PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS: _____

CITY, STATE:_____ **ZIP CODE:**_____

TELEPHONE NUMBERS-HOME:_____**WORK:** _____**CELL:** _____

E-MAIL ADDRESS:_____

SOCIAL SECURITY NUMBER:_____

INSURANCE COMPANY:_____ **NAME OF INSURED (IF DIFFERENT):**_____

POLICY NUMBER:_____ **GROUP NUMBER:**_____

RELATIONSHIP TO INSURED:_____ **DATE OF BIRTH OF INSURED:**_____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the above referenced practitioners to furnish information to insurance carriers concerning my illness and treatment and I assign to the practitioners all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

PATIENT'S SIGNATURE **DATE**

PATIENT'S FORMS:

I hereby acknowledge that I was given an opportunity to review the following forms for the practice:

Medical Home Description	Financial Policies
Referrals to Other Providers	Office Policies
Credit Card Policy	Vaccine Policy
Physician Participation and Affiliation Information	Documentation Preparation Fees

Language Spoken	○ English ○ Spanish ○ Korean ○ Other Language: _____	**Ethnicity:**	○ Decline to State ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown
Race:	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White ○ Other Race: _____	**Marital Status:**	○ Single ○ Married ○ Other: _____
		Student Status	○ Not a Student ○ Full Time ○ Part Time
Sexual Orientation:	○ Lesbian, gay or homosexual ○ Straight or heterosexual ○ Bisexual ○ Something else, please describe ○ Do Not Know ○ Choose Not to Disclose	**Gender Identity**	○ Identifies as Male ○ Identifies as Female ○ Female to Male ○ Male to Female ○ Genderqueer ○ Additional Gender ○ Choose Not to Disclose
Gender:	○ Male ○ Female ○ Other: _____		

MEDICAL HISTORY AND CURRENT MEDICATION UPDATE:

The following information regarding my medical history and current medications should be added to my chart:

_____

_____ _____

PATIENT'S SIGNATURE **DATE**

HEATH MAINTENANCE RECORD			
When was your last … (please provide the year)			
Physical Exam		**Female Patients**	
Colonoscopy		Pap Smear	
Gastroenterologist's Name		Last Menstrual Period	
Cardiac Workup		Breast Examination	
Cardiologist's Name		Mammogram	
Eye Exam		Bone Density	
Ophthalmologist's Name		*OB/GYN's Name*	
Chest X-ray			

Male Patients		
Prostate Specific Antigen (PSA)		
Urologist's Name		

Have you fallen within the last year? ❑ YES ❑ NO **If yes, how many times:**

VACCINE RECORD			
Name of Vaccine	**Year of Last Dose**	**Name of Vaccine**	**Year of Last Dose**
Flu Vaccine		Pneumonia Vaccine	
Covid-19 Vaccine		Other Vaccines	

ADVANCED HEALTHCARE DIRECTIVE:

Do you have an ADVANCED HEALTHCARE DIRECTIVE? (a legal document in which a you specify what actions should be taken for your health if you are no longer able to make decisions for yourself because of illness or incapacity)

- Health Care Proxy
- Living Will
- Other: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA"):

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read, if I so choose) and understood the Notice. I also acknowledge that Dr. Scafuri & Associates uses a HIPAA Compliant and secure virtual remote scribe which allows them to complete their medical charts more quickly and efficiently and focus more on me. If I have any questions about their remote scribe, I agree to let them know.

Sharing Health Information with Family Members and Friends: The following is a list of the names those who I wish to receive my medical information (which includes test results):_____

_____

_____

Please note the following:

- **Only those listed on the line above may call the office and speak with our staff regarding your health;**
- **Include your SPOUSE or PARENT, if you are over 18 years old, if you want our staff to speak with them; and**
- **This form overrides any previous HIPAAs completed.**

_____ _____

PATIENT'S SIGNATURE **DATE**

UPDATED CREDIT CARD:

Name on Card: _____ Card Number: _____

Visa _____ Master Card _____ Amex _____ Discover _____

3-4 Digit Security Code: _____ Billing Zip Code: _____ Exp:_____

Please indicate if this is an HAS/FSA Card ____ or Credit Card ____.

Our office does not take Debit cards.

Please Note: We offer both a cash and credit card price. To see our pricing schedule, visit: https://www.drscafuri.com/club/scripts/library/view_document.asp?NS=MS&DN=VaccineandCopay.

PLEASE LIST THE SPECIALISTS YOU ARE SEEING:

Allergies/ENT		Orthopedist	
Cardiologist		Pain Management	
Chiropractor		Podiatrist	
Dermatologist		Psychiatrist	
Endocrinologist		Pulmonologist	
Nephrologist		Rheumatologist	
Neurologist		Surgeon	
OB/GYN		Urologist	
Oncologist/Hematologist		Vascular	
Ophthalmologist		Other	

I AUTHORIZE THE RELEASE OF HEALTH INFORMATION TO DR. SCAFURI & ASSOCIATES FROM ANY SPECIALISTS LISTED ABOVE.

_____ _____

PATIENT'S SIGNATURE **DATE**

VACCINE POLICY:

Please be aware that it is our office policy to collect payment for vaccinations prior to the time the vaccine is administered.

Yellow Fever & Typhoid Vaccines: If you are receiving one of these vaccinations, we take payment upfront. It is the patient's responsibility to submit a receipt for reimbursement to their insurance company. We do not bill these vaccines to your insurance company. We will, however, bill your insurance company for the office visit.

Other Vaccinations, Other than for Travel: We will submit the charge to your insurance company and, in the event we are reimbursed for the ***vaccine***, we will in turn reimburse you.

VACCINES ADMINISTERED	CASH PRICE	CREDIT CARD PRICE
TDaP (tetanus)	$75.00	$77.25
Hepatitis A Vaccine	$125.00 (2 doses)	$128.75 (2 doses)
Hepatitis B Vaccine	$150.00 each (3 doses)	$154.50 each (3 doses)
Haemophilus B Conjugate Vaccine	$50.00	$51.50
HPV 9	$325.00 each (3 doses)	$334.75 each (3 doses)
Influenza Vaccine Flurix/Fluzone	$25.00	$25.75
High Dose Flu (65 years old and older)	$80.00	$82.40
Meningococcal/Menquadfi	$175.00	$180.25
MMR	$100.00 each (2 doses)	$103.00 each (2 doses)
Pneumonia Vaccine Prevnar 20	$350.00	$360.50
PPD	$30.00	$30.90
Rabies Intramuscular	TBA each	TBA each
Shringrix	$250.00 each (2 doses)	$257.50 each (2 doses)
Trumenba	$275.00	$283.25
Twin Rx (Hep A & B Combination)	$200.00	$206.00
Typhoid Vaccine	$150.00	$154.50
Varicella Vaccine	$175.00	$180.25
Yellow Fever Vaccine	$225.00	$231.75

The above cost is per vaccine, so if you are to receive multiple doses of the vaccine, please multiply the cost by the amount of doses. Involved in the administration of the vaccine is an office visit. As a result, in addition to the vaccine payment, you will be responsible to pay your co-pay at the time of your first visit. If your insurance company pays us for your office visit and not the vaccine, your payment will not be returned. Instead, as stated previously, if we are reimbursed by your insurance company for the ***vaccine***, we will in turn reimburse you. Again, this does not apply to the yellow fever or typhoid vaccines, because we do not bill your insurance company for these (please see above).

We do not accept checks or debit cards for the payment of vaccines – all payments must be made either in cash or by credit card (Visa, MasterCard, American Express, or Discover Cards). If your insurance company pays for the vaccine, you will be reimbursed the cash price, not the credit card price, regardless of payment method.

If payment is not taken when the vaccine is administered, and your insurance company denies payment, you agree to pay for the cost of each vaccine. Lastly, please be aware that payments and/or explanations of benefits from your insurance company may take more than one month for us to receive. Therefore, we ask for your patience with regard to your refund. By signing this form you acknowledge you have read the above, agree to the terms and acknowledge that you have received the *Center for Disease Control's Vaccine Information Sheet* regarding the vaccine being administered.

_____ _____

PATIENT'S SIGNATURE **DATE**