INTERNAL MEDICINE PARTNERS, LLC
1726 MEDICAL BLVD SUITE 201, NAPLES, FL 34110 PHONE (239)596-8804 / 8806 Fax: (239)596-8793

Patient Information

Please Give Insurance Card(s) & Driver License To Front Desk For Copying- Thank You.

Patient's Name:_____ Birth Date: _____
First Middle Last (MM/DD/YYYY)

Home Phone:_____ Cell Phone:_____

Address:_____
City, State **Zip Code**

Status:
○ Single ○ Divorced ○ Married ○ Widowed Social Security:_____
○ Separated ○ Living with significant other

(OPTIONAL)
Race_____Religion:_____

Patient's Occupation: _____Employers:_____

Current Employer's
Address:_____Phone:_____

Spouse or Parent:_____ Phone:_____

Emergency Contact:
Name_____ Relation:_____ Phone:_____

E-mail_____

How did you hear about us?

○ Friend / Relative ○ Patient ○Internet ○ Newspaper ○ Physician/ Nurse _____

○Other_____

Insurance Information / REQUIRED:

Primary Insurance		
Insurance Name	Principal Subscriber Name	
Policy Number:	Relation to Patient	Subscriber Date of Birth

Secondary Insurance (If applicable)		
Insurance Name	Principal Subscriber Name	
Policy Number:	Relation to Patient	Subscriber Date of Birth

INTERNAL MEDICINE PARTNERS, DBA
INTERNAL MEDICINE AND WOUND CARE SPECIALIST, LLC

AUTHORIZATION, ASSIGMENT OF BENEFITS, AND INFORMATION RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and other medical professionals and institutions that I may be referred for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatices, audit compliance, utilization managemnt, and complaint resolution. I authorize payment directly to Internal Medicine and Wound Care Specialists, LLC for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am Financially responsible for all co-payments, coinsuracnce, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: X_____ Date:_____

FINANCIAL AGREEMENT

I understand that I'm directly responsible for all the charges incurred for medical service for myself and my dependents regardless of insurance coverage. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I owe.
It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable.
AGREEMENT: This above information is for the purpose of obtaining credit and is warranted to be true.
CANCELATION POLICY: If you have any inconvenience for showing to your appointment please call us at least 24 hours before your appointment, in order to reschedule it. **Our No-Show fee will be $50**, and it's have to be paid before your next appointment.

RETURNED CHECKS: Your account will be charged $30 fee for each returned check.

Signature: X_____ Date:_____
Patient / Parent / Guardian

REQUEST FOR TREATMENT

I authorize the group personnel to perform the care ordered by my physicians. I understand that I have the the right to be informed by my physicians of the nature of any proposed procedure and any available alternative methods or treatment, together with an wxplanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physician to provide according to recognized standards of medical practice, and I acknoledge that the group and its personnel are responsible for providing this information.

Signature: X_____ Date:_____

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form you aknowledge receipt of the Notice of Privacy Practices for Internal Medicine and Wound Care Specialist, LLC (Internal Medicine Partners, DBA). Our Notice of Privacy Practice provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change.

X_____ _____
Signature Patient's/ Parent/ Guardian Date

_____ _____
Name of Patient or Representative (Print please) Relationship to Patient

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Office use:
We attempted to obtain written acknowledgement , but couldn't be obtained for the following reason:

- ☐ Patient or Representative Refused to Sign
- ☐ Emergency Situation Prevented Signature Initials of employee:_____
- ☐ Other:_____

INTERNAL MEDICINE AND WOUND CARE SPECIALIST, LLC

NEW PATIENT HEALTH QUESTIONAIRE

Name:_____ Height:_____ Weight:_____ ○Female ○Male

Age today:

1. Describe the primary reason of your visit:

2. Do you use alcoholic beverages?

 Yes, Type_____

 Amount:_____

 No

3. Last Primary Doctor

_____

4. Do you use tobacco products?

 No, I have never smoked.

 No, I quit smoking _____months/years ago.

 Yes, I smoke_____ packs per day. Years_____

 Other:_____

Preferred Pharmacy Name:_____

Address:_____ **ZipCode:**_____

Phone:_____

PAST MEDICAL HISTORY

BRAIN
- TIA (transient ischemic attack)
- Stroke

ENDOCRINE
- Insulin dependent diabetes
- Non-insulin dependent diabetes
- Hypercholesterolemia
- Hypothyroidism
- Severe Osteoporosis

HEART
- Coronary artery disease
- Myocardial infarction (heart attack)
- Hypertension/High Blood Pressure

INFECTIOUS
- HIV
- Hepatitis
- Cellulitis
- Syphilis
- Joint infection

KIDNEY
- Chronic renal failure

LUNG
- Pulmonary embolism
- Chronic bronchitis
- Asthma
- COPD

MUSCULOSKELETAL
- Low back pain
- Sciatica
- Spinal Stenosis
- Degenerative disk disease
- Juvenile Rheumatoid Arthritis
- Lupus
- Rheumatoid Arthritis
- Psoriasis
- Osteoarthritis
- Severe Osteoporosis

CANCER
Type:_____

PSYCHIATRIC
- Alcohol abuse
- Major depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia

STOMACH AND INTESTINE
- GERD/Reflux
- Gastric ulcer
- Irritable Bowel Syndrome

VASCULAR
- DVT
- Phlebitis
- Sickle cell anemia

OTHER:

1._____
2._____
3._____

ALLERGIES

NO KNOWN ALLERGIES

MEDICINE	REACTION	GENERAL	REACTION
Aspirin	_____		
Erythromycin	_____	Latex	_____
NSAIDs	_____	Adhesive	_____
Penicillin	_____	Other	_____
Sulfa	_____		_____

FAMILY HISTORY

- ☐ Cancer _____
- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ Other _____

OTHER PAST SURGICAL HISTORY

BREAST
- ☐ Lumpectomy *(left or right side)*
- ☐ Mastectomy *(left or right side)*

CARDIOVASCULAR
- ☐ Pacemaker
- ☐ Coronary artery Bypass
- ☐ Valve replacement

ORTHOPEDIC
- ☐ Joint Replacement
- ☐ Spine
- ☐ Sports/
- ☐ Trauma

GASTROINTESTINAL
- ☐ Hernia repair
- ☐ Resection of large bowel
- ☐ Removal gall bladder

VASCULAR
- ☐ Abdominal aortic aneurysm
- ☐ Femoral Bypass
- ☐ Dialysis shunt
- ☐ Varicose vein stripping

OTHER:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

REVIEW OF SYSTEMS
Please mark any symptoms that you are currently experiencing.

GENERAL
- ☐ Good general health
- ☐ Chills
- ☐ Feeling tired all the time
- ☐ Dizziness
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain of more than 10 lbs
- ☐ Weight loss of more than 10 lbs

SKIN
- ☐ Rashes
- ☐ Psoriasis
- ☐ Bruise easily
- ☐ Abnormal Lumps
- ☐ Painful breast

HEENT
- ☐ Blurry vision
- ☐ Sinusitis
- ☐ Fainting

NECK
- ☐ Difficulty swallowing

RESPIRATORY
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Irregular heartbeat
- ☐ Heart murmur

GASTROINTESTINAL
- ☐ Anorexia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Loss of bowel control
- ☐ Blood in stool

GENITOURINARY
- ☐ Blood in Urine
- ☐ Painful urination
- ☐ Loss of bladder control
- ☐ Increased frequency of Urination
- ☐ Kidney Stones

MUSULOSKELETAL
- ☐ Fractures/sprains
- ☐ Osteoporosis
- ☐ Joint swelling

NEUROLOGICAL
- ☐ Dizziness
- ☐ Headaches/ migraine
- ☐ Convulsions /seizures
- ☐ Loss of consciousness

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression

ENDOCRINE
- ☐ Thyroid Problems
- ☐ Appetite changes
- ☐ Diabetes

HEMATOLOGY
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding
- ☐ Spontaneous bleeding

OB/GYN (females only)
PREGNANCIES _____
Abortions_____

Surgeries:_____

Other current problems (please describe):

MEDICATIONS
Please provide a list or ask for a Medication List Table from the FDA.

INTERNAL MEDICINE PARTNERS

PATIENT COPY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our Internal Medicine practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

INTERNAL MEDICINE PARTNERS Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

PRIVACY OFFICER- LILLY ALICEA, MHSA
INTERNAL MEDICINE PARTNERS
1726 MEDICAL BLVD SUITE 201
NAPLES, FL 34110

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective February 1, 2014.

Internal Medicine Partners, LLC

Office Policies

We would like to thank you for choosing Internal Medicine Partners as your medical provider. We have written this document to keep you informed of our current office policies.

Office Hours: Our clinic is open Monday - Friday, 9:00 a.m. – 5:00 p.m.

Appointments: We see patients by appointment only. Same day appointments are usually available for urgent or sudden illness.

Hospitalizations: One of our advantages is that our physicians have medical privileges in **NCH North Hospital**. If you are hospitalized your can ask in the hospital to call our physician to see you. During the weekends they aren't always available. If they aren't available other Hospitalist physician will admit you.

After Hours and Emergencies: For a serious emergency call 911 right away. If you are not sure and you call our office, please be sure to tell the person who answers the phone that it is an emergency. After hours you will reach our answering service. They will page the provider on call.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. **The No-Show fee is $50**.

Lab Work: Some lab work we do in our office-like glucose tests, urinalysis, Coumadin checks, hemoglobin A1C's. These tests are drawn by one of the medical assistants. Other lab work we send out to a reference lab. In some situations, insurance company requirements dictate that we send out lab work we could otherwise do in our office. For example Medicare patients will be sent to Quest. Patients with commercial insurances can have the blood drawn in the office for a convenience fee $15.

LAB OR TEST RESULTS- VERY IMPORTANT!! DO NOT CALL THE OFFICE FOR THIS:

Due to the overwhelming number of calls for test and lab results, Dr. Rodriguez and Dr. Blanco will discuss the results during your next office visit, unless there is problems with the results. **WE WILL CONTACT YOU RIGHT AWAY IF THERE IS A PROBLEM OR HEALTH CONCERN WITH THE RESULT.** Please do not call the office requesting discussion of test or lab. Results can be faxed or picked up. The first request for copies will be free. After that there will be a processing fee of $1.00 per page for the first 25 pages and .25 cents for each additional page. Also, if you are registered for our patient portal Kareo, you can securely access some test results online. Quest and Lab Corp also have patient portals so you can access Labs online.

Test Results: If you have diagnostic testing, i.e., lab, x-ray, echo, ultrasound, sleep study, please schedule a follow-up appointment, within 7-10 days, to go over the results with your physician and you will be subject to your copay/co-insurance. Results will not be given over the phone.

Prescriptions and Refills:

- The best time to get a prescription refill is at your appointment.
- Please provide the correct Pharmacy name and phone number of your favorite pharmacy to our medical assistants.
- If the information is not correct and we send the prescription already you can request the pharmacy to do a transfer of the prescription to another pharmacy.
- **If you need to call for refills, don't wait until you have run out**. Most refills require the doctor's approval. If your doctor is out for the afternoon, it may be the next day (or Monday) before it can be authorized.
- Don't go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready
- Refill requests called to us before 12:00 p.m. will be handled by the end of the day. After 12:00 p.m., it may be the next morning before your request can be addressed.
- Some medications have potential side effects that must be monitored:
    - **Maintenance Medications:** We require check ups every 3 or 4 months for these medications. Be sure to

    - **Narcotics:** Medications controlled and monitored by the DEA requires the patient to be seen for each prescription done. Examples of this are Ambien, Oxycodone, Xanax, etc.
- Some prescriptions cannot be called in. The prescription must be printed for you to pick up.
- **Don't call after hours for prescription refills. There is no access to your chart and we may not be able to help you.**

Complete Physical Exams: We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover "wellness" and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

Samples: We sometimes offer you samples to help you try out a new medication before you purchase it. Remember that samples are not a long-term way to fill your prescription. We do not always have samples of your medications. Please do not rely on samples for medications you take long term.

Narcotics: We do not prescribe narcotics for chronic use. We do not call in narcotics after hours. If you require use of narcotics, our physicians will refer you to a pain management specialist.

Mail Order Prescriptions: Many insurance plans offer financial incentives for using mail order pharmacies. We are glad to print out prescriptions for your mail order pharmacy needs. You can pick these up at our office. We do not fax or call in mail orders.

Referrals: Sometimes this can be done on the same day as your appointment and sometimes it can take days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained.
As a patient, it is your responsibility to ensure that your specialist is on your plan. It is also your responsibility to ensure your specialist receives your test results. You should pick-up a copy of your test results from our office and hand deliver them to your specialist. We will not fax test results and it is possible that the specialist will not see you without these. Please understand that it can sometimes take a few weeks to get an appointment with a specialist. This is not something we have control over.

Dismissal: If you are "terminated" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice. We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form. ***Common Reasons for Dismissal*** • Failure to keep appointments, frequent no-shows• Noncompliance, which means you won't follow physician instructions about an important health issue • Abusive to our staff • Failure to pay your bill

Disability, Insurance Forms, Attending Physician Statements, FMLA: There will be different charges for the completion of medical forms depending on the complexity and sometimes you may be required to schedule an appointment. Payment is due at the time that you pick-up these forms. Please allow 5-10 days for the completion of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing. FMLA forms require that you come in for an appointment.

Medical Records: We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Collections: Accounts that are not paid within 30 days begin our in house collection process. If your balance becomes 65 days old, your doctor will be notified and you may be subject to dismissal from the practice.