MyCARE HEALTH PARTNERS
REKHA KINI, MD
KIM L. BANGO, MD

8299 South Dixie Highway
Miami, FL 33143
Tel: (786) 528-3000
Fax: (888) 971-4034
Email: info@mycaredoctors.com
mycaredoctors.com

**Patient Information:**

Patient Name: _____ Social Security Number: ____/____/____

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

Address: _____Zip Code:_____

Home Phone: (_____) _____-_____ E-mail Address: _____

Cell Phone: (_____)_____-_____ (for appointment confirmations)

**Preferred Language:** (Spanish) or (English)

Employer Name: _____Employer Phone: (____)_____

Referring Physician: _____

****How did you hear about our Practice?** _____

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**Who to call for an emergency:**

Name: _____Address:_____

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

Cell Phone: (_____) _____-_____

Relationship: _____

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**INSURANCE INFORMATION**

Plan Name: _____ ***I.D. Number: _____

Group Number: _____ ***Policy Holder:** _____

Effective Date: _____Policy Holder's Social Security Number: _____ - _____ -_____

*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 Social Security Number: _____ - _____ - _____

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

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****If your insurance requires a referral for you to see Dr. Bango or Dr. Kini, it is your responsibility to provide our office with the referral. If your insurance company denies payment (due to no referral) you, the patient, agree to pay MyCare Health Partners in full for any charges incurred during your visit.**

Patient Signature: _____ Date: _____

## Insurance Release Information

**I hereby authorize the office MyCare Health Partners, 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 MyCare Health Partner. 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.

**Referral 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.

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

**Test Results**: MyCare Health Partners may require a follow-up visit to review and discuss any diagnostic testing or pathology results

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**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.**

Finally, this is your information plan. 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.

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: _____

Date of Birth: _____ Age: _____

**Pharmacy** (Must have one for future use)

Name: _____ Phone: _____

Address: _____

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

_____

_____

**How long have you had this problem:**

_____

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

**Medications:**

| Name | Dose | How many times a day? |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

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

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

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

Are you interested in Allergy Testing? YES or NO

_____

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

1._____ 2._____

3._____ 4._____

5._____ 6._____

**Hospitalization**

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4: _____ Date: _____

**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 any or if not please write"None")**

_____

_____

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**Social History**

Do you smoke: **YES** **NO** _____Packs a day _____Years

Ex-smoker: _____Packs a day _____Years Quit: _____Years/Ago

Do you drink Alcohol? **YES** **NO** Type: _____ Drinks/Week:_____

# of Years_____

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

Additional information we should know about you:

_____

_____

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**Medical Use Only**

Vital Signs: BP _____ HR _____ TEMP _____ BMI _____ WT _____ HT _____

R _____ OX _____

---

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

Patient Name (print): _____ Date: _____

Signature: _____ Med. Asst: _____

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# Notice of Privacy Acknowledgement

## MyCare Health Partners, 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

**Telephone: 786-528-3000**

**Fax: 1-888-971-4034**

**E-mail: info@mycaredoctors.com**

_____ _____

Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to **MyCare Health Partners**:

Name: _____ Telephone#: _____

Address: _____ Fax#: _____

_____

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Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ 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.11111