LUIS A. BOBEICA, M.D., P.A.
16244 S. MILITARY TRAIL, SUITE 220, DELRAY BEACH, FL 33484
PHONE: (561) 404-1022; FAX: (561) 404-1566

PATIENT INFORMATION FORM

LAST NAME, **FIRST** NAME, **MIDDLE** NAME: _____

Social Security No: _____ Date of Birth: _____ Sex (M/F): _____

Local Address: _____

City: _____ State: _____ Zip: _____

Out of State Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ **Work Phone**: (_____)_____

Cell Phone/Pager: (_____)_____ **E-mail**: _____

Married: _____ Widowed:_____ Divorced: _____ Spouse's name: _____

Emergency contact: _____ **Phone**: _____

Who referred you to our office? _____

PLEASE PROVIDE THE INSURANCE CARDS INFORMATION FOR OUR RECORDS

NAME OF PRIMARY INSURANCE: _____

Identification Number: _____ Group/ Policy Number: _____

NAME OF INSURED (if different than Patient): _____

Date of Birth: _____ Sex (M/F):____ Relationship: _____

NAME OF SECONARY INSURANCE: _____

Identification Number: _____ Group/ Policy Number: _____

Responsible Party Signature: X _____

PRINT NAME: _____ **Date**: _____

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I understand that it is my responsibility to pay any deductible amount, coinsurance or any other amount not paid by insurance or third party payer within a reasonable period of time not to exceed 60 days. If it becomes necessary to effect collections of any amount owned for this or subsequent visits, the undersigned (or personal and/or legal guardian or representative) agrees to pay for all costs associated with said collection including reasonable attorney fees. Furthermore, accounts assigned to collections will be assessed a 30% collection fee.

Signature (Patient/Legal Guardian) X _____

I request that payment of authorized benefits be made on my behalf to LUIS A. BOBEICA, M.D., P.A. for any services furnished to me by this provider. I authorize any holder of medical information about me to release to my insurance carrier(s) or its agents any information needed to determine these benefits or benefits payable for services from this provider.

Signature (Patient/Legal Guardian) X _____

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PATIENT NAME: _____ **DOB**:_____ MR#_____

Reason for your visit today: _____

ALLERGIES _____

Have you been treated by a physician in the past 2 years? _____ YES _____ NO

If so, for what condition(s)? _____

Date of last Yearly Routine Physical: _____ Date of your most recent blood work: _____

Date of: LAST COLONOSCOPY _____ LAST PSA _____ LAST PAP _____ LAST MAMMO_____

PLEASE CHECK ANY OF THE FOLLOWING THAT MIGHT APPLY TO YOU:

____ High blood pressure
____ Prior heart attack
____ Heart failure
____ Chronic lung disease
____ Diabetes __ pills __ insulin
____ Unintended weight loss
____ Unintended weight gain
____ Fatigue
____ Fever/chills
____ Sweats
____ Intolerance of heat
____ Insomnia

EYES:
____ Loss of vision
____ Cataracts
____ Cataract surgery
____ Glaucoma
____ Intolerance of bright light

CARDIOVASCULAR:
____ High Cholesterol
____ High Lipids
____ Angina/Chest pain
____ Bypass surgery
____ Angioplasty
____ Irregular beat
____ Palpitations
____ Poor circulation

RESPIRATORY:
____ Emphysema
____ Asthma
____ Sleep apnea
____ Shortness of breath
____ Chronic cough
____ Hoarseness

GASTROINTESTINAL:
____ Ulcers
____ Acid reflux
____ GERD
____ Persistent heartburn
____ Nausea
____ Vomiting
____ Constipation
____ Diarrhea
____ Blood in stool
____ Abdominal pain
____ Difficulty swallowing
____ Hepatitis

URINARY:
____ Kidney stones
____ Kidney failure
____ Dialysis
____ Burning w/urination
____ Blood in urine
____ Past infections

MUSCULOSKELETAL:
____ Arthritis
____ Replacements
____ Gout
____ Osteoporosis

BREAST/GYN:
____ Biopsies
____ Lumps
____ Abnormal Mammogram
____ Breast pain
____ Bleeding/discharge
____ Pelvic pain

SKIN:
____ Skin cancer
____ Moles
____ Eczema

NEUROLOGIC:
____ Epilepsy
____ Seizures
____ Fainting
____ Stroke (date _____)
____ Headaches
____ Numbness
____ Tingling
____ Dizziness

PSYCHIATRIC:
____ Depression
____ Anxiety
____ Feeling of despair
____ Panic attacks
____ Mental illnesses

ENDOCRINE:
____ Overactive thyroid
____ Underactive thyroid
____ Mass

HEMATOLOGY:
____ Blood clots
____ Varicose veins
____ DVT
____ Anemia
____ Bruising

FAMILY HISTORY: Father: _____ Alive _____ Deceased Medical Problems _____
Mother: _____ Alive _____ Deceased Medical Problems _____
Brothers _____ Sisters _____

Does anyone in your immediate family suffer from: __Heart Disease; __High Blood Pressure; __Cancer; __Diabetes?

Cancer Survivor (Details please): _____

Do you: _____ Smoke _____ Drink _____ Use recreational drugs

Past surgical history: _____

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MEDICATION SHEET

(Please list ALL prescription and OTC medication)

Patient's Name: _____ DOB: _____

Your Pharmacy is: _____ Phone#: _____

DATE	MEDICATIONS	DIRECTIONS	COMMENTS

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NOTICE OF PRIVACY PRACTICES

Patient's Copy

THIS NOTICE DESCRIBES HOW YOUR MEDICAL HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy practices, our legal duties, and your rights concerning your health information. We must follow the Privacy practices that are described in this Notice while it is in effect. This Notice took effect on April 14, 2003 and will remain in effect until further notice.

We reserve the right to change our Privacy Practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our Privacy Practices and the new terms of our Notice effective for all health information that we maintain, including health information that we created or received before we made the changes. Before we make a significant change in our Privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations; for example:
TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.
PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.
HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone. If you give us an authorization, you may revoke it as long as it is in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
VERBAL REQUEST: when you call our office and request test results to be faxed or mailed to another doctor's office we will be confirming your identity by asking for asking for your date of birth.
To your family and friends – We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Person involved in care – We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Marketing Health – Related Services – We will not use your health information for marketing communications without your written authorization.
Required by Law – We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect – We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or others.
National Security – We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to a correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders – We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access – You have the right to look at or get copies of your records with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.
Disclosure accounting – You have the right to receive a full list of insurances in which we or our business associates discloses your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction – You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will be abide by your agreement (except in an emergency).
Alternative Communication – You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations you request.
Amendment – You have the right to request that we amend your health information. Your request must also be in writing, and it must explain why the information should be amended. We may deny your request under any circumstances.
Electronic Notice – if you receive this Notice on our website or by electronic (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services, address provided upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact information:

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16244 S. Military Trail, Suite 220
Delray Beach, FL 33484
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign the acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices. You have my permission to release my medical records/ information to my _____, whose name is _____.

Date: _____

Signature: _____

FOR OFFICE USE ONLY

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be contained because:

_____ Patient refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency prevented us from obtaining the acknowledgement

_____ Other: _____

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Dear Patient,

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Therefore, we urge you, the patient or the representative, to call your insurance company regarding your coverage. It is your responsibility to know your individual coverage and to be aware of any changes. Failure to comply could result in you being responsible for all costs incurred at this office. Please remember your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

We are happy to assist you in this process by calling the insurance company prior to your initial visit to get you benefit coverage. However, as the insurance companies tell us, verification is not a guarantee of payment. Some insurance companies do not allow the patients to go out of network. Others do allow the patients to go out of network, but at a higher cost to the patient.

After contacting your insurance company, please call our office if you have any questions or concerns.

Returned Check Policy: Writing a bad check is against the law. There is a $30 fee for all returned checks. If we receive a returned check, you must pay the balance, including the fee, with Visa, MasterCard or cash only.

Having read the above, please sign below.

Thank you.

Name of Patient or Representative _____

Signature X_____ Date_____

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CONSENT TO RELEASE INFORMATION TO POWER OF ATTORNEY/ NEXT OF KIN

DATE: _____

I (print name) _____ give my consent to release medical information or my whereabouts from LUIS A. BOBEICA, M.D., P.A.'s office to _____, relationship being _____.

Signature: X _____
(Patient Signature)