Dr Mercade & Associates, LLC

Thank you for choosing Dr Mercade & Associates for your primary care needs . We are proud of the line of services we can provide you with. We have implemented a work flow that allows us to dedicate as much time as is needed when you come for your visit .

As any medical practice in the country we follow all the State and Federal laws, one of those include Health Insurance Portability and Accountability Act (HIPAA)is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. What this means for you is that all the information that you share with us is confidential , secured and it is protected by law .

As in many other industries that provide services , we will ask you to share your credit card information with us to streamline the process of check in, check out. Once your health insurance pays its portion , if there is any remaining balance that you are responsible for , you will be charged to your credit card and a copy will be send to you .

In order to maintain accurate information we will ask you to renew your demographic and billing information when you check in.We will also charge the copayment prior to rendering services .

Please do not hesitate to contact our billing department if you have any question or concern.

Sincerely yours

Fernanda Mercade, MD

Medical Director

Dr Mercade & Associates 747 Ponce De Leon Blvd, Suite 405 , Coral Gables, Fl,33134 Phone 786-442-2100

Fax 786-442-2101 https://drmercade.com

Dr. Mercade & Associates LLC

TopLine MD Alliance

REGISTRATION FORM

Patient Information:

Patient Name: _____

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

ZipCode:_____Home Phone: (_____) _____-_____

E-mail Address: _____

Cell Phone: (_____)_____-_____ (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 our Practice? Family: ☐ Friend: ☐ Insurance: ☐

Who to call in case of an emergency:

Name:_____
Address:_____
Home Phone: (_____) _____ - _____ Work Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Relationship: _____

INSURANCE INFORMATION
Plan Name: _____

*I.D. Number: _____ Group Number: _____
*Policy Holder: _____ Effective Date_____
*Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____ Group Number: _____Policy Holder: _____

Effective Date: _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

Insurance Release Information

I hereby authorize the office of Dr Mercade & Associates, 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 Dr Mercade & Associates. I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient Signature: _____

Date: _____

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, Identification Card and credit card information 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 pay in 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. Balances will be charge to the credit card on file. If a balance is due over 45 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.

In the situation when there is uncertainty about whether a service would be covered by the insurance, Dr Mercade & Associates, LLC will collect the cost of the service at the time of the visit and place the amount on account. If your health insurance covers those services, our practice will refund that amount, usually within 30 days of receiving payment from the insurance company.

Dr Mercade & Associates LLC would use a collection agency to pursue delinquent accounts. As a patient you agreed to be liable for any cost associated with the collection of my account if delinquent.

Referrals Policy: 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 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. We do not accept same day referrals.

Late fee/cancellation/no show/new pt appt: if you confirmed an appt and do not show up, cancel within 24 hours of the appointment or arrive 20 minutes late, Dr Mercade & Associates, LLC will charge a $50 non-refundable fee.

New patient: in order to confirm your appointment, you will be charged a $50 fee to hold the spot. Once you are seen, if payment is not required, that fee will be returned to you. If you do not cancel within 24 hours of your appt, this refund will not apply.

Forms: will require a visit with the doctor.

Test Results: We developed a process where we will communicate with you regarding your labs results. If a visit is needed, we will let you know.

Walk-In Policy: We see all patients by appointments and offer same day appointment after our staff triage the call. 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 reevaluation before a refill is provided. We do not call in or refill antibiotics without having seen the patient first. All controlled substances require by Law a face-to-face visit with the doctor.

Patient's individual rights: I have the right to review or obtain a copy of my personal health information at any time. I have the right to request that Dr Mercade & Associates, LLC correct any inaccurate or incomplete information in my records. I also have the right to request a list of instances where Dr Mercade & Associates, LLC has disclosed my personal

health information for reasons other than treatment, payment or other related administrative purposes.

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.

I have read and understand the above information.

Patient Name: _____
Signature: _____

Date: _____ Witness:
_____

Notice of Privacy Acknowledgment Dr Mercade & Associates, 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:
_____

Card On File Authorization

A valid credit card is required to be on file at all times in order to receive care and/or services from DR MERCADE & ASSOCIATES LLC.I authorize DR MERCADE & ASSOCIATES LLC to charge any outstanding balances on my account,including co-pays, deductibles, coinsurance, fees for late cancellation of appointment, first time appointment and no-show fees to the credit card information I have provided below. I understand that this authorization will remain in effect indefinitely. I understand that DR MERCADE & ASSOCIATES LLC must be notified immediately of any changes/updates to my credit card information and that failure to notify of such change will result in DR MERCADE & ASSOCIATES LLC's right to charge any active credit card on file in the event my primary authorized card becomes compromised, expired, or canceled.

Patient's Name:

_____

Patient's Date of Birth:

_____

Type of Card: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ FSA/HAS

Name as it appears on the card:

_____

Billing Address:

_____

Last four digits of card: ____ ____ ____ ____ **Expiration Date**: ____ / ____ / _____

I authorize the DR MERCADE & ASSOCIATES LLC to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Cardholder's signature:

_____

Date:

_____

**** Our office is PCI-DSS compliant, and all staff are thoroughly background checked as a condition of employment. Your card data will be securely stored in a PCI-DSS compliant database in which your full card details will not be accessible. ****

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: _____

Date of Birth: _____ Age: _____

Pharmacy Name: _____

Phone:_____Address:_____

What brings you to the office today?

_____
_

How long have you had this problem?

_____

List your current medications: (prescribed and over the counter/,herbs):

Medication Name	Strength	Daily frequency

List your Medical Problems: check what applies to you

Diabetes	Hypertension	High Cholesterol	Dementia
Arthritis	Renal failure	Heart Attack	Seizures
Prostate problems	Asthma	Atrial Fibrillation	Anxiety
Osteoporosis	Thyroid issues	Migraines	Depression
Stroke	Urinary incontinence	Glaucoma	Colon Polyps

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

_____

For WOMEN:

Pregnancies: how many :

Complications during pregnancies: YES NO

Use of birth control: YES NO Which one:

Menopausal: YES NO

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

1._____
2._____
3._____

Hospitalization

1. _____

Family Medical History

1._Mother_____
2.__Father:_____
3._____

Social History:

Do you smoke: YES NO Ex-smoker: YES NO

Do you drink Alcohol? YES NO

Ex-Drinker: Drank for _____ Years _____Drinks/Week Quit: _____Years/Ago

Immunizations:

Flu	Pneumonia	Covid 19
HPV	MMR	Tdap
Hepatitis	Shingles	other

Have you had this test done in the past:

colonoscopy	date	result
mammogram	date	result
Bone density	date	result
PAP smear	date	result

Cardiac stress test	date	result

Additional information we should know about you:

_____

_ _____

How did you hear about us:

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

Patient Name (print): _____Date: _____

Signature: _____

Thank you for choosing us for your Annual Exam, as you know an annual exam include discussions, ordering test and medications related to preventive medicine. This is an exam that your insurance should provide to you, at no cost to you.

This might include :

Blood pressure screening

Obesity screening

Colorectal cancer screening

Breast cancer screening

Cervical cancer screening

STI’s screening just to name a few.

If you have any other medical problem that requires further discussion, examining, testing or prescribing, that is not included within a preventive visit, you will be responsible for a copay, deductible, co-insurance based upon your insurance plan.

I have read and understand the above information

Patient’s name

Signature Date

E-mail Consent & Acknowledgment Form

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider’s intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.

b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail.
Any questions I may have had were answered.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (Print) : _____

Patient Signature : _____ Date :

_____

Patient Email:

_____

CONSENT FOR VOICE AND
TEXT MESSAGING COMMUNICATION

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for Dr Mercade & Associates, LLC to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Dr Mercade & Associates, LLC.

I further understand that in order for Dr Mercade & Associates, LLC to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to (Dr Mercade & Associates, LLC I also understand that my healthcare information at Dr Mercade & Associates, LLC 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 Dr Mercade & Associates, LLC 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.

Patient Name (Please Print): _____

Date: _____

Patient Signature: _____ Cell #: _____

(this number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

MEDICAL RECORD RELEASE FORM

_____ _____

Patient Name Date of Birth

I hereby authorize the below listed entity (physician or group) to release medical information to Dr Mercade & Associates, LLC : Fax 786-442-2101

Name: _____ Telephone#: _____

Address: _____ Fax#: _____

Medical Information Requested:

All Records

Labs
Specific Records from _____ to _____

Consults

Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}

X_____ X_____

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.11111

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

PLEASE CLICK WHAT APPLIES TO YOU

( ) a female Gynecological Exam which may include a rectal exam and a pelvic exam

( ) An Ultrasound Exam which may include a probe placed in the vagina.

( ) A rectal exam only

( ) A genital exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

( ) DECLINE ALL PRECEDURES LISTED ABOVE

This examination will be performed by any provider from Dr Mercade & Associates, LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18 Date

FLORIDA STATUTES

501.0575 Weight-Loss Consumer Bill of Rights

(1) The Weight-Loss Consumer Bill of Rights shall consist of the following provisions:

(A) WARNING: RAPID WEIGHT LOSS MAY CAUSE SERIOUS HEALTH PROBLEMS. RAPID WEIGHT LOSS IS WEIGHT LOSS OF MORE THAN 1 1/2 POUNDS TO 2 POUNDS PER WEEK OR WEIGHT LOSS OF MORE THAN 1 PERCENT OF BODY WEIGHT PER WEEK AFTER THE SECOND WEEK OF PARTICIPATION IN A WEIGHT-LOSS PROGRAM.

(B) CONSULT YOUR PERSONAL PHYSICIAN BEFORE STARTING ANY WEIGHT-LOSS PROGRAM.

(C) ONLY PERMANENT LIFESTYLE CHANGES, SUCH AS MAKING HEALTHFUL FOOD CHOICES AND INCREASING PHYSICAL ACTIVITY, PROMOTE LONG-TERM WEIGHT LOSS.

(D) QUALIFICATIONS OF THIS PROVIDER ARE AVAILABLE UPON REQUEST.

(E) YOU HAVE A RIGHT TO:

1. ASK QUESTIONS ABOUT THE POTENTIAL HEALTH RISKS OF THIS PROGRAM AND ITS NUTRITIONAL CONTENT, PSYCHOLOGICAL SUPPORT, AND EDUCATIONAL COMPONENTS.

2. RECEIVE AN ITEMIZED STATEMENT OF THE ACTUAL OR ESTIMATED PRICE OF THE WEIGHT-LOSS PROGRAM, INCLUDING EXTRA PRODUCTS, SERVICES, SUPPLEMENTS, EXAMINATIONS, AND LABORATORY TESTS.

3. KNOW THE ACTUAL OR ESTIMATED DURATION OF THE PROGRAM.

4. KNOW THE NAME, ADDRESS, AND QUALIFICATIONS OF THE DIETITIAN OR NUTRITIONIST

WHO HAS REVIEWED AND APPROVED THE WEIGHT-LOSS PROGRAM ACCORDING TO s. 468.505(1)(j), FLORIDA STATUTES.

(2) The copies of the Weight-Loss Consumer Bill of Rights to be posted according to s. 501.0573(6) shall be printed in at least 24-point boldfaced type on one side of a sign. The palm-sized copies to be distributed according to s. 501.0573(5) shall be in boldfaced type and legible. Each weight-loss provider shall be responsible for producing and printing appropriate copies of the Weight-Loss Consumer Bill of Rights.

History.—s. 4, ch. 93-274; s. 45, ch. 2000-154.

Patient Informed Consent for Weight- Management Medication

I, _____ authorize Dr. _____to assist me in my weight- reduction efforts. I understand my treatment may involve, but is not necessarily limited to, the use of anti-obesity medications. I understand the results are not guaranteed and may vary.

I have read and understand that it is my responsibility to follow the instructions of my physician carefully and to report to my physician treating me for my weight any significant medical problems.

I understand that my physician has outlined the risks and benefits of obesity medication treatment and I consent to the treatment and am willing to accept the risks of side effects, even if they are serious for the possible help that the medication used in this manner may provide. Some potential risks are nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart rate, and heart irregularities. Less common but more severe are pancreatitis, pulmonary hypertension, medullary thyroid cancer and valvular heart disease.

I understand that my continuing to receive the weight-management medication will be dependent on my progress in weight reduction and weight maintenance.

I acknowledge that I have been given the opportunity to read and understand this form, as well as discuss with my physician the risks associated with the proposed treatment.

I was given a copy of the Florida Statues called Weight loss consumer Bill of Rights

Patient's Name_____ (print)

Signature _____

Date _____