Kenneth A. Giraldo, M.D., P.A.

Thank you for choosing our practice.

- **Attached is the paperwork** we need you to complete and bring to your appointment. It is not necessary for you to mail it.
- **Please arrive 30 minutes** prior to your appointment time.
- **Please bring your insurance card**(s) and photo I.D. with you to your first and all subsequent visits.
- **If you are unable to keep your appointment,** please notify us as far in advance as possible.
- **Office hours** are from 8:00 a.m. to 5:00 p.m., Monday through Friday. Although we make every effort to see patients on time, at times we experience lengthy procedures, so longer waits are unavoidable. We will make every effort to inform you in advance and reschedule your appointment if necessary.
- **Co-payments** required by your insurance company are expected to be paid at your visit. Self pay patients, payment in full is required at time of service.
- **Medication refill requests** are handled Monday through Thursday, 8:00 a.m. to 3:00 p.m. we ask that you allow 72 hours to process your request. We do not process requests on Fridays, so please plan ahead.

We look forward to being involved in your care!

5831 BEE RIDGE RD., SUITE 100-A
SARASOTA, FLORIDA 34233

PHONE (941) 343-1040
FAX (941) 343-1098
www.doctorgiraldo.com

1211 JACARANDA BLVD
VENICE, FLORIDA 34292

Kenneth A. Giraldo, MD, P.A.

5831 Bee Ridge Rd. Suite 100
SARASOTA, FL 34233
(941) 343-1040

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

As a courtesy we will file your insurance, however, the patient is responsible for all co-pays, deductibles and any services not covered by your insurance at the time of service. If your insurance requires pre-authorization it is the patient's responsibility to obtain the authorization before services are rendered. It is the patient's responsibility to know what facilities to utilize for procedures, laboratory work, x-ray studies, etc. There is a $50.00 fee for no show. A "no-show" is defined as a missed appointment or an appointment cancellation less than 24 hours prior.

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________

Kenneth A. Giraldo, M.D., P.A.

CONSENT FOR TREATMENT

I give permission to the physicians and staff of Kenneth A. Giraldo, M.D., P.A. ("the Practice") to administer or perform medical treatment. I acknowledge that risks, if any, will be explained to me as well as any other medical options. I understand that no guarantee can be made as to the efficacy or outcome of treatment. The Practice may also use my Protected Health Information (PHI) to treat me or disclose my PHI to other health care providers, such as my referring physician or primary doctor, for purposes related to my treatment.

____________________________________ ________________

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: ____________________________________

CONSENT TO RELEASE INFORMATION

I consent that the Practice may release any medical information that has been obtained during my course of treatment to any lab, hospital, physician or insurance company to answer any inquiries per Federal and State regulations. The Practice may use or disclose my PHI internally or disclose my PHI to other health care providers and entities as necessary to operate their business. The Practice may use and disclose my PHI to contact me for appointment reminders and to inform me of potential treatment options or alternatives. The Practice may use and disclose my PHI to advise a friend or family member that is involved in my care or who assists in taking care of me. My PHI may also be used and disclosed when Federal, State, or local law requires. The Practice may share my PHI with third party "Business Associates" that perform activities on their behalf such as billing software maintenance.

____________________________________ ________________

Signature of Patient or Legal Representative Date

FINANCIAL CONSENT

I herby authorize direct remittance of payment of insurance benefits including Medicare, if applicable, to the Practice for all covered medical services rendered. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated by the Practice, and will constitute a continuing authorization, maintained on file with the Practice, for all subsequent and continuing treatment, services, and/or supplies provided to me by the Practice. The Practice may use and disclose my PHI in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections. I accept legal responsibility for charges that my insurance company does not cover and I will pay for these at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. I understand that the Practice may not be a participating provider with my insurance company. **Should I receive payment directly from the insurance company, I agree to forward the check and "Explantation of Benefits" to the Practice within 10 days of receipt.** If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

____________________________________ ________________

Signature of Patient or Legal Representative Date

WRITTEN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Kenneth A. Giraldo, M.D., P.A. Notice of Privacy Practices that describes how my health information is used and shared. I understand that the Practice has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at the doctor's office.

____________________________________ ________________

Signature of Patient or Legal Representative Date

5831 BEE RIDGE RD., SUITE 100-A
SARASOTA, FLORIDA 34233

PHONE (941) 343-1040
FAX (941) 343-1098
www.doctorgiraldo.com

1211 JACARANDA BLVD.
VENICE, FLORIDA 34292

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: ______________________________ Date of Birth: _______________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ______________________________ Fax: ____________________

Address: ______________________________ phone: _________________

City: ___________________________ State _______ Zip code: ____________

This request and authorization applies to

___Healthcare information relating to the following treatment, condition or dates:

____

___All Healthcare information

___Other: ____

Patient signature: ______________________________ Date: ________________

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization is valid until it is revoked in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

We welcome you to our Practice. Please complete the following form before seeing the Doctor.

Name: ______________________________ Age: __________

Date: ______________ Referred by: ______________________________

I. MEDICAL/SURGICAL HISTORY

1. Allergies: ______________________________ Latex Allergy: Yes / No

2. Have you ever had any of the following conditions?

	YES	NO
High Blood Pressure		
Heart Disease/Angina		
Heart Attack/Failure		
Palpitations/Irregular Heart Beat		
Pacemaker		
Diabetes		
Cancer		
Liver/Jaundice		
Shortness of Breath		
Asthma/Bronchitis/Pneumonia		
Psychiatric Disorder		

	YES	NO
Kidney Disease/Failure		
Dialysis		
Ulcers		
Stomach/Bowel Problems		
Thyroid Disease		
Epilepsy/Seizure		
Migraines		
Stroke		
Easy Bruising		
Nose Bleed		
Opiod/Narcotic Abuse		

3. List all prior surgeries and dates:

Surgeries	Date	Surgeries	Date

4. List all NON-PAIN medications you are currently taking:

5. List all PAIN medications you are currently taking:

6. List all PAIN medications you have tried and are not currently taking:

II. SOCIAL HISTORY

	YES	NO
Do you drink alcohol?		
Do you smoke?		
Are you married?		
Are you currently working?		

Occupation: ______________________________

____

If not working, is this due to your medical condition?

Yes______ No______

III. PAIN INFORMATION:

1. How did your pain start and when?

____

____

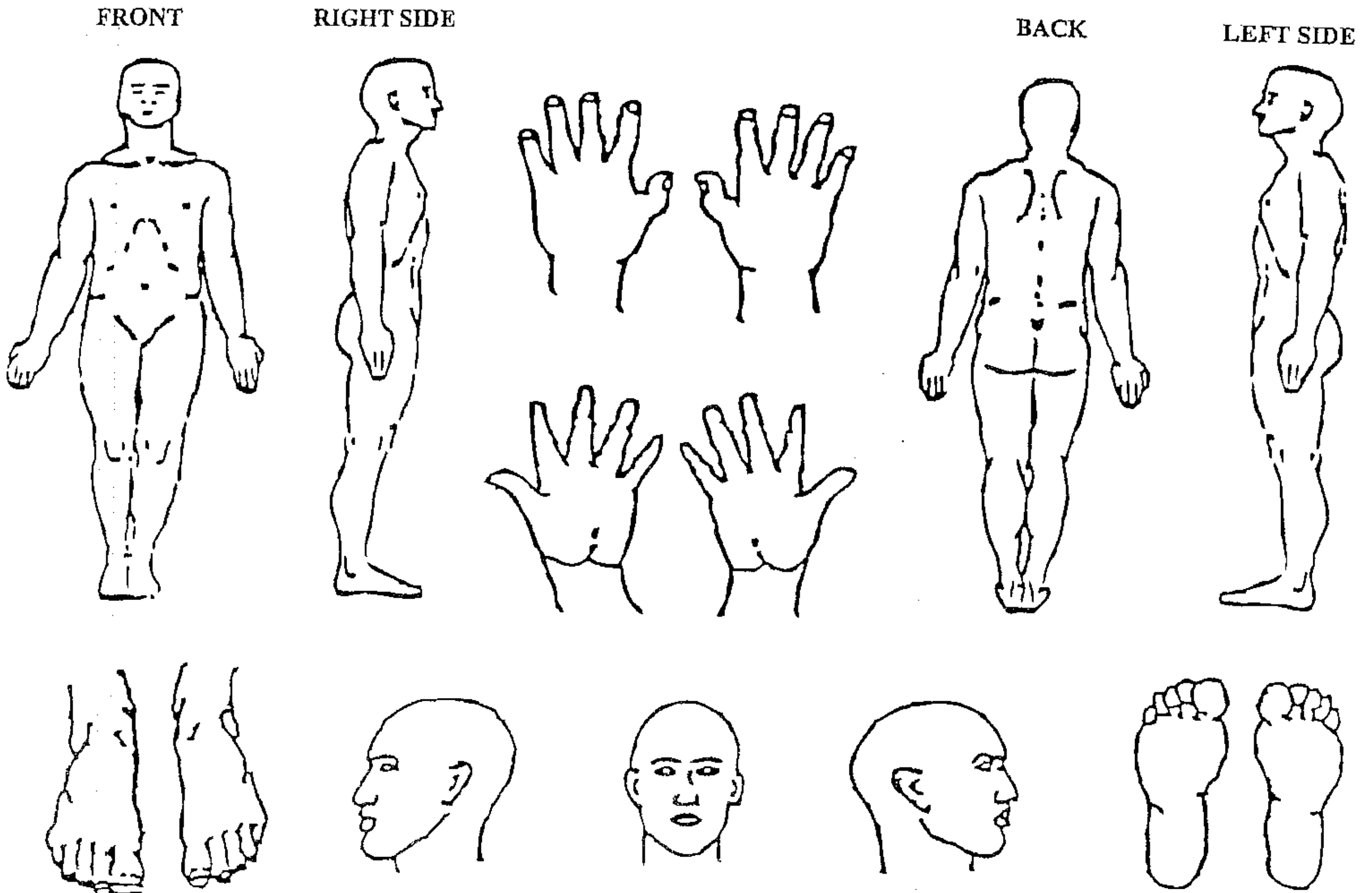
____

____

2. Where is your pain located? (circle all that apply)

Head	Neck	Hand	Upper Back	Groin	Hip	Toes
Face	Shoulder	Finger	Middle Back	Anal	Thigh	Others:
Teeth	Arm	Chest	Lower Back	Vagina	Knee	
Jaw	Elbow	Ribs	Buttock	Perineum	Calf	________
Eyes	Wrist	Abdomen	Pelvis	Testicle	Foot	________
						________

3. Indicate on the diagram where your pain is localized by shading the painful area(s):



4. On a scale of 0 to 10, where 0 is no pain and 10 is the worst imaginable pain, which number describes your pain:
   right now?________ at its worst?________ at its least?________ on average?________

5. How frequently do you have your pain?

Constant (100% of the time-24 hours a day)	
Intermittent (25 - 75% of the time)	
Occasional (less than 25% of the time)	

   Are you sometimes pain free: ____Yes ____No

6. Describe your pain: (circle all that apply)

Dull	Achy	Shooting	Electric Shock	Heavy	________
Sharp	Throbbing	Stabbing	Numb	Pin and Needle	________
Crampy	Spasm	Knife-like	Burning	Other:	________

7. Do you have:

	YES	NO		YES	NO
Numbness			Were symptoms present before pain began?		
Weakness			Were symptoms present before pain began?		
Tingling			Were symptoms present before pain began?		
Bowel Incontinence			Were symptoms present before pain began?		
Bladder Incontinence			Were symptoms present before pain began?		
Muscle Spasms			Were symptoms present before pain began?		
Sedation			Were symptoms present before pain began?		

8. How do the following affect your pain?

	Increase	Decrease	No Effect
Walking			
Standing			
Sitting			
Movement			
Stress			
Eating			
Urinating			
Rest			

	Increase	Decrease	No Effect
Bowel Movement			
Coughing/Sneezing			
Menstruation			
Heat			
Cold			
Light Touch			
Clothing			
Other:			

9. What test have you had done: (please circle)

X-ray	MRI	Bone Scan	Ultrasound
EMG	CT-Scan	Nerve Conduction	Other: ________________

10. Who have you consulted for pain relief? (please circle)

Family Physician	Physical Rehabilitation	Psychologist
Neurosurgeon	Internist	Acupuncturist
Orthopedic Surgeon	Neurologist	Chiropractor
Anesthesiologist	Psychiatrist	Other________________
	Pain Physician	

11. Circle the treatment you have tried and indicate their results:

	Date (month/year)	Pain Better	Pain Worse	No Effect
Medication				
Nerve Blocks				
Epidural Steroid Injection				
Surgery				
Physical Therapy				
Psychotherapy				
ENS (electrical stimulation)				
Biofeedback				
Massage				
Meditation/Relaxation				
Hypnosis				
Heat/Ultrasound Therapy				
Chiropractor				
Oriental Medicine				
Supplements				
Acupuncture				

V. Is there a lawsuit pending as a result of your pain? ______Yes ______No
If yes,
What is the name of your attorney? ____
Are you seeking disability insurance as a result of your pain? ______Yes ______No
Are you seeking workers compensation as a result of your pain? ______Yes ______No

VI. LIFESTYLE ACTIVITIES

1. How much has pain affected the following?

	A great deal	Moderately	Very little	Not at all
Family Life				
Social Activities				
Marriage				
Work				
Appetite				
Sleep				
Exercise/Stretching				
Rest/Relax				

2. What do you do to cope with the pain?

____

____

3. What kind of emotional support do you have?

____

____

4. What is your goal for consulting Kenneth A. Giraldo, M.D.?

____

____

We thank you for sharing your thoughts with us.

Kenneth A. Giraldo, M.D.

Patient Controlled Substance Agreement

Informed Consent Form

The following agreement relates to my use of controlled substance for chronic pain prescribed by Kenneth A. Giraldo, P.A. I recognize that they are policies regarding the use of controlled substance that are followed by the staff. I will be provided controlled substances while actively participating in this program only if I adhere to the following regulations:

I will use the substances only within the parameters given by my treating physician.

I will not receive replacement medications for "lost" or "stolen" medications.

I will receive controlled substances only from my treating physician. Information that I have been receiving controlled substances prescribed outside this office will lead to discontinuation of treatment.

I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my new prescription runs out. I will be responsible for "stretching out" my medications if my new prescription is dated for a weekend, holiday or any other date when I cannot fill the prescription. Prescriptions will not be rewritten for a new date under any circumstances.

Under no circumstances will a refill of medications be given over the telephone.

By law, maximum of thirty days supply of medicine will be prescribed at any one time. Extra medicine will not be prescribed for longer month.

I will accept generic brands of my prescription medicine.

If it appears to the physician that there are no demonstratable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as prescribed by the physician. I will not hold any member of the Kenneth A. Giraldo, P.A. liable for problems caused by discontinuation of controlled substances, provided that I receive 15 days' notice of termination.

I agree to submit to urine and blood screens to detect the use of non-prescribed medications at any time.

I agree to medication counts as needed, within a 24-hour notice.

I am permitting the right of disclosure to law enforcement in the event of violation or breach of the agreement.

I recognize that my chronic pain represents a complex problem, which may benefit from behavioral medicine strategies and psychotherapy. I also recognize my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program in order to secure increased function and improvement in learning how to cope with my condition.

______________________________ ______________

Patient Signature Date

______________________________ ______________

Physician Signature Date

______________________________ ______________

Witness, Family Member or Significant Other Signature Date