# SURGICAL ASSOCIATES OF VENICE & ENGLEWOOD

***Please read and complete the entire form.***

**Last Name _____First_____ MI __ Date of Birth_____ SS#_____**

**Address _____ City _____State_____ Zip_____**

**Northern Address _____ City _____ State _____ Zip_____**

**Home phone # _____Cell # _____Northern Ph # _____**

**Circle which phone number should be your PRIMARY contact number>>> Home Cell Work**

**Employer_____ Employer Phone # _____**

**Email Address _____ May we email regarding cosmetic services we offer? Yes No**

**Primary Insurance Co:_____ Policy Holder: _____ Policy Holder DOB: _____**

**Secondary Insurance Co: _____ Policy Holder: _____Policy Holder DOB: _____**

**SS# Primary Policy Holder: _____SS# Secondary Policy Holder: _____**

**Emergency Contact: _____ Telephone: _____**

## Authorization for Direct Payment & Release of Information via Auto-Fax

I authorize release of information to my insurance companies, and any holder of Medicare and/or other insurance companies to support reimbursement for services rendered at Surgical Associates of Venice & Englewood. I request that payment of authorized benefits be made on my behalf. I agree to assign benefits payable to the physicians or facility furnishing the services. I understand that I am responsible for my bill, including any deductible or portion of my bill not covered or reimbursed by my insurance companies. I authorize Surgical Associates of Venice & Englewood to release information from my medical record to my referring physician, primary care physician, and other physicians involved in my treatment for the purpose of continued care.

_____

***Patient Signature*** ***Date***

## Financial Agreement

I understand that I am fully responsible, upon receipt of services or billing invoice, for any charges incurred by me for professional services rendered by the physicians at Surgical Associates of Venice & Englewood. I understand that I may be required to make a payment at the time of any visit, if an insurance co-payment or deductible payment is required. I will be required to make payment on any past due balances on my account. I understand that if Surgical Associates of Venice & Englewood should file a claim with my medical insurance and/or third party representative, it is for my convenience and does not constitute any guarantee of payment by insurance or representative. If care is required and my insurance plan or contract determines the treatment is a non-covered service, and if the plan refuses payment to the provider, I understand I am responsible for full payment of services prior to, or at, the time of services rendered. I understand that, should the charges incurred be the result of an injury involving a third party and I have involved an attorney for purposes of a liability claim against the third party, I am responsible for all charges at the time services are rendered and not at the time of any liability settlement.

_____

***Patient Signature*** ***Date***

**Surgical Associates of Venice & Englewood**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge:

A copy of Surgical Associates of Venice & Englewood's Notice of Privacy Practices was given/offered to me. If I received healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practical after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

Staff Use Only

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- Patient/family member received notice but refused to sign acknowledgment
- Emergency treatment situation
- Patient was incapacitated and no family member was present
- Unable to communicate due to language barriers
- Other (as described below)

_____

_____

_____ _____

Signature of SAVE staff member Date

436 Nokomis Avenue So.
Venice, FL 34285
Phone 941-488-7742
Fax 941-484-7756

5741 Bee Ridge Road
Suite 320
Sarasota, FL 34233

Bryan L. Smith, M.D., F.A.C.S.
Issam A. Halaby, M.D., Ph.D., F.A.C.S.
Christopher M. Willkomm, M.D., F.A.C.S.
Wadi S. Gomero-Cure, M.D.

**Patient Last Name _____First Name _____MI_____**

Consent to Treatment

I am presenting myself for medical and/or surgical treatment to Surgical Associates of Venice & Englewood and I voluntarily consent to the rendering of such care, including diagnostic tests and medical treatment, by authorized agents and employees of Surgical Associates of Venice & Englewood, physicians, or their designees, as may in their professional judgment be deemed necessary or beneficial to my wellbeing.

I understand that when the physicians treat me in the hospital, wound care center, or surgery center that they are functioning as independent contractors and will bill separately from those facilities or from other physicians who treat me in those facilities. I understand that the physicians are not employed by those facilities and that they are independent contractors who have been granted the privilege of using the hospital / medical facilities for the care and treatment of their patients.

I understand that examination and treatment received on an emergency basis is not intended as a substitution or replacement for complete medical care.

Medicare Certification Release

I certify that the information given by me in applying for payment under the Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Surgical Associates of Venice & Englewood.

Insurance Assignment

I hereby assign to and authorize Surgical Associates of Venice & Englewood and it's physicians involved in my care during this period of illness and treatment, or their duly authorized assigns to take all necessary steps, without limitations, to insure that any insurance benefits otherwise payable to me or my estate are paid directly to Surgical Associates of Venice & Englewood. This assignment of benefits includes but is not limited to billing insurance, filing petitions, filing suit, in my name or on behalf of the physicians, filing proofs of claim, filing probate claims and filing grievances and all other similar procedures, as may be amended from time to time with the state department of insurance. I also agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the other purposes.

Fraud

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, or files a statement of claim containing false, incomplete or misleading information may be subject to prosecution under applicable law.

Electronic Prescriptions

I am granting permission to Surgical Associates of Venice & Englewood to submit my prescriptions electronically when applicable and retrieve pharmacy benefits electronically for reconciliation purposes.

_____ _____

Signature of Patient or Legally Authorized Representative Printed Name of Person Signing

Date _____

Surgical Associates OF VENICE & ENGLEWOOD

Patient Name _____

In response to the Health Insurance Portability and Accountability Act, Surgical Associates of Venice & Englewood would like permission to disclose your confidential information and request that the following determinations are made which give us guidelines as to who you would like to have access to your confidential information.

**Please place an X on the line(s) beside each name to advise as to what information we are permitted to share with each individual. If you list a name but no designation, we will assume that any/all types of information may be shared.** We do NOT need the names of your physicians or Healthcare facilities, ONLY the names of your family and/or friends.

| **Name(s)** | **Appointment** | **Financial** | **Medical** | **ALL** |
|---|---|---|---|---|
| _____ | ____ | ____ | ____ | ____ |
| _____ | ____ | ____ | ____ | ____ |
| _____ | ____ | ____ | ____ | ____ |
| _____ | ____ | ____ | ____ | ____ |

I understand that the only way to change the permissions given above is to complete and sign a subsequent form. In addition, I agree that Surgical Associates of Venice & Englewood may leave appointment information on my home answering machine.

Patient Signature _____ Date _____

**436 Nokomis Avenue South**
**Venice, FL 34285**

**5741 Bee Ridge Road**
**Suite 320**
**Sarasota, FL 34233**

436 Nokomis Avenue So.
Venice, FL 34285
Phone 941-488-7742
Fax 941-484-7756

5741 Bee Ridge Road
Suite 320
Sarasota, FL 34233

Bryan L. Smith, M.D., F.A.C.S.
Issam A. Halaby, M.D., Ph.D., F.A.C.S.
Christopher M. Willkomm, M.D., F.A.C.S.
Wadi S. Gomero-Cure, M.D.

# Welcome To Our Office! Please keep this reference sheet for later use.

As a patient at Surgical Associates of Venice & Englewood, our physicians and staff are dedicated to providing you with the highest quality care. Our Venice office hours are Monday thru Friday 8:30 am to 4:30 pm; however we do offer ultrasound appointments starting at 7:00 am. Our Sarasota office is open Monday and Wednesday by appointment. Please read the following information to welcome and acquaint you with our office. For additional information, please visit our website at **VeniceSurgery.com.** We offer **aesthetic services** such as spider vein injections, BOTOX cosmetic and dermal filler injections. For more information please visit our website at **WestCoastLooks.com**.

The Physicians at Surgical Associates of Venice & Englewood ask that all **new patients arrive 30 minutes** in advance of their appointment time and **established patients arrive 15 minutes** before their appointment time to ensure sufficient time at check-in. Patients will be asked to present their insurance cards and driver's license.

New patients are asked to complete a Patient History Questionnaire. It is very important that you **list all of the medications** (and dosages) that you are currently taking. This ensures our ability to provide you with the safest medical care by keeping our records accurate.

Surgical Associates of Venice & Englewood participates with certain managed care plans that require an authorization from the patient's primary care physician. If you belong to one of these insurance plans, please remember that it is the patient's responsibility to notify and obtain an authorization from their primary care physician. Surgical Associates of Venice & Englewood will try to assist with this process, but cannot honor an appointment that does not have proper authorization from your insurance company.

When you have completed your scheduled visit, you will be asked to schedule any return visits that the Physician has ordered and to pay your portion for the services provided.

If you are requesting records from our office to take to another physician, please allow 5 working days for reproduction of the records. You will be asked to sign an Authorization for Records Release Form and there may be a charge for the duplication service.

There is always a Surgical Associates of Venice & Englewood **physician on call** to assure continuity of care. For calls when the office is closed, please inform the answering service of your problem and leave your full name and phone number. The "On Call" physician will respond as quickly as possible. Please be prepared to accurately describe your problem and list the medications you are taking. Routine calls can best be addressed during regular office hours.

## NURSE CALLS (941) 584-1002 (Clinical questions and Prescription refills)

Please leave a message if you reach the voice mail and your call will be answered on the same business day. Nurse calls will be answered throughout the day between patients**. Emergent issues should not be left on voice mail.** If you need to have a **prescription** refilled, please give us at least 24 hours notice. This will allow our clinical team time to reach your pharmacy or to get a signature on a prescription from your Physician. The fastest way to a prescription refill is often by Electronic Prescription. You may drop off your prescription refill request at the front desk, or call our clinical staff.

## DIRECT LINES: Procedure Scheduling (941) 485-1384 Billing Department (941) 484-1203

Please note that our office will be calling your home to confirm your appointment and also to provide treatment information, etc. We utilize automated systems to contact our patients. If you have any restrictions as to receiving phone calls, please notify the receptionist and indicate your preferences on our HIPAA release form.

# Surgical Associates of Venice & Englewood
# Notice of Privacy Practices

**This notice describes how medical information about you at Surgical Associates of Venice & Englewood may be used and disclosed, and how you can get access to your health information. Please review this notice carefully.**

We are dedicated to maintaining the privacy of your health information. There will be records created each time you visit our physicians or receive treatment from us. We may also collect information from others such as medical records from your other physicians and prior test results. These records may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future treatment, and billing-related information. This notice applies to all of the records of your care generated by Surgical Associates of Venice & Englewood.

**Our Responsibilities**
We are required by law to maintain the privacy of your protected health information, to provide you with this notice of our legal duties and the privacy practices we maintain concerning your protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

**Uses and Disclosures – How we may use and disclose protected health information about you**

**For Treatment** -We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians and medical students or other personnel who are taking care of you. As an example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

**For Payment –**We may use and disclose your protected health information to bill and collect payment from you, your insurance company, workers compensation company or a third-party payer. As an example, we may need to provide your insurance company with information about your diagnosis so that it will pay us or reimburse you for the treatment or so we may get approval for payment and or determine if your plan will pay for treatment.

**For Healthcare Operations** –We may use and disclose your protected health information to run our practice. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and obtaining accreditation, certificates, licenses and credentials we may need to serve you. We will use these results to continually try to improve the quality of care for all patients that we serve.

Surgical Associates of Venice & Englewood may also use and disclose protected health information:

- To remind you that you have an appointment for medical care
- To determine your satisfaction with our services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To business associates we have contracted with to perform an agreed upon service
- To inform you about health-related benefits or services
- To inform you about possible treatment alternatives
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

**Individuals involved in Your Care or Payment for Your Care:** We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

**Law Enforcement / Legal Proceedings:** We may release protected health information for law enforcement purposes as required by law or in response to a valid subpoena or court order. We also may disclose your information in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**As Required by Law**, we may also disclose information to the following types of entities, included but not limited to:

- Public health or legal authorities charged with preventing or controlling disease, injury, disability or other threat to health or safety
- A funeral director, medical examiner or coroner to identify a deceased individual or to identify the cause of death.
- The U. S. Food and Drug Administration
- Workers' Compensation Agents
- Correctional Institutions (if you are in custody of a correctional institution or law enforcement officer)
- Military command authorities
- Organ and tissue donation organizations
- Health oversight agencies
- National security and intelligence agencies
- Protective services for the president and others

**Future Communications:** We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

**Changes to This Notice:** The terms of this notice applies to all records containing your protected health information created and retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records created or maintained in the past and future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

**Your Health Information Rights:** While your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and obtain a copy of the protected health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. You may also request that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request.

- Ask to amend your protected health information if you believe it is incorrect or incomplete, and you must request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. You must provide us with reasons that support your request for amendment. Our practice reserves the right to deny your request if you ask us to amend information that is in our opinion, inaccurate and incomplete and not part of the protected health information kept by or for our practice. You will be notified of the reason for the denial.

- Request an "accounting of disclosures". An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes. Use of your protected health information as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. All requests for accounting of disclosures must indicate the time period involved.

- Request in writing that we restrict disclosures of protected health information if the disclosure is for payment or healthcare operations, is not required by law, and the protected health information pertains solely to a healthcare item or service for which the individual, or someone on the individual's behalf other than the health plan, has paid Surgical Associates of Venice & Englewood in full. Additionally, you may request restrictions on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- Request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at work or by U. S. Mail. In order to request a type of confidential communication, you must make a written request to Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285. In order to request communication at an alternate location, your request must include a mailing address where you will receive bills for services and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means at other locations if you fail to respond to any communication from us that requires a response.

- Receive a paper copy of our Notice of Privacy Practices even if you agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our website VeniceSurgery.com.

**Other Uses of Your Protected Health Information That Require Your Authorization:**
Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Examples of these additional authorizations involve the release of psychotherapy notes (if any), marketing, or the sale of your protected health information. Any authorization you provide to us regarding the use and disclosures of your protected health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your protected health information for the reasons described in the authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to remain our records of the care that we provided to you.

**Complaints:**
If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Privacy Officer, 436 Nokomis Avenue South, Venice, FL 34285 or by calling 941-488-7742. You will not be penalized for filing a complaint.

For further information, please contact our Practice Administrator who serves as our Privacy Officer at 436 Nokomis Avenue South, Venice, FL 34285 or 941-488-7742. Effective Date 09/01/2013

Surgical Associates OF VENICE & ENGLEWOOD

# Patient History Questionnaire –Please bring to your appointment!

## PATIENT INFORMATION

**Last Name** _____**First** _____**MI**___ Sex M F Date:_____
Referring physician: _____ Birth date: _____ Age: _____
Primary Dr: _____Cardiologist_____
Other Doctors _____

Race: ***(Circle One)*** White Am. Indian/AK Native Asian Black/African Am. Nat. Hawaiian Other Race Declined

Ethnicity: ***(Circle One)*** Hispanic or Latino Non-Hispanic or Latino Declined

## HISTORY OF PRESENT ILLNESS

**Reason for your visit:** _____

♦ Location of Problem: _____Duration: _____
***(Where on the body symptom occurs- Right or Left side if applicable)*** ***(How long have you had symptom? How long does it last?)***

♦ Severity: _____ Quality: _____
***(Severe, worse, slightly. Pain scale 1-10)*** ***(Character of symptom...burning, gnawing, stabbing)***

♦ Timing: _____ Context: _____
***(When symptoms occur)*** ***(Situation associated with symptom)***

♦ Modifying Factors: _____
***(Things that make symptoms better or worse)***

♦ Associated Signs/Symptoms: _____
***(Other things that happen when this symptom occurs)***

**Medical History:** *Please circle **Yes** or **No** if you have the following medical problems& explain below.*

High Blood Pressure . ..Yes No Respiratory Problems . ..Yes No >Type _____
Diabetes …… .Yes No Bleeding Problems. . . . .Yes No>Type_____
Stroke…… . . . .Yes No Heart Trouble……Yes No> Type_____
Cancer…….. Yes No >> Type_____
Other Problems_____

What is your current weight? _____ Height? ____feet _____inches

Preferred Pharmacy_____ Location/Phone_____

**Current Medications/Dosage:**

_____
_____
_____

Drug Allergies: _____
_____

Are you allergic to contrast dye? Yes No

**Continue on reverse side of page**

**Past Hospitalizations/Surgeries/Injuries and Approximate Dates**:

_____

_____

_____

_____

**Family History:** *Please list any medical problems in your relatives.*

Father: _____

Mother: _____

Siblings:_____

Others:_____ _____

**Social History:** Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Tobacco Use:❑ Never ❑ Quit/ What age? _____ ❑ Smoker/ how much?_____

Alcohol Use: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily ❑ How much?_____

Recreational Drug Use: ❑ Never ❑ Type and frequency _____

Occupation: _____ Permanent Resident? Yes No

**Review of Systems** *Please circle **Yes** or* **No** *if you have any of the following problems.*

**Constitutional**

Good General Health Yes No
Recent weight change Yes No
Night sweats, fevers Yes No
Fatigue Yes No

**Ears/Nose/Mouth/Throat**

Hearing loss or ringing Yes No
Sinus problems Yes No
Nose bleeds Yes No
Sore throat/voice change Yes No

**Eyes**

Wear glasses/contacts Yes No
Blurred/double vision Yes No
Eye disease or injury Yes No
Glaucoma Yes No

**Cardiovascular**

Chest pain Yes No
Palpitations Yes No
Heart trouble Yes No
Swelling hands/feet Yes No

**Respiratory**

Shortness of breath Yes No
Cough Yes No
Wheezing/asthma Yes No
Coughing up blood Yes No

**Gastrointestinal**

Nausea/vomiting Yes No
Abdominal pain Yes No
Rectal bleeding Yes No
Bowel problems Yes No

**Musculoskeletal**

Muscle pain or cramp Yes No
Stiffness/swelling joints Yes No
Joint pain Yes No
Trouble walking Yes No

**Neurological**

Frequent headaches Yes No
Paralysis or tremors Yes No
Convulsions/seizures Yes No
Numbness/tingling Yes No

**Integumentary (Skin/Breast)**

Change in hair or nails Yes No
Rashes or itching Yes No
Breast lump Yes No
Breast pain/discharge Yes No

**Endocrine**

Excessive thirst/urination Yes No
Thyroid disease Yes No
Hormone problem Yes No

**Hematologic / Lymphatic**

Bruise easily Yes No
Slow to heal Yes No
Enlarged glands Yes No

**Allergic/Immunologic**

Food allergies Yes No
Aspirin allergies Yes No
Antibiotic allergies Yes No

**Genitourinary -Male only**

Blood in urine Yes No
Kidney stones Yes No
Sexual problems Yes No
Testicle pain Yes No

**Genitourinary -Female only**

Blood in urine Yes No
Kidney stones Yes No
Sexual problems Yes No
Menstrual problems Yes No

**Psychiatric**

Insomnia Yes No
Confusion/memory loss Yes No
Depression Yes No
Other _____

_____

**Patient statement: To the best of my knowledge, the above information is accurate and complete.**

**Signed _____ Date_____**

436 Nokomis Avenue South
Venice, FL 34285

5741 Bee Ridge Road, Ste 320
Sarasota, FL 34233

# *Payment Policy*

***PLEASE NOTE THAT WE DO NOT ACCEPT NEW MEDICAID PATIENTS IN THE OFFICE.***

**No Insurance**

Patients are expected to pay in full at time of service. **A prompt payment discount of twenty percent is available for payment upfront *when no insurance is to be filed by the patient or the office*.** In the event that the bill exceeds $150, patients have the opportunity to establish a payment plan for balances over that amount. We do not offer prompt payment discounts when payment is not made in full at time of service.

**Traditional Medicare Only**

Patients will be asked for their 20% coinsurance at the time of service unless there is secondary insurance coverage. Medicare will be filed. Patients are also responsible for their annual deductible and will be billed for this amount. Authorization for direct payment must be obtained.

**Managed Care Insurance**

This is a private insurance company with which Surgical Associates of Venice & Englewood has signed a contract (generally known as Managed Care). The patient is not asked for any payment at the time of service, unless your insurance company requires a co-payment amount or deductible. Authorization for direct payment must be obtained.

**Commercial Insurance**

Surgical Associates of Venice & Englewood files your insurance as a courtesy. We will ask that you pay all deductible, coinsurance, or co-payments as designated by your insurance card upon check out.

**Non U.S. Residents**

Surgical Associates of Venice & Englewood will file foreign insurance (policies with addresses outside the United States) for the patient as a courtesy, however, the patient is asked to pay in full at the time of service.

**Forms of Payment Accepted**

Surgical Associates of Venice & Englewood accepts cash, check, Visa, MasterCard, Discover, and American Express. If your situation warrants, our patient representatives will be happy to work out an extended payment plan.

**Please call our Billing Department at 941-484-1203 with financial questions.**

**Phone 941-488-7742 Fax 941-484-7756**