Robert Fortino, D.O.

PATIENT INFORMATION FORM

LEGAL Name (First)_____(Last)_____M_____

Street Address: _____

City: _____ State:_____ Zip: _____

Cell Phone (Preferred):_____ Home:_____

Email: _____

Date of Birth: _____

How did you hear about Dr. Fortino? _____

Please remember that we will never leave a message regarding weight loss, and only state that you have an appointment with Dr. Fortino.

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Financial Policy

Thank you for selecting Robert Fortino, D.O. for your health care needs. We are honored to provide you this service. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Debit Cards and Cash. We do not accept personal checks, American Express or Discover.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature: _____Date:_____

Robert Fortino, D.O.

Broad Street Weight Management Center, Inc., 1822 South Broad Street, Philadelphia, PA 19145
Premiere Physicians Weight Loss, LLC., 129 Johnson Road, Turnersville, NJ 08021, Unit A-3
Robert Fortino, D.O. Medical Director 215.336.8000 / 856.318.4100

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Broad Street Weight Management Center, Inc., and Premiere Physicians Weight Loss, LLC, respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, health information from other providers, billing, and payment information relating to these services. Federal and state law allows us to use and disclose this information for payment purposes.

Examples of use and disclosures of protected health information for treatment, payment and health operations

Treatment:	Information obtained by a nurse, physician, or other member of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you.
Payment:	We may request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.
Health Care Operations:	We use your medical records to assess quality and improve services. We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff. We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefits and services. We may contact you to raise funds. We may use and disclose your information to conduct or arrange services to include medical quality review by your health plan, accounting, legal, risk management, insurance services, audit functions, fraud and abuse detection, and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have the right to:

- Receive, read, and ask questions about this notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any written request
- Request and receive from us a paper copy of the most current *Notice of Privacy Practices for Protected Health Information*
- Request in writing that you be allowed to see and get a copy of our protected health information
- Have us review a denial of access to your health information, except in certain circumstances
- Ask us to change your health information. You must request this in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records
- When you request, we will give you a list of disclosures of your health information. This will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to keep your protected health information private. We will give you this “Notice”. We will follow the terms of this “Notice.” We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this “Notice.” You may receive the most recent copy of this “Notice” by calling and asking for it or by visiting our office to pick one up.

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To ask for help or make a complaint

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact the office at 215-336-8000. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the office. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory: your name, location, general condition, and religion.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows

- Medical Research: if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- Funeral Directors or Coroner: consistent with applicable law to allow them to carry out their duties.
- Organ Procurement Organizations: (tissue donors) or persons who obtain, store, or transplant organs
- Food and Drug Administration: (FDA) relating to problems with food, supplements, and products.
- Workers' Compensation Laws: if you make a workers' compensation claim.
- Public Health and Safety Purposes: as allowed or required by law to prevent or reduce a serious, immediate threat to the health or safety of a person or the public. To the public health and safety. To prevent or control disease, injury or disability. To report vital statistics such as births or deaths.
- Report Suspected Abuse or Neglect: to public authorities.
- Correctional Institutions: if you are in jail or prison, as necessary for your health and the health and safety of others
- Law Enforcement: purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime
- Health and Safety Purposes: such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- Health and Safety Oversight Activities: we may share health information with the Department of Health
- Disaster Relief Purposes: we may share health information with disaster relief agencies to assist in notification of your condition to your family.
- Work Related Conditions That Could Affect Employee Health: an employer may ask us to assess health risks on a job site.
- Military Authorities of the U.S. and Foreign Military Personnel: the law may require us to provide information necessary to a military mission.
- The Course of Judicial/Administrative Proceedings: at your request, or as directed by a subpoena or court order.
- Specialized Government Functions: we may share information for national security purposes

Uses and disclosures not in the "Notice" will be made as allowed or required by law or with your written authorization.

Effective January 1, 2020

Signature:_____Date:_____

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MEDICAL HISTORY FORM

Name:_____ Age:_____ Sex: M F

Family Physician:_____Phone (if known):_____

Present Status

1) To the best of your knowledge, are you in good health at the present time? YES NO

2) Are you under a doctor's care at the present time? YES NO

If yes, for what?_____

3)If you are taking any medications, please list:

_____

_____

4) Any Allergies to medications? _____

5) Do you have/had? High Blood Pressure / Heart Problems / Heart Attack / Heart Valve Problem / Stroke / Diabetes / Thyroid Issues / Liver Disease / Kidney Disease / Depression / Anxiety / Arthritis / Stomach Issues / Intestine Issues / Anemia / Neurological Disease / Asthma / COPD / Cholesterol / Cancer / Infectious Disease /

Last Blood Labs:_____Other Medical Issues: _____

6) Hospital Admissions/Surgical History/Serious Injuries, (Specify with dates):

_____

_____

_____

_____

7) Female Gynecologic History: Pregnancies: # _____ Dates: _____

Natural Delivery or C-Section (specify): _____

When was the first day of your most recent menstrual cycle? _____

Birth Control Method:_____

8) Men's Health History: Signs and symptoms you are experiencing (circle all that apply)

Decreased libido / Decreased Sexual Desire / Depressed Mood / Weight Gain / Decrease in Lean Muscle Mass

Fatigue / Hot Flashes / Gynecomastia (Male breast tissue growth) / Poor Concentration / Poor Sleep Quality

Sleep Apnea / Poor Concentration / Infertility / Decreased Sperm Production / Decreased Bone Mineral Density

Urological Surgical Issues: Prostate Cancer / Prostate Surgery / Prostate Enlargement / Testicular Cancer /

Undescended Testicle / Testicular Surgery / Prior Testosterone Replacement Therapy / Bladder Cancer / STD

Explain:_____

_____

_____

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9) Family History: (do not list names)

ALIVE PASSED AGE HEALTH DISEASE

Father:_____

Mother:_____

Brothers:_____

Sisters:_____

Family Members With: High Blood Pressure / Heart Disease / Stroke / Diabetes / Thyroid Issues / Liver Disease / Kidney Disease / Depression / Anxiety / Arthritis / Neurological Disease / Lung Disease / Anemia / Blood Disorders / Cancer / Other:

_____

Habits and Goals:

10) In what time frame would you like to be at your desired weight?_____

11) What is the main reason for your decision to lose weight?_____

12) When did you begin gaining excess weight? (Give reasons, if known):_____

13) Is the weight you are today the most you ever weighed? (non-pregnant) YES NO

14) Previous diets followed/Previous use of appetite suppressant medication:_____

15) How often do you eat at restaurants? _____

16) How often do you eat "fast foods"? _____

17) Who plans meals? _____ Cooks? _____ Shops?_____

18) Food allergies:_____ Food dislikes:_____

19) Food(s) you crave: _____

20) Any specific time of day you have uncontrolled eating or cravings?_____

21) Do you drink alcohol? YES NO What?_____ How much? _____

22) Do you awaken hungry during the night? YES NO What do you do? _____

23) What are your worst food habits? _____

24) When you are under stress, do you tend to eat? _____

25) Do you smoke, or have you ever smoked in the past? If so, how much?_____

26) Describe your usual energy level:_____

27) Do you exercise regularly? _____

28) Please describe your goals you wish to accomplish:_____

_____

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