RATNASABAPATHY SIVASEKARAN, M.D.

Board Certified Internist

REGISTRATION FORM

(Please Print)

Today's date:				Previous PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:				❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F	Do you have advanced directives? Yes or No If not would you like a copy? yes or No		
Street address:			Main phone no.: ( )			Alternative phone no.: ( )
City:	State:		ZIP Code:			Email:
Language Preference:	Race: ▫ American Indian ▫Hispanic ▫Asian ▫Pacific Islander ▫African American ▫White					Ethnicity: ▫Not Hispanic or Latino ▫Refused
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other						
Other family members seen here:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance ❑ Medicare ❑ Medicaid ❑ Florida Blue ❑ Other Blue ❑ Humana ❑ Cigna ❑ Aetna ❑ Other _____					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Main phone no.: ( )	Alt phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Patient Medical History

Patient name: _____ Date of Birth: _____

Language Preference: Race: □American Indian □Hispanic □Asian □Pacific Islander □African American □White

Ethnicity: □Not Hispanic or Latino □Refused

Please list any Surgeries, hospital visits, or procedures that you have had below:

Hospitalization, Procedure, Surgeries	Date	Location

What is your Social History?

Marital Status: □Single □Married □Divorced □Widow/Widower

Current Occupation/Employer_____ What Kind of Work? _____

Do you Smoke?_____How many packs a day?_____How many years? _____

Do you drink alcohol?_____How many drinks?_____per day_____per week_____per month _____

Do you use illicit drugs?_____If yes, what kind?_____Are you sexually active? _____

Depression screening

Please answer the following questions with a corresponding number 0-3;

0-not at all, 1-several days, 2-More than half of the days, 3-Nearly every day

1) Little interest or pleasure in doing things_____
2) Feeling down, depressed or hopeless_____
3) Trouble falling or staying asleep, or sleeping to much_____
4) Feeling tired or having little energy_____
5) Poor appetite or overeating_____
6) Feeling bad about yourself or that you are a failure, or have le yourself or family down_____
7) Trouble concentrating on things, such as reading newspaper or watching television_____
8) Moving or speaking so slowly that other people could have notices; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual_____
9) Thoughts that you would be better off dead or hurting yourself in some way_____

Family History (ie: Parents, Grandparents, Siblings, Children):

Family Member	Age	Health Status	Medical conditions

Do you have a **Living Will**? □ YES □ NO If not, would you like one? □ YES □ NO

If yes, name and number for health care surrogate/power of attorney: _____

Please list Allergies and reactions below:

Allergy	Reaction

What pharmacy do you use?_____Pharmacy phone number_____

IN CASE OF EMERGENCY:

Name of local friend or relative (not living at same address):

Relationship to patient Main phone no.: ( ) Alt phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

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CURRENT MEDICATION LIST

Patient Name:_____ **DOB:**_____

MEDICATIONS TAKEN (Prescription, non-prescription, vitamins, herbals)		
MEDICATION	**DOSAGE**	**DIRECTIONS**

The accuracy of the information in this document depends on the accuracy and completeness of information provided by the patient at the time this document was prepared. The patient is responsible for advising the pharmacist of any change to these medications.

Revised 06/29/2018

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Thank you for trusting SIVA MD professionals with your medical care. We give our personal commitment that we will do everything possible to exceed your expectations for quality medical care. In return we expect the following responsibilities as a patient.

Health Insurance: We are contracted with most insurance plans as well as Medicare and Medicaid. In order to verify your coverage and keep our records current, we may ask for your insurance card at each visit. If it is your first visit to our office, we will also ask for your picture ID to verify your identity. If you do not have your picture ID at your first visit we will have to reschedule until you have proof of identity. If you do not have your insurance card and we cannot verify coverage at the time of service you will be required to pay for your visiting full at the time of service. Please be aware that you are responsible for the charges billed for the services you receive at our office. We bill your insurance as a courtesy to you. If your insurance does not remit payment we will bill you for those services. Copayments are due at the time of service. If you have a balance due on your account for claims that he already been processed by your insurance company you will be asked for payment at your next visit. Payments are due within thirty day of the statement date. If the account is not paid within 60days it is considered past due and may be sent to our collection agency. It is illegal for our office to waive co-pays and deductibles due to breach of insurance contracts.

Services not covered by your insurance: We make every effort to order tests that meet "medical necessity" guidelines set by Medicare/Medicaid and insurance plans. We cannot possibly know what is covered under every plan. If your insurance does not cover certain services you will be responsible for those charges. If you prefer you do have the option of calling your insurance to check coverage prior to receiving services.

New patients: We require you to bring all your medication bottles in the original bottles, prescription and over the counter. This is so we document to correct dosage in your medical record. All new patients are required to give a urine sample for screening.

Missed Appointments: We will assess a charge of $25 for any missed appointment or an appointment that is cancelled with less than 24 hours' notice. We ask for 24 hours' notice so that we may open that appointment time for other patients that may wish to be seen, this fee must be paid before another appointment.

Medication refills: For best care possible please try to refill all medications at the time of your visit. Please make sure that you have enough medications to last you until the next appointment. You are responsible for making your own refill request. We do not take faxed refill request from pharmacies or call in requests from pharmacies. Please allow 24-48 hours for all refill requests to be processed.

Referrals: Some referrals, medications, and testing require prior authorization from your insurance plan with documentation and processing time. Please be patient as we will work diligently with your insurance and respond promptly.

Test results: If your provider orders labs or other testing for you, we will ask you to return for an appointment to discuss those results. We do not give results of any testing over the phone. You are able to pick up copies of your results after they have been reviewed and signed by the doctor. There will be a medical records fee.

It is your responsibility to follow the treatment plan established by your doctor and you. This includes going to appointments for further testing, attending recommended therapies, taking prescribed medications and doing home activities that the doctor recommends to you. If you do not comply you may be discharged from the practice.

We do not accept worker's compensation or Motor Vehicle claims what so ever. No exceptions.

Patient signature_____Date_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE READ ITCAREFULLY.

This office is required by law to protect the privacy of your health information, give you a Notice of our office legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of this office, which include, but are not limited to, our administrative and operations administrative staff.

1. **Uses and Disclosures of Your Health Information:** The following categories describe some of the ways that this office may use and disclose your health information.

Treatment: This office will use your health information to provide you with medical treatment/services and for treatment activities of other health care providers. *Example:* Your health information may be used by others involved in your care.

Payment: This office may use your health information for payment activities, such as to determine plan coverage, to bill/collect, or to help another health care provider with payment activities. *Example:* Your health information may be released to an insurance company to get pre-approval of or payment for services.

Operations: This office may use your health information for uses necessary to run its healthcare businesses, such as to conduct quality assessment activities, train, or arrange for legal services. *Example:* this office may use your health information to conduct internal audits to verify proper billing procedures.

Business Associates: This office may disclose your health information to other entities that provide a service to this office or on this office's behalf that requires the release of your health information, such as billing service, but only if this office has received satisfactory assurance that the other entity will protect your health information.

Individuals Involved in Your Care or Payment for Your Care: This office may release your health information to a friend, family member, or legal guardian who is involved in your care or who helps pay for your care.

Directory: This office may include your name, location, general condition, and religious affiliation in a directory if you are staying overnight. Your religious affiliation may be given to a clergy member, even if you are not asked for by name, and your other information may be released to people who ask for you by name. *If you do not want to be in the directory,* notify us when you register at the facility and complete an "opt out" form.

Research: This office may use and disclose your health information to researchers for research. Your health information may be disclosed for research without your authorization if the authorization requirement has been waived or revised by a committee charged with making sure the disclosure will not pose a great risk to your privacy or that steps are being taken to protect your health information, to researchers to prepare for research under certain conditions, and to researchers who have signed an agreement promising to protect the information. Health information regarding deceased individuals can be released without authorization under certain circumstances.

Organ and Tissue Donation: If you are an organ donor, this office may release health information to organ donation banks or organizations that handle organ or tissue procurement or transplantation.

Fundraising/Marketing: This office may use (or release to an office-related foundation) certain information such as your name, address, department of service, and treatment dates for fundraising. If you do not want to be contacted for fundraising efforts, notify this office's Privacy Official.

De-Identification: We may also create and distribute health information by removing all reference to individually identifiable health information.

Contact: We may contact you by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications that may be of interest to you

2. **Uses and Disclosures of Health Information Required/Permitted By Law**: The following categories describe some of the ways that this office may be allowed or required to use or disclose your health information.

Required by Law/Law Enforcement: This office may use and disclose your health information if required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for purposes such as responding to a court order.

Public Health and Safety: This office may use and disclose your health information to prevent a serious threat to the health and safety of you, others, or the public and for public health activities, such as to prevent injury. *Example:* Florida law requires this office to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: This office may disclose health information about incidents related to food, supplements, product defects, or post-marketing surveillance to the FDA and manufacturers to enable product recalls, repairs, or replacements; and to health oversight agencies for activities authorized by law, such as audits.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-patient privilege, this office may disclose your health information under a court/administrative order, subpoena, or discovery request after attempting to inform you of the request.

Coroners, Medical Examiners, and Funeral Directors: This office may release your health information to coroners, medical examiners, or funeral directors to enable them to carry out their duties.

National Security/Intelligence Activities and Protective Services: This office may release your health information to authorized national security agencies for the protection of certain persons or to conduct special investigations.

Military/Veterans: This office may disclose your health information to military authorities if you are an armed forces or reserve member.

Inmates: If you are an inmate of a correctional facility or are in the custody of law enforcement, this office may release your health information to a correctional facility or law enforcement official so they may provide your health care or protect the health and safety of you or others.

Florida law requires that this office inform you that health information used or disclosed may indicate the presence of a communicable or non-communicable disease. It may also include information related to mental health.

3. **Your Rights Regarding Your Health Information:** You have the rights described below in regard to the health information that this office maintains about you. You must submit a written request to exercise any of these rights. Forms for this purpose are available at any of the locations where this office provides medical services.

Right to Inspect/Copy: You have the right to inspect and get a copy of health information maintained by this office and used in decisions about your care. This right does not apply to psychotherapy notes and certain other information. By law, this office may charge in advance $1.00 for the first page, $.50 for additional pages, up to $5.00 per x-ray, image, or slide, and $.12 cents per digital page, plus postage, payable prior to the release of the requested records (or those amounts permitted by current law). This office may deny your request in certain circumstances. You may request a licensed health care professional chosen by this office to review a denial based on medical reasons; this office will comply with this decision.

Right to Amend: If you believe health information this office created is inaccurate or incomplete, you may ask this office to amend it. This office cannot delete or destroy any information already included in your media record. You must provide a reason for your request. this office may deny your request if you ask to amend information that this office did not create (unless the person or entity that created the information is not available to make the amendment); that is not part of the health information this office maintains; that is not part of the information you are permitted by law to inspect and copy; or that is accurate and complete.

Right to Accounting of Disclosures: You have the right to ask for a (free) list of disclosures this office has made of your health information. This office is not required to list all disclosures, such as those you authorized. *You must state a time period, which may not be longer than 6 years or include dates before April 14, 2003*. If you request more than one accounting in a 12-month period, this office may charge you for the cost of the list. This office will tell you the cost; you may withdraw or change your request before the copy is made.

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Right to Request Restrictions: You have the right to request a restriction or limit on how this office uses or discloses your health information. You must be specific in your request for restriction. You may restrict disclosure of your health information to a health plan if you choose to pay out-of-pocket in full for the services at the time they are provided. This office is not required to agree to every request. If this office agrees or is required to comply, this office will comply with the request unless the information is required to be disclosed by law or is needed in case of emergency. *Example*: You may want to pay cash in advance for services rather than have your insurance billed.

Right to Request Confidential Contacts: You have the right to request that this office contact you about medical issues in a certain way, such as by mail. You must specify how or where you wish to be contacted; this office will try to accommodate reasonable requests.

Right to a Copy of This Notice: You have the right to a paper or electronic copy of this Notice, which is posted and available at each location where medical services are provided and is on this office's website or both.

Right to be Notified: This office will notify you if your unsecured health information is breached.

4. **Changes to this Notice**: This office reserves the right to change this Notice and to make the revised Notice effective for health information this office created or received about you prior to the revision, as well as to information it receives in the future. Revised Notices will be posted and available at each location where medical services are provided and on this office's website.

5. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with this office's Privacy Official or with the "Secretary of the Department of Health and Human "Services, Office of Civil Rights.

6. **Communication authorization:**

_____ I authorize the office permission to leave messages on my home or cell phone to communicate.

_____I do not authorize permission to leave messages on my home or cell phone to communicate.

_____ _____

Signature Date

_____

Printed Name

I hereby authorize the following individuals to receive information regarding my care:

Name:_____Telephone #_____Relationship:_____

Name:_____Telephone #_____Relationship:_____

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NARCOTIC AGREEMENT

Controlled substance medications (i.e. narcotics, tranquilizers, androgens and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **WILL NOT BE REPLACED** regardless of the circumstances.

_____2.) Refills of controlled substance medications;

a) Will be made only during regular office hours Monday through Friday, in person, prescribed days per discretion of Dr. R. Siva and no more than a 30 day prescription, and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.

b) Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

c) I understand that I must call ahead within 72 hours to schedule an appointment.

_____3.) It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.

_____4.) I agree to comply with urine drug testing and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____5.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities and the prescription will not be refilled.

_____6.) I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____7.) I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____8.) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

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Due to the recent law signed by Governor RickScott, HB 21, HB 7095, concerning controlled substances, we at Dr. R. Siva, will be instituting the following policies effective immediately.

1. All schedule 2, 3, and 4 medications* will be written for no more than one month at a time or weekly dependent on compliance and Drug Screen Final Results. Every month, I will be seen in the office and will review my pain management contract with Dr. R. Sivasekaran

*This includes the following:

- All forms of hydrocodone – (vicodin, Lorcet, Lortab)
- All forms of oxycodone- (Percocet/percodan, oxycontin, Tylox)
- Most muscle relaxers- (valium, soma, Etc.)
- Duragesic, Fentanlyl patches
- Most sleeping agents- Ambien (Zolpidem), Lunesta,
- All Benzodiazepines- Klonopin (clonazepam), Restoril (temazepam), Serax (oxazepam), Xanax (Alprazolam)
- Codeine Preparations (Tylenol # 3, Tussionex)
- Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)
- Diet Medications

2) I understand that refills may take from 24-48 hours to process and I do not expect to receive my refilled medications at the pharmacy the same day as the office visit.

I have been fully informed by Dr. Ratnasabapathy Sivasekaran regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

To monitor controlled substance prescriptions, Dr. Siva performs a check Florida's Prescription Drug Monitoring Program (PDMP) every time a patient is to receive Schedule II to V medications. These prescriptions can include Depo-Testosterone, Xanax, Valium, temazepam and Adderall.

We are dedicated to providing you with the appropriate treatments for your specific health care needs. We understand that some provisions of this law could create hardships for you, who is already in a difficult situation. We will do our best to help manage your pain safely, in the least inconvenient way possible and within the scope of the law.

I have been advised that there are other treatment options for me to pursue that can be addressed with non-narcotic medication.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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2845 SE 3rd. Ct, Ocala, FL 34471
Phone: (352) 369-5300 Fax: (352) 369-5309

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____
_____
_____

To release copies of all medical records compiled during office visits and or hospital admissions.

Patient: _____
DOB: _____
SSN: _____

Purpose or need for information: To continue medical care/treatment

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Signature:_____ Date: _____

Print Name: _____

ANY DISCLOSEURE OF MEDICAL INFORMATION BY THE RECIPIENT(S) IS PROHIBITED