WELCOME TO
Nodal Medical center LLC

Phone (813) 488-4801 Fax (813) 405-4506

Enclosed you will find the new patient paperwork for your upcoming appointment.
We ask that you arrive with your completed paperwork at least **15 minutes** prior to your appointment time.

Your new patient packet includes the following:

- **Our practice brochure**
- **Patient demographic page**
- **A copy of the Privacy Practices Act (keep for your records)**
- **Signature sheet (for authorization to release information to individuals, insurances, pharmacies, and acknowledgment of receipt of the Privacy Practices Act)**
- **New patient questionnaire**
- **Medical Record Release (if there are any physicians from whom we should get records for you.)**
- **Our credit card policy (required)**

**For those patients with Medicare replacement plans, we ask that you forward a copy of your card prior to your appointment date so we can verify benefits.

On the day of your appointment, please bring in the bottles of **all** medications including prescriptions, over-the-counter medications, and vitamins that you are presently taking. While we understand many patients have printed lists of medications, we do ask that the actual bottles are brought to the office.

We will also need your actual insurance cards and photo ID for scanning into our system. We cannot accept copies they must be original cards.

Should you have any questions regarding this paperwork, please call our office at 813-488-4801.

Osvanny Nodal, MD.
2123 W Martin Luther King Jr Blvd suite 101
Tampa, Florida, 33607

Nodal Medical Center LLC is the premier primary care practice in Tampa, Florida. Our physician takes care of patients of all ages and has appointments available upon request. Our facility offers on-site diagnostic services including a full **Laboratory, EKG, Diagnostic Studies, and more.**

Our mission is to care for you and your family promptly, carefully and compassionately. We believe that the quality of medical care is improved when the patient and healthcare provider work together in partnership, and maintain clear and open communication. To ensure this, it is the policy of Nodal Medical Center LLC to not exclude, deny benefits to, or otherwise discriminate against any individual, visitor, patient, participant, applicant, or employee on the basis of disability or perceived disability, including those who are deaf or who are hard of hearing. Nodal Medical Center LLC, is committed to ensuring that people with disabilities, including those who are deaf or hard of hearing, can participate in, have access to, and receive the full and equal enjoyment of the goods, services, facilities, privileges, procedures, advantages, or accommodations provided by its clinic, programs, or activities whether carried out by Nodal Medical Center LLC directly or through a contractor or other entity with which Nodal Medical Center LLC, arranges to carry out its programs and activities. To ensure effective communication with patients and companions who are deaf or hard of hearing, we provide appropriate auxiliary aids and services free of charge, such as: sign language and oral interpreters, note takers, written materials, assisted listening devices and systems, and real-time transcription services.
If you have any questions regarding our policy or wish to request an accommodation, please contact our front office at (813) 488-4801

Interactive Patient Portal:
We are also pleased to announce the addition of our **Patient Portal**. This service will allow our patients to access their medical summary, request refills of medications, update information, and ask questions of our medical professionals. Additionally, individuals wanting to join our practice may pre-register.

Contracted Insurances:
Primary Care participates with **Medicare**, **Medicaid**, **Humana**, **Ambetter, Solis**, **Cigna, Freedom Health, Optimum, Aetna, Multiplan (PHCS), and Florida Blue Medicare, BCBS**. As the list of insurances is subject to change and some plans under even contracted insurances may not have coverage in our office, please call for verification of benefits. We do not accept any HMO policies other than those listed.

Office hours:
Our physicians are available in the office **Monday through Friday 8:30am-5:00pm. We also have extended office visits available on specific days for existing patient. Same day appointments** are always available for existing patients and we make every effort to extend the same to new patients wanting to join the practice.

Additionally, our office is accessible by phone 24 hours a day through our answering service. A physician within the practice is always **on call** so you will be speaking to our own physicians. We also have appointments available on **Saturdays from 9:00am-12:00pm** for our existing patients should they need to be seen outside normal office hours.

Prescription Refills: We try to write prescriptions that will see you through to your next scheduled appointment. If you are running low on a regular medication, it may mean that you are due for a follow up exam or testing. If you are not due for an appointment, please contact your pharmacy directly with your refill request. This will be the quickest way for us to have your medications refilled. Refills of controlled substances (such as pain medications) will only be filled by your personal physician during office hours (no evenings, weekends, or holidays.

Patient Information Form

Date: _____

Account Number: _____

Patient Information:

First: _____Middle: _____ Last: _____ Jr. / Sr.

Date of Birth: _____ Social Security Number: _____ - _____ - _____ (SS # is for identification purposes only)

If patient is a child, Name of parent/tutor (s) _____date of birth: ____/____/_____

Sex: Male _____ Female _____ Marital Status: (circle one) Married Single Divorced Widow(er)

Postal address: _____

City: _____State: _____ Zip code: _____

Street Address (if different from mailing): _____

Phone numbers: Please place a check in the box next to the one we should use to contact you.

☐ Cell Phone: _____ ☐ Home Phone: _____ ☐ Work Phone: _____

Email Address: _____ (Not for solicitation-only for communication only)

We request the following information to better treat medical conditions which may be related to these items and to ensure communication is clear. Please take a moment to answer each of these:

1. Race: _____
2. Ethnicity (please select one): Hispanic or Non- Hispanic
3. Preferred Language: _____

I give Primary Care permission to check my prescription history for verification of my medications. *Initials:* _____

I have a/an: ( ) Organ Donor Card ( ) Do Not Resuscitate Order ( ) Designated Healthcare Surrogate ( ) Power of Attorney

I do not have any of these items ( )

(As your doctor, it is important that we have these documents. If we don't have a copy, please provide us with one.)

Employer Information:

Are you employed (please circle one)? Yes / No / Retired / Student

Employer: _____

*Care giver: Please list the name and phone number of anyone else who helps take care of you.

Name: _____ Phone: _____

*Name of nearest relative or friend **who DOES NOT LIVE with you** that we may contact in case of emergency:

Name: _____Relationship to you: _____Phone #: _____

*Please list the pharmacy that we should use when we call in prescriptions.

Name: _____Phone_____

Location: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Member ID: _____ Secondary Member ID: _____

Medicaid Number: _____ Secondary Member name: _____

Copay amount: _____ Secondary Member DOB: _____ sex: M ___ F ___

If subscriber is different from patient please add:

Subscriber name: _____

Subscriber member ID: _____

Subscriber DOB: _____

Subscriber Social Security #:_____

Subscriber sex: M ___ F____

Subscriber phone number: _____

Patient relationship to subscriber: _____

Extended information:

Do you have any visual impairment that will prevent you from Reading written material from your doctor? ☐ yes ☐ No

Do you have a hearing impairment that will complicate spoken communication with your doctor? ☐ yes ☐ No

Do you have any limitation/disabilities of which we should be aware or that requires special accommodation? ☐ Yes ☐ No

Do you need to be provided with an interpreter, other auxiliary help such as transcription service, note taker, audition team, etc.? ☐ Yes ☐ No

Patient signature: _____ Date: ____/____/_____

Name printed: _____

NODAL MEDICAL CENTER LLC

Privacy Practices Act Notification

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 CLOSELY.

Uses & Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professions 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 services, the services provided and the medical condition being treated.

Healthcare Operations: Your health information may be used as necessary to support the day-to-day activities and management of Primary Care of the Treasure Coast. 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 without your permission, 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 & 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.

Additional Uses of Information

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

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

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

- the right to request restrictions on the use and disclosure
- the right to receive confidential communications
- the right to inspect and copy your protected health
- the right to amend or submit corrections to your protected
- the right to receive an accounting of how and whom disclosed
- the right to receive a printed copy of this Notice

Nodal Medical Center LLC 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 are also 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. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information: 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 our Privacy Officer. There may be a charge for this service.

Complaints: If you have any complaints or 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. You will not be penalized or otherwise retaliated against for filing a complaint. We ask that you send a letter outlining your concerns to: Nodal Medical Center LLC, 2123 W Martin Luther King Jr Blvd Tampa FL, 33607 Fax # 813-405-4506

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is as noted above, or telephone numbers is (813) 488-4801.

Effective Date: This Notice is effective on or after January 1, 2017.

Patient Name _____ Date of Birth_____

Patient Name _____ Date of Birth _____

Payment and/or Insurance information is due at the time of service.

(To ensure compliance of Federal Laws, Co-pays, Deductibles, and Co-insurance balances will be collected)

A. ***Medicare:*** We are participating providers of Medicare***.*** We will accept assignment on all Medicare claims. Patients are responsible for meeting and keeping track of their annual deductible and for paying the ***20%*** co-payment at the time of service unless you have a secondary/supplemental insurance plan which covers this. As a courtesy, we will file your secondary/supplemental insurance. However, in the event the secondary does not pay within 45 days, you will be responsible for payment.

B. ***Contracted, PPO:*** If we are contracted participating providers of your insurance carrier, we will file your claims. However, you are responsible for paying your annual ***deductible, co-pays and co-insurance***. You will be responsible for ***all non-covered services***. Payment on all services (based on your plan) is due at the time of service.

C. Commercial, Non-Contracted: If you are covered by any plan with which our physicians are not contracted participating providers, ***you will be responsible for payment at the time of service.***

D. ***No Show or late cancellations of appointments:*** Any patient that cancels less than 24 hours prior to their appointment or is a no show for their appointment may be charged a fee of $35.00

E. In the event it is necessary for Nodal Medical Center LLC. to retain the services of an attorney to collect any amounts due it from the Patient, the prevailing party shall be entitled to recover their reasonable costs, fees and expenses, including, but not limited to, attorney, paralegal and legal assistant fees, costs and expenses whether suit be brought or not, and whether in settlement, at trial or on appeal.

For payment of service rendered, we are always happy to accept cash. For your convenience, we also accept payment by Visa, MasterCard, Discover, American Express as well as personal checks.

Your Individual rights:

- Review or receive your medical information. You must make your request in writing. If you request copies of your records, there will be a charge of $1.00 per page and postage if records are mailed. After receipt of your notice, you will be informed of cost. Payment will need to be rendered prior to picking up or mailing records. Please allow 7 to 10 business days for processing request.
- There is no charge for documents that you have forwarded for continuation of Medical care to other providers that you designate in writing. These records may be mailed or faxed to the representative you have chosen.

You're Rights regarding release of information:

*You have the right to choose to whom we may release your health information with regards to your family members. Please indicate by checking below:

All Family member's ___ Spouse only ___ Nobody ____ Name of Spouse or Individual _____

"I authorize the release of medical information to my primary care or referring physician and to consultants as necessary to process insurance claims, insurance applications, and prescriptions as so noted on my patient registration form. I also authorize payment of medical payments to the physicians." If any of the information changes, I will notify the office of all changes in written notification.

Patient/Responsible party's Signature: X_____ Date _____

*I have received the Privacy Practices Acknowledgment and I have been provided an opportunity to review it.

Patient/Responsible party's Signature: X_____ Date _____

Health Information Form

Date: _____

Account Number: _____

Patient name: _____

Date of Birth: _____/_____/_____

Medications

Name of all medications you're currently taking(include over the counter and vitamins)	Dosis/Frequency	Name of all medications you're currently taking(include over the counter and vitamins)	Dosis/Frequency

Allergies

Please list any reactions you have had to medications in the past	What was the reaction?

Hospitalizaciones and surgieres

Hospitalizations and surgeries	Date	Name of the Doctor

Chronic Health Conditions:

Chronic Health Conditions	Date (year) Diagnosed:	Doctor you see/saw for this condition:

Current Physicians:
(Please list only physicians you have seen within the last 12 months and whose records would be helpful to you medical wellbeing.)

Name and Specialty	City and State where physician practices

Immunizations:

Flu shot	
Pneumonia shot	
Shingles vaccine (Zostavax)	
Gardasil	
Tetanus shot	

Social History:

Are you a seasonal resident? **Yes / No**	**If so, for what months are you here?**
Do you use tobacco? (This applies to ANY type of tobacco use at ANY time in your life) **Yes / No**	**If so, how much daily and for how long?**
Do you drink caffeinated beverages? **Yes / No**	**If so, how much daily, what type, and for how long?**
Do you drink alcoholic beverages? **Yes / No**	**If so, how much daily, what type, and for how long?**
Do you exercise? **Yes / No**	**If so, how often and what type?**
Recreational drug use? **Yes / No**	**If so, how often and what type?**

Family/Medical History:

Family member:	**Living?**	**Chronic illnesses or cause of death:**
Mother	Yes / No	
Father	Yes / No	
Brothers	Yes / No	
Sisters	Yes / No	
Grandparents	Yes / No	
Children (# of _____)	Yes / No	

Medical History:

Item/Procedure:	**Please list the date (even if it's just the year) you last had each of these:**
Yearly physical	
Fasting blood work	
Hepatitis screening	
Chest x-ray	
EKG	
Bone density test	
Stress test	
Colonoscopy	
Eye exam	
Hearing test	
Abdominal ultrasound	
Thyroid ultrasound	
Echocardiogram	
Carotid ultrasound	
Aortic ultrasound	
Women ONLY: Date of last menstrual cycle:	
Year of Menopause onset:	
# of Pregnancies	
# of live births:	
Last Mammogram:	
Last Pap:	

Neurology	Yes	No	Please describe or explain if “yes”.
Chronic headaches			
Seizures			
Stroke			
Blackouts			
Weakness of arms/legs			
Tingling/Numbness			
Eye/Ear/Nose/Throat			
Double vision			
Loss of vision in one eye			
Ringing in ears			
Ear pain(Right, Left, Both)			
Sinus problems			
Runny or bloody nose			
Pain on swallowing			
Difficulty swallowing			
Respiratory			
Persistent cough			
Shortness of breath			
Coughing blood			
Tuberculosis			
Asthma			
Cardiac			
Chest pain			
Palpitations			
Black outs			
Angina/Heart attack(s)			
Heart murmur			
Gastro-Intestinal			
Nausea/Vomiting			
Diarrhea			
Constipation			
Black or bloody stool			
Sigmoidoscopy/Colonoscopy			

Genito-Urinary			
Urinary tract infection			
Stones			
Prostate problems			
Bladder problems			
Kidney disorders			
Neuromuscular			
Arthritis			
Muscle pain/spasm			
Fracture of bones			
Back trouble			
Endocrine			
Diabetes			
Thyroid disorder			
Hematological			
Anemia			
Bleeding disorder			
Blood clot(s)			
Psychiatric			
Depression			
Anxiety			
Constitutional			
Fever/Chills			
Night sweats			
Weight loss/ gain			
Others			

Name: _____ Date of Birth: _ _____/_____/_____

MEDICAL RECORD RELEASE AUTHORIZATION

Date:

Patient Name: _____ Middle Name: _____ last name: _____
SS#:_____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____Home Phone: _____Cell/Work: _____

A) I hereby authorize records FROM:
Name; _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

B) To be released TO:
Name; _Dr. O. Nodal_
Address: _2123 W MLK Jr Blvd ste 101_
City/State/Zip: Tampa, Florida 33607
Phone: 813-488-4801___
Fax: _813-405-4506

For the purpose of:
- ___ Litigation
- ___ Disability
- ___ Insurance
- ___ Self/Personal Copy
- ___ Transfer or Continuity of Care
- ___ Work Comp
- ___ Other

Date Range _____to _____
- ___ Physician Office Notes
- ___ Digital Images/X-Rays
- ___ Operative/Procedure reports
- ___ Cardiology/EKG Report
- ___ Lab/Path Reports
- ___ Radiology/X-Ray/MRI Reports
- ___ Minimum Necessary
- ___ Other

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

This authorization will expire one year from the above date unless I specify an expiration date: _____
Expiration date of authorization

_____ _____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

Credit/Debit card Consent Form

Please read in entirety

Account number: _____

Patient Name: _____

Nodal Medical Center LLC, in an attempt to better serve you and reduce costs that could be passed on to you, has implemented a new policy. This new policy has gone into effect for the entire practice and your participation is required. Patients who refuse to comply with this policy will be asked to leave the practice. Under our new policy, we will keep credit or debit card information on file for all patients. It will be used to cover any charges not paid by insurance. Patients will still be expected to pay known co-pays, co-insurance, and applicable deductibles at the time of service. If a balance remains after insurance has paid, you will receive one statement for the services and after 30 days, any amount left on your account after insurance has been processed will be placed on your credit/debit card. (It will be the responsibility of the patient to contact our office if there is any question regarding the claim or amount due). All of our employees are bonded and as added security, your information is kept separate from our computer system and under lock and key. We ask that you complete the form below that will give all the necessary information. The information we acquire will be kept securely and will only be used for your medical expenses.

Your understanding and patience with this new policy is important. We are confident that once you begin working with this policy, you will find it is much easier to keep track of your medical expenses and gives you an opportunity to get proof of your coverage from your insurance company (by way of an explanation of benefits) before you are charged. No charges will be placed on your card until after we hear from your insurance carrier.

In addition, feel free to ask any questions of our staff

Please circle card type: Visa / MC / AMEX / DISC *Expiration date:* _____/_____

Card Number _____-_____-_____-_____ *Security code:* _____

Credit card holder name: _____

Patient's name (If different from above) _____

Address to which credit card is billed: _____

City: _____ State: _____ Zip code: _____

Cardholder signature: _____

******Primary Care will not call any patient prior to applying charges to a credit card AFTER a statement has been sent and 30 days have passed. Any contact regarding charges or disputes will be the responsibility of the patient. ******

-I authorize Nodal Medical Center LLC.to maintain my credit/debit card information for payment if any balance not paid by my insurance as agreed below.
-I assign my insurance benefits to the provider listed above authorizing payment by my insurance company to Nodal Medical, Center LLC.
-I authorize Nodal Medical Center LLC to apply the balance of my account to the credit/debit card listed below to include co-pays, deductibles, and any balance that might remain after my insurance has been processed.
- I understand that this form is valid until I provide written notice that it is revoked (after all balances are paid in full.) I also understand that if I change charge cards, I will supply Nodal Medical Center LLC the new credit/debit card information.

Patient's Signature: _____ *Date:* _____/_____/_____

Medicare patients only:

Notice: We are participating providers of traditional and HMO Medicare***.*** We will accept assignment on all Medicare claims. Patients are responsible for meeting and keeping track of their annual deductible and for paying the ***20%*** co-payment at the time of service unless you have a secondary/supplemental insurance plan which covers this. As a courtesy, we will file your secondary/supplemental insurance. However, in the event the secondary does not pay within 45 days, you will be responsible for payment. This office is required to keep your signature on file authorizing us to file claims to ***Medicare*** for you and to release information to the payer if they require it for proper consideration of a claim. Please read and sign the statement:

"I authorize any holder of medical or other information about me to be released to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or related Medicare claim. I permit copy of this authorization be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply."

Signature as it appears on your Medicare card: X_____ Date _____

Medicare replacement policies (such as Medicare Advantage Plans):

Insurance plans that work as replacements for Medicare (Advantage plans) have co-pays, deductibles, and co-insurances that may differ from Traditional Medicare. We are not contracted with most advantage plans. This means that we are considered out-of-network and therefore you may be responsible for a higher deductible, co-insurance or visit co-pay as applied by your insurance carrier. By signing this document, you acknowledge that you are aware of these differences and are in agreement to adhere to the terms of your insurance carrier. Regardless of the contract status, we will still see you as a patient and file your insurance as a courtesy.

Signature as it appears on your insurance card: *X*_____ *Date:* _____

PLEASE PROVIDE ALL OF YOUR CURRENT INSURANCE CARDS AND YOUR DRIVERS LICENSE TO BE SCANNED FOR OUR RECORDS.