

Robert Sadaty, M.D.
9400 Fountain Medical Court
Suite 100
Bonita Springs, FL 34135
Phone: 239-494-6244
Fax: 239-992-4121
Email: info@robertsadaty.com

Dear _____:

Welcome to the practice!

Enclosed you will find registration materials and a short summary of my medical background. While you are completing these forms, try your best to be as precise and possible, especially with medication dosages. **PLEASE DO NOT MAIL THE FORMS BACK TO US.** Rather, you can bring them with you on your first appointment.

Also, remember to bring your insurance card(s) with you. If you have a co-pay, please note that we only accept personal checks. We do not accept cash or credit cards.

If you plan to bring in any outside medical records, please **MAKE PHOTOCOPIES** of them for us to keep in your chart. This will help save the office the time it takes to make copies of your originals.

Lastly, it is helpful to us if you arrived about 15 minutes early so that we can process your paperwork.

We look forward to meeting you at your first visit.

Sincerely,

Robert Sadaty, M.D.

Robert Sadaty, M.D.
9400 Fountain Medical Court, Suite 100
Bonita Springs, FL 34135

Dear Sir or Madam,

Thank you for inquiring about my practice. I understand that you would like information about me and my training background. I hope that this letter will provide you with the information that you need.

I received my medical degree from Cornell University in 1996. I completed a medical internship and residency at Case Western Reserve University in 1999. During that period, I spent time in Uganda treating patients with malaria, heart disease, malnutrition, and other illnesses endemic to the developing world. I also conducted research in AIDS and Tuberculosis.

From 2000 to 2005, I worked as a hospitalist physician, specializing in the treatment of patients admitted to the hospital. In addition, I served as Medical Director for two large medical groups.

In September 2005, I started my current solo, private practice. As a primary care physician, I believe in the importance of continuity of medical care. Therefore, I continue to take care of all my patients in the hospital and do not outsource the responsibility to other physicians. Each morning, I make round at the North Collier Hospital seeing all of my patients through their hospital course.

Within the general field of internal medicine, my practice focuses on Cardiovascular Risk Reduction, Preventative Medicine, and Weight Management. I also aim to promote healthy living by minimizing the use of prescription medications, using them only when a clear benefit would be derived.

As a certified specialist in wound care, I also manage patients at the Wound Healing Center in Bonita Springs in association with Naples Community Hospital. Among many different therapies, I provide state-of-the-art wound care treatment including hyperbaric oxygen therapy, skin grafting, and wound debridements.

Lastly I believe that my practice is unique in that I intentionally hope to keep it smaller than other practices. This allows me to attend to the urgent needs of my patients in a timely fashion. It also affords my patients the luxury of dealing directly with me, rather than through physician extenders (physician's assistants, nurse practitioners, et cetera). The result of all lab work and diagnostic tests are explained to my patients by me.

I hope that I have provided you with the useful information that you needed.

Sincerely,

Robert Sadaty, M.D.

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9400 Fountain Medical Court
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FIRST VISIT CHECKLIST:

1. Forms Completed with Precise Medication Dosages.
2. Bring Insurance Cards.
3. Make Copies of Medical Records for us to keep.
4. Co-pay's are to be paid with personal check or credit card– NO CASH .
5. Please arrive 15 minutes early.

****PLEASE REMEMBER TO BRING ALL PAPERWORK WITH YOU TO YOUR FIRST APPOINTMENT – WE PREFER THAT YOU DO NO MAIL IT TO THE OFFICE.***

THANK YOU.

Robert Sadaty, M.D.
9400 Fountain Medical Court, Suite 100
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Name: _____

Date of Birth: _____

Referral: _____

Your Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # (required to process bill through Medicare and Private Insurances):

_____ - _____ - _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

PHARMACY Name _____ PHONE/FAX

Occupation (if retired, former occupation): _____

Spouse's Name: _____

Emergency Contact Name/Phone: _____

Out of State Address (if you are seasonal): _____

City: _____ State: _____ Zip Code: _____

Seasonal Phone Number: _____

The above information is true to the best of my knowledge. I authorized my insurance benefits to be paid directly to the physician, Dr. Robert Sadaty, MDPA. I understand that I am financially responsible for any balance.

*Signature: _____ Date: _____

Permission for Treatment: I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment by Dr. Robert Sadaty, M.D., deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

*Signature: _____ Date: _____

Privacy Notice: I have received a copy of Dr. Sadaty's privacy notice as required by HIPAA and understand my privacy rights as outlined.

*Signature: _____ Date: _____

(Please make sure that you have signed your name in the THREE designated locations.)

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AUTHORIZED TO RELEASE HEALTHCARE INFORMATION

Name: _____

Date of Birth: _____

I request and authorize the release of all my healthcare information to Dr. Robert Sadaty's office. This authorization includes all STD results, HIV/AIDS testing, drug alcohol, or mental illness treatment.

Signature: _____

Date: _____

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you have been experiencing lately:

GENERAL: Weight changes, appetite changes, unusual weakness, fevers, chills, fatigue, night sweats, vision/hearing changes, nosebleeds, unusual sneezing, sore throat, trouble swallowing, ear pain, hoarse voice.

NECK: Neck pain, swelling, stiffness.

LUNGS: Cough, shortness of breath, coughing up blood.

HEART: Palpitations, chest pain.

GASTROINTESTINAL: Abdominal pains, nausea, vomiting, vomiting blood, diarrhea, constipation, bloody/black stools, abnormal amount of passing gas, abnormally thin stools.

URINATION: Painful urination, frequently urinating, slow urine flow, incontinent of urine, blood in the urine.

GYNECOLOGIC (sees for woman only): Vaginal discharge, vaginal bleeding, hot flashes.

BONE/JOINTS: Joint pain, joint stiffness, back pain, muscle cramps, muscle pain.

SKIN: Rashes, lesions, abnormal amount of itching.

NEUROLOGICAL: Memory Loss, disorientation, passing out, seeing double, dizziness, vertigo “room spinning”, abnormal clumsiness, numbness, tingling, headache.

Patient Name: _____

Robert Sadaty, M.D.

9400 Fountain Medical Court, Suite 100
Bonita Springs, FL 34135

PRIVACY NOTICE

The following notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review the information carefully.

Please be advised that your confidential health care information may be released under the following conditions:

1. To other health-care professionals within the organization for the purpose of providing you with quality health care and treatment.
2. To your health insurance provider for the purpose of receiving payment in the course of providing you with health-care services and treatment.
3. To public or law enforcement officials in the event that investigation in which you are a victim of abuse, a crime, or domestic violence.
4. To other health-care providers in the even that you need emergency care.
5. To a public and federal organization in the even t of a communicable disease or to report a defective device or untoward even to a biological product such as food of medication.
6. For any other purpose than that which is identified in this notice.

Your confidential health care information may be released only after receiving written authorization from you. You may revoke authorization to release confidential health care information at any time in writing.

You have the right to:

- * Restrict the use of your confidential health care information. However, the organization may deny this restriction if it is a conflict of providing you with quality health care or in the event of an emergency situation.
- * Receive confidential communication about your healthcare status.
- * Review and ask for copies of any or all portions of your healthcare information and for what purpose.
- * Make changes to your healthcare information.
- * Be informed of who has accessed your confidential information and for what purpose.
- * Have a copy of this privacy notice upon request. This copy can be in the form of an electronic transmission or hard copy.

Robert Sadaty is required by law to protect the privacy of his patients. In doing so, will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices securing confidential health care information.

Furthermore, Dr. Robert Sadaty, M.D. will abide by the terms of this notice and will reserve the right to make changes to this notice, while continuing to maintain the confidentiality of all healthcare information. Patients will receive a copy of any changes to this notice within 60 days of making the changes via electronic transmission or hard copy.

You have the right to file a complaint with Dr. Robert Sadaty if you believe your rights have been violated. All complaints could be mailed to:

Dr. Robert Sadaty, M.D. 9400 Fountain Medical Court, Suite 100, Bonita Springs, FL 34135

All complaints will be investigated and no personal issue will be raised if a complaint is filed with Dr. Robert Sadaty.

This privacy notice is effective August 1, 2005.

PAST MEDICAL HISTORY

NAME:

PLEASE LIST ALL OF YOUR ONGOING MEDICAL PROBLEMS (for example, Hypertension, Coronary Artery Disease, etc.)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD (for example, appendectomy, coronary bypass surgery, pacemaker placed):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

MEDICATION LIST

Patient Name:

***PLEASE INCLUDE ALL MEDICATIONS THAT YOU TAKE INCLUDING VITAMINS, SUPPLEMENTS, AND PAIN MEDICATIONS. BE AS ACCURATE AS YOU CAN WITH THE NAME, DOSE, AND FREQUENCY (for example: *Ibuprofen 200 mg tablets, one tablet twice per day*).**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

List any drug allergies that you have.

1. _____

2. _____

3. _____

4. _____