INTERNAL MEDICINE AND WOUND CARE SPECIALIST, LLC

1726 MEDICAL BLVD SUITE 201, NAPLES, FL 34110 PHONE (239)596-8804 / 8806 Fax: (239)849-8793

For office use/ MR#:________________

Patient Information

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

Home Phone:_________________________________ Cell Phone:_______________________________
Sex: ○Male ○ Female
Address:____
City, State **Zip Code**

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

Social Security:____________________________

Race_____________Religion:____________________

Patient's Occupation: ______________________________Employers:___________________________

Current Employer's Address:____Phone:_____________________

Spouse or Parent:____ Phone:_____________________

Emergency Contact:
Name___________________________________ Relation:____________ Phone:__________________

E-mail__________ _________________________ Appointment Reminder: ○ Email ○ Call ○ Text

How did you hear about us?

○ Friend / Relative ○ Patient ○Internet ○ Newspaper ○ Physician ________________________________

○ Other____

Insurance Information:

Primary Insurance		
Insurance Name	Effective Date	End Date
Principal Subscriber Name	Policy Number:	Group #
Subscriber Date of Birth	Relation to Patient	Employer

Secondary Insurance (If applicable)		
Insurance Name	Effective Date	End Date
Principal Subscriber Name	Policy Number:	Group #
Subscriber Date of Birth	Relation to Patient	Employer

PLEASE GIVE INSURANCE CARD(S) TO FRONT DESK FOR COPYING- THANK YOU

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
Other:____________________________________

Initials of employee:____________

INTERNAL MEDICINE AND WOUND CARE SPECIALIST, LLC

NEW PATIENT QUESTIONAIRE

Patient's Name:____________________________ Height:_________ Weight:________ ○Female ○Male

Age today:_______	3. Last Primary Doctor _______________________________
1. Describe the primary reason of your visit:	
2. Do you use alcoholic beverages? Yes, Type________________ Amount:_____________ No	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:____ **Zip Code:**________________

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	______________	Other	______________
Heart Disease	______________		______________
Diabetes	______________		______________

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. ______________

MEDICATION INFORMATION

(Please circle the medications you are taking.)

High Blood Pressure:
- Accupril (Quinapril)
- Atenolol
- Capoten (Captopril)
- Cardizem (Diltiazem)
- Cardura (Doxazosin)
- Cozaar (Losartan)
- Diovan (Valsartan)
- Vasotec (Enalapril)
- Zestril (Lisinopril)
- Lopressor/Toprol (Metoprolol)
- Lotensin (Benazepril)
- Norvasc (Amlodipine)
- Procardia (Nifedipine)

Heart Medication:
- Lanoxin (Digoxin)
- Nitroglycerin

Cholesterol Lowering Drugs:
- Lipitor (Atrovastatin)
- Pravachol (Pravastatin)
- Zocor (Simvastatin)

Diuretics (Water Pills):
- Dyazide (HCTZ + Trimterrene)
- Lasix (Furosemide)
- Hydrochlorothiazide (HCTZ)

Diabetes:
- Glucophage (Metformin)
- Glucotrol (Glipizide)
- Insulin (Humulin)

Gastrointestinal (Stomach):
- Nexium (Esomeprazole)
- Prevacid (Lansoprazole)
- Prilosec (Omeprazole)
- Zantac (Ranitidine)

Rheumatology:
- Methotrexate
- Plaquenil

NSAIDs:
- Advil/Motrin (Ibuprofen)
- Aleve (Naproxen or Naprosyn)
- Bextra
- Celebrex
- Mobic

Pain:
- Davocet (Acetaminophen +Propoxyphene)
- Dilaudid
- Duragesic Patch (Fentanyl Patch)
- Endocet/Percocet/Tylox (Oxycodone) Acetaminophen)
- Lortab/Vicodin(Hydorcodone + Acetaminophen)
- MS Contin
- Neurontin
- Neurontin
- Oxycodone/Oxycontin
- Tylenol #3(Acetaminophen + Codeine)
- Ultram (Tramadol)

Blood Thinners: Aspirin Coumadin (Warfarin) Plavix	Prednisone	

OTHER MEDICATION(S):

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

GENERAL	RESPIRATORY	MUSULOSKELETAL
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	Shortness of breath Chronic cough Wheezing	Fractures/sprains Osteoporosis Joint swelling
SKIN Rashes Psoriasis Bruise easily Abnormal Lumps Painful breast	CARDIOVASCULAR Chest pain Palpitations Irregular heartbeat Heart murmur	NEUROLOGICAL Dizziness Headaches/ migraine Convulsions /seizures Loss of consciousness
HEENT Blurry vision Sinusitis Fainting	GASTROINTESTINAL Anorexia Constipation Diarrhea Nausea/vomiting Loss of bowel control Blood in stool	PSYCHIATRIC Anxiety Change in sleep pattern Depression
NECK Difficulty swallowing	GENITOURINARY Blood in Urine Painful urination Loss of bladder control Increased frequency of Urination Kidney Stones	ENDOCRINE Thyroid Problems Appetite changes Diabetes HEMATOLOGY Enlarged lymph nodes Prolonged bleeding Spontaneous bleeding

OB/GYN (females only)
PREGNANCIES ________________ Surgeries:____
Abortions____________________

All Other Systems Negative
Others:____

Other problems (please describe):

Internal Medicine Partners
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
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.