EXPRESS FAMILY CARE

PATIENT INFORMATION

First Name:_____ Middle: _____ Last: _____

Date of Birth:_____ Sex: _____ SSN: _____

Mailing Address: _____

City:_____State:_____ Zip Code:_____

Home Phone: _____ Cell: _____

Email:_____

How do you prefer to be contacted? (Please Circle) Home Cell Email

PRIMARY INSURANCE

Please complete all insurance information. If you do NOT have insurance check here: ☐

Plan: _____ Policy #:_____

Group #: _____ Policyholder's Name: _____

Policyholder's Relationship to Patient: _____ Policyholder's DOB: _____

SECONDARY INSURANCE

Plan: _____ Policy #:_____

Group #: _____ Policyholder's Name: _____

Policyholder's Relationship to Patient: _____ Policyholder's DOB: _____

EMERGENCY CONTACTS

In the event of an emergency, who should we contact?

_____

Name Relationship

_____

Home Phone Cell Work

_____

Name Relationship

_____

Home Phone Cell Work

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CONSENTS

Please read each statement and acknowledge by signing below.

I voluntarily consent to medical treatment and diagnostic procedures provided by Express Family Care and its associated physicians, clinicians and other personnel. I understand that my doctor or my doctor's designee will discuss my care and treatment options with me. I know I can refuse to consent to any procedure or treatment.

I hereby authorize Express Family care to bill my insurance carrier(s) for services rendered and authorize direct payment of medical benefits to Express Family Care for these services. I further authorize the release of all necessary information including records, reports and services rendered as requested by my insurance carrier(s). I understand that charges for all services provided, but not covered by my insurance carrier(s), will be my financial responsibility.

I certify that the information on these forms is true to the best of my knowledge.

Patient or Parent/Guardian Signature: _____ Date: _____

CONFIDENTIAL COMMUNICATIONS

This is a request for confidential communications of your protected health information (PHI). On occasion, our office may need to contact you to remind you of doctor's appointments, discuss lab results, medications, or other protected health information. Please tell us how you would like to be contacted for this type of information.
For appointment reminders, please select all that apply.

Phone:_____ ☐ Text ☐ Call

☐ Email:_____

For more sensitive information:

Phone:_____

☐ Leave a detailed message ☐ Leave a basic message with request to call back ☐ DO NOT leave a message

Please list the following people that you give Express Family Care permission to release your detailed medical information to. If you choose not to release your medical information, please write NONE below.

_____

Name Relationship

_____

Name Relationship

Patient or Parent/Guardian Signature: _____ Date: _____

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PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT

I acknowledge and agree to adhere to the notice of privacy practices as required by federal and state laws. I understand that I may request and review a copy of these practices at any time from the office staff.

Patient or Parent/Guardian Signature: _____ Date: _____

BILLING INSURANCE

We will file your insurance as a courtesy. If your insurance carrier denies your claim, you are responsible for the bill.

When you receive a bill from Express Family Care, it indicates that your insurance company has finished processing your claim and has paid its share of the bill.

The explanation of benefits letter you receive from your insurance company will help you understand why you have received a bill from Express Family Care. Carefully review the explanation of benefits. This will show your deductible (if you have one), how much of your deductible you have paid, the copay or coinsurance you are responsible for, any charges not covered by your insurance that you are responsible for, and your current coverage details.

Your health insurance policy is a contract between you and your insurance company. For your benefit, please take the time to understand your policy. There are too many different insurance plans for Express Family Care (any outpatient practice) to know all the specific details of each plan.

Remember that your insurance company, not Express Family Care, makes the decision about what will and will not be paid/covered.

It is up to you to provide correct information in order to process and bill your claim at the time of service. Out of date care, incorrect cards and any incorrect information can cause unnecessary delays in the payment of your claim and the balance may ultimately become your full financial responsibility.

If you have a deductible plan, the estimated deductible allowed amount will be collected at the TIME OF SERVICE. All copays and coinsurance amounts are to be paid at the TIME OF SERVICE. Time of service payment, such as copays or coinsurance, is not always your full patient responsibility. You are ultimately responsible for any balance remaining on the account after your insurance has paid or total charges even if the insurance is pending or denied.

In the event payment is not received, Express Family Care may send the account to a third-party collections agency. You will be required to reimburse Express Family Care the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I have read the above information and understand it.

_____ _____

Patient/Guardian Signature Date

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OFFICE POLICIES

Successful medical care requires ongoing collaboration between patients and physicians. Please review our office policies below.

1. We take a team approach and your visits may rotate among our providers. We have established practice protocols that allow all providers to stay on the same page for your care while giving you their unique perspectives.
2. Unless canceled at least 24 hours in advance, you may be subject to a $30 NO SHOW/CANCELATION fee at the physician's discretion. If you are 15 minutes late, we reserve the right to reschedule your appointment. Please help us serve you by keeping scheduled appointments.
3. An Annual Wellness Visit (AWV) is an opportunity for you and your healthcare team to reflect on your medical history and create a wellness plan. It is a free service to improve your health, prevent disease, and maximize your wellness. The AWV is not a physical exam, but more of a one on one discussion to assess your current health conditions and focus on maintaining good health practices to help prevent future visits to the doctor's office or emergency department. It is important for the AWV to be completed annually. Most insurance plans cover an AWV once every 12 months at 100%. If additional services are provided, you may be responsible for your copay/deductible. To provide the best care, we require our patients to have an AWV once per year.
4. For refills of prescriptions, please contact your pharmacy. Refill requests will be processed in 24-72 hours.
5. When appropriate, our office will complete FMLA paperwork for a fee of $30.
6. Your insurance company has contracted with a lab for any blood work, PAP smears or biopsies. You should know which lab to visit for blood work. We will make every attempt to send any specimens collected in the office to the correct lab.
7. If you are prescribed any controlled substance, we reserve the right to conduct periodic drug screening to ensure you are taking these medications safely and as prescribed.

Name: _____ Date of Birth:_____

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WELCOME TO OUR PRACTICE!

I am here for: ☐ General Visit ☐ Problem Visit ☐ Both

Concerns to Discuss with Provider_____

GENERAL HEALTH

Allergies: _____ _____ _____

_____ _____ _____

Medications/Supplements: (Please include strength, quantity and how often you take the medication)

_____

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy: _____

Social:

Do you smoke cigarettes/cigars? ☐ Never ☐ Quit ☐ Current Smoker

If you are a current smoker, how many cig / day? _____ How many years? _____

If you are a former smoker, when did you quit? _____

Are you ready to quit? ☐ No ☐ Yes

Do you use other smokeless tobacco products? ☐ No ☐ Yes

Do you use other drugs? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

If yes, how many drinks per week? ☐ 0-6 ☐ 7-10 ☐ 11-14 ☐ >14

Do you drink caffeinated beverages? (coffee, sodas, energy drinks) ☐ No ☐ Yes

If yes, how many per week? ☐ 0-6 ☐ 7-10 ☐ 11-14 ☐ >14

Do you regularly exercise? ☐ No ☐ Yes

Do you regularly wear a seat belt when riding or driving a vehicle? ☐ No ☐ Yes

Wellness:

Last Dental Exam: _____

Last Eye Exam: _____

Last Colonoscopy: _____

Last Mammogram: _____

Have you had an abnormal mammogram? ☐ No ☐ Yes

Last Pap Smear: _____

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Last Bone Density: _____ Have you had an abnormal pap smear? ☐ No ☐ Yes
Last Flu Vaccine: _____ Last Pneumonia Vaccine: _____

Advanced Directive Planning:

Do you have a Living Will?	☐ No	☐ Yes
Do you have a Power of Attorney?	☐ No	☐ Yes
Do you have a DNR order?	☐ No	☐ Yes
Is a blood transfusion acceptable in an emergency?	☐ No	☐ Yes

PAST MEDICAL HISTORY

Please circle if you have, have ever had or have been diagnosed with any of the following conditions.

ADD or ADHD	Diverticulitis	Mumps
Alcoholism	Drug Addiction	Parkinson' Disease
Anemia	Emphysema	Personality Disorder
Anxiety	Essential Tremors	Pleurisy
Asthma	Fibroids	Preeclampsia
Back Pain	Gallbladder Disease	Psoriasis
Bells' Palsy	Heart Disease	Pulmonary Fibrosis
Blood Disorder	Hemorrhoids	Raynaud's Disease
Brain Injury	Hepatitis A / B / C	Recurrent UTIs
Breast Cancer	High Blood Pressure	Rheumatoid Arthritis
Cerebral Palsy	High Cholesterol	Rubella
Chicken Pox	HIV/AIDS	Schizophrenia
Colon Cancer	Hyperlipidemia	Shingles
Congenital Heart Disease	Kidney Disease	Sickle Cell
COPD	Kidney Stones	Skin Cancer
Coronary Artery Disease	Leukemia	Sleep Apnea
Crohns' Disease	Lung Cancer	Stomach Cancer
Cystic Fibroids	Lupus	Stroke
Depression	Measles	Thyroid Disease
Diabetes	Migraine Headaches	TIA

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Other: _____

SURGICAL HISTORY

Operations:

Appendectomy	Hernia Repair	Splenectomy
Carotid Endarterectomy	Hysterectomy	Spinal Surgery
Cataract Surgery	Joint Replacement	Stent Placement
Cholecystectomy	Pacemaker	Thyroidectomy
Coronary Artery Bypass (Heart Bypass)	Partial Colectomy	Tonsillectomy

Other:_____

FAMILY HISTORY

ADD/ADHD	☐ Mother ☐ Father ☐ Other:
Alzheimer's Disease	☐ Mother ☐ Father ☐ Other:
Anemia	☐ Mother ☐ Father ☐ Other:
Anxiety	☐ Mother ☐ Father ☐ Other:
Arthritis	☐ Mother ☐ Father ☐ Other:
Asthma	☐ Mother ☐ Father ☐ Other:
Blood disorders	☐ Mother ☐ Father ☐ Other:
COPD	☐ Mother ☐ Father ☐ Other:
Cancer_____(type)	☐ Mother ☐ Father ☐ Other:
Chronic Headaches/Migraines	☐ Mother ☐ Father ☐ Other:

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Cystic Fibrosis	☐ Mother ☐ Father ☐ Other:
Dementia	☐ Mother ☐ Father ☐ Other:
Depression	☐ Mother ☐ Father ☐ Other:
Diabetes	☐ Mother ☐ Father ☐ Other:
Hard of Hearing	☐ Mother ☐ Father ☐ Other:
Heart Disease	☐ Mother ☐ Father ☐ Other:
Hemophilia	☐ Mother ☐ Father ☐ Other:
High Blood Pressure	☐ Mother ☐ Father ☐ Other:
High Cholesterol	☐ Mother ☐ Father ☐ Other:
Huntington's Disease	☐ Mother ☐ Father ☐ Other:
Mental Illness	☐ Mother ☐ Father ☐ Other:
Muscular Dystrophy	☐ Mother ☐ Father ☐ Other:
Obesity	☐ Mother ☐ Father ☐ Other:
Sickle Cell	☐ Mother ☐ Father ☐ Other:
Spinal Musc Atrophy	☐ Mother ☐ Father ☐ Other:
Tay-Sachs Disease	☐ Mother ☐ Father ☐ Other:
Other	☐ Mother ☐ Father ☐ Other:

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Authorization for Release of Information

Patient's Name:	DOB:
Address:	Phone Number:

The above listed patient authorizes Express Family Care/ Rebeca Juarbe Arrillaga, MD to
☐ Release To ☐ Obtain From

Entity / Individual:	Address:
Phone & Fax:	City, State, Zip Code:

Needed Information:	Dates of Service:	Purpose of disclosure:
☐ Last 2 years of records available ☐ Radiology Reports _____ ☐ Lab Results ☐ Other: _____	☐ All available ☐ Most recent visit ☐ From: _____ to: _____ ☐ Other: _____	☐ Continuation of Care ☐ Referral ☐ Change of Ins or Physician ☐ Other: _____

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization. I understand that I have a right to receive a copy of this Authorization.

Patient's Name:_____ Date of Birth:_____

300 S. Main st
Crescent city fl 32112
P: (386)698-1221
F: (386)698-1514

6100 St Johns Ave, Unit 3
Palatka, FL 32177
P: (386) 530-4990
F: (386-385-4826

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Patient-Prescriber Expectations and Responsibilities Agreement

I, _____, understand and agree to the following conditions that are required for continued treatment with controlled substances.

Please initial next to each statement below.

_____ My provider has explained, and I understand the risks and benefits of using this medication(s).

_____ I have read the medication guide and understand that there are possibilities that my response to a medication may be an unforeseen reaction and will report any immediately to my provider.

_____ I will tell my provider immediately about any new medical conditions or medications.

_____ I will only get my prescription(S0 pain/controlled medication(s) from the prescriber listed on the agreement, and only in his.her absence, by the covering provider.

_____ I will always get my prescription(s) filled at the same pharmacy, and if I need to change pharmacies, I will notify the office immediately.

_____ I will always get my prescription(s) issued by my listed provider filled at the same pharmacy, and if I need to change pharmacies, I will notify you immediately.

_____ I will bring the original medication container for each medication with me to every office visit.

_____ If I receive a prescription for any of my controlled medications before a refill date is due, I will not attempt to refill the prescription until the stated date on the prescription.

_____ I understand that my controlled medications may not be replaced if lost, damaged, destroyed, or stolen.

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_____ I will keep my scheduled appointments as a requirement for treatment.

_____ I give my provider permission to discuss details of my diagnoses and treatment with my pharmacist and other healthcare providers involved in my health care.

_____ I will submit without prior notice to have a urine and or blood test performed; as needed to monitor my treatment.

_____ I understand that the presence of unauthorized substances in my urine or blood test may prompt referral for assessment for addictive disorder.

_____ I understand that if unauthorized substances are found in my test results, further treatment may be reassessed, deferred to a specialist, and or concluded by my provider.

_____ I understand that any medical treatment is a trail, and that continued prescribing is dependent upon the evidence of clinical benefit determined by my provider.

_____ I will take the prescribed medication exactly as prescribed.

_____ I will take my medication as prescribed; I will not alter their form or route of administration in any way (ie: break, crush, chew, dissolve, inhale through nasal passages, and or inject.

_____ I will not abruptly stop taking my prescribed medications.

_____ I understand that I am solely responsible for keeping my medications safe from accidental use by ANYONE; children, adults, the elderly, and or animals. If an event occurs, this is a true emergency! Get emergency help - CALL 911!

_____ I understand that if I stop taking my medications prescribed by my provider, I should f;ush any unused medication down the toilet.

_____ I will abide by Florida law that mandates that I will not sell/give my medications and I will always keep my medications in their prescribed containers.

Patient/Parent/Guardian

Signature: _____ Date: _____