ADULT MEDICINE CENTER

601 University Blvd, Suite 207 Jupiter, FL 33458
Phone (561) 745-7878 Fax (561) 745-7876

PLEASE PRINT

Cell # ____________________

Date ____________________ Home # ____________________

Patient ____
Last Name First Name Middle Initial

Street Address ____

City ____________________ State __________ Zip ________-______

Out of town address ____

City ____________________ State __________ Zip ________-______

Sex ◻ Male ◻ Female Age ______ Birth date ____________ ◻Single ◻Married ◻Widowed ◻Separated ◻Divorced

Race ◻Caucasian ◻African American ◻Asian ◻Indian/Alaskan ◻Pac-Isle ◻Other/Multi **Ethnicity** ◻Hispanic ◻Non-Hispanic

First Language Spoken ____________ E-Mail ____________@__________

Patient Employed By ____________________ Occupation ____________

Business Address ____________________ Business Phone ____________

Spouse Name ____________________ Birth date ____________

Business Address ____

Occupation ____________________ Business Phone ____________

Who is responsible for this account? ____________ Relationship to patient ____________

Social Security # ____________ Spouse's Social Security # ____________

Do you have Medical Insurance? **No Yes** Are you the policy holder? **YES NO** If NO, who is? ____________

If yes, Name of Primary Ins. ____________________ ID # ____________

Name of Secondary Ins. (if any) ____________________ ID # ____________

In case of emergency, who should be notified? ____________________ Phone # ____________

How did you learn of our practice? ____

ASSIGNMENT AND RELEASE

I, the undersigned have insurance coverage with ____________________ and adding directly to Dr. Irma Lopez all medical benefits, if another payable to me for service rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____________________ ____________________
Signature **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Irma Lopez for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in the item 9 of the HCFA-1500 forms, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorize releasing of the information to the insurer or agency shown, in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier,

____________________ ____________________
Signature **Date**

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MEDICAL HISTORY

Name ______________________________ Date ______________

Reason for this visit:				
Have you ever been diagnosed with:				
Diabetes		Allergic Rhinitis		**Others:**
High Blood Pressure		Ulcers		
Stroke		Cancer (where)		
Heart Disease		Bleeding Disorder		
Lung Disease (COPD)		Venereal Disease		
Asthma		Anemia		
Myocardial Infarction (Heart Attack)				

Pharmacy Name: **Phone:**

Current List of Medications		
Name	Dose	Frequency

Vitamins and over the counter Medications		
Name		

Drug Allergies	Severity			Reactions			
	Mild	Mod.	Severe	Shock	Asthma	Rash	Nausea, Diarrhea

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FAMILY AND PERSONAL HEALTH HISTORY

Name ______________________ Occupation ______________________

FAMILY RECORD Check all conditions of any blood relative who has or has had any of the condition listed below	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism						
Allergies						
Anemia						
Cancer, Tumor						
Diabetes						
Emphysema						
Epilepsy						
Heart Attack						
Heart Disease						
High Blood Pressure						
Mental Illness						
Migraine						
Nervous Breakdown						
Obesity						
Stroke						
Suicide						

FAMILY MEMBERS			
	Living	Deceased	
	Age	Age at death	Cause of death
Father			
Mother			
Brother(s)			
Sister(s)			
Son			
Daughter			

OPERATIONS	YES	NO	DATE
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast			
Uterus (female)			
Ovaries (female)			
Prostate (male)			
Other:			

Do you: If yes, daily consumption			
Smoke Pkgs.			
Drug use			
Beer oz.			
Hard liquor oz.			

Immunizations			
Pneumonia Vaccine			
Tetanus			
Influenza			
Zostavax (Shingles)			
COVID-19 Vacc. 1st dose			
COVID-19 Vacc. 2nd dose			
COVID-19 Vacc. Booster			

When was your last mammogram?	
When was your last colonoscopy?	
When was your last bone density?	
When was your last pap smear/pelvic?	
When was your last chest x-ray?	
When was your last fecal occult blood?	

Notes:

STUDY OF SYSTEMS

NAME: ______________________________ DATE: ______________

Check either yes or no for each item except where applies to only male or female.

Section	Conditions	Yes	No
GENERAL	Fever		
	Chills		
	Bruise Easily		
	Swollen Glands		
	Loss of Memory		
	General Weakness		
	Aches/pains		
HEAD	Double Vision		
	Light Flashes		
	Blurred Vision w/o glasses		
	Halos around lights		
	Eye pains		
	Ear pains		
	Ear Drainage		
	Buzzing/ringing in ears		
	Nosebleeds		
	Sinus Problems		
	Swallowing Problem		
	Deafness		
	Mouth, Tooth or Tongue problems		
	Persistent Hoarseness		
	Severe Headaches		
	Other *		
SKIN	Rash		
	Changing Moles		
	Pigmentation		
	Other Skin Problems		
CHEST HEART LUNGS	Irregular Heartbeat		
	Shortness of Breath		
	Low Exercise Tolerance		
	Heart Flutters		
	Chest Pains		
	Frequent Coughs		
	Cough up Blood		
	Wheezing		
	Night Sweats		
	Swollen Ankles		
	Cramps in legs		
	Other *		

Section	Conditions	Yes	No
NECK	Stiffness		
	Swelling		
	Lumps		
	Others *		
GASTRO	Appetite Poor		
	Indigestion/Heartburn		
	Nausea		
	Vomiting Blood		
	Abdominal Pain or Cramps		
	Abdominal Tension		
	Diarrhea		
	Constipation		
	Bowel Habit Changes		
	Rectum Blood Passage		
	Black tar type BM		
	Other *		
KIDNEY	Up Nights to Urinate		
	Blood In Urine		
	Burning or pain while urinating		
	Problems passing urine		
	Trouble controlling urine		
	Other *		
NEU MUSC	Leg or Arm Weakness		
	Balance problems		
	Dizziness		
	Fainting		
	Speech problems		
	Other *		
JOINTS	Joint Pains		
	Joint swelling		
	Muscle Strength Loss		
	Muscle Lump or Swelling		
	Lump on Bone		
	Pains in back		
	Other *		
ENDOC	Constant Thirst		
	Most Always Cold		
	Too Warm Most Times		
	Very Sluggish or Tired		
	Jumpy/Nervous		

Section	Conditions	Yes	No
PSYCHOLOGICAL	**Is Your Life:**		
	Satisfactory		
	Boring		
	Demanding		
	Unsatisfactory		
	Is there worry over:		
	Home Life		
	Marriage		
	Job		
	Children		
	Money		
	Do you:		
	Often Feel Depressed		
	Have Irrational Fears		
	Feel Upset		
	Feel things Often Go wrong		
	Feel Shy		
	Cry Easily		
	Feel Inferior		
	Have you:		
	Attempted Suicide		
	Seriously consider Suicide		
MALE	Lump in Testicles		
	Penis Discharge		
	Breast Lump		
	Sore on penis		
	Erection Difficulties		
	Other *		
FEMALE	Breast Lump		
	Nipple Discharge		
	Vaginal Discharge		
	Non period bleeding		
	Hot Flashes		
	Pain w/ Intercourse		
	Possible Pregnant		
	Change in Periods		
	Pain other than w/ periods		
	Other *		

Explain Other*

Doctor's Use Only – Summary

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient's Name: ______________________________ Date of Birth: ______________________

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR 164.508]. I authorize the above-named practice my physician and or administrative and clinical staff to:

___ obtain a copy of my full complete medical record. I understand that the information contained in my medical records is protected health information.

____

____

____

____

This authorization shall be in force and effect until: (1):____ [*hereinafter referred to as expiration date*] or (2) upon the occurrence of the event more fully described as follows: ______________________________

____

at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at the above practice address. I understand that a revocation is not effective to the extent that the above-named has relied on the use or discloser of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to content a claim.

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.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care service are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign this authorization.

If the use/disclosure for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

______________________________ ______________________________

Signature of patient or Personal Representative **Date**

______________________________ ______________________________

Print name of patient or Personal Representative Description of representative's authority

PLEASE FAX MEDICAL RECORDS TO 561-745-7876.

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To our patients,

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI), the individual is also provided the right request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physician and staff of Adult Medicine Center respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preference for the area noted below.

I wish to be contacted in the following manner (check all that apply)

Home Telephone ______________________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Cell Phone ______________________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone ______________________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communications
- ☐ O.K. to mail my home address
- ☐ O.K. to mail my work address

Fax ______________________________
- ☐ O.K. to fax

Other individuals (family, friends, caregiver, etc.) you may speak with about
- ☐ my care or treatment
- ☐ my bill

Name	Relationship
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

______________________________ ____________________
Print Patient Name Date of birth

______________________________ ____________________
Patient Signature **Date**

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PAYMENT POLICY

Please read and sign this form as it concerns you, the patient.
*****YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY**
Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is your responsibility to know your individual coverage and its limitations as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred. **Please remember that your insurance policy is a contract between you and your insurance company. It is you're responsible to know or find out whether or not we are providers for your specific network. Please call your insurance company and learn about your coverage, it will save you a lot of the time, confusion and money.**

***Referrals:** if you need a referral from our office, we ask that you give us at least a 48 hour notice to obtain the referral.

***Non-participating provider policy**: If we are not a provider for your insurance company, payment in full is due at the time of service.

________ I hereby authorize Dr. Lopez to furnish information to insurance carriers concerning my illness (es) and/or treatment.

________ I hereby assign to Dr. Lopez all payments for medical services to myself or my dependent.

________ I further agree, in the event such account must be referred to a collection agency or an attorney or for count action for collection, I shall be responsible for any and all resulting from such action, including but not limited to, agency fee, legal fees, court fees.

________ I am aware that there may be a charge for any appointment not canceled 24 hours in advance.

________ I am aware that a $25.00 fee will be charged for all returned checks.

Signature of responsible party, after reading and initialing the above statements.

____________________________________ __________________

Signature **Date**

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CONSENT FOR THE USE AND/OR DISCLOSURE OF PROECTED HEALTH INFORMATATION

I hereby give consent to Adult Medicine Center of South Florida, and all health care providers furnishing care within the practice to use and disclose my protected health information for the purpose of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, called from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our notice of privacy practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of your Notice of privacy Practices, You may obtain a copy of the current notice by contacting our Privacy Officer at 561-745-7878.

You have the right to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but will be effective only when we actually received the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Print name of patient: ____

Sign: ______________________________ Date: ________________

If you are signing as the patient's representative:

Print your name: ________________________ Date: ________________

Describe your authority: ____

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Name: ______________________________ **Date:** ____________

Current List of Doctors/Specialists (include out of state doctors)			
Name	**Specialty**	**Reason**	**Phone No.**

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Consent for Non Face-to-face (Virtual Visits)

I, ____ hereby voluntarily consent to receive "virtual" care.

Virtual check-ins – You and your treating provider may have a brief phone call to determine whether or not an in-person visit or other appropriate treatment is needed.

E-visit – You may communicate with your treating provider through our patient portal or secure email.

Telehealth visits – You and your treating provider can use real time interactive audio and video communication that permits real time communication – like FaceTime, Skype or What's App – to conduct a visit while you are home.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Adult Medicine Center.

"Virtual Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements. (Please initial)

- ________ Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider.
- ________ I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording.
- ________ I understand there are potential risks to this technology, including, but not limited to , interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- ________ I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangement for follow-up care.
- ________ I understand that standard deducible and coinsurance amounts apply to these "Virtual Visits" and I consent to Virtual Treatment.

______________________________________ ____________________

Signature of patient or Personal Representative **Date**

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Dear Patient,

As a patient with two or more chronic conditions, you may benefit from a new program that is available to Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors and facilities; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

Your assigned clinician in charge of your care is Dr. Irma Lopez and Nurse Practitioner Ginette LaFleur. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

- As needed, we will share your health information electronically with physicians involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
- We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is $42.00, of which your portion will be $8.40. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

- A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
- Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program. Yes ______ No ______

______________________________________ ____________________
Patient Signature Date

____
Print Name