DOCS
DOCTORS OF CLINICAL SPECIALTIES

☐ 483 N Semoran Blvd, Ste 210 Winter Park, FL 32792
☐ 255 Citrus Tower Blvd, Ste 212 Clermont, FL 34711
☐ 515 W State Rd 434, Ste 301, Longwood, FL 32750
☐ 515 W State Rd 434, Ste 302, Longwood, FL 32750
☐ 1307 S. International Pkwy, Ste 2071, Lake Mary, FL 32746
☐ 634 Deltona Blvd, Ste B Deltona, FL 32725
☐ 801 West Oak St, Ste 202, Kissimmee, FL 34741

Check DOCS location above that you are visiting:

Patient Name: _____
Date: _____

Last Name:		First Name:		Mid. Initial:	
DOB:		SSN#:		Sex:	
Race:		Ethnicity:		Language:	
Home Address1:				Apt/Suite #:	
City, State, Zip:		Email:			
Home Phone:		Work Phone:		Mobile Phone:	
Preferred Phone Method: ☐ Home ☐ Work ☐ Mobile			Communicate by: ☐ Voice ☐ Email ☐ Text		

EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)

Name: Phone: Relationship:

Name of Primary Care Provider: **Provider Number:**

PLEASE GIVE THE RECEPTIONIST YOUR CURRENT INSURANCE CARD AND YOUR DRIVERS LICENSE

PRIMARY INSURANCE

Plan/Policy Name: Group #:
Plan Phone: Subscriber DOB:
Subscriber Name: Subscriber ID:

SECONDARY INSURANCE

Plan/Policy Name: Group #:
Plan Phone: Subscriber DOB:
Subscriber Name: Subscriber ID:

PREFERRED PHARMACY

Pharmacy Name: Pharmacy Phone:

PATIENT METHOD OF DISCLOSURES

The HIPAA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home Phone: _____
☐ Ok to leave detailed message
☐ Leave message with call back number only

Work Phone: _____
☐ Ok to leave detailed message
☐ Leave message with call back number only

Mobile Phone: _____
☐ Ok to leave detailed message
☐ Leave message with call back number only

☐ **Ok to mail to my home address listed above**

☐ **Ok to E-mail to:**
Name: _____

☐ **Ok to sign up for patient portal**

☐ **I have a Power of Attorney (POA)**

☐ **I have an Advance Directive (Living Will)**

List any Persons Allowed to obtain your Health Info on your behalf:_____

_____

I am aware that by providing my home and mobile phone number and email, I am agreeing to receive automated phone calls, text messages and email reminders. I am aware if at any time I no longer want these services, it is my responsibility to notify the office in writing to opt out.

Patient or authorized person's signature: _____

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Patient Name: _____
Date: _____

Authorization for Treatment

Consent to treatment: I and/or authorized representative voluntarily consent to any and all medical care by DOCS that may include but not limited to examinations, tests, photographs, and treatments by physicians and the staff. No promises have been made to me as to the results of treatments or examinations.

Patient or authorized person's signature: _____

Authorization for Release of Information

Authorization for Release of Confidential Information: I hereby authorize DOCS to release medical information contained in my (the patient's) records to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of records may also be sent to referring physicians and primary care providers for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures performed in our office**.**

Patient or authorized person's signature: _____

Consent for Review of Prescription History

I authorize DOCS to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medications used in the past. I understand my prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff.

Patient or authorized person's signature: _____

Notice of Privacy Practice Acknowledgement Form

I understand that I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been offered a copy of DOCS Notice of Privacy Practices (available in our office or on our website) and understand that the Notice may change at any time. I give consent to DOCS to obtain my prior medical records from outside practices and send office notes to other physicians to coordinate care on my behalf. You have the right to revoke this consent, in writing, except if we have already made releases in reliance on your prior consent.

Patient or authorized person's signature: _____

Financial Policy

In compliance with the Federal Consumer Protections Act, DOCS is providing you with information regarding your financial responsibilities.

We ask that you take the time to read our policy so we can avoid any misunderstandings. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions.

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care.

Insurance: DOCS participates in many insurance plans. Please contact your insurance company to make sure we participate with your insurance. We do our best in verifying your eligibility and benefits, however, it is your responsibility to know your insurance coverage. It is our policy that you provide us with your insurance card at every visit to our office. If you cannot provide active insurance coverage at the time of services rendered you will be considered uninsured and payment will be due at time of service. It is your responsibility to notify DOCS of any insurance and/or policy changes.

Referral / Authorization: If your insurance company requires a referral/authorization for office visits, testing, or procedures, you are responsible for obtaining the referral/authorization. If the referral/authorization is not obtained, you will be responsible for payment in full for services rendered on the date of service. Some insurance plans require your primary care provider to pre- authorize services done by a specialist. As a courtesy, DOCS will try to obtain the referral/ authorization for you.

Patient Payments: Co-pays, deductibles, co-insurance (20%, etc.), services not covered by your insurance plan or outstanding balances are due at the time of your appointment. We accept cash, checks, and most major credit cards. Returned checks will be subject to a fee of $25.00 charged by this office for each check returned to us by your bank. Should you have any balances on your account, we will provide you with a monthly statement. The statement will include but not limited to amounts billed to you, any payments received and detailed aging. It is your responsibility to keep your mailing address current. In cases of hardship, please contact manager or billing representative to see if payment arrangements can be made for outstanding balances. This will be done on case by case bases.

Collections Policy: Payment for services which have been billed to you is due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule, your account may be turned over to an outside agency for resolution.

No Show Fee: Effective June 16, 2006 there will be a $25.00 fee assessed for no show appointments. No shows are appointments that are not cancelled with a 24 hour notice. With appropriate notice, we are able to schedule other patients in a vacant time slot and to also decrease wait times by not having to work-in emergent patients. Some of our testing and procedures have a separate no show policy.

I assign payment directly to DOCS, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be a delay in payment. I agree to actively pursue collection insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

I understand that I am financially responsible for my (the patient's) account with DOCS, regardless of my insurance benefits.

I authorize a copy of this form to be valid as the original.

Patient or authorized person's signature: _____

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Patient Name: _____
Date: _____

Social History- Please check all that apply

Marital Status	☐ Single	☐ Widower	☐ Divorced	☐ Married
Employment statues	☐ Full Time	☐ Part time	☐ Student	☐ Retired
List your occupation	_____			

Are you a smoker ☐ YES ☐ NO If yes, how many daily? _____

☐ **Former Smoker** When did you quit? _____

Do you Drink Alcohol? ☐ YES ☐ NO If yes, how much? _____

Do you use illicit drugs? ☐ YES ☐ NO If yes, what drug and how often?

Family History- Please check all that apply

Are you adopted? ☐ Yes

Father ☐ Living ☐ Deceased ☐ Cause of Death / age: _____

Mother ☐ Living ☐ Deceased ☐ Cause of Death / age: _____

When was your last eye exam? _____ Do you have: ☐ Eyeglasses ☐ Contacts

Medication- Please List any medication allergies or intolerances and reactions: _____
_____
_____

Please List all your current medications (including supplements, vitamins and over the counter):

Medication Name	Dose / Instruction	Medication Name	Dose / Instruction
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

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Patient Name: _____
Date: _____

Review of Systems

Please check all that apply

Constitutional:	☐Weight Loss	☐ Weight Gain	☐ Fatigue
Cardiovascular:	☐ Angina, Chest Pain	☐ Abnormal blood pressure	☐ Abnormal heart rate
	☐ Abnormal EKG	☐ Hypertension	☐ Palpitations
	☐ Heart Attack	☐ Edema, Swelling in legs or feet	☐ Arrhythmia
	☐ Heart Murmur	☐ Edema, Swelling in abdominal	☐ Passing out or Black-out Spells
	☐ Congenital Heart defects	☐ Claudication issues	☐ Leg pain ☐ R ☐ L
	☐ Varicose ☐ R ☐ L	☐ Restless legs ☐ R ☐ L	☐ Leg discoloration ☐ R ☐ L
Respiratory:	☐ Cough	☐ Coughing up blood	☐ Shortness of Breath
	☐ COPD	☐ Asthma	☐ Pneumonia
Ear, Nose and Throat (ENT):	☐ Difficulty hearing	☐Ringing in ears	☐ Vertigo
	☐ Bleeding Gums	☐ Sore Throat	☐ Allergies
Gastrointestinal:	☐ Heartburn	☐ Nausea/Vomiting	☐ Blood in Stool
	☐ Change in bowel movement	☐ Constipation	☐ Diarrhea
	☐ Abdominal Pain	☐ Hemorrhoids	☐ Ulcers
Genitourinary:	☐ Pain while Urinating	☐ Burning while Urinating	☐ Difficult Urinating
Hematologic:	☐ Bruising Easily	☐ Anemia	☐ Enlarged Glands
Musculoskeletal:	☐ Arthritis	☐ Decreased Motion	☐ Gout
	☐ Back Pain	☐ Muscle Pain	☐ Neck Pain
	☐ Joint Pain	☐ Joint stiffness	
Skin:	☐ Rash or Sores	☐ Itching/Burning Skin	☐ Psoriasis
Neurological:	☐ Dizziness	☐ Seizures	☐ Weakness
	☐ Numbness	☐ Tremor	☐ Headache
	☐ Spasticity (Spasm)	☐ Memory Loss	☐ Stroke
	☐ Speech impairment	☐ Difficulty with walking	☐ Difficulty with balance
Psychiatric:	☐ Anxiety	☐ Depression	☐ Insomnia

Patient or authorized person's signature: _____

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Patient Name Date of Birth

Please provide us with the following information so your prescription (if any) may be expeditiously sent to the pharmacy of your choice electronically. Our system communicates with thousands of pharmacies nationwide, we would like to make sure if a prescription is assigned to you, it **reaches** the pharmacy of your choice.

Local Pharmacy

Name: _____

Phone Number:_____

Address:_____

City & Zip code:_____

Long Term Pharmacy (90 days or more)

Name:_____

Phone Number:_____

Address:_____

City & Zip code:_____