ROSA M. GARCIA, M.D

PATIENT INFORMATION

DATE: ____________________ ALLERGIES: ________________ REACTION: ______________________

NAME: ____DOB:___/______/______

SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED ( ) S. S. # __________________ MALE ( ) FEMALE ( )

RACE: ___________________________ ETHNICITY: ____

PREFERRED LANGUAGE: ____

HOME ADDRESS: ____

CITY: ___________________________STATE: ____________ ZIP: ____________________________

PHONE: ___________________________ CELL #: ____

EMAIL: ____

SPOUSE NAME: ____

PHARMACY NAME & PHONE NUMBER: ____

EMERGENCY CONTACT NAME AND RELATION: ____

CONTACT PHONE #: ____

PRIMARY INSURANCE NAME____________________SUBSCRIBER'S NAME ______________________DOB______

PATIENT RELATION TO SUBSCRIBER _________________SUBSCRIBER ID #____________GROUP#__________

SECONDARY INSURANCE NAME ___________________SUBSCRIBER'S NAME ____________________DOB______

PATIENT RELATION TO SUBSCRIBER____________________SUBSCRIBER ID #____________GROUP#_________

PATIENT EMPLOYER: ____

EMPLOYER ADDRESS: ____________________________CITY: _______________ STATE : ____ ZIP__________

OCCUPATION: ___________________________________ PHONE: ______________________________

REFERRED BY: ____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION & CLAIM PAYMENTS

I HEREBY AUTHORIZE ROSA M. GARCIA, M.D, TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HER AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE CLAIMS.

___________________________ ____

DATE PATIENT (PARENT /GUARDIAN)

I HEREBYY AUTHORIZE AND DIRECT INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE FOR THE SERVICES RENDERED BY ROSA M. GARCIA, M.D, TO BE MADE DIRECTLY TO HER. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR FEES. FOR SERVICES RENDERED.

DATE PATIENT (PARENT/GUARDIAN)
____

Notice of Privacy Acknowledgement

Rosamundo, 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: ________________________________

Rosa M. Garcia, M.D

APPOINTMENT CANCELLATION/ NO SHOW POLICY

We work diligent to maintain our high level of personalized service and strive to accommodate our patient's needs for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelling appointments without adequate notice. We respectfully request your understanding and agreement to our policy as it is stated below.

We will give you a reminder call 48 hours in advance of your scheduled appointment. Any patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours prior to their appointment will be required to pay a fee of $50.00. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will have to be paid prior to your next appointment.

Fees

All fees charge by Rosa M. Garcia, M.D pursuant to this no show/cancellation policy are not payable by your Insurance Company.

All fees are payable on or before your next office visit or 30 days of receipt of a billing statement.

Print Name: ____

Patient Signature: ________________________________ Date: ____________________

Rosa M. Garcia, M.D., P.A.

Diplomate, American Board of Internal Medicine
Diplomate, American Board of Sleep Medicine

PATIENT CARE AGREEMENT

I,______________________________, IN EXCHANGE FOR RECEIVING TREATMENT AND CARE FROM ROSA M. GARCIA,M.D., HEREBY ACKNOWLEDGE AND ACCEPT THE FOLLOWING,

THAT NEITHER DR. ROSA M. GARCIA, NOR HER OFFICE CARRIES MALPRACTICE LIABILITY INSURANCE.

THAT I HAVE BEEN GIVEN AND READ PATIENT NOTIFICATION OF NO MALPRACTICE INSURANCE AS REQUIRED BY FLORIDA STATUE.

THAT WITH THE EXCEPTION PF ANY COLLECTIONS ACTION, I AGREE TO SETTLE ANY AND ALL CONTROVERSY OR CLAIM INCLUDING ANY CLAIM FOR MEDICAL MALPRACTICE, WHETHER IN TORT OR CONTRACT, ARISING FROM THE CARE AND TREATMENT I RECEIVE FROM DR. ROSA M. GARCIA, EXCLUSIVELY BY ARBITRATION, THAT THE DECISION OF THE ARBITRATOR SHALL BE A FINAL AND BINDING RESOLUTION WHICH MAY BE ENTERED AS A JUDGEMENT BY ANY COURT OF COMPETENT JURISDICTION, AND THAT THE ARBITRATION WILL BE CONDUCTED UNDER THE THEN IN FORCE RULES OF THE AMERICAN ARBITRATION ASSOCIATION.

THAT THE DAMAGES, INCLUDING ECONOMIC AND NON-ECONOMIC DAMAGES, RECOVERABLE IN ARBITRATION BY THE PATIENT SHOULD NOT EXCEED UNDER ANY CIRCUMSTANCES $100,000.

THAT I AM NOT ENTITLED TO RECOVER PUNITIVE DAMAGES FOR ANY CONTROVERSY OR CLAIM, INCLUDING ANY CLAIM FOR MEDICAL MALPRACTICE, WHETHER IN TORT OR CONTRACT, ARISING FROM THE CARE AND TREATMENT I RECEIVE FROM DR. ROSA M. GARCIA.

THAT EACH PARTY SHALL PAY HIS/HER OWN ATTORNEY'S FEES AND COSTS ARISING FROM ANY LEGAL PROCEEDINGS, INCLUDING ANY ARBITRATION, ARISING FROM ANY AND ALL CONTROVERSY OR CLAIM, INCLUDING ANY CLAIM FOR MEDICAL MALPRACTICE, WHETHER IN TORT OR CONTRACT, ARISING FROM THE CARE AND TREATMENT I RECEIVED FROM DR. ROSA M. GARCIA.

THAT DR. ROSA M. GARCIA WILL SUMMIT HER FEE FOR SERVICES TO MY HEALTH CARE INSURANCE COMPANY, MEDICARE AND OR MEDICAID. IN THE EVENT THAT THE SERVICES PROVIDED BY DR. ROSA M. GARCIA ARE NOT COVERED BY ANY OF THESE THIRD PARTY PAYERS, I REMAIN PERSONALLY RESPONSIBLE FOR DR. ROSA M. GARCIA'S FEE FOR SERVICES.

THIS AGREEMENT IS ENTERED INTO AND SUBJECT TO THE LAWS OF THE STATE OF FLORIDA. IF ANY PROVISION OF THIS AGREEMENT SHALL BE FOUND BY A COURT OF COMPETENT JURISDICTION TO BE UNENFORCEABLE, THE VALIDITY AND ENFORCEABILITY OF THE REMAINING PROVISIONS SHALL NOT BE AFFECTED.

*IF YOU DO NOT CANCEL ONE DAY PRIOR TO APPOINTMENT THERE WILL BE A $25.00 FEE.

*TO ALL PATIENTS, IF YOU ARE IN NEED OF COPIES THERE IS CHARGE OF $1.00 PER PAGE.

____________ ____________________________

DATE PATIENT

____________ Rosa M. Garcia, MD

DATE ROSA M. GARCIA, M.D.

9220 SW 72 Street, suite 104 Miami, Florida 33173
Phone: (305) 274-1054 Fax: (305)596-1081

Rosa M. Garcia, M.D., P.A.

Diplomate, American Board of Internal Medicine
Diplomate, American Board of Sleep Medicine

PATIENT NOTIFICATION OF NO MALPRACTICE INSURANCE AND RECEIPT OF NOTICE OF PRIVACY PRACTICES AND WRITTEN ACKNOWLEDGEMENT FORM.

"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 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 JUDGEMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS NOTICE IS PROVIDED PERSUANT OF FLORIDA LAW."

THIS DECISION WILL NO WAY IMPACT THE QUALITY OF CARE I DELIVER.

HOWEVER, I AM REQUIRING ALL PATIENTS THAT WOULD LIKE TO CONTINUE THEIR CARE AND TREATMENT WITH ME TO SIGN THE ATTACHED PATIENT SERVICE AGREEMENT. I WILL UNDERSTAND IF YOU ELECT NOT TO SIGN THE AGREEMENT AND DECIDE TO SEEK TREATMENT ELSEWHERE. IF YOU ELECT TO SIGN THE PATIENT SERVICE AGREEMENT, I THANK YOU FOR THE HONOR AND PRIVILEDGE OF BEING YOUR PHYSICIAN.

I, AS PATIENT OF THIS OFFICE AND THIS PHYSICIAN, FULLY UNDERSTAND AND ACKNOWLEDGE THE INFORMATION PROVIDED ABOVE.

NEVER THE LESS, I HAVE DECIDED TO STILL BE A PATIENT IN THIS OFFICE AND THIS PHYSICIAN.

________________ DATE

________________________ PATIENT NAME

9220 SW 72 Street, suite 104 Miami, Florida 33173
Phone: (305) 274-1054 Fax: (305)596-1081

Rosamundo, LLC
7265 SW 93rd Ave, Suite 202, Miami, FL, 33173,
Telephone: (305) 274-1054 ~ Fax: (305) 596-1081

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________ ID Number: __________________

Date of Birth: ______________________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

______________________________ ______________________

Signature of Patient or Legal Representative Date

______________________________ ______________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

ROSA M. GARCIA, MD
DIPLOMATE IN INTERNAL, SLEEP AND OBESITY MEDICINE

NAME ______________________________ DATE ____________________

Please tell us about your health concern: ______________________________
____

(ALWAYS BRING YOUR MEDICATION LIST AND YOUR QUESTIONS)

CONSULTATION WITH OTHERS DOCTORS:

NAME	SPECIALTY	DATE/REASON	RECENT TEST

MEDICATION PRESCRIBED BY OTHER DOCTORS:
____
____

MEDICATIONS OVER THE COUNTER:
____
____

VACCINATIONS / WHEN?

INFLUENZA ( ) ____________________
PREVNAR 13 ( ) ____________________
PNEUMOCOCCAL 23 ( ) ____________________
T DAP ( ) ____________________
SHINGLES # 1 ( ) ____________________
SHINGLES # 2 ( ) ____________________

HISTORY OF SURGERIES: DATE:
____________________ ____________________
____________________ ____________________

HAVE YOU GAIN WEIGHT? YES ( ) NO ( )
HAVE YOU EVER THOUGHT ABOUT LOOSING WEIGHT? ____________________
WOULD YOU LIKE TO DISCUSS YOUR WEIGHT WITH DR. GARCIA? YES ( ) NO ( )
HOW READY ARE TO START EATING HEALTHIER?
CHOOSE: 1 2 3 4 5 6 7 8 9 10

HOW READY ARE YOU TO BE MORE PHYSICAL ACTIVE?
CHOOSE: 1 2 3 4 5 6 7 8 9 10

NUTRITION:
NUMBER OF SERVINGS OF FRUITS DO YOU HAVE A DAY?
( ) 1-3 ( ) 4-7 ( ) 7-10 ( ) >10 ( ) NONE
NUMBER OF SERVINGS OF VEGETABLES DO YOU HAVE A DAY?
( ) 1-3 ( ) 4-7 ( ) 7-10 ( ) > 10 ( ) NONE

PREFERRED FOOD CHOICES: SALTY ( ) SWEETS ( ) MEATS ( ) OTHERS ____________________

Patient Questionnaire/ Preguntas al Paciente

How many hours do you sleep? / Cuantas horas duerme usted? _______________

Do you wake up sleepy? / Usted se levanta con sueño? _______________________

Do you need to drink coffee to state awake? / Usted necesita tomar café para mantenerse despierto? _________

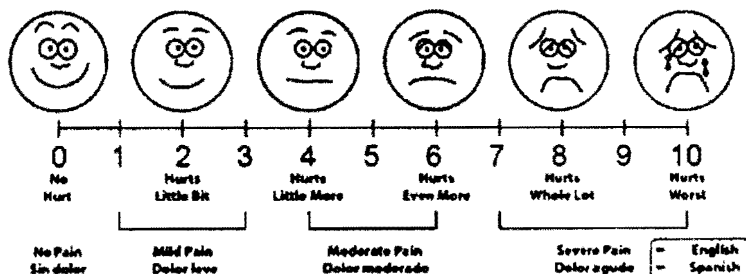
Have you had a Sleep Study? /Se ha hecho usted una prueba del sueño?___________________________________

Do you have a living will/advanced directive? / Tienes un testamento vital? ______________________________

Do you wish to discuss end-of –life issues with the provider? ____

Do you have vision, hearing or gait difficulties? / Tiene dificultades de vision, escuchar o caminar? _________

Do you have pain? / Tiene usted dolor? _________, Where? /Donde? _______________ Circle: (0-10)



When was your last blood test? / Cuando fue su ultimo examen de sangre? _____________________________

Any abnormal result? / Algun resultado abnormal? ____

When was your last / Cuando fue su ultimo:

- Eye Exam/Examen de vision ______________________________
- Colonoscopy/Colonoscopia ______________________________
- Mammogram/Mamografia ______________________________
- Bone Density / Densidad osea ______________________________
- Pap smear/Prueba Citologica ______________________________
- Dental visit/ Visita al Dentista ______________________________
- Dermatology skin exam/ Examen de la piel____________________

SOCIAL HISTORY QUESTIONNAIRE

PATIENT NAME: ____

HIGHEST LEVEL OF EDUCATION? ______________________________________

WHAT IS YOUR OCCUPATION? ____

DO YOU HAVE ANY PETS? NO [ ] YES [ ]

WHAT ARE YOUR HOBBIES? ____

WHAT IS YOUR RACE/ETHNICITY? _____________________________________

WHAT IS YOUR PRIMARY LANGUAGE? __________ OTHER LANGUAGES? ________

DO YOU HAVE CHILDREN? SON(S) _____ DAUGHTER(S) _____

WHOM DO YOU LIVE WITH?

- SPOUSE/PARTNER [ ] FAMILY [ ] FRIEND(S) [ ] ALONE [ ]

WHO HELP YOU WITH IMPORTAN DECISIONS? ____________________________

DO YOU HAVE ADVANCE DIRECTIVE (LIVING WILL) OR POWER OF ATTORNEY? NO [ ] YES [ ]

RECREATIONAL DRUG USAGE? NO [ ] YES [ ] WHAT TYPE: ___________________

ARE YOU SEXUALLY ACTIVE? NO [ ] YES [ ]

WHAT IS YOU SEXUAL ORIENTATION? __________________________________

HOME SAFETY SCREENING		
Do you have easy access to a phone at home?	YES	NO
Are emergency numbers easily accessible?	YES	NO
Do you have functioning smoke/carbon monoxide alarms in your home?	YES	NO
Do you have non-slip surface and grab bars in bath/shower?	YES	NO
If you climb stairs at home, are there secure railing?	YES	NO

FALL RISK ASSESSMENT		
Have you fallen in the past year?	YES	NO
If yes, how many times?	YES	NO
Where you injured?	YES	NO

EXERCISE

How many days a week do you exercise?

( )0 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

Duration:

( ) 30 minutes each time ( ) Less than 30 minutes each time ( )more than 30 minutes each time

What type of exercise? ______________________________

ANXIETY SCREENING	
0-Not at all 1-Several days 2-More than half the days 3-Nearly every day	
Feeling nervous, anxious or on the edge	
Not being able to stop or control worrying	
Worrying too much about different things	
Having trouble relaxing	
Becoming easily annoyed or irritable	
Being so restless that it is hard to sit still	
Feeling afraid as if something awful might happen	
GAD-2 Score:	
GAD-7 Score:	

DEPRESSION SCREENING

0-Not at all 1-Several days 2-More than half the days 3-Nearly every day	
Little interest or pleasure in doing thing **(Poco Interes o placer en hacer cosas)**	
Feeling down, depressed or hopeless **(Se ha sentido decaido(a),deprimido(a) o sin esperanzas)**	
Trouble falling or staying asleep or sleeping too much **(Ha tenido dificultad para quedarse o permanecer dormido(a)o ha dormido demasiado)**	
Feeling tired or having little energy **(Se ha sentido cansado(a) o con poca energia)**	
Poor appetite or overeating **(Sin apetito o ha comido en exeso)**	
Feeling bad about yourself that you are a failure or have let yourself or your family down **(Se ha sentido mal con usted mismo(a),o que es un fracaso que ha quedado mal con usted o con su familia)**	
Trouble concentrating on things such as reading the newspaper or watching television **Ha tenido dificultad concentrandose , leyendo periodico o mirando television**	
Moving or speaking so slowly than other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual **(Se ha movido o hablado tan lento que otras personas podrian haberlo notado o lo contrario muy inquieto o agitado que ha estado moviendose mucho mas de lo normal)**	
Thoughts that you would be better dead or of hurting yourself in some way **(Pensamientos de que estara major muerto(a) o de lastimarse de alguna manera)**	

*If you have experience any of these problems, how difficult have they made it for you to do your work, take care of things at home or get along with other people?
(Si marco cualquiera de los problemas, que tanta dificultad ha tenido para hacer su trabajo,sus tareas diarias o llevarse bien con otras personas?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
(No ha sido tan dificil)	**(Un poco dificil)**	**(Muy dificil)**	**(Extremadamente dificil)**

PATIENT NAME: ______________________________

ALCOHOL SCREENING		
Did you have a drink containing alcohol in the past year?	Yes	No
If yes, how often did you have a drink containing alcohol in the past year? ( ) monthly or less ( ) 2 to 4 times a month ( ) 2 to 3 times per week ( ) 4 or more times a week		
If yes, how many drinks did you have on a typical day when you were drinking in the past year? ( ) 1 or2 ( ) 3 or 4 ( ) 5 or 6 ( ) 7 to 9 ( ) 10 or more		
If yes, how often did you have six or more drinks on one occasion in the past year? ( ) never ( ) less than monthly ( ) monthly ( ) weekly ( ) daily or almost daily		

TOBACCO SCREENING		
Are you a? ( ) Non-smoker ( ) Former smoker ( )Current day smoker ( ) Chewing tobacco ( ) E-Cigarette	Yes	No
If former smoker, how long has it been since you last smoked? ( ) < 1 month ( ) 1-3 months ( )3-6 months ( )6-12 months ( )1-5 yrs. ( ) 5-10 years ( ) > 10 yrs.		
If current daily smoker, how many cigarettes a day do you smoke? ( ) 5 or less ( ) 6-10 ( ) 11-20 ( ) 21-30 ( ) 31 or more		
If current daily smoker, how soon after you wake up do you smoke? ( ) within 5 min ( ) 6-30 min ( )31-60 min ( ) after 60 min		
If current daily smoker, are you interested in quitting? ( ) Ready to quit ( ) Thinking about quitting ( ) Not ready to quit		

SLEEP QUESTIONNAIRE		
Do you snore? Usted ronca?	Yes	No
Do you awaken with gasping for air or shortness of breath? Usted se despierta esfoezandose para respirar o con falta de aire?	Yes	No
Are you excessively sleepy during the day? Usted se siente exesicvamente soñoliento durante el dia?	Yes	No
Do you have problems with keeping your legs still at night? Usted tiene problemas para mantener sus piernas quietas?	Yes	No
Do you take naps? (Usted toma siestas?	Yes	No

FUNTION SCREEN/ACTIVITIES OF DAILY LIVING		
Do you prepare your meals, do laundry and maintain your house? Usted prepara sus comidas, lava la ropa y mantiene su casa?	YES	NO
Do you need help getting from bed to chair? Necesita ayuda para moverse de la cama a la silla?	YES	NO
Do you need help getting to the toilet? Necesita ayuda para ir al baño?	YES	NO
Do you need help getting dressed? Necesita ayuda para vestirse?	YES	NO
Do you need help bathing or showering? Necesita ayuda para bañarse?	YES	NO
Do you use the telephone or a cellular phone? Ustes usa el telefono o el celular?	YES	NO
Do you need help taking your medications? Necesita ayuda para tomar sus medicamentos?	YES	NO
Do you handle your own finances? Usted maneja sus propias finanzas?	YES	NO
Do you go grocery shopping? Usted va a hacer las compras para la comida de su casa?	YES	NO
Do you drive a car? Usted conduce un automovil?	YES	NO
Do you need help climbing a flight stairs? Usted necesita ayuda para subir las escaleras ?	YES	NO
Do you use a? ( )walker ( ) wheelchair ( ) cane Usted usa? ( )andadera ( ) Silla de ruedas ( ) baston	YES	NO
Can you walk one block? Usted puede caminar una cuadra?	YES	NO
Have you experience incontinence? ( ) Urine ( ) Fecal Ha tenido incontinencia? ( ) Urinaria ( ) Fecal	YES	NO

PATIENT NAME: ______________________________

Family History	Mother	Father	Siblings	Siblings
Living age				
Deceased age				
Cause of death				
Cancer Type				
Diabetes				
Hypertension				
Heart Disease				
Osteoporosis				

- **Is there Cancer history in your grandparents? YES ( ) NO ( )**
  ( ) Breast , Age____ ( ) Colon , Age ____ ( ) Ovarian , Age___ ( ) Prostatic Cancer ,Age ____

- **Any other significant diseases in your family?**
  ____
  ____

SAFETY

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

How often does anyone, including family and friends, physically hurt you?

( ) Never
( ) Rarely
( ) Sometimes
( ) Fairly often
( ) Frequently

How often does anyone, including family and friends, insult or talk down to you?

( ) Never
( ) Rarely
( ) Sometimes
( ) Fairly often
( ) Frequently

How often does anyone, including family and friends, threaten you with harm?

( ) Never
( ) Rarely
( ) Sometimes
( ) Fairly often
( ) Frequently

How often does anyone, including family and friends, scream or curse at you?

( ) Never
( ) Rarely
( ) Sometimes
( ) Fairly often
( ) Frequently