☐16470 ☐1745 ☐2209

Welcome to Practical Management, Inc
Scott R. English MD., PA.
PATIENT INTAKE FORM

Name/Nombre: _____ SS#:_____
LAST/APELLIDO FIRST/NOMBRE

Address/Direccion:_____

Email:_____ Age:_____ ☐ Male ☐ Female

Home Phone/Telefono:_____ Cell Phone/Telefono Celular:_____

Date of Birth/Fecha de Nacimiento:_____ Marital Status:_____

Ethnicity:_____ Race:_____

Current Work Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐Disabled ☐Homemaker ☐Do not Work

Employer/Empleador:_____Occupation/Ocupacion:_____

Emergency Contact/Contacto Emergencia:_____Phone/Telefono:_____

Preferred Pharmacy/Farmacia:_____Phone/Telefono:_____

INSURANCE TYPE:

Is your visit related to an accident?_____ If yes, circle type AUTO/WORK/SLIP&FALL/OTHER

Date of Injury/Accident:_____ Claim #:_____

Case Manager (if applicable)_____Phone_____

Attorneys Name (if applicable)_____Phone_____

Primary Insurance /Seguro Primario:_____ Policy #/Poliza #:_____

Guarantor/Garante:_____

Guarantor Date of Birth/ Garante fecha de nacimento:_____ Relationship/Relacion:_____

Secondary Insurance/Seguro Secundario:_____ Policy #/Poliza #:_____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service. **I understand that there will be a $25.00 charge that may be made for missed/no show appointments unless 24 hours notice is given.**

I authorize this office to apply benefits on behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

Patient signature/Firma:_____ Date/Fecha:_____

How did you hear about us?_____

MEDICAL HISTORY

Name_____ **Date of Birth**_____

Date of Last Physical Exam_____ **Today's Date**_____

Chief Complaint_____

DRUG ALLERGIES

_____

_____

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

❑ Headache _____ ❑ Lactose intolerance _____ ❑ Depression _____
❑ Shortness of breath _____ ❑ Gallbladder disease _____ ❑ Gout _____
❑ Heart palpitations _____ ❑ Prostate disease _____ ❑ Scarlet fever _____
❑ Heart murmur _____ ❑ Bowel irregularity _____ ❑ Chronic rashes _____
❑ Chest pain _____ ❑ Incontinence _____ ❑ Rheumatic fever _____
❑ Dizziness/Fainting _____ ❑ Sexual/menstrual dysfunction _____ ❑ Mumps _____
❑ Peripheral vascular disease _____ ❑ Venereal disease _____ ❑ Measles _____
❑ Allergies/Hay fever _____ ❑ Frequent infections _____ ❑ Rubella _____
❑ Asthma _____ ❑ Hepatitis _____ ❑ Polio _____
❑ Bronchitis _____ ❑ Anemia _____ ❑ Diphtheria _____
❑ Pneumonia _____ ❑ Arthritis _____ ❑ Tetanus _____
❑ Ulcer _____ ❑ Osteoporosis _____ ❑ Other _____
❑ GI disorder _____ ❑ Nervousness _____ ❑ Other _____

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

MEN ONLY: *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* ❑ *Yes* ❑ *No*
How often does this occur? ❑ *Frequently* ❑ *Sometimes* ❑ *Rarely*

HABITS

❑ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____

❑ Exercise routine: _____
_____
_____

❑ Coffee: Cups daily _____
Other caffeine _____

❑ Alcohol: Type _____
Amount _____

❑ Diet: Salt intake _____
Fat intake _____

❑ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____

OTHER HEALTH CARE PROVIDERS

Primary Care Provider _____

OB/GYN _____

Other _____

_____
Preferred Pharmacy

_____
Pharmacy Address/ Phone Number

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES? ❑ YES ❑ NO MAY WE HAVE A COPY FOR YOUR RECORDS? ❑ YES ❑ NO

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

Practical Management, Inc
Scott R. English MD, PA

RULES OF THE OFFICE: NO EXCEPTIONS

1. WE GO BY APPOINTMENT TIME, NOT THE TIME OF ARRIVAL, ALTHOUGH YOU MIGHT HAVE COME EARLY, THE PATIENT THAT IS HERE AT THEIR TIME WILL BE SEEN FIRST.
2. IF YOU DO NOT HAVE YOUR COPAY AT THE WINDOW, YOU WILL NOT BE SEEN.
3. EXCEPT FOR MEDICARE PATIENTS, ALL PATIENTS THAT CHOOSE TO HAVE THEIR BLOOD DRAWN HERE AT THE OFFICE, THERE WILL BE A $20.00 FEE.
4. IF YOU REQUIRE A PHYSICAL FORM, FMLA OR JURY DUTY EXCUSE FORM FILLED OUT, THERE IS A FEE ATTACHED. IF IT IS 1 PAGE, FEE IS $50 COPAY. IF MORE THAN ONE PAGE, EACH ADDITIONAL PAGE IS $25. FMLA IS A FLAT FEE OF $100.
5. PLEASE HAVE YOUR CELLPHONE OFF OR ON VIBRATE WHILE IN THE WAITING ROOM OR FRONT OFFICE, ESPECIALLY WHEN IN THE ROOM WITH THE PROVIDER.
6. NO TEST RESULTS GIVEN BY PHONE UNLESS EXPRESSED BY PROVIDER.
7. PRESCRIPTION REFILLS ARE DONE AT THE END OF THE DAY. ALLOW THE NURSES TIME TO CALL/SEND THEM IN.
8. PLEASE ALLOW 7-10 DAYS MINIMUM FOR NON-URGENT REFERRALS/ AUTHORIZATIONS.

IF YOU HAVE ANY QUESTIONS OF CONCERNS PLEASE ADDRESS THEM TO ONE OF THE FRONT DESK EMPLOYEES OR YOUR PROVIDER DIRECTLY.

DATE: _____

PATIENT SIGNATURE: _____

STAFF INITIAL: _____

Practical Management, Inc
Scott R. English MD, PA

16470 NE 10th Ave	1745 NE 124th Street	2209 North University Drive
North Miami Beach, FL 33162	North Miami, FL 33181	Pembroke Pines FL, 33024
PH: (305) 651-9988	PH: (305) 893-5725	PH: (954)674-2455
FX: (305) 651-7875	FX: (305) 893-0002	FX: (954)674-2459
Jessyca_english@yahoo.com	Practicalmanage1745@gmail.com	info@sremd.com

Patient Name:_____

Account Number:_____

Date of Birth:_____

TELEMEDICINE AGREEMENT: You agree that by signing below you consent and request that Practical Management, Inc its affiliates, and those acting on its/their behalf, may call or text you regarding your care. The types of calls or texts you may receive include those concerning patient care, scheduling, reminders, prescriptions, lab and diagnostic results and recommendations. **Depending on your insurance, there may be a copay to be collected before speaking to the provider.**

I have read and understood the above.

Patients name printed:_____

Guarantor/Patient Signature:_____

Date:_____

PLEASE RELEASE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT.

MEDICAL RECORDS RELEASE TO:

Practical Management, Inc

Scott R. English MD, PA

16470 NE 10th Ave North Miami Beach, FL 33162 PH: (305) 651-9988 FX: (305) 651-7875 Jessyca_english@yahoo.com	1745 NE 124th Street North Miami, FL 33181 PH: (305) 893-5725 FX: (305) 893-0002 Practicalmanage1745@gmail.com	2209 North University Drive Pembroke Pines FL, 33024 PH: (954)674-2455 FX: (954)674-2459 info@sremd.com

PATIENTS NAME _____ DATE OF BIRTH _____ LAST 4 SOCIAL SECURITY _____

ADDRESS, CITY, STATE, ZIP CODE _____

SIGNATURE _____ DATE SIGNED _____

I understand that this authorization will allow this provider and its affiliates to use or disclose my protected health information. I **understand that my medical record may contain sensitive information such as mental health treatment, HIV/AIDS, substance abuse disorder, sexual abuse and/or other related conditions.** I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without and expressed/written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative as provided by state or federal law.

IMPORTANT: This facsimile transmission contains confidential information, some or all which may be protected information as defined by federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to which it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return of destruction of the information and all copies.

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HIPPA Acknowledgment and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practice. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practice.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organizations not required to agree to my requested restrictions, but if the organization does agree, then it is abounded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patients Name DOB

_____ _____

Signed (Patient or Legal Representative for patient) Date

_____

Legal Representative's Relationship to Patient

Practical Management, Inc

Scott R. English MD, PA

PATIENT HIPPA ACKOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's Notice of Privacy Practice:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I chose) and understand that Notice of Privacy Practice (NPP) and I agree to the terms.

Name of Patient _____ **DOB** _____ **Signature Patient/Guardian** _____ **Date** _____

II. **Designation of Certain Relatives, Close Friends, and other Caregivers as my Personal Representative:**
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare payment relating to my health care.

Print Name:_____ **DOB:**_____
Print Name:_____ **DOB:**_____
Print Name:_____ **DOB:**_____

III. **Request to Receive Confidential Communications by Alternative Means:**
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by alternative means that I have listed below.

Home Telephone Number:

_____
____OK to leave message with detailed information
____Leave message with call back number ONLY

Written Communication Address:

_____
___OK to mail to address listed above
___Email me

Work Telephone Number:

_____
___OK to leave message with detailed information
___Leave message with call back numbers only

Email/Fax Communication:

_____
___OK to Email/Fax

Other:_____

IV. **The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):**

Print Name:_____ **Print Name:**_____
Print Name:_____ **Print Name:**_____

V. **The HIPAA Privacy rule requires health care providers to take reasonable steps to limit the use or** disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Services of disclosure	Person completing request	Date complete d