6150 SW 76 St, 1st Floor
Miami, FL 33143
Tel: (786) 709-9990
Fax : (800) 445-9844

Patient Information:

Patient Name: ___________________________________ Social Security Number: ______/______/______

Date of Birth: _____/_____/_____ Sex: M / F (**Circle one**) Marital Status: Married/Single/Divorced/Widow

Address: ____ Zip Code:__________________

Home Phone: (______) _______-_______ Cell Phone: (_____)_________-_________

E-mail Address: __________________________________ (to view future labs on your portal/appt confirmations)

Preferred Language: Spanish or English

Employer Name: _______________________________ Employer Phone: (____)________________

Referring Physician: ____

****How did you hear about us?** ____

Who to call for an emergency:

Name: _________________________ Address:____

Home Phone: (_____) _______ - ________ Work Phone: (_____) _______-_______

Cell Phone: (______) _______-________

Relationship: ________________________

INSURANCE INFORMATION

Ins. Company: ______________________________________*I.D. #: _______________________ Group #: _____________

*Policy Holder: ________________________________ Policy Holder's SS#: _______________ Date of Birth:___________

SECOND INSURANCE INFORMATION

Ins. Company: ______________________________________*I.D. #: _______________________ Group #: _____________

*Policy Holder: ________________________________ Policy Holder's SS#: _______________ Date of Birth:___________

Advance Directive

1. Do you have a health care surrogate? Yes/No
   Name of the health care surrogate: _________________________ Relationship: ____________ Ph: ___________
2. Do you have a Living Will? Yes/No
   Person that a representative can speak to regarding my conditions: _____________________________________

Insurance Release Information

I hereby authorize the office Prime MD Miami, to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Prime MD Miami. I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient Signature: ___________________________________ Date: ________________________

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Notice to All Patients

Your health plan has specific regulations you must follow in order for you to avoid liability from full payment on service rendered by our physicians.

Payment Policy: Please be prepared to present your insurance card and Identification Card at every visit. Ensure that our Doctor actively participate with your insurance carrier. Be aware of your insurance policy benefits and limitations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to paying full at the time of the visit. All insurance co-payments, deductibles, and Co-insurance must be paid at the time of service.

Patients may receive and are responsible for bills for services sent to another facility such as a laboratory or diagnostic center which may not be covered by the insurance. Patients will be responsible for any bills of unpaid services, including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statements will be mailed for unpaid services. Balances must be paid in 30 days. If a balance is due over 90 days and we have not been contacted to arrange payments, the account may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan. We accept Cash, Visa, MasterCard, Discover, and Personal checks.

Please familiarize yourself with every rule of the health plan you are enrolled in. your insurance company will mail a summary of charges, payments, denials, or requests for your further information. Please review all insurance correspondence.

Referrals Policy: Many Insurance companies require authorization through you PCP before seeing a specialist. This process can take **up to 5 business** days to complete. If your PCP believes you need to see a specialist, call the specialist to confirm the doctor is on your insurance plan and make an appointment. Call our office back with the name of specialist, the appointment date, and time. **Allow 3-5 business day for the completion of your referral**.

Non-Cancellation Policy: Please be courteous and call us if you cannot make your scheduled appointment 24 hours in advance. This allows us to see other patients who may be in need is our services. Patients who do not cancel their appointment you will be charged a **NO-SHOW fee of $25.00**

Forms: There is a $20 to complete the non-insurance related disability, jury duty or school forms.

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Test Results: Please call the office after a week from the day of specimen collection for results, depending on the results Prime MD Miami may require a follow-up visit to review and discuss any diagnostic testing or pathology results

Walk-In Policy: We see all patients by appointments and offer same day appointment scheduling. Unless deemed urgent, patients who arrive without an appointment will be given the **next available open appointment**.

Prescription Refill Policy: Prescription refill requests should be phoned in during regular office hours. Provide all pertinent information including the patient's name, date of birth, name of medication, dose, pharmacy name and number. Allow up to 3 business day for us to prepare the prescription. Certain Chronic and recurrent conditions

May require a visit for re-evaluation before a refill is provided. **We do not call in or refill antibiotics without having seen the patient first.**

Please sign and return to the front desk after reading it. If you have any questions, feel free to speak to one our office personnel.

I have read and understand the above information.

Patient Name: ____

Signature: ____ Date: ______________________

Witness: ____

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Medical History

Please complete the following questionnaire prior to your appointment with the physician. This information is very important to us for your care so please answer all the sections as accurately as possible.

Name: ____ Date of Birth: ___________________________ Age: _________

Pharmacy (Must have one for future use)

Name: ____ Phone: __________________________

Address: ____ Zip Code___________________

****Why are you seeing the doctor today:**

____

How long have you had this problem: ____

List your current medications: **(if not please write "None")**

Medications:

Name	Dose	How many times a day?
1. _______________________________	___________	_______________________
2. _______________________________	___________	_______________________
3. _______________________________	___________	_______________________
4. _______________________________	___________	_______________________
5. _______________________________	___________	_______________________

List your **Medical Problems:** (example: high blood pressure, diabetes, etc.)

1. ______________________	2. ______________________	3. ________________________
4. ______________________	5. ______________________	6. ________________________
7. ______________________	8. ______________________	9. ________________________

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Do you have any **Allergies**? **(if not please write "None")** ____

List all your previous **Surgeries** and dates **(if not please write "None"):**____________________

1.____________________________2.____________________________3.____________________________
4.____________________________5.____________________________6.____________________________

Hospitalization

1.____________________________2.____________________________3.____________________________
4.____________________________5.____________________________6.____________________________

Family History

Do you have anyone in your immediate family who has been diagnosed with Heart disease, Diabetes, Arthritis, Kidney disease, blood disorder, Blood clots, etc.? If yes, please list below the family member affected and what their condition was. **(if not please write "None")** ________________

RELATIVE	**CONDITIONS**
Mother:	
Father:	
Paternal Grandmother and/or Paternal Grandfather	
Maternal Grandmother and/or Maternal Grandfather	
Other:	
Other	

Social History

Do you smoke? **NO/YES** cigarettes pks/day_______#Years______ Ex-smoker: _______ Quit: ______Years/Ago
Do you drink Alcohol? **NO/YES** Type: ________________ Drinks/Week: __________# of Years_______
Ex-Drinker: Drank for _______ Years _______Drinks/Week Quit: _________Years/Ago
Are you sexually active? **YES/ NO**
Do you consume any drink that has caffeine? **NO/YES** type: coffee/tea/energy drink/____________ cups per day _____
Do you exercise: **NO/YES** if yes how many days a week _________
Additional information we should know about you:
____

I acknowledge the above information is true to the best of my knowledge.

Patient Name (print): ____Date: ____________________

Signature: ______________________________________Med. Asst: ______________________

Medical Use Only

Vital Signs: TEMP_______HR_______BP_______HT_______WT_______BMI_______R_______OX_______

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MIAMI

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Patient Name:____DOB_____________

Depression Screening

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __*0*__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Notice of Privacy Acknowledgement

Prime MD Miami, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ ____________________

Patient Name or Legal Guardian (print) Date

____

Signature

Office Use Only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _______________ Attempt: ____

Staff Name: ___________________________________

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MEDICAL RECORD RELEASE FORM

Prime MD Miami

Rekha Kini, MD
Kim Bango, MD

Patient Name ____________________________________ Date of Birth ______________________

I hereby authorize the below listed entity to release medical information to **Prime MD Miami**:

Name: ____ Telephone#: ___________

Address: ______________________________________ Fax#: ______________

____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records: ____________________________________
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.} ____________________

____ ____________________

Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.