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): _____

_____

CompleteCare
Family Medicine

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:**	**Current / 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:	Entered by: Verified by:
Immunizations: Flu: Pneumonia: Last Tetanus: Other:	**Specialists Seen / For What Condition:**

Preferred Pharmacy Name: _____

Address: _____ **Phone #** _____

How did you hear about us? _____

Patient Signature: _____ **Date:** _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING _0_ + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

CAGE Test

Have you ever felt you should **C**ut down on your drinking?	Yes / No
Have people **A**nnoyed you by criticising your drinking?	Yes / No
Have you ever felt bad or **G**uilty about your drinking?	Yes / No
Have you ever had a drink first think in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?	Yes / No

CompleteCare
Family Medicine

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 _____