CompleteCare
Family Medicine

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 our 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 CLINICS :
2400 N. Courtenay Pkwy, Suite 100, Merritt Island, FL 32953
119 Banana River Drive, Merritt Island, FL 32952
PALM BAY CLINIC : 590 Malabar Rd SE, Suite 7, Palm Bay, FL 32907
Phone: (321) 985-9097 Fax: (321) 301-4869
Website: www.CompleteCareFL.com

COMPLETE CARE

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

Patient Name: _____ Date of Birth: _____

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

1) Name: _____ Relationship: _____

   Phone #: _____

2) 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.

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Date: _____ **New Patient Information**

Name:	**Date Of Birth:**
Reason for visit:	**Occupation:**
Marital Status (circle): Married / Single / Widowed / Divorced / Separated **Any religious or cultural preferences you would like us to know:** _____ **What gender do you identify with (circle):** Male / Female / Transgender **Alcohol Use: Y/N** How much/day _____ **Caffeine Use: Y/N** How much/day _____ **Recreational Drug Use (drug/how often):** Yes / No _____	**Drug Allergies:** _____ _____ **Food Allergies:** _____ **Sexual Orientation (circle):** Heterosexual / Homosexual / Bisexual / Other: _____ **Exercise: None OR Exercise type:** _____ _____days / week _____ minutes/day **Diet Type:** _____ **Current Health Status (circle): Excellent/Good/Fair/Poor**
Tobacco Use: Y/N How much/day _____ **Are you interested in quitting?:** Yes / No **Quit year:** _____ **Packs/Day:**_____ **# of Years:**_____ **Surgical History:**	**Past Medical History:**
Family History: Please note Condition / Relation Cancer (type): Diabetes: Heart Disease: Hypertension: Other:	**Current Medications Prescribed and OTC to include vitamins, herb, supplements:**
Preventative Care: Last Physical: Last Eye Exam: Last Pap Smear (women): Last Mammogram (women): Last Dexa Scan: Last Dental Exam: Last Colonoscopy: Last Lab Work / where:	**Specialists Seen / For What Condition:**
Immunizations: Flu: Pneumonia: Last Tetanus: Other:	

Preferred Pharmacy Name: _____

Address: _____ **Phone #** _____

How did you hear about us? _____

Patient Signature: _____ **Date:** _____