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.

COMPLETE CARE FAMILY MEDICINE
Patient Registration Demographic Information

Patient Name: _____ **DOB:** _____ **Date:** _____

Address: _____ **Legal Sex:** _____

_____ **Mobile Phone:** _____

_____ **Home Phone:** _____

Email: _____

Consent to Call: Yes ____, **No** ____
(and leave Voice message)

Emergency Contact: _____

_____

Consent to Text: Yes ____, **No** ____
(and leave text message)

Phone #: _____
Relationship: _____

Primary
Insurance Company: _____ **Member ID#:** _____

Address: _____ **Group #:** _____

_____ **Phone #:** _____

Circle One: HMO, PPO,

Secondary
Insurance Company: _____ **Member ID#** _____

Address: _____ **Group #:** _____

_____ **Phone#:** _____

Default Pharmacy: _____

Preferred Lab : (If not sure, please call your insurance and ask): _____

Preferred Imaging Facility: (If not sure, please call your insurance and ask): _____

_____

Patient Pediatric Health History Form

For well-child checks, please also use the appropriate well-child questionnaire

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:**_____

CHILD'S PREVIOUS DOCTOR/PCP: _____

BIRTH AND PREGNANCY

What city was your child born in?_____Name of hospital: _____

Is this your child by: _____ Birth _____ Adoption _____ Step-child Other: _____

Birth weight: _____ Was your baby premature? **Y / N**

Were there any significant medical problems during your pregnancy? **Y / N**

Were there any significant complications during labor or the baby's newborn period? **Y / N**

If yes, to any of the above questions, please explain: _____

_____

GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? **Y / N**

If yes, please explain: _____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY

HAS YOUR CHILD:

Had any serious medical illness?	**Y / N**	Had broken bones/frequent or severe sprains?	**Y / N**
Had a history of asthma or wheezing?	**Y / N**	Had any mental or behavioral problems?	**Y / N**
Ever used an inhaler or nebulizer?	**Y / N**	Had a positive tuberculosis skin test?	**Y / N**
Had surgery?	**Y / N**	Been hospitalized overnight?	**Y / N**

If yes, to any of the above, please explain: _____

_____

IMMUNIZATIONS: ***Please bring your child's immunization records to your appointment***

Have you ever refused vaccines for your child? **Y / N**

If yes, why? _____

MEDICATIONS AND ALLERGIES

Please list current medications, vitamins, and supplements, even those used intermittently: _____

_____

Please list allergies or reactions to medications, vaccines or foods

Allergy	Reaction
_____	_____
_____	_____
_____	_____

FAMILY HISTORY:
Please indicate with a check (./) family members who have had any of the following conditions:

Medical Condition	Admin. use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autism	128												
Autoimmune Disorder	34												
Birth Defect/Congenital Anomaly	36												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer: Please Specify Type _____													
Cancer: Please Specify Type _____													
Depression	14												
Diabetes	81												
Eczema (Atopic Dermatitis)	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever (Allergic Rhinitis)	20												
Hearing Disorder	21												
Heart Attack/Coronary Artery Disease	13												
High Cholesterol (Hyperlipidemia)	22												
High Blood Pressure (Hypertension)	23												
Immune Disorder	24												
Inflammatory Bowel Disease (Crohns/UC)	59												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Migraine Headaches	71												
Psychiatric/Mental Illness	75												
Scoliosis	76												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	122												
Tuberculosis	31												
Death before age 56 or reasons not listed above													
Other:													
Other:													

SOCIAL HISTORY: Please list patient's family and household members:

Name Age Relationship Occupation/Employer Cell Phone Number

_____

_____

_____

_____

_____

Are your child's parents: ___Married ___ Unmarried ___ Separated ___ Divorced (If divorced or separated, when?)

Child-care situation: ___ Parents ___ Others (specify who and hours per day) _____

_____

Concerns about your child: ___ Alcohol use ___ Tobacco ___Sexual activity ___Aggressive behavior

Is violence at home a concern? ___ Yes ___ No Are there pets in the home? ___ Yes ___ No

Are there guns in the home? ___ Yes ___ No Do any family members smoke? ___ Yes ___ No

Updated 9/2021

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No-Show & Cancellation Policy

This policy applies to new and established patients. If a patient is in violation of the no show & cancellation policy of Complete Care Family Medicine, no-show fees 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.

Appointment cancellations must be made 24 hours before the scheduled date and time of appointments. Complete Care Family Medicine can be made aware of the need for cancellation by telephone on 321-985-9097.

Complete Care Family Medicine has the following no-show policy that applies to no-shows within a 12-month calendar year from the first visit.

- $25.00 fee per no show
- Upon third no show, patients will no longer be able to be seen by our providers and will be discharged.

Patient Signature	Date
Patient Printed Name	DOB
Patient's Representative	Date Relationship