Patient Information

*Please Note: So that we may maintain the most up to date and accurate information on our patients, we will request that you review and update this form at least once a year. *

DATE: _____

Patient Name: **DOB:** / / **Age:**

Social Security #: - - **Marital Status:** Married ☐ Single ☐ Divorce ☐

Cell #: - - **Home #:** - -

Address: **Email Address:**

Emergency Contact Name: **Emergency Contact Phone #:** - -

Primary Language Spoken: **How did you hear about us?**

Pharmacy Name: **Pharmacy Address:**

Healthcare Insurance Information

Primary Insurance Name: **ID #:** **Group #:**

Subscriber Name/DOB: **Relationship to Subscriber:** Self ☐ Spouse ☐ Parent ☐

Secondary Insurance Name: **ID #:** **Group #:**

Subscriber Name/DOB: **Relationship to Subscriber:** Self ☐ Spouse ☐ Parent ☐

Release of Information and Assignment of Benefits

I directly assign all medical/surgical benefits to LDC PRIMARY CARE and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement should be as valid as the original.

X _____

Patient Signature

LDC PRIMARY CARE

- Eduardo Lopez Del Castillo, M.D.
- Maria Pereda, APRN

2623 SW 147TH AVE
Miami, FL 33185
Phone:305-677-0227
Fax:866-381-6623

Patient Name: **DOB:** / / **Date:**

Medical History

Reason for your visit: Annual ☐ Sick ☐ Other ☐ **If Other please explain**:

Past Medical History / Allergies & Type of Reactions

o None	o Cancer	o **No allergies**
o Hypertension	o Type of Cancer: _____	**Allergies:**
o Diabetes	o Arthritis	o Latex
o Heart attack	o Depression	o Iodine
o Heart disease	o Anxiety	o Tape
o Stroke	o Coagulation disorders	o Food
o Thyroid disease	o Epilepsy	If yes, please list Allergies to medication:
o Asthma	o Sleep apnea	_____
o High blood cholesterol	o High blood triglycerides	_____
o Others:	o Others	_____
_____	_____	
_____	_____	
_____	_____	

Surgeries (TYPE AND YEAR):

Vaccines:

Current Medications:

X _____

Patient Signature

X _____

Physician's Signature

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Patient Name: **DOB:** / / **Date:**

Social History

Do you smoke? Yes ☐ No ☐ **If yes, how much and for how long?**

Do you drink? Yes ☐ No ☐ **If yes, how often?** Daily ☐ Occasionally ☐

Do you use drugs? Yes ☐ No ☐ **If yes, please list:**

Do you exercise? Yes ☐ No ☐ **If yes, how frequently: 1-3 times weekly** ☐ **4-7 times weekly** ☐

Type of diet:

Family History

**Please check any family members who have the following health problems:

Medical Condition	Father	Mother	Brother	Sister	Grandparent	Other
Hypertension						
Diabetes						
Cancer (list type)						
Heart attack						
Heart disease						
Stroke						
Asthma						
Thyroid Disease						
High blood cholesterol						
High blood triglycerides						
Mental illness (list type)						
Coagulation disorders						
Glaucoma						
Other						

X _____

Patient Signature

X _____

Physician's Signature

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Office Policies

Financial Responsibility: I understand that is my responsibility to know my In-Network and Out-of-Network benefits. I understand that I'm financially responsible for all charges whether they are or not paid by my insurance. I understand that a payment for the office visit is required at the time of service for patients without insurance / patients with private insurance / patients who are not covered by one of our contracted insurance plans / patients who do not provide us with contracted insurance information. Payments accepted are cash/credit or debit card.

Late Appointments: If a patient is late to their appointment there is no guarantee that he/she can be seen since our office goes by appointment times. We recommend all patient to arrive 10 minutes prior their appointment time.

Missed Appointments: We ask all patients to notify the office 24-48 hours prior your appointment date if you will not be able to attend, this way our office can fill the empty appointment slot with another patient that needs an appointment. If notification is not given on time patient will be responsible for a $25.00 fee.

Walk-ins: There is no guarantee you will be able to be seen as a walk in. We see all patients by appointments and offer same day appointment if available.

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

Prescription Refills Protocol: Prescription refill requests should be phoned in during regular office hours. Provide all pertinent information including the patient's name, date of birth, medication name, dose, pharmacy name, pharmacy address and phone number. Allow up to 3 business days 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 or oral steroids without having seen the patient first.

Notice for Labs to Insured / Non-insured Patients: LDC Primary Care LLC offers to draw blood work to all our patients in the office as a courtesy. To our insured patients, please be informed that we do not verify benefits for lab tests, or culture samples, therefore we will not be aware of your policy coverage or if authorization is required. All blood work and cultures samples collected will be sent to the in-network laboratory along with your insurance information, so it can be processed through your insurance. We are not responsible if copay/ deductible applies, or if a test is not covered by your insurance policy. To our Self-pay patients, please make sure you are aware of the prices before we draw the blood work or collect any culture sample as it must be paid the same day. All patients have the option to get their blood work drawn at any laboratory that belongs to this insurance network.

Consent for voice and text messaging communication: To relay Normal results faster to our patients we have implemented Electronic Medical Records. I understand that for LDC Primary Care to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to LDC Primary Care. I further understand that in order for LDC Primary Care to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to (insert LLC Name) I also understand that my healthcare information at LDC Primary Care is protected, and a copy of the Notice of Privacy Practices is available upon my request. **Consent for Messages:** I give my written express consent to LDC Primary Care to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system.

X _____

Patient Signature

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Notice of Privacy Practice Acknowledgement

LDC Primary Care

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

X _____

PATIENT SIGNATURE

_____

Date

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Notice of Privacy Practices

LDC Primary Care

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

2623 SW 147TH AVE
Miami, Florida 33185

Office:305-677-0227
Fax: 866-381-6623

Attn: Compliance Contact

Please sign the accompanying "Acknowledgement" form