

# ADULT MEDICINE CONCIERGE

601 University Blvd, Suite 207 Jupiter, FL 33458

Phone (561) 745-7878 Fax (561) 745-7876

Cell # \_\_\_\_\_

**PLEASE PRINT**

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 Adult Medicine Concierge 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 Adult Medicine Concierge 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.

\_\_\_\_\_  
Signature Date



# ADULT MEDICINE CONCIERGE

## FAMILY AND PERSONAL HEALTH HISTORY

Name \_\_\_\_\_

<b>FAMILY RECORD</b> <i>Check all conditions of any blood relative who has or has had any of the condition listed below</i>	<b>F</b> <b>A</b> <b>T</b> <b>H</b> <b>E</b> <b>R</b>	<b>M</b> <b>O</b> <b>T</b> <b>H</b> <b>E</b> <b>R</b>	<b>B</b> <b>R</b> <b>O</b> <b>T</b> <b>H</b> <b>E</b> <b>R</b>	<b>S</b> <b>I</b> <b>S</b> <b>T</b> <b>E</b> <b>R</b>	<b>S</b> <b>O</b> <b>N</b>	<b>D</b> <b>A</b> <b>U</b> <b>G</b> <b>H</b> <b>T</b> <b>E</b> <b>R</b>	<b>OPERATIONS</b>	<b>YES</b>	<b>NO</b>	<b>DATE</b>
Alcoholism							Tonsils			
Allergies							Appendix			
Anemia							Gall Bladder			
Cancer, Tumor							Stomach			
Diabetes							Kidney			
Emphysema							Colon			
Epilepsy							Thyroid			
Heart Attack							Hernia			
Heart Disease							Breast			
High Blood Pressure							Uterus (female)			
Mental Illness							Ovaries (female)			
Migraine							Prostate (male)			
Nervous Breakdown							Other:			
Obesity							<b>Do you: If yes, daily consumption</b>			
Stroke							Smoke	Pkgs.		
Suicide							Drug use			
							Beer	oz.		
							Hard liquor	oz.		
							<b>Immunizations</b>			
							Pneumonia Vaccine			
							Tetanus			
							Influenza			
							Zostavax (Shingles)			
							COVID-19 Vacc. 1 <sup>st</sup> dose			
							COVID-19 Vacc. 2 <sup>nd</sup> 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?			

  

<b>FAMILY MEMBERS</b>			
	<i>Living</i>	<i>Deceased</i>	
	<i>Age</i>	<i>Age at death</i>	<i>Cause of death</i>
Father			
Mother			
Brother(s)			
Sister(s)			
Son			
Daughter			

Notes:

# ADULT MEDICINE CONCIERGE

Irma V. Lopez, M.D. • Elizabeth M. Valdes, D.O.  
Emily A. Haly, M.D. • Ginette A. 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, 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.**

# ADULT MEDICINE CONCIERGE

Irma V. Lopez, M.D. • Elizabeth M. Valdes-Gall, D.O. • Emily A. Haly, M.D. • Ginette A. LaFleur, N.P.

601 University Blvd, Suite 207 Jupiter, FL 33458

Phone (561) 745-7878 Fax (561) 745-7876

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

---

# ADULT MEDICINE CONCIERGE

601 University Blvd, Suite 207 Jupiter, FL 33458

Phone (561) 745-7878 Fax (561) 745-7876

## 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 Adult Medicine Concierge to furnish information to insurance carriers concerning my illness(es) and/or treatment.

\_\_\_\_\_ I hereby assign to Adult Medicine Concierge 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 court 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



# ADULT MEDICINE CONCIERGE

*Irma V. Lopez, M.D. • Elizabeth M. Valdes-Gall, D.O. • Emily A. Haly, M.D. • Ginette A. LaFleur, N.P.*

601 University Blvd, Suite 207 Jupiter, FL 33458

Phone (561) 745-7878 Fax (561) 745-7876

## 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" means 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 that 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 deductible and coinsurance amounts apply to these "Virtual Visits" and I consent to Virtual Treatment.

\_\_\_\_\_  
**Signature of patient or Personal Representative**

\_\_\_\_\_  
**Date**

# ADULT MEDICINE CONCIERGE

601 University Blvd, Suite 207 Jupiter, FL 33458

Phone (561) 745-7878 Fax (561) 745-7876

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, Dr. Emily Haly, 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