



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: _____

Health Questionnaire

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	<input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Tension <input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Night Sweats <input type="checkbox"/> Irritability <input type="checkbox"/> Fainting <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Unexplained Weight Loss/Gain <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Change in Sleep Patterns
Skin	<input type="checkbox"/> Rashes	<input type="checkbox"/> Cancers	<input type="checkbox"/> Change in Hair, Skin or Nails
Eyes	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Changing Vision	<input type="checkbox"/> Double Vision <input type="checkbox"/> Discharge	<input type="checkbox"/> Pain
Ear, Nose & Throat	<input type="checkbox"/> Ear Pain <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Sore Throat <input type="checkbox"/> Change in Voice <input type="checkbox"/> Sinus Pain/Trouble	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Persistent Runny Nose
Heart	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Swelling in Ankles	<input type="checkbox"/> Palpitations
Lungs	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing
Gastro-Intestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Constipation	<input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in Bowel Movements	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting
Genito-Urinary	All: <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful or Frequent Urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Excessive Urination	Women: <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Change in Menstrual Cycle or Sexual Function	Men: <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Decreased Urinary Stream <input type="checkbox"/> Penile Discharge <input type="checkbox"/> Change in Sexual Function
Muscul-Skeletal	<input type="checkbox"/> Painful Joints <input type="checkbox"/> Numbness <input type="checkbox"/> Arm Pain (R or L) <input type="checkbox"/> Elbow Pain (R or L)	<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Back Pain <input type="checkbox"/> Leg Pain (R or L) <input type="checkbox"/> Wrist Pain (R or L)	<input type="checkbox"/> Muscle Spasm <input type="checkbox"/> Neck Pain <input type="checkbox"/> Knee Pain (R or L) <input type="checkbox"/> Shoulder Pain (R or L)
Neuro/Psych	<input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo	<input type="checkbox"/> Tremor <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Hand, Arm or Leg Weakness
Allergy	<input type="checkbox"/> Hives	<input type="checkbox"/> Hayfever	
Circulation	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Blood Clots	

List additional symptoms not listed above:



Health Questionnaire

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Emphysema/Lung Disease | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> 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)

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Emphysema/Lung Disease | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> 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



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 or Legal Representative

Witness

Legal Representative's Relationship to Client



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



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 are 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.

I authorize Total MD to make audio recordings of my visit(s) with health care providers at the practice. Such recording(s) will be used by the practice for treatment and operations purposes using AI technology and may be shared with their business associates for troubleshooting and product improvement purposes. Recordings will be maintained for a limited period of time for validation purposes before they are destroyed.

Signature of Patient or Personal Representative

Date:

Printed Name of Patient or Personal Representative

Relationship to Patient



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

2700 W. Cypress Creek, Suite C100
Fort Lauderdale, Florida 33309
P: (954) 974-3111 F: (954) 974-6191

8200 Okeechobee Blvd.
West Palm Beach, Florida 33411
P: (561) 964-1111 F: (561) 967-3144

933 N. University Drive
Coral Springs, Florida 33065
P: (954) 345-6789 F: (954) 345-7998

6501 Congress Ave., Suite 350
Boca Raton, Florida 33496
P: (561) 981-8011 F: (561) 981-8013

1380 N. University Dr., Suite 103
Plantation, Florida 33322
P: (954) 975-1111 F: (954) 974-6191

1100 SW St. Lucie West Blvd., Suite 105
Port St. Lucie, Florida 34986
P: (772) 249-5598 F: (772) 249-5752

Signature of Patient or Personal Representative

Date:

Printed Name of Patient or Personal Representative

Relationship to Patient



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