ADULT MEDICINE CONCIERGE

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 to 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 the 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 _____

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.

	Conditions	Yes	No		Conditions	Yes	No		Conditions	Yes	No
GENERAL	Fever			NECK	Stiffness			PSYCHOLOGICAL	**Is Your Life:**		
	Chills				Swelling				Satisfactory		
	Bruise Easily				Lumps				Boring		
	Swollen Glands				Others *				Demanding		
	Loss of Memory			GASTRO	Appetite Poor				Unsatisfactory		
	General Weakness				Indigestion/Heartburn				**Is there worry over:**		
	Aches/pains				Nausea				Home Life		
HEAD	DoubleVision				Vomiting Blood				Marriage		
	Light Flashes				Abdominal Pain or Cramps				Job		
	Blurred Vision w/o glasses				Abdominal Tension				Children		
	Halos around lights				Diarrhea				Money		
	Eye pains				Constipation				**Do you:**		
	Ear pains				Bowel Habit Changes				Often Feel Depressed		
	Ear Drainage				Rectum Blood Passage				Have Irrational Fears		
	Buzzing/ringing in ears				Black tar type BM				Feel Upset		
	Nosebleeds				Other *				Feel things Often Go wrong		
	Sinus Problems								Feel Shy		
	Swallowing Problem			KIDNEY	Up Nights to Urinate				Cry Easily		
	Deafness				Blood In Urine				Feel Inferior		
	Mouth, Tooth or Tongue problems				Burning or pain while urinating				**Have you:**		
	Persistent Hoarseness				Problems passing urine				Attempted Suicide		
	Severe Headaches				Trouble controlling urine				Seriously consider Suicide		
	Other *				Other *			MALE	Lump in Testicles		
SKIN	Rash			NEU MUSC	Leg or Arm Weakness				Penis Discharge		
	Changing Moles				Balance problems				Breast Lump		
	Pigmentation				Dizziness				Sore on penis		
	Other Skin Problems				Fainting				Erection Difficulties		
CHEST HEART LUNGS	Irregular Heartbeat				Speech problems				Other *		
	Shortness of Breath				Other *			FEMALE	Breast Lump		
	Low Exercise Tolerance			JOINTS	Joint Pains				Nipple Discharge		
	Heart Flutters				Joint swelling				Vaginal Discharge		
	Chest Pains				Muscle Strength Loss				Non period bleeding		
	Frequent Coughs				Muscle Lump or Swelling				Hot Flashes		
	Cough up Blood				Lump on Bone				Pain w/ Intercourse		
	Wheezing				Pains in back				Possible Pregnant		
	Night Sweats				Other *				Change in Periods		
	Swollen Ankles			ENDOC	Constant Thirst				Pain other than w/periods		
	Cramps in legs				Most Always Cold				Other *		
	Other *				Too Warm Most Times						
					Very Sluggish or Tired						
					Jumpy/Nervous						

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Irma V. Lopez, M.D., Elizabeth Valdes, D.O.
Ginette LaFleur, N.P.
601 University Blvd, Suite 207 Jupiter, FL 33458
Phone (561) 745-7878 Fax (561) 745-7876

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. The assigned clinician in charge of your care is Dr. Irma Lopez, Dr Elizabeth Valdes 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 health is valuable and hope you consider participating in the program with our practice.

I agree to participate in the Chronic Care Management program. Yes_____ No_____

_____ _____

Patient Signature Date

_____

Print Name