# Welcome to my practice.

**Striving together for a healthier You.**

**And thank you for considering me as your physician.**

**My mission is to:**

**Provide personalized concerned care.**

**Observe, hear and see the total you.**

**And to be available.**

| | |
|---|---|
| **Professional background:** | **Board Certified Family Physician** |
| **1984-2004** | **Family physician in Miami** |
| **2005-2011** | **Family physician at the Veterans Administration** |
| **2013-Present** | **Family physician in Miami** |
| **2000** | **'Physician of The Year'** |
| | **The Florida Academy of Family Practice** |
| **2003-2005** | **President and Chairman of** |
| | **The Florida Academy of Family Practice** |

***A copy of my CV is available upon request.***

**Once again, striving together for a healthier You!**

*Sincerely,*

**Fleur Sack MD**

# Fleur Sack M.D.

## Office Information

| | |
|---|---|
| **Tel & Fax & Email:** | Tel: 786-871-7188 Fax: 786-718-1417 Email: Simonfrank@fleursack.com |
| **Office Hours:** | Monday & Thursday 9:30 AM – 5:00 PM |
| | Tuesday & Friday 8:00 AM – 3:30 PM |
| | Lunch 1:00 PM – 2:00 PM. |
| | Wednesday: No Appointments. Dr. Sack and Maria are not in the office. |
| **Address:** | 8740 SW 88th St, Suite 112, Miami, FL 33176. |
| **Notify the office:** | Most important to immediately notify Dr Sack if you go to an Urgent Care Center or an ER or are admitted to the hospital. – Dr. Sack needs to know |
| **Patient Portal:** | Your best choice to send messages to the office is to enroll in the Patient Portal. . |
| **Staff:** | Donna Gehring – Office Manager: Donnagehring@fleursack.com |
| | Maria Quiroz – Medical Assistant: Mariaquiroz@fleursack.com |
| | Simon Frank – Practice Manager: Simonfrank@fleursack.com |
| **Parking:** | Free valet parking opposite the middle building. Parking is permitted on the grass on 87th Court. |
| **Fees:** | Filling out forms - $20 |
| | Blood draw - $20 |
| | No show - $100 |
| **HMO Insurance:** | **HMO PATIENTS – YOU MUST CALL THE HMO AND LIST DR. SACK AS THE PCP.** |
| **Vaccines:** | Medicare Part D does not cover vaccines in a doctor's office. |
| **Co-pays and Co-ins:** | Co-pays, Co-insurance and Deductibles are patient responsibilities. |
| **Wellness Visits:** | Note: Insurance allows only **one** free annual wellness visit in a year. |
| **Self Pay:** | Ask for the Self Pay Fee Schedule. |
| **Coverage:** | A panel of colleagues cover when Dr. Sack is not available. |
| **Arbitration:** | Signing the arbitration agreement is mandatory. |
| **Liability Insurance:** | Notification: Dr. Fleur Sack does **not** carry medical liability insurance. |
| **Vital Information:** | CALL THE OFFICE IF TELEPHONE, ADDRESS or INSURANCE CHANGE; PLEASE! |

ONCE AGAIN "WELCOME TO OUR PRACTICE"

STRIVING TOGETHER FOR A HEALTHIER YOU!

Dr. Fleur Sack, Maria, Donna and Simon

# Patient Information Sheet

**Name:** _____
Title First Last Nickname

Date of Birth: _____ Gender Identity: _____ Marital Status: _____

Race: _____ Ethnicity: _____

Referred by: _____

Address: _____
Street City State ZIP code

Phone: _____
Home Mobile Work

Email: _____

**Primary Insurance**: _____ Insured's Name: _____

Policy # _____ Group # _____

Second Insurance: _____ Insured's Name: _____

Policy # _____ Group # _____

**Local Pharmacy:** _____
Name Phone

Address: _____
Street City State ZIP code

Mail Order Pharmacy: _____
Name Phone

Address: _____
Street City State ZIP code

**Emergency Contact:** _____
First Last

_____ _____
Relationship Phone

**Fleur Shirna Sack M.D. LLC/Fleur Sack M.D.**
**Patient Consent Form**

*I fully understand that I am financially responsible to Dr. Sack for all charges, including balances or fees not covered by my insurance or if I have no valid insurance.

*I give permission to Dr. Sack and her staff to leave messages concerning my lab results and personal health information on my answering service/voicemail: (Circle) YES NO

*I understand email is not secure, however, I give Dr. Sack and her staff permission to email my lab results and personal health information to me on my request: (Circle) YES NO

*Dr. Sack and her staff may discuss my personal health information with the following:

**Name:** _____ **Relationship:** _____ **Phone:**_____

**Name:** _____ **Relationship:** _____ **Phone:**_____

*I am aware that I am entitled to request a copy of Dr. Sack's Notice of Privacy Practice. I am aware that this notice may be changed at any time. (Circle) YES NO

*I am aware that Dr. Sack does not carry Professional Liability Insurance (also known as Medical Malpractice Insurance). (Circle) YES NO

*I am aware I am required to sign a Mandatory Arbitration Agreement that governs any legal disputes that may arise and on signing the Agreement I give up my right to a trial by jury.
(Circle) YES NO

*I am aware if I do not consent to any of the above items or later revoke my consent, the practice may refuse to treat me.

Name: _____Sign: _____Date: _____

# Fleur Shirna Sack, M.D./Fleur Shirna Sack M.D. LLC

**8740 North Kendall Drive**

**Miami, FL 33176**

**Under Florida law, Physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.**

## YOUR DOCTOR, FLEUR SACK M.D. HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

**This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.**

**I have read and understood the above.**

**By Patient: Sign:**_____ **Date:** _____

**Print Name:**_____

# Fleur Shirna Sack, M.D./Fleur Shirna Sack M.D. LLC

## ARBITRATION AGREEMENT

By signing this agreement you are waiving your right to a jury trial and you are agreeing to arbitrate all claims arising out of or related to your medical care and treatment.

### ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT.

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE AND TREAMENT. The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. WAIVER OF RIGHT TO JURY TRIAL. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

3. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including the patient, the patient's estate, any spouse or heirs of the patient, any biological or adoptive parent of the patient and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim.

   In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

**Initial ____**

4. ARBITRATION PROCEDURES. The parties agree and recognize that the provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, 766.106 or 766.207, the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Accordingly, any demand for arbitration shall not be made until the conclusion of the pre-suit screening period under Florida Statutes, Chapter 766. Within (20) twenty days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each have an absolute and unfettered right to appoint an arbitrator of its choice and shall give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

5. NICA. Nothing in this Agreement shall be construed as a waiver of any law related to Florida's Birth Related Neurological Injury Compensation Plan (Florida Statutes 766.301 - 766.316, hereinafter the "Plan"). If a request to submit a claim to the Plan is made by a party to this Agreement, all arbitration proceedings shall be stayed until it is determined whether the claim filed with the Plan is compensable. In accordance with the Plan, claims for "birth-related neurological injury", as defined by the Plan, shall be the exclusive remedy except that a civil action shall not be foreclosed and shall be submitted to binding arbitration in accordance with the Agreement where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety or property, provided that such suit is filed prior to and in lieu of payment of an award under the Plan and provided that such suit shall be filed before the award of the Division of Administrative Hearings becomes conclusive and binding.

6. ARBITRATIION EXPENSES. Expenses of the arbitration will be shared equally by the parties to this agreement.

7. APPLICABLE LAW. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. **Initial ____**

The arbitration panel shall allow for reasonable discovery in accordance with the issues raised related to any claim based upon a reasonable schedule set by such arbitration panel, which shall at least include discovery related to: the disclosure of experts and witnesses; expert, witness and party depositions; and written discovery, including the power of each party to issue subpoenas. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims and damages related thereto, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, caps on damages under Florida Statutes 766.118, the applicable statute of limitations and repose as well as and the application of collateral sources and setoffs shall be applied. Venue for the arbitration shall be held in the county where the medical services, that are the subject of the arbitration were rendered.

8. EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION. In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this arbitration agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this arbitration Agreement who refuses to go forward with the arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

9. SEVERABILITY. If any provisions of this Agreement are held invalid or unenforceable, the remaining provisions will remain in full force and shall not be affected by the invalidity of any other provision.

ACKNOWLEDGEMENTS BY PATIENT. The patient by signing this agreement also acknowledges that he or she has been informed that:

a. NO DURESS. The agreement shall not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree. **Initial** ____

b. AGREEMENT BASED UPON OWN FREE WILL. The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician.

c. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL. Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement.

The resolution of claims covered by this Agreement will be determined by a panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision.

d. READ AGREEMENT AND UNDERSTOOD. I have read and understand the above Agreement. I understand I have the right to have my questions about arbitration or this Agreement answered and I do not have any unanswered questions. I execute this agreement of my own free will and not under any duress.

e. SIGNATURE OF AGREEMENT. This Agreement shall be effective upon the patient and/or the patient's representative's signature below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

By signing this Agreement you are waiving your right to a jury trial and you are agreeing to arbitrate all claims arising out of or related to your medical care and treatment.

**By Patient:** Sign: _____ Date: _____

Print Name: _____

**By Physician:** **Sign**: _____ Date: _____

Print Name: Fleur Sack MD

# Clinical Information

Name: _____ Date: _____

What is purpose of office visit today? _____

_____

_____

Social History

Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other

Sexually Active? ( ) Yes ( ) No

Birth Control: _____

Education Level: _____

Occupation: _____

Religion: _____

Smoking Status: ( ) Never Smoker

( ) Present Smoker – How long? _____, How much? _____

( ) Former smoker – Date quit _____,

How long? _____, How much? _____

Alcohol: How much? _____

Drug use: Present _____ Past _____

Exercise: ( ) Sedentary ( ) Moderate ( ) Vigorous

Mental Health Provider? _____

_____

## Family History

Mother: ( ) Alive ( ) Deceased, Medical problems: _____

Father: ( ) Alive ( ) Deceased, Medical problems: _____

Maternal Grandmother: ( ) Alive ( ) Deceased, Medical problems: _____

Maternal Grandfather: ( ) Alive ( ) Deceased, Medical problems: _____

Paternal Grandmother: ( ) Alive ( ) Deceased, Medical problems: _____

Paternal Grandfather: ( ) Alive ( ) Deceased, Medical problems: _____

Siblings: ( ) Alive ( ) Deceased, Medical problems: _____

Children: ( ) Alive ( ) Deceased, Medical problems: _____

## Personal History

Present Health Issues: _____

_____

Past Health Issues: _____

_____

## Past Hospitalizations

_____

_____

## Surgical History

_____

_____

_____

## Preventive Care

Have you had?

( ) Bone Density Date_____ Place of Service: _____

( ) Mammogram Date_____ Place of Service: _____

( ) Colonoscopy Date_____ Place of Service: _____

( ) PSA – screening test for prostate cancer Date: _____

_____

## Immunizations

( ) Tdap – vaccine for tetanus & whooping cough Date:

( ) Flu vaccine Date: _____

( ) Pneumococcal vaccine Date: _____

( ) Prevnar vaccine Date: _____

( ) Zoster - Shingles vaccine Date: _____

( ) HPV - Gardasil vaccine Date: _____

Allergies to Medications: _____

_____

Current Medications & Dosages: _____

_____

_____

_____

_____

_____

Names of other Providers: _____

_____

_____

_____

_____

_____