



Primary Care of the Treasure Coast, Inc.

801 Wellness Way

Suite 204

Sebastian, FL 32958

Phone (772) 567-6340 Fax (772) 567-3564

www.primarydocs.net

Enclosed you will find the new patient paperwork for your upcoming appointment at Primary Care. We request that if at all possible you return this packet **2-3 days prior** to your appointment including copies of your insurance cards. You may also go to our portal link at the bottom of our patient resources page to access our portal and complete your new patient paperwork.

Your new patient packet includes the following:

- **Our practice brochure (keep for your records)**
- **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)**
- **Our credit card policy (required)**
- **New patient questionnaire**
- **Medical Record Release (if there are any physicians from whom we should get records for you.)**
- **Communication form**

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.

While we accept these plans, we are not contracted and are considered out-of network.

*****Your deductible, co-pay or co-insurance may be higher because of this.*****

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 (772) 567-6340.



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Primary Care of the Treasure Coast is the premier primary care practice in Vero Beach, Florida. Our physicians, Board Certified in Family Practice, Geriatrics, and Internal Medicine, take care of patients of all ages and have appointments available upon request. Our facility offers on-site diagnostic services including a full Laboratory, X-Ray, EKG, Nerve Conduction Studies, Diagnostic Ultrasound, Bone Density Measurement Capabilities, and Audiology Center.

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 Primary Care of the Treasure Coast 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.

Primary Care of the Treasure Coast 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 Primary Care of the Treasure Coast directly or through a contractor or other entity with which Primary Care of the Treasure Coast 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 (772) 567-6340.

Get to know us:

Our website, www.primarydocs.net provides information on each of our physicians including pictures and a brief biography on each doctor as well as practice updates.

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.

For more information, please call our office or visit: <https://mycw3.eclinicalweb.com/sure/jsp/100mp/login.jsp> .

Contracted Insurances:

Primary Care participates with Medicare, Blue Cross/Blue Shield of Florida, Health First, United Healthcare, AVMED. 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 8:00am-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).

«NextAppt»

PRIMARY CARE OF THE TREASURE COAST, INC.
Patient Information Form
Please read and complete entire form. Please print.

«PatientAccountNumber»

«ProviderName»

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

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

If patient is a child, please list **Parent(s) / Guardian(s)** name(s) and date(s) of birth:

Sex: Male _____ Female _____

At what address do you get your mail?

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: _____

If you would like to use our patient portal, please provide your **email. If not leave blank:** _____

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: _____

Marital Status: (circle one) Married Single Divorced Widow(er)

Spouse or S/O: _____ Phone: _____ Date of Birth: _____

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.)

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: _____ Location: _____

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

Primary Care of the Treasure Coast 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: Primary Care of the Treasure Coast, 1265 36th Street, Vero Beach, Florida 32962, or fax 567-3564.

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 (772) 567-6340.

Effective Date: This Notice is effective on or after January 1, 2010.

Patient Name _____ «PatientAccountNumer» 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 traditional Medicare but not most Medicare *HMO plans*. We will accept assignment on all Medicare claims except Medicare *HMO*. 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.
- A. **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.
- B. **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.**
- C. **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
- D. In the event it is necessary for Primary Care of the Treasure Coast, Inc. 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.

Your 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 members ___ Spouse Only ___ Other ___ Name of Spouse or Individual _____

Release of Information

"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 _____

I give Primary Care permission to check my prescription history for verification of my medications.

Patient/Responsible party's Signature: X _____ Date _____

Medicare patients only:

Notice: We are participating providers of traditional Medicare only. We will accept assignment on all Medicare claims except Medicare *HMO*. Patients are responsible for meeting and keeping track of their annual deductible (\$183.00) 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

Name:	Date of Birth:	Account #:
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801 Wellness Way, Sebastian, FL 32958
 Phone (772) 567-6340 Fax (772) 567-3564

Please read in entirety
in addition, feel free to ask any questions of our staff

Primary Care of the Treasure Coast, 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 your medical chart. 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.

Today's Date: _____
Please circle card type: *Visa / MC / AMEX / DISC* **Expiration date** _____

Card Number _____ - _____ - _____

Patient(s) name(s): «FirstName» «MiddleInitial» «LastName»

(Additional patients to add to this card: _____)

Address to which credit card is billed:

Name of card holder if not patient and relation to patient:

X

Signature of Cardholder as it appears on card

Account Number: «PatientAccountNumer» **Physician:** «encDocName»

*****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.*****

Credit/Debit card Consent Form

I authorize Primary Care of the Treasure Coast, Inc. 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 Primary Care of the Treasure Coast. I authorize Primary Care of the Treasure Coast, Inc. 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 Primary Care of the Treasure Coast, Inc the new credit/debit card information.

Local pharmacy (name and general location): (This will be used for any medications that need to be started immediately)
Mail away pharmacy you use:
Do you have any limitations/disabilities of which we should be aware or that require special accommodations? If so, please describe.
If you are hearing impaired and need a translator, please contact our office prior to your appointment so that appropriate arrangements can be made.

Medications: Verified at appointment with no changes: Verified with changes:

<u>Name of Medications you are currently taking:</u> Please include-prescriptions, over-the-counter AND any vitamins	<u>Dosage:</u> 1. What is the strength of your medication? 2. How much do you take at one time? 3. How much do you take each day?

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

Medical History:

<u>Item/Procedure:</u>	<u>Please list the date (even if it's just the year) you last had each of these:</u>
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:	

Immunizations:

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

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

Past surgeries /Hospitalizations	Date of Surgery/Hospitalization	Physician

Family/Medical History:

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

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) If so, how much daily and for how long?	Yes / No
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?

<u>Please list any reactions or problems you have had to medications</u>	<u>Please tell us what the reaction was?</u>
Medication name:	

Name: _____ **Date of Birth:** _____

Description	Yes	No	Please describe or explain if "yes".
Neurology			
Chronic headaches			
Seizures			
Stroke			
Blackouts			
Weakness of arms/legs			
Tingling/Numbness			
Ear/Nose/Throat			
Double vision			
Loss of vision in one eye			
Ringing in ears			
Room spinning			
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			
Sigmoidscopy			
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			



Medical Record Release Authorization Fax Completed Form to 772-567-3564

1265 36th Street Vero Beach, Florida 32960 Telephone: (772) 567-6340 Medical Records Fax: (772) 567-3564

Patient Name: Maiden Name: SS#: Date of Birth: Home Phone: Cell/Work: Address: City/State/Zip:

Paper records only no CD's

A) I hereby authorize records FROM:

B) To be released TO:

Name: Address: City/State/Zip: Phone#: Fax#:

Name: Address: City/State/Zip: Phone#: FAX#:

C) For the purpose of:

- Litigation Insurance Self/Personal Copy Transfer or Continuity of Care Disability Work Comp Other

Date Range: Physician Office Notes Digital Images/Xrays Operative/Procedure Reports Other Cardiology/EKG Reports Lab/Path Reports Radiology/XRay/MRI Reports Minimum Necessary

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.

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) **Subject to Fees

*PLEASE READ

Fee Information: Primary Care of the Treasure Coast contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy. DataFile Technologies: 816-437-9134 www.datafiletechnologies.com

Acct # «PatientAccountNumber»

«FirstName» «MiddleInitial» «LastName»

DOB «DOB»

PREFERRED METHOD OF COMMUNICATION:

- Email Email Address: _____
- Voicemail
- Text Phone #: _____

PREFERRED LANGUAGE:

- English
- Spanish

PREFERRED TIME TO CALL:

- Morning
- Afternoon
- Evening

TYPE OF REMINDERS:

- Select All
- Appointments
- Health Maintenance
- Rx Confirmation
- General Notification