



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): _____



Date: _____

New Patient Information

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

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 Cut down on your drinking? | Yes / No |
| Have people Annoyed you by criticising your drinking? | Yes / No |
| Have you ever felt bad or Guilty 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 (Eye-opener)? | Yes / No |



3/18/2026

No Show, No Call & Cancellation Policy

This policy applies to new and established patients. We require 24 hours' notice for Appointment cancellations. **Call 321-985-9097** and or **Text to: 321-306-0012** to cancel.

There are many patients waiting to have an appointment sooner. If we receive enough notice from a cancellation, then we can offer the appointment to someone else. Please be considerate of our clinic schedule and this policy. All No Show/No Call, fees must be paid BEFORE the next appointment.

- \$50.00 fee per No Show/No Call offense
- Upon third No Show/No Call, patients will no longer be able to be seen, and will be discharged from the Practice.

Patient Signature

Date

Patient Printed Name

DOB

Patient's Representative, Relationship

Date

Merritt Island: 2400 N. Courtenay Pkwy, Suite 100, Merritt Island, FL 32953

Palm Bay: 590 Malabar Road SE, Suite 7, Palm Bay, FL 32907

Merritt Island: 119 N. Banana River Dr., Merritt Island, FL 32952

Cocoa Beach: Minuteman CSWY, Unit 455 Cocoa Beach, FL 32931

Phone: (321) 985-9097 **Fax:** (321) 301-4869

Website: www.completecarefl.com