TOTALMD

Patient Information Sheet

Date:_____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ SS# _____ - _____ - _____

Date of Birth: ____ / ____ /____ Sex: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Race: ☐ White ☐ Black ☐ Other _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic Language: ☐ English ☐ Spanish ☐ French/Creole ☐ Other_____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Care Physician (PCP): _____

Address: _____ Phone: _____

Preferred Pharmacy:_____

Address: _____ Phone: _____

Primary Insurance

Insured's Name: _____ Date of Birth: ____ /____ /____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____ SS# _____ - _____ - _____

Insurance Company: _____ Group #: _____ ID#: _____

Secondary Insurance

Insured's Name: _____ Date of Birth: ____ /____ /____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____ SS# _____ - _____ - _____

Insurance Company: _____ Group #: _____ ID#: _____

Employment

Employer Name: _____ Occupation: _____

Employer Address: _____

Employer Phone: _____

If Minor Patient:

Mother's Name: _____ Mother's Phone: _____

Father's Name: _____ Father's Phone: _____

TOTALMD

Health Questionaire

Date: _____

Full Name: _____ Date of Birth: ____ /____ /_____

Reason for visit: _____

Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

General	☐ Fever ☐ Fatigue ☐ Tension ☐ Loss of Balance	☐ Night Sweats ☐ Irritability ☐ Fainting ☐ Excessive Thirst	☐ Unexplained Weight Loss/Gain ☐ Chills ☐ Night Sweats ☐ Change in Sleep Patterns
Skin	☐ Rashes	☐ Cancers	☐ Change in Hair, Skin or Nails
Eyes	☐ Blurred Vision ☐ Changing Vision	☐ Double Vision ☐ Discharge	☐ Pain
Ear, Nose & Throat	☐ Ear Pain ☐ Nose Bleeds ☐ Ringing in Ears	☐ Sore Throat ☐ Change in Voice ☐ Sinus Pain/Trouble	☐ Hearing Loss ☐ Light Sensitivity ☐ Persistent Runny Nose
Heart	☐ Chest Pain ☐ Heart Murmur	☐ Swelling in Ankles	☐ Palpitations
Lungs	☐ Cough	☐ Shortness of Breath	☐ Wheezing
Gastro-Intestinal	☐ Nausea ☐ Blood in Stool ☐ Constipation	☐ Ulcers ☐ Heartburn ☐ Change in Bowel Movements	☐ Diarrhea ☐ Vomiting
Genito-Urinary	**All:** ☐ Blood in Urine ☐ Painful or Frequent Urination ☐ Incontinence ☐ Sexually Transmitted Disease ☐ Excessive Urination	**Women:** ☐ Vaginal Discharge ☐ Change in Menstrual Cycle or Sexual Function	**Men:** ☐ Testicular Pain ☐ Decreased Urinary Stream ☐ Penile Discharge ☐ Change in Sexual Function
Muscul-Skeletal	☐ Painful Joints ☐ Numbness ☐ Arm Pain (R or L) ☐ Elbow Pain (R or L)	☐ Muscle Weakness ☐ Back Pain ☐ Leg Pain (R or L) ☐ Wrist Pain (R or L)	☐ Muscle Spasm ☐ Neck Pain ☐ Knee Pain (R or L) ☐ Shoulder Pain (R or L)
Neuro/Psych	☐ Seizures ☐ Headaches ☐ Vertigo	☐ Tremor ☐ Depression ☐ Dizziness	☐ Diarrhea ☐ Vomiting ☐ Hand, Arm or Leg Weakness
Allergy	☐ Hives	☐ Hayfever	
Circulation	☐ Leg Swelling	☐ Blood Clots	
List additional symptoms not listed above:			

TOTAL MD

Health Questionaire

Is your condition due to an accident: ☐ Auto ☐ Work. Comp ☐ Slip/Fall ☐ Other

If so, date of accident: ____ /____ /____

Please place a checkmark next to any chronic conditions you may have:

☐ High Blood Pressure	☐ Low Blood Pressure	☐ Heart Disease
☐ Stroke	☐ Emphysema/Lung Disease	☐ Kidney Problems
☐ Diabetes	☐ Anemia	☐ Thyroid
☐ Epilepsy	☐ Glaucoma	☐ Asthma
☐ Cancer	☐ High Cholesterol	☐ Arthritis

List additional conditions not identified above:

List any prior surgeries and hospitalizations (include date) _____

_____

_____

Current medications (Name, dose, frequency)_____

_____

_____

Allergies (Reactions to meds, foods, etc.) _____

_____

_____

Family medical history (Check all that apply)

☐ High Blood Pressure	☐ Low Blood Pressure	☐ Heart Disease
☐ Stroke	☐ Emphysema/Lung Disease	☐ Kidney Problems
☐ Diabetes	☐ Anemia	☐ Thyroid
☐ Epilepsy	☐ Glaucoma	☐ Asthma
☐ Cancer	☐ High Cholesterol	☐ Arthritis

List additional conditions not identified above:

Patient Signature:_____ **Date:** ____ /____ /____

Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, or files a statement of claim containing any false or misleading information, commits insurance fraud and is punishable as provided in Florida Statute 817.234

TOTAL MD

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

We are honored that you have chosen Central Palm Beach Physicians and Urgent Care, Inc. d/b/a Total MD and/or Total MD Orthopedics and Neurosurgery, LLC (collectively "TOTAL MD") to serve as your healthcare provider. Except as otherwise provided by statute or regulation, Federal and State laws require your express written authorization to release protected health information including but not limited to, HIV/AIDS and Sexually Transmitted Diseases ("STDs"), Alcohol and Drug Treatment and/or Mental Health Treatment.

This form authorizes the release of sensitive health information and/or HIV-related information. By checking the box(es) below and signing this form, sensitive health information and/or HIV-related information can be given to the people listed herein, for the reason(s) listed.

Authorization. I hereby consent to the disclosure of the following health information **(please initial all that apply)**:

_____ Complete Medical Record
_____ Intake Forms
_____ Physician/Provider Notes
_____ Radiology Films and Reports
_____ Lab/Pathology Testing and Results
_____ Diagnostic Testing and Reports
_____ Medical Billing Records

I hereby further specifically consent to the disclosure of the following specific health information **(please initial all that apply)**:

_____ HIV/AIDS
_____ Sexually Transmitted Diseases
_____ Alcohol and Drug Treatment
_____ Mental Health Treatment
_____ Genetic Counseling/Testing Information
_____ Communicable Diseases

Recipient. My health information described above may be disclosed by TOTAL MD to the following person(s) or class of persons:

- Any other treating physician, provider or diagnostics/imaging center (ex: labs, MRIs, CAT scans, etc.)
- Insurance companies; 1st, 2nd, 3rd party payers or life/disability insurance companies.
- Prescribed medical durable supply companies and pharmacies.
- Workers' Compensation: By workers' compensation guidelines all your consultations, labs and test results pertaining to the injury are required to be released to your employer, workers' compensation carrier and their attorney, and you, the patient. Refusing to sign does not apply to a work related injury.
- Attorney: _____
  Telephone: _____
- Relative: _____
  Relationship: _____
  Telephone: _____
  Other: _____
  Relationship: _____
  Telephone: _____

Right to Revoke. I understand that I may restrict the individuals or organizations to whom my healthcare information is released. Further, I understand that I may revoke my authorization at any time; however, my revocation must be in writing via certified US mail to TOTAL MD at the office address listed below and/or facsimile at (561) 641-8303. TOTAL MD must only comply with such revocation to the extent it is consistent with its Notice of Privacy Practices. The revocation will be effective immediately upon TOTAL MD's receipt of my written notice, except that the revocation will not have any effect on any action taken by TOTAL MD in reliance on this Authorization before it received my written notice of revocation

Re-disclosure. Information that TOTAL MD uses or discloses based on the authorization I am giving may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal or state privacy rules.

Refusal. I have the right to refuse to give TOTAL MD this authorization. If I do not give the authorization, it will not affect the treatment I receive.

Inspect/Copy. I may inspect or copy the information that TOTAL MD may send at any time.

Term. Unless otherwise revoked, this authorization is effective as of the date set forth below and will remain in effect until (expires in one year if no date is provided):

_____ The following date or event: _____
_____ Total MD fulfills the request.

Purpose. I authorize TOTAL MD to use or disclose my sensitive health or HIV-related information to the recipient and for the term described above for the following specific purpose [for example: "At the request of the patient," "For purposes of diagnosis or treatment" or "For the purposes of my assessment, treatment plan, attendance or discharge plan"]:

I hereby acknowledge that I have received a copy of this authorization. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize TOTAL MD to use or disclose my sensitive health and/or HIV-related information in the manner described above.

_____
Signature of Patient

_____
Signature of Parent or Guardian (if applicable)

_____
Name of Patient (Print)

_____
Name of Parent or Guardian (Print)

Dated: _____

Purpose. I authorize TOTAL MD to use or disclose my sensitive health or HIV-related information to the recipient and for the term described above for the following specific purpose [for example: "At the request of the patient," "For purposes of diagnosis or treatment" or "For the purposes of my assessment, treatment plan, attendance or discharge plan"]:

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_____
Signature of Patient

_____
Signature of Parent or Guardian (if applicable)

_____
Name of Patient (Print)

_____
Name of Parent or Guardian (Print)

Dated: _____

USE THIS SECTION ONLY IF CLIENT REVOKES CONSENT

_____ _____
Date Consent Revoked | Signature of Client ot Legal Representative

_____ _____
Witness | Legal Representative's Relationship to Client

TOTAL MD

ASSIGNMENT OF BENEFITS

I, _____ , hereby authorize and direct_____ (Name of Insurance Carrier) to pay directly to Total MD, 4623 Forest Hill Blvd, Suite 101, West Palm Beach, FL 33415, such that may be due and owing for services rendered to me.

I hereby IRREVOCABLY ASSIGN to Total MD any rights and benefits, including the right to bring suit or settle claims, under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Total MD. In the event that my insurance company does not pay Total MD' bills in full and pursuant to the terms of my policy of insurance, I hereby instruct the insurance carrier to set aside all funds in an amount that would be sufficient to pay such bills in full in accordance with the charges submitted. As part of this assignment of benefits, I further instruct the insurance carrier to notify the provider immediately after any dispute as to the payment so that I may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examinations under oath or independent medical examinations. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief. In return for patient assigning the rights and benefits under insurance, Total MD will allow patient to have services rendered without collecting payments at this time.

Initials X_____

RELEASE OF INFORMATION: I hereby authorize Total MD (i) to release to my insurance company or attorney with any and all information that may be contained in my medical records including, but not limited to drug/alcohol treatment, mental health records, HIV/AIDs testing and results and STD testing and results; (ii) to obtain coverage information telephonically from my insurer; (iii) to request a written, non-redacted PIP payout log from the insurers; and (iv) to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors, without the patient's or the provider's prior expressed written permission. A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Total MD or any insurers providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein.

Initials X_____

POWER OF ATTORNEY: I hereby appoint and authorize Total MD and its agents and employees as power of attorney to endorse or sign my name on any checks, drafts or money orders for payment of medical services provided to me. Furthermore, I hereby appoint and authorize Total MD or any of its agents as power of attorney to sign my name on any paper that will be necessary to enhance, expedite and/or allow any claim for payment or payment to said provider.

Initials X_____

_____ _____

Signature of Patient or Personal Representative **Date:**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

TOTAL MD

CONSENT FOR EXAMINATION, CARE AND TREATMENT

I voluntarily consent to all medical examinations, testing, procedures, course of treatments, the administration of all anesthetics, and all medications which in the judgment or medical opinion of Total MD may be considered necessary or advisable for my diagnosis or treatment. I understand such services may include, but at not limited to, diagnostic tests, examinations, medications, radiological services, physical therapy and chiropractic treatments. I voluntarily consent to such medical services and treatments from any physician, mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), or other health care professionals, employees, independent contractors or designees of Total MD.

This consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, and this consent extends to all Total MD offices or any other satellite office or entity under common ownership or control. This consent will remain in full force and effective until it is revoked in writing. I understand I have the right to revoke this consent or discontinue the services of Total MD at any time. I also understand that I may be released by Total MD before my medical condition or issues are known or treated. It is my responsibility to make arrangements for any necessary follow-up care.

I understand I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I understand I am encouraged to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative **Date:**

Printed Name of Patient or Personal Representative **Relationship to Patient**

TOTAL MD

REQUEST FOR MEDICAL RECORDS

Date:_____

Patient Name: _____ Date of Birth: ____ / ____ /____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax:_____ Email: _____

I authorize the release of my medical records and/or other health care information, including intake forms, chart notes, reports, x-rays, and any other information concerning my health and treatment be sent to Total MD at the specified office location below.

In addition, I specifically authorize the release of the following protected health information to Total MD (initial all that apply):

____ Mental Health **____ HIV Testing** **____ Genetic Counseling/Testing**

____ Drug and/or Alcohol **____ AIDS Records** **____ STD/Communicable Disease**

☐	☐	☐	☐	☐
4623 Forest Hill Blvd. West Palm Beach, Florida 33415 P: (561) 967-8888 F: (561) 641-8303	8200 Okeechobee Blvd. West Palm Beach, Florida 33411 P: (561) 964-1111 F: (561) 967-3144	1905 Clint Moore Rd. Suite 308, Boca Raton, Florida 33496 P: (561) 981-8011 F: (561) 981-8013	2700 W. Cypress Creek Suite C100, Fort Lauderdale, Florida 33309 P: (954) 974-3111 F: (954) 974-6191	8100 Royal Palm Blvd. Suite 105 Coral Springs, Florida 33065 P: (954) 345-6789 F: (954) 345-7998

Signature of Patient or Personal Representative **Date:**

Printed Name of Patient or Personal Representative **Relationship to Patient**

TOTAL MD

CANCELLATION AND MISSED APPOINTMENT POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. It is important patients arrive on time for all scheduled appointments or cancel the appointment **24 hours** in advance. Total MD reserves the right to charge a fee of $30.00 for all missed or cancelled appointments without 24-hours advance notice.

The fee will be billed to the patient's account at Total MD's sole discretion. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple failures to provide timely notice of cancelled appointments, in any 12 month period, may result in your termination as a patient from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature of Patient or Personal Representative **Date:**

Printed Name of Patient or Personal Representative **Relationship to Patient**