ Biopsy of prostate
- ❑ Coronary artery bypass graft
- ❑ Entire transplanted kidney
- ❑ Excision of basal cell carcinoma
- ❑ Excision of melanoma
- ❑ Excision of squamous cell carcinoma
- ❑ History of colostomy
- ❑ History of tubal ligation
- ❑ History of appendectomy
- ❑ History of bilateral mastectomy
- ❑ History of cholecystectomy (gallbladder)
- ❑ History of colectomy
- ❑ History of liver excision
- ❑ History of PTCA (coronary angioplasty)
- ❑ History of heart valve replacement
- ❑ History of total cystectomy (urinary bladder)
- ❑ History of prostatectomy
- ❑ Hysterectomy
- ❑ Kidney biopsy
- ❑ Low anterior resection of rectum
- ❑ Lumpectomy of breasts ❑R ❑ L
- ❑ Mastectomy of breasts ❑ R ❑ L
- ❑ Oophorectomy (ovaries removed)
- ❑ Pancreatectomy
- ❑ Procedure: Kidney stones
- ❑ Portosystemic shunt operation
- ❑ Prostate removed: Prostate cancer
- ❑ Prosthetic arthroplasty of hips
- ❑ Spleen removed
- ❑ Surgical biopsy of skin
- ❑ Total nephrectomy (kidneys)
- ❑ Total orchidectomy (testicles)
- ❑ Total replace of hips ❑ R ❑ L
- ❑ Total replace of knees ❑ R ❑ L
- ❑ Transplantation of heart
- ❑ Transplantation of liver

Other: _____

SKIN DISEASE HISTORY: (please check all that apply)

- ❑ **NONE**
- ❑ Acne
- ❑ Actinic keratosis
- ❑ Asteatosis cutis
- ❑ Basal cell skin cancer
- ❑ Contact dermatitis from poison ivy
- ❑ Dysplastic nevus of skin
- ❑ Eczema
- ❑ History of asthma
- ❑ History of hay fever
- ❑ Melanoma
- ❑ Pruritis of scalp
- ❑ Psoriasis
- ❑ Squamous cell skin cancer
- ❑ Sunburn of second degree

Other:_____

Do you wear sunscreen? **Yes** **No** **If yes, what SPF?** _____
Do you tan in a tanning salon? **Yes** **No**
Do you have a <u>family history</u> of melanoma? **Yes** **No**

If yes, which relative(s)?_____

MEDICATIONS: (Please list all current medications, including name, dosage and how often used, if possible)

❑ **I do not take any medications**

_____

_____

_____

_____

_____

_____

ALLERGIES: (Please list all allergies and reactions)

❑ **I do not have any allergies to medications**

_____

_____

_____

SOCIAL HISTORY: (Please check all that apply)

Tobacco Use: ❑ Never smoked ❑ Quit; former smoker ❑ Smokes less than daily ❑ Smokes daily

Alcohol Use: ❑ None ❑ Less than one drink per day ❑ 1-2 drinks/ day ❑ More than 3 drinks per day

Men: How many times in the past year have you had more than 5 drinks in one day? _____

Women / All Adults > 65 years: How many times **in** the past year have you had more than 4 drinks in a day?_____

Have you ever felt that you should cut down on your drinking? ❑ Yes ❑ No

❑ Yes ❑ No I have received a pneumonia vaccine.

❑ Yes ❑ No I have received an influenza vaccine. If no, circle reason: **Allergy Medical Reason Declined**

❑ Yes ❑ No I have received a shingles vaccine. If no, circle reason: **Allergy Medical Reason Declined**

❑ Yes ❑ No I have received a Covid vaccine.

❑ Yes ❑ No I have a Living Will/ other (Please provide a copy, if possible).

Living Will surrogate/ decision maker (if applicable): _____ ***Relationship***:_____

REVIEW OF SYSTEMS: (Are you currently experiencing problems with any of the following?)

❑ Bleeding
❑ Healing
❑ Scarring
❑ Rashes
❑ Immune system
❑ Hay fever
❑ Chest pain
❑ Fever / chills
❑ Night sweats
❑ Unintentional weight loss
❑ Thyroid
❑ Sore throat
❑ Blurry vision
❑ Abdominal pain
❑ Joint aches
❑ Muscle weakness
❑ Headaches
❑ Seizures
❑ Cough
❑ Shortness of breath
❑ Wheezing
❑ Anxiety
❑ Depression

ALERTS: (Please check all that apply)

❑ Allergy to adhesive
❑ Allergy to lidocaine
❑ Allergy to topical antibiotics
❑ Artificial heart valve
❑ Artificial joints in past 2 years
❑ Blood thinners
❑ Defibrillator
❑ MRSA
❑ Pacemaker
❑ Premedication prior to procedures
❑ Rapid heartbeat with epinephrine
❑ Pregnancy or planning a pregnancy

COSMETIC INTEREST:

Do you have any skin care or anti-aging concerns today? (i.e. fine lines, brown spots, etc.) ❑ Yes ❑ No

Have you had any cosmetic treatments in the past? (i.e. Botox, fillers, laser, facials, etc.) ❑ Yes ❑ No

Are you interested in hearing about the cosmetic procedures we offer in our office today? ❑ Yes ❑ No

WOMEN ONLY:

Do you experience any bladder problems such as painful urination, leaking, or frequency? ❑ Yes ❑ No

Do you have any pelvic health issues such as loss of libido or laxity due to childbirth? ❑ Yes ❑ No

Patient HIPAA Privacy Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Woodruff Institute provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

- We will **not** release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office
- The Woodruff Institute has a Notice of Privacy Practices that is available for review
- The Woodruff Institute reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but The Woodruff Institute does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Woodruff Institute may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service)

Omnibus Final Rule- *Final modifications to the HIPAA Privacy, Security and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, are as follows*:

- You have the right to be notified of a protected health information breach.
- You have the right to ask for a copy of your electronic medical record in an electronic form.
- You have the right to opt out of fundraising communications for The Woodruff Institute.
- The Woodruff Institute cannot sell your health information without your permission.
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practice will only be made with your authorization.
- If you pay in full for services out-of-pocket, you can instruct The Woodruff Institute not to share information about your treatment with your health plan.

I _____ grant authorization for The Woodruff Institute and its associates to
Patient Name
disclose information regarding my diagnosis and or treatment to (via in person or by phone):

Authorized person	*Relationship*	*Telephone Number*
Authorized person	*Relationship*	*Telephone Number*
Authorized person	*Relationship*	*Telephone Number*

Patient or Patient Representative Signature **Date**

THE WOODRUFF INSTITUTE

Financial Policy

Thank you for choosing The Woodruff Institute as your healthcare provider. We strive to render excellent medical care to you, your family, and all of our patients. Along with providing you with quality service, The Woodruff Institute would also like to assist you with your billing needs.

Any change in home address, phone number, insurance information, or a change of primary doctor must be given to us prior to your appointment. Charges incurred if this information is not given will be patient responsibility.

As a courtesy to you, we will file claims with your health insurance plan and assist you in every way we can. Please contact your insurance company prior to your visit to clarify your covered benefits for services. ***Our office does not guarantee that your insurance will pay. Please understand that if, for whatever reason, the company does not pay for the services, you will be responsible for the unpaid balance.***

We require all patients to pay their insurance deductible, copay and/or coinsurance payment at the beginning of each visit. We do our best to verify your benefits prior to your appointment to make sure we collect the appropriate amount owed and to make sure your visit will be covered by your insurance plan. However, it remains the policy holder's responsibility to know their insurance policies, as The Woodruff Institute cannot know every detail of your specific plan. It must be fully understood that the contract is between you and your insurance company, and you are fully responsible for any unpaid balances

*(Initial)*_____**Basic Policy**: Payment for service in full is expected at the time of service, without exception. For your convenience we accept Visa, MasterCard and American Express. Payment plans will be extended to established patients of the practice only. All special arrangements must be made in advance.

*(Initial)*_____**For Patients with Insurance**: We participate with many PPOs, POS plans, HMOs and other health insurance plans including Medicare. Each plan contains unique rules which must be followed by patients. Please familiarize yourself with the particular benefits and rules of your health care plan since the contract is between you (the patient) and your health insurance carrier.

*(Initial)*_____ **Medicaid Patients:** At this time, we do not participate with Medicaid or any of its advantage plans. This includes Medicare QMB and United Healthcare Dual SNP PPO & HMO plans. If you (the patient) have Medicaid as your secondary insurance please refer to our Medicaid Policy form for additional information on how your claims will be processed.

*(Initial)*_____**Medicare Patients:** As a participating provider, we will bill Medicare for you. However, you will still be responsible for the 20% that Medicare does not cover. (Please note: Not all services are covered by Medicare). We will also bill secondary insurance carriers for you that we participate and are credentialed with. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.

*(Initial)*_____**Referrals:** Some insurance plans require a referral. It is the patient's responsibility to obtain a referral for all of their visits including any renewal referrals. This may involve calls to your primary care or referring physician. If you do not have a referral for an office visit or procedure, you will be required to pay for your visit on the day of service, or given the option to reschedule your appointment.

*(Initial)*_____**Electronic Health Record:** Our practice utilizes an Electronic Health Recording system. Occasionally, progress notes may be in a preliminary state and awaiting final review from the

provider when a patient checks out. In the event your billing status changes from time of check out, a refund will be issued and/or you will be responsible for the balance. Only finalized notes that have been reviewed and signed by a provider are submitted to insurance companies.

*(Initial)*_____**Minor Patient Policy:** The adult accompanying a minor patient or the parents/guardians of the minor patient are responsible for full payment.

*(Initial)*_____**Surgery Fees:** All copays, deductibles, and payments for noncovered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

*(Initial)*_____**Non-covered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

*(Initial)*_____**Personal Injury Cases:** This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

*(Initial)*_____**Worker's Compensation:** This office does not bill for worker's compensation cases. You are responsible for payment at the time of service.

*(Initial)*_____**Yearly Skin Screenings:** Periodic preventive skin screenings may or may not be covered under your health insurance policy; however, they may be recommended by your provider.

*(Initial)*_____**Pathology Services:** If you have a tissue biopsy done, you will receive a separate bill from an outside pathology laboratory in addition to your bill from The Woodruff Institute, as pathologists perform the analysis of the tissue biopsy. There may be times where additional diagnostic testing needs to be done at a referenced lab to support the diagnosis; therefore, you will receive an additional bill for these services if applicable.

*(Initial)*_____**Laboratory Services:** If you receive laboratory services, such as blood tests, you may receive a bill from an outside laboratory, as they perform the analysis of the lab specimen. Services may/ may not be covered by your insurance company.

*(Initial)*_____**Returned Check Fee:** All returned checks will incur a $25.00 fee.

*(Initial)*_____**Statements:** Prompt payment of mailed invoices is required. In the event you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 10 days. Payments can be mailed to 2235 Venetian Court, Suite 1, Naples, FL 34109; paid for via credit card by calling 239-596-9337 Option 4; or online at www.thewoodruffinstitute.com

*(Initial)*_____**Skin Care Products:** Returns are not accepted on any of our skin care products.

*(Initial)*_____**Patient Satisfaction:** The Woodruff Institute takes pride in the services that are rendered to our patients. Our goal is to provide you with the highest quality of care in a courteous and professional setting. If at any time your experience with us did not meet your expectations, please contact us at any time to report your question, issue or concern. You can reach us by calling 239-596-9337 Option 4 or email at billing@thewoodruffinstitute.com

I have read this Financial Policy and understand the billing procedures of The Woodruff Institute. I agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.

_____	_____	_____
Signature of Patient or Responsible Party	**Print Name**	**Date**

THE WOODRUFF INSTITUTE

OPTIONAL AUTHORIZATION FOR CREDIT CARD USE FORM

Print and complete this authorization ONLY if you wish to keep a credit card on file.
All information will remain confidential.

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: [ ] Visa [ ] Master Card [ ] AMEX

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits on back of VISA/MC or 4 digits on front of AMEX)

Maximum Amount to Charge: $_____

I have read and agree to The Woodruff Institute's financial policy. I hereby authorize The Woodruff Institute to charge the amount listed above to the credit card provided herein to pay any invoices for my account. I will be provided a copy of my receipt by fax, mail or electronically at my discretion.

This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by submitting a written request to the address listed below.

Cardholder- Please Sign and Date

Signature: _____

Print Name: _____

Date: _____

I wish to receive receipts via:

[ ] Fax _____

[ ] Mail _____

[ ] E-mail _____

The Woodruff Institute Billing Department
2235 Venetian Court, Suite 1
Naples, FL 34109