Jupiter Internal Medicine Associates, P.A.

CONCIERGE Internal Medicine

House Call Specialists

NEW PATIENT INFORMATION

Date: _____ Contact Preference: ☐ Home ☐ Mobile ☐ Text ☐ Email

Mr. Mrs. Miss Dr. Other _____

Patient's Name:_____

SS#_____

Sex at Birth:_____ Preferred Pronouns:_____ Race:_____

Age:_____ Date Of Birth:_____

Marital Status:

☐ Single ☐ Married ☐ Windowed ☐ Divorced

Home Telephone Number:_____ Mobile Number:_____

Local Address:_____

_____

E-Mail Address: _____

**(by giving us your email address, you are signing up for our patient portal, a website used to view lab results, request appointments and prescription refills, and communicate with the doctor.)

Out of State Address:_____

Patient's Employer:_____

Pharmacy:_____

Are you a Seasonal Resident? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person:_____

Telephone:_____ Relationship:_____

Is this person Power of Attorney or Health Care Surrogate? ☐ Yes ☐ No

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MEDICAL HISTORY:

Patient's Full Name:_____

Known Allergies (including reactions):_____

PAST MEDICAL ILLNESSES:

- ☐ HYPERTENSION
- ☐ HEART DISEASE
- ☐ RESPIRATORY DISEASE
- ☐ THYROID DISEASE
- ☐ STROKE
- ☐ ANXIETY
- ☐ KIDNEY DISEASE
- ☐ PHLEBITIS
- ☐ HIV/AIDS
- ☐ DIABETES MELLITUS
- ☐ HEPATITIS
- ☐ ATRIAL FIBRILLATION
- ☐ EMPHYSEMA (COPD)
- ☐ PEPTIC ULCER DISEASE
- ☐ TUBERCULOSIS
- ☐ LIVER DISEASE
- ☐ HEART MURMUR
- ☐ CANCER: TYPE AND WHEN DIAGNOSED

_____

OTHER; PLEASE SPECIFY _____

MEDICATIONS ANO MILLIGRAMS: _____

_____

SURGICAL HISTORY: _____

_____

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Patient's Name:_____

SOCIAL HISTORY:

Do you have regular exercise habits? ☐ Yes ☐ No

Do you sleep regularly? ☐ Yes ☐ No

Do you eat well-balanced meals? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much_____How Long_____

Have you ever smoked? ☐ Yes ☐ No When did you quit?_____

Do you drink? ☐ Yes ☐ No How much per week?_____

FAMILY HISTORY:

Mother living? ☐ Yes ☐ No Age at Death_____ Cause:_____

Father living? ☐ Yes ☐ No Age at Death_____ Cause:_____

Brothers living? ☐ Yes ☐ No Age at Death_____ Cause:_____

Sister living? ☐ Yes ☐ No Age at Death_____ Cause:_____

Does anyone in your immediate family have heart disease, diabetes, cancer, or any other chronic illness?

_____

_____

HEALTH MAINTENANCE:

Do you take aspirin? ☐ Yes ☐ No

Have you had a colonoscopy? ☐ Yes ☐ No When? _____

Have you had a pneumonia vaccine? ☐ Yes ☐ No When? _____

Have you had a mammogram? ☐ Yes ☐ No When? _____

Have you had a breast exam? ☐ Yes ☐ No When? _____

Date of last gynecological exam?_____

Date of last digital rectal exam? _____

Have you had a PSA (if male)? ☐ Yes ☐ No When? _____

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Patient's Name:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ Phone: _____

ID#: _____ Group#: _____

SECONDARY INSURANCE: _____

ID#: _____ Group#: _____

AUTHORIZATION TO SHARE MEDICAL INFORMATION:

I authorize the medical practice to use and disclose a copy of health and medical information to the following:

Name of Person Authorized to Receive Information:_____

Phone: _____ Additional Phone: _____

{ } No Expiration Date

{ } Expiration Date

{ } I authorize the medical practice to leave messages on my voicemail/answering machine, such as test results and messages that may contain personal information.

AUTHORIZATION TO Bill AND RELEASE MEDICAL INFORMATION:

I authorize the submission of claims(s) for payment to Medicare, Medicaid, or any other payor for any services provided to me by medical practice. I authorize the release of any information acquired during my treatment to my insurance company. I understand that I am financially responsible for the services and supplies provided to me by medical practice regardless of my insurance coverage, and, in some cases, I may be responsible for an amount in addition to that paid by my Insurance (i.e., copays and deductibles). I request that authorized benefits be paid to me or on my behalf for any services received. I agree to immediately remit to the medical practice any payments I receive directly from insurance or any source whatsoever for the services provided to me. I also assign all rights to such payments to the practice. I authorize the medical practice to appeal payment denials or other adverse decisions on my behalf. I authorize any holder of medical information or other relevant information about me to release such information to the practice, Its billing agents, the Center of Medicare and Medicaid Services, and any other payers or insurers and their respective agents or contractors as may be necessary to determine benefits payable for any services provided to me by the practice.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

ADVANCE PATIENT NOTICE FORM

Should you be a patient of House Call Specialists, currently the practice is only participating with Medicare insurance? We are a non-participating provider with all other insurance carriers. You have the right to receive services at a participating facility or from a participating physician or provider to obtain full benefits under your health coverage. If you have questions or want to locate an in-network physician, provider, or facility, please contact your customer service provider using your insurance card.

To be completed by the patient or patient's legal guardian:

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that the non-participating facility/provider that will be involved in my care does not participate with my insurance company.
2. I understand that I will be responsible for all costs associated with the services provided by the non-participating facility/provider.
3. I was allowed to contact my insurance company before obtaining these services to confirm my benefits for these non-network services and to obtain names of participating facilities and providers that can provide the recommended service or procedure.
4. I am voluntarily choosing on behalf of myself or my adult child/legal guardian to obtain the service or procedure from the non-participating faciliand/or physician.

_____ _____

Patient Signature: Date:

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Vax Care Notice

Patient's Name:_____

DOB: _____

Jupiter Internal Medicine Associates carries many immunizations and medications from Vax Care. While we administer them we do not own them.

- If you receive an injection today, our staff will let you know if you are responsible for coinsurance or copayment or if it is not covered.
- If the staff member has not explained this information, please do not accept the injection(s).
- If you feel the benefits presented need to be corrected, do not accept the injection(s).
- Your insurance benefits are provided to us by Vax Care, not our office.

If you want to receive the injection, you will sign a waiver, and the staff member will collect any amount due. Your payment will go directly to Vax Care.

By signing this release, you understand if you receive an invoice from Vax Care, our office cannot adjust or write any amounts off. You will need to contact Vax Care directly regarding your invoice. We can try to assist you with any questions regarding an invoice you may have received.

Patient Signature:_____

Date: _____

No-Show Canceled Appointment Policy

Thank you for choosing Jupiter Internal Medicine Associates. We appreciate your trust and are committed to providing you with the highest quality and compassionate healthcare.

We value our patients and your healthcare needs, and in doing so, we allocate time for each appointment accordingly. We realize unexpected circumstances may occur beyond your control that may not allow you to provide us with a 24-hour notification. Failure to notify the office or cancel, or change your appointment without a 24-hour notice is considered a "No Show". To help remind you of your appointment we have an automatic reminder system. Please confirm that we always have your correct contact information, so we can confirm your appointments.

- ★ All "No Show" or "Canceled Appointments" without a 24-hour notice will be documented in your medical records.

Charges for "No Show" and "Canceled Appointments" without a 24-hour notice are as follows:

- ➔ First Time: No Charge
- ➔ Second Time: $50.00 Third Time: $75.00
- ➔ Fourth Time: This could result in being discharged from the practice.

This letter serves notice of our "No Show" policy and fees.

I acknowledge that I have read and understand the policy.

Patient Signature:_____

Date: _____

Patient Agreement for Controlled Substance Prescriptions

To ensure safe and effective management of controlled substance prescriptions, please acknowledge the following rules:

★ **Please Initial Each Box:**

☐ **Prescribing:** Controlled substance prescriptions will only be granted during a scheduled visit with your provider.

☐ **Prescription Timing:** Please allow until the end of our business day (5:00 PM) for controlled substances to be transmitted by our office to your pharmacy.

☐ **Follow-Up Appointment:** Please schedule your follow-up appointment at checkout to avoid running out of your prescription without a scheduled appointment. We do not want you to run out of your medication.

☐ **Frequency of Visits**: Patients receiving controlled substance prescriptions must schedule an appointment every three months for continued evaluation management.

☐ **Early Refill Requests:** We are unable to fulfill early refill requests for controlled substance prescriptions.

☐ **Pharmacy Change:** Once a controlled substance prescription has been sent, we cannot switch pharmacies. Please inform the medical assistant (MA) or provider of any pharmacy changes before leaving the office.

Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physical certification, health, effectiveness, date, and information set (HEDIS).

I have been given the right to review the Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change this Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Name:_____DOB:_____

Signature:_____Date:_____

Due To The HIPAA regulations, I hereby authorize the following names of those listed below to discuss and participate in my medical care. I understand that if the names are not listed below, the office of Jupiter Internal Medicine, can not release any information.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

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Notice of Privacy Practices

Patient's Name:_____

DOB: _____

PATIENT ACKNOWLEDGMENT

By signing this form I,_____(Print Name) acknowledge that Jupiter Internal Medicine Associates has provided me with its Notice of Privacy Practices, which explains in detail the uses and disclosures of my protected health information that may be made by this practice. This includes, but is not limited to treatment, healthcare operations, payment, and administration of plans. My signature also authorizes the practice to use or disclose my health information for research and other purposes, as described in the Notice. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Patient Signature:_____ Date:_____

Relationship to Patient (If signed by a personal representative):_____

_____

Office use only:

<u>Complete if Acknowledgement of Notice of Privacy Practices is not obtained.</u>

I,_____(print name) delivered the Notice of Privacy Practices to the patient/client listed above and made a good faith effort to obtain this written authorization.
Reason NOT obtained:_____

Signature of Staff:_____Date:_____

HIPAA

HIPAA NOTICE OF PRIVACY PRACTICES As required by the Privacy Regulations Promulgated under the Health Insurance Portability and Accountability Act of 1996(HIPAA)

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please REVIEW IT CAREFULLY,

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes permitted or required by law. It also describes your rights to access and control your protected health Information. "Protected health information is Information about you, including demographic Information, that may identify you and relate to your past, present, or future physical or mental health or condition, and related healthcare services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff, and others outside of our office who are involved in your care and treatment to provide health care services to you, to pay your health care bills, to support the operation of the organization. And any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This Includes coordinating or managing your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health Information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: As needed. We may use or disclose your protected health information to support our organization's business activities. These activities Include but are not limited to, quality assessment activities, and employee review activities. Accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility.

We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information In the following situations without your authorization: as Required by Law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food And Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers 'Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, Investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization, or Opportunity to Object unless required by law. You may revoke this authorization, at any time, In writing, except to the extent that your physician or this organization has relied on the use or disclosure indicated in the authorization.

Your Rights: The following statement states your rights concerning your protected health information. You have the right to Inspect and copy your protected health Information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; Information compiled In reasonable anticipation of, or use In a civil, criminal, or administrative action or proceeding; and protected health information that Is subject to law that prohibits access to protected health Information.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends Involved In your care or for notification purposes as described In this Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization Is not required to agree to a restriction you may request. If our organization believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You Have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have your organization amend your protected health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as this notice provides.

Complaints: If you believe we have violated your privacy rights, you may complain to us or the Secretary of Health and Human Services. You may file a complaint with us by notifying our privacy contact. We will not retaliate against you for filing a complaint.
We are required by law to maintain the privacy of and provide Individuals with this notice of our legal duties and privacy practices concerning protected health Information. If you have any questions or objections to this form, please ask to speak with our President in person or by phone at 561-972-1986 or email info@juplterinternalmedicjne.net. Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you Medical Information Is provided.
We welcome your comments. Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.