MIAMI 9 to 5 FAMILY MEDICINE

# Office Policies

**Ten Minutes Late Policy**

- All late appointments are cancelled and considered a No-Show after 10 minutes
- This is our most strict policy and since 2012 we have never made an exception

**New Patients: Two Days Cancellation and Reschedule Policy**

- Minimum two days notice is required to cancel or reschedule your initial appointment
- Cancelling or rescheduling one day before will preclude you from becoming our patient

**Existing Patients: Termination from Practice**

- Three Cancellations/Reschedules - Same day or one day before your visit. No Exceptions
- Full or disconnected voicemail - After three attempts
- Non-Compliance to follow-up care due to abnormal test results - After 30 days
- Being confrontational and/or hanging up the phone

**Yearly Physicals and a Consultations Cannot Be Done The Same Day**

- Yearly physicals are covered by your insurance and are free of charge
- Consultations are not free of charge - Co-Payments and deductibles do apply
- Yearly physicals can only be performed when a patient is healthy
- Consultations include: Follow up care, blood work, going over results & addressing an illness or injury
- If in the middle of a physical you begin to discuss any symptoms the visit becomes a consultation

**We DO NOT prescribe "Controlled Substances" as defined by the Federal Controlled Substance Act of 1970**

- We DO NOT prescribe or refill medication for ADD or ADHD. We are not a Psychiatric practice
- We DO NOT prescribe narcotics of any kind. We are not a registered Pain Management Clinic

**We are a Primary Care Practice not an Urgent Care Center, as such we are exempt from the federal law known as EMTALA, and thus we reserve the right to refuse any patient for any reason.**

*I have read and understand the above policies, and agree to all provisions outlined herein.*

_____

Signature Date

_____

Print Name

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# Lab Results

**1. How do I get my lab results?**

A. Please follow these steps:

• Download the "MyQuest for Patients" or the "LabCorp | Patient" app on your phone

• The lab will post your results as soon as they become available

• If your results appear in any color other than red they are within normal limits

• If they are in **RED** call 305-392-0449 to schedule a follow up visit

• Your co-payment and deductible apply to all follow up visits

• Abnormal test results cannot be discussed over the phone, even if you are traveling

**2. Can I refuse a follow up appointment to discuss abnormal test results?**

A. Follow-up appointments due to abnormal test results are made for the following reasons:

• Perform additional testing and/or extensive counseling

• Prescribe or update medication(s)

• Refer you to a specialist

If you refuse follow-up care or if we do not hear back from you for 30 days after contacting you, you will receive a certified letter terminating the Doctor/Patient relationship.

_____

Signature Date

_____

Print Name

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# Financial Policy

**Authorization to Pay Benefits to Physician:**

By signing this form, you authorize and agree to assign payment from your insurance provider directly to Brickell Family Medicine, LLC for all medical services provided.

Please be aware that if you have a yearly deductible on your plan, you are responsible for all fees until your deductible amount has been met.

**Responsibility For Payment**

If your insurance is cancelled, we will attempt to get compensation from them by using your personal information. If that fails, you will receive a final notice explaining your responsibility for full payment for all services provided. If payment is not received, you will be sent to a collections agency after 60 days and terminated from our practice.

**Three reasons why we need your complete Social Security number when you have health insurance**
**Please note: Your S.S. number will be encrypted and will not be shared with anyone**

1. It is a secondary way to find your information when dealing with insurance companies.
2. Lab tests are identified by your social security number, not by your card ID number
3. If your insurance is cancelled it is our only way to seek compensation.

**If you are unable or unwilling to provide your full Social Security number**
We will be glad to see you as a Self-Pay patient. Once your insurance has made a full payment on your behalf, we will reimburse these funds back to you.

*I have read and understand the above benefits and policies, and agree to all provisions outlined herein.*

_____

Signature Date

_____

Print Name Social Security Number

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# HIPAA Consent

By signing this form, you voluntarily give permission to **Brickell Family Medicine, LLC** to provide you with medical care, as well as authorize treatment for as long as you seek care or until you withdraw your consent in writing.

## Legal Notice of Privacy Practices – HIPAA Acknowledgment Form

HIPAA - Health Insurance Portability and Accountability Act of 1996

The HIPAA Privacy regulations require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of (PHI) Personal Health Information, including paper, oral, and electronic, etc. Furthermore, only the minimum health information necessary to conduct business is to be used or shared. Upon signing you are authorizing **Brickell Family Medicine, LLC** to release any information acquired in your examination or treatment to your referring physician and/or your insurance.

**In layman terms:**

1. **We will not share your information with anyone unless you give us permission to do so**
2. **We will use the least amount of information required to get compensated by your insurance**
3. **If needed, we will send your medical information to your referring doctor and/or insurance.**

For a detailed explanation of this law, a copy of the ***Brickell Family Medicine, LLC Notice and Privacy Practices*** is available at the front desk.

*I have read and understand the above benefits and policies, and agree to all provisions outlined herein.*

_____

Signature Date

_____

Print Name

Name _____ Gender _____ Age _____

Date of Appointment: _____

## Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

## Current Medications

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

## Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

## Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

## Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

## Women Only:

# of Pregnancies _____ # of Miscarraiges _____ # of Abortions _____ # of Living _____

Last Pap Smear _____ Last Mammogram _____ Birth Control Method _____

## Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

## Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

# drinks/week _____

How much caffeine do you drink per day?

# drinks/day _____

How often do you exercise?

# times/week _____

Name _____ Gender _____ Age _____

Date of Appointment: _____

## Review of Systems

### General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

### Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide–Thoughts/Attempts

### Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

### Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

### Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

### Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

### ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

### Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

### Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

### Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

### Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

### Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

### Other Symptoms

_____

_____

_____

## Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

| | Month & Year | | Month & Year |
|---|---|---|---|
| ☐ Cholesterol Test | _____ | ☐ MRI | _____ |
| ☐ Colonoscopy | _____ | ☐ Physical Exam | _____ |
| ☐ CT/CAT Scan | _____ | ☐ Cardiac Stress Test | _____ |
| ☐ EKG | _____ | ☐ Ultra Sound | _____ |
| ☐ Echocardiogram | _____ | | |

## Immunizations

Please check and date all immunizations you have had.

| | Month & Year | | Month & Year |
|---|---|---|---|
| ☐ Hepatitis A | _____ | ☐ MMR (Measles, Mumps, Rubella) | _____ |
| ☐ Hepatitis B (Series of 3) | _____ | ☐ Pneumonia | _____ |
| ☐ HPV Vaccine | _____ | ☐ Polio | _____ |
| ☐ Influenza (Flu Shot) | _____ | ☐ Tetanus | _____ |
| ☐ Meningitis | _____ | | |