CompleteCare

PLEASE NOTE: YOU MUST ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME FAILURE TO DO SO WILL RESULT IN RESCHEDULING

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are required by law to protect medical information about you. Please review it carefully.

We are required by law to protect the privacy of medical information about you and what identified you. The medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with the Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting areas
- Have copies of the new Notice available upon request. Please, contact your office at 321-985-9097 to obtain a copy of our current Notice.

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related to complaint.

If at any time you have questions about information in this Notice or about any privacy practices, procedures, or policies you can contact our office at 321-985-9097.

We may use and disclose medical information about you in several circumstances.

We use and disclose medical information about patients daily. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these disclosures, or about any of our privacy practices, procedures, or policies, contact our office at 321-985-9097.

Patient printed name:_____ Patient DOB: _____

Patient to Signature: _____ Date: _____

Patients representative: _____ Relationship:_____ Date: _____

MERRITT ISLAND CLINIC : 2400 N. Courtenay Pkwy, Suite 100, Merritt Island, FL 32953
PALM BAY CLINIC : 1840 Eldron Blvd SE, Palm Bay, FL 32909
Phone: (321) 985-9097 Fax: (321) 301-4869
Website: www.CompleteCareFL.com

COMPLETE CARE

Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____

State: _____ Zipcode: _____ E-mail: _____

Phone #: _____ Cell #: _____

Emergency Contact: _____ Phone #: _____

Privacy Practices Acknowledgement Information

Notice of Privacy Practices of Complete Care can be found in the waiting room. If you would like a copy one can be provided to you. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Please sign below that you read and have been informed.

Signature: _____ Date: _____

Assignment of Benefits/Advanced Beneficiary Notice/Financial Policy

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. Assignments of benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment checks directly to Complete Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I furthermore understand that I am waiving any anti-assignment clauses that are written in to my health care contract. I have requested that the office of Complete Care be my agent in the filing, processing and appealing of claims related specifically to medical treatment rendered by this office. I understand that I have the opportunity to submit my bills directly to my health insurance carrier but have chosen voluntarily to have the claims submitted by and paid directly to the office of Complete Care with accompanying explanation of benefits. Authorization to Release Information: I hereby authorize Complete Care to: (1) release any information necessary to insurance carriers regarding my illness and treatments (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Complete Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I further understand the fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: _____

Permission to Speak Form

Patient Name: _____ Date of Birth: _____

I give permission to Complete Care to VERBALLY discuss the following medical and billing information about me:

- ☐ Scheduling / Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan
- ☐ Behavioral Health Information, including my symptoms, diagnosis, medication, and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan
- ☐ Lab /Test Results
- ☐ Billing and payment information

1) Name: _____ Relationship: _____

   Phone #: _____

2) Name: _____ Relationship: _____

   Phone #: _____

3) Name: _____ Relationship: _____

   Phone #: _____

Signature:_____ Date: _____

I understand that I may cancel this permission at any time by writing Complete Care, but that cancelling it will not affect and information that has already been released. I understand that I do not have to list anyone on this form. If so please mark N/A on name line.

PREVENTATIVE CARE & PATIENT HISTORY

Last Eye Exam: _____ Last Mammogram: _____

Last Colonoscopy: _____ Last Pap Test: _____

Last Blood Work: _____ Last PCP Visit: _____

Name of last PCP: _____

SOCIAL HISTORY: Do you drink alcohol? Social / Occasionally / Light / Heavy

If so how many per day? Beer: _____ Wine: _____ Liquor: _____

Current smoker? Yes / No If so how much per day? _____ How long have you been smoking? _____

Former Smoker how long did you smoke? _____ How long since you quit? _____

Do you use: Dip / Cigars / Chew / Pipe? Yes / No If so for how long? _____

Caffeine Use: Do you use caffeine? _____ How many per day? Coffee _____ Tea _____ Soda _____

Energy Drinks _____

Education / Occupation:

Highest level of education: _____ Military: _____

What type of employment do you have? _____ Retired: _____

Habits / Lifestyle

Do you follow a specific diet? _____ Do you exercise? _____

How often / what kind? _____ Hours of sleep at night? _____

Dentures _____ Corrective Eye Wear _____ Last Hearing Test _____

Household: Marital Status: _____ Do you have children?_____

Who do you live with? _____ Do you have pets? _____

Safety: How many falls in the last year? _____

Substance Use: Do you use recreational or street drugs? Yes / No If so what kind? _____

How long have you used? _____

FAMILY HISTORY: List any diseases that run in your family (blood relatives only)

Relative	Alive	Age now or deceased age	Diseases i.e. (cancer, heart disease, stroke, high blood pressure, diabetes)
Mother	Y / N		
Father	Y / N		
Sister	Y / N		
Brother	Y / N		
Grandmother	Y / N		
Grandfather	Y / N		

Medical Information

Name: _____ Date of Birth: _____

What is the reason you are here today?

_____

REVIEW OF MEDICAL SYSTEMS – Circle any current problems that you are having

Change of appetite	Abdominal pain	Back Pain	Earaches	Headaches	Shortness of breath
Change in Vision	Chronic Cough	Chest Pain	Nausea	Fever	Leg Swelling
Loss of Balance	Hearing Loss	Constipation	Numbness	Dizziness	Fatigue
Loud Snoring	Heartburn	Stressed	Wheezing	Itchy / Rash	Fainting
Ringing in ears	Allergies	Joint Pain	Incontinence	Weakness	Muscle Pain
Weight Change	Bleeding	Eye Pain	Arthritis	Cough	

Additional: _____

PAST MEDICAL HISTORY – Circle any problems you have had in the past

Hepatitis A/B/C	Lyme Disease	Liver Disease	Thyroid Disease	COPD
Heart Disease	Diabetes	Gout	Bronchitis	Asthma
Carpal Tunnel	Blood Clots	Heat Attack	Sleep Apnea	Anemia
Cancer	Migraines	High Cholesterol	Seixures	Hernia
CHF	Parkinsons	Diverticulitis	Erectile Dysfunction	

Additional not listed:

_____

_____

HOSPITALIZATION / SURGERIES – Date, Diagnosis and Hospital name

_____

_____

_____

Controlled Substance Agreement

The Florida legislature has laws governing the prescription of controlled substances. These drugs include but not limited to all narcotics, sleeping aids, benzodiazepines and ADHD medications. To comply with laws and prevent misunderstanding, I act knowledge and agree to the following:

1. I understand that the main treatment goal is to reduce pain and improve my ability to function. In consideration of this goal and the fact that I am being given a potent medication to reach my goal; 1) I agree to use my medication at the rate no greater than prescribed. 2) I will not sell, trade or share my medication. 3) I will not consume alcohol while on controlled substances. 4) I will not drive or operate Henry machinery while on controlled substances.

2. I understand that prescriptions for controlled substances can only be written for a 30 day supply and requires a face-to-face Doctors visit to obtain refills. Refills must be written not faxed or called in. Refills will only be given a scheduled appointments. Refills will not be given on weekends or holidays.

3. It is a crime to obtain controlled substances under false pretenses. This could include getting medications from another Doctor, misrepresenting myself to obtain medications, or using them in a manner other than prescribed. If my physician has reason to believe that I have violated this agreement my physician has the right to contact law-enforcement and discharge me from the practice.

4. I understand that my physician is not responsible for misplaced, lost or stolen medications. Controlled substances cannot be re-filled before the 30 day renewal date.

5. I agree to comply with random you're on drugs screenings and random pill counts. Any use of illegal substances or absence of my prescribed medication is a direct violation of this agreement and will result in a discharge from the practice.

6. I understand that the long-term advantages and disadvantages of chronic opioid use has yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long-term use of controlled substances.

7. I am fully aware of the psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to medications and necessitating a dose increase to achieve the desired effect and doing so may increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for more than several weeks. Therefore, when I need to stop taking the medication, I must comply and slowly taper off under medical supervision or I may have withdrawal symptoms.

8. I understand that if I violate this controlled substance agreement due to non-compliance of medical directions, failure to take medications as prescribed, utilizing other illicit drugs, refusal for urine drug screens or excess of no-show appointments, I will be discharged from the practice.

I hold Complete Care physicians harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

Patient / Guardian Signature: _____ Date: _____

Patients Printed Name: _____ DOB: _____

Medication Information

MEDICATION ALLERGIES? _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Medication List - Please list ALL current medications. Please include herbal supplements.

Medication (ex: Aspirin)	**Strength & Dosage** (ex: 81mg daily)	**Reason for taking** (ex: headaches)	**Prescribing Doctor** (if applicable)

I understand that all of the information that I have provided will become part of my permanent medical records and will be used as part of my medical treatment. I also a test that all of the information is accurate.

Signature:_____

Date:_____

Patient Name: _____ DOB: _____ Date: _____

Alcohol Use Disorders Identification Test (AUDIT): Self-Report Version

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that your healthcare provider asks some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Please place an X in one box that best describes your answer to each question.

Return the completed form to your healthcare provider.

Questions	**0**	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total:	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DOB:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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CompleteCare

Consent For Lab & Imaging Test Orders

Patient Name: _____

Patient DOB: _____

I authorize Complete Care LLC to send my lab tests to _____ lab for testing and imaging tests to _____ facility for imaging.

I understand that I am responsible for any amounts not payable by my insurance. If my insurance denies the claim, I agree to be responsible to pay the full balance.

I also understand that I am responsible for making Complete Care LLC aware of any changes to the above.

Signed:_____

Date: _____

CompleteCare

NO SHOW AND CANCELLATION POLICY

This policy applies to new and established patients. If a patient is in violation of the no show policy of Complete Care, LLC, fines will be charged directly to the patient/guarantor and NOT the health insurance company. All no show fees must be paid BEFORE the next appointment can be scheduled.

- Appointment cancellations must be made 24 hours before the scheduled date and time of appointment. Complete Care, LLC can be made aware of the need for cancellation by
  - Telephone
    - 321-985-9097
  - E-mail via the patient portal

- Complete Care, LLC has the following no show policy that applies to no shows within a 12-month calendar year from first visit
  - For the first missed appointment, no charge for established patients, and $25 for new patients.
  - For the second missed appointment, $25 for established patients, and $50 for new patients.
  - For the third missed appointment, new and established patients will no longer be able to be seen by our providers and will be fined $100.

_____ _____

Patient Printed Name Date of Birth

_____ _____

Patient Signature Date

_____ _____ _____

Patient's Representative Date Relationship to Patient

Updated 02/10/2016