NEW PATIENT FORM CHECK LIST

Did you complete and sign the following pages?

Check	Description	page(s)
☐	Demographics (Must include copy of insurance card and driver license)	2
☐	Health Information	3,4,5
☐	Medication List	6
☐	Obtain your medical record form	7,8,9,10
☐	Consent for treatment /Authorization to release information / Cancellation notification	11
☐	Statement of financial liability Insurance change notice	12
☐	Preferred disclosure	13
☐	Acknowledgement of Receipt of Notice of Privacy Practice	14
☐	Florida Living will and Directive to Physician	15,16,17
☐	How did you hear about us?	18
	Patient keep copy of these – no need to return	19, 20

Please fill out and sign forms carefully and return to office prior to office visit either by email, mail or fax at address below. Uncompleted forms/missed signature will cause extra waiting time at office. No appointment will be made until we receive your forms back. Thank you for your cooperation.

Dr. Martha M. Rodriguez
2015 Ocean Drive, Suite 11
Boynton Beach, FL 33426
Phone: 561-364-8056 / Fax: 561-364-8507
appointments@mmrhealthcare.com

FOR OFFICE USE ONLY			
Forms received by:	**Forms entered/scanned into soapware by:**	**Update Insurance Info by:**	**Appointment made:**

DEMOGRAPHICS

Last Name:			
Middle Name:			
First Name			
Address:			
City:			
State/ Zip code			
Home phone:			
Work phone:			
Cell phone:			
Email:			
Sex:	Male □	Female □	
Date of Birth:			
Social Security#:			
Race:			
Ethnicity:			
Employer/Address	Employer: Address:		
Martial status:	Single □	Married □	Others:
Language spoken:	English □	Spanish □	Others:

Insurance Information (MUST)

Please make a photocopy of **FRONT AND BACK** of the followings:

1. Your insurance card
2. Your driver licenses

(No appointment will be made if insurance card and driver information are not received by us)

Contact in case of Emergency

Name:	
Relationship:	
Phone number:	
Cell phone:	

HEALTH INFORMATION

1. Do you currently suffer from any of the followings listed in table below:

High blood pressure	□	Angina	□	Palpitations	□
Murmurs	□	Clots	□	Asthma	□
Emphysema	□	Bronchitis	□	Pacemaker	□
Defibrillator	□				
Others:					

2. Had you been in hospital recently? Yes □ No □
   If yes, which hospital? _____

3. Do you have diabetes: Yes □ No □
   If yes, what type of medicine are you using? Insulin □ Pills □
   Please answer the following questions:

	Date	Where
Foot exam		
Eye exam		
EKG		

4. Medical History
   a. Did you ever have a stroke? Yes □ No □
      If yes, please specify the date: _____
   b. Are you taking coumadin? Yes □ No □
   c. Do you have cancer? Yes □ No □
   If yes, what type of cancer: _____
   If yes, what kind of treatments: Chemo □ Radiation □ Surgery □

5. Did you have heart surgery: Yes □ No □
   If yes, please indicate: Bypass □ Valve Replacement □
   Date of surgery: _____

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HEALTH INFORMATION (continued)

6. Did you have any other surgeries? Yes □ No □
   If yes, please describe:

Type of surgery	Date of surgery

7. Medication: see page 6.

8. Pharmacy name: _____

   a. Pharmacy phone:_____
   b. Pharmacy Address:
   _____

9. Allergies: Yes □ No □
   If yes: describe: _____

10. Are you allergic to any medications: Yes □ No □
    If yes, please describe: _____

11. Family Health History: Yes □ No □
    Please check mark following if it applied to you.

	CAD	Diabetes	Cancer
Mother:			
Father:			
Siblings:			

12. Tobacco: Yes □ No □ Occasional □

13. Alcohol: Yes □ No □ Occasional □

HEALTH INFORMATION (continued)

14. Immunizations: Do you have any of the following shots? Yes □ No □
If yes – please check below:

Type of shots	Date of last shot
Pneumovax	
Influenza	
Hepatitis B	
Others:	

15. Radiology: Do you have any radiology done recently? Yes □ No □
If yes, please describe:

Type of labs	Date	Where
Chest x-ray		
Other x-rays		
Mammogram		
Bone Density		
Colonoscopy		
Others:		

16. Social History
    a. Married □ Divorced □ Retired □
    b. Are you currently employed? Full-time □ Part-time □
    c. What type of work do you do? _____

MEDICATION LIST

(Please print out clearly in capital letter)

Date	Medication	Dose	Qty	Frequency

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REQUEST FOR MEDICAL RECORD

Please note that it is patient responsibility to obtain his/her own medical records from their previous Physician and bring the records at his/her first appointment (or prior to the appointment) with Doctor. This record is very important for Doctor to better treat patient.

PATIENT NAME:	
PHONE NUMBER:	
DATE OF BIRTH:	
SOCIAL SECURITY #:	

I would like to obtain my medical record for the last 5 years. Please have it ready and I will come to pick up. Thank you for your cooperation.

Patient signature:	
Date:	

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AUTHORIZATION FOR RELEASE MEDICAL RECORDS

1. ____ I am requesting medical records from *Martha M Rodriguez, MD, PA.*

_____I am requesting medical records be sent to *Martha M Rodriguez, MD, PA* at the address / fax listed above.

2. The Records are being (circle one) Sent to / Requested From:
(Insert Healthcare Provider Name, Address & Phone or 'Self')

_____

_____

PATIENT NAME _____

DATE OF BIRTH _____**PHONE** _____

ADDRESS _____

Covering the period(s) of health care:
FROM (Date):_____ **To** (Date): _____

3. Information for disclosure, if included in my records:

____ Complete Health Record
____ Visit Summary
____ History & Physical
____ Consultation Reports
____ Medications List
____ Progress Notes
____ Procedure Reports
____ EKG
____ Photographs, Videos, Digital or Other Images
____ Anesthesia Record
____ Diagnostic Imaging
____ Laboratory tests (please specify) _____
____ Other (please specify) _____

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4. If applicable, I also give permission for the following to be disclosed (please initial)**:**

   ____ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
   ____ Behavioral Health Services / Psychiatric Care
   ____ Treatment for Alcohol and/or Drug abuse
   ____ Sexually Transmitted Diseases (STD)
   ____ Genetic Counseling / Testing

5. Why do you need these records?)_____
   _____
   _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

7. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

8. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

---

9. Fees for copies of medical records in paper or electronic onto disk to be charged in accordance with the State of Florida fee schedule and the actual cost of postage.

_____

Signed: (Patient, Legal Representative, Parent or Legal Guardian) Date

ID Provided: _____

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CONSENT FOR TREATMENT

I (print your name), _____ ,
Voluntarily consent to the rendering of medical care. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry his/her instructions.

Patient signature: _____
Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I (print your name), _____ ,
Authorize Dr. Martha M. Rodriguez to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, worker's compensation of Medicare benefit payment.

Patient signature: _____
Date: _____

CANCELLATION NOTIFICATION

I (print your name), _____ ,
The undersigned, agree to comply with the 24 hour notice to cancel an appointment with the physician(s). If I do not notify the office of my cancellation before 24 hours period I will be charged $25.

Patient signature: _____
Date: _____

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STATEMENT OF FINANCIAL LIABILITY

I (print your name), _____ ,

Guarantee payment of any and all bills rendered for said patient who are not covered or allowable by insurance. This office will file the bill to your insurance company provided you supply and proper and current information.

Patient signature: _____
Date: _____

INSURANCE CHANGE NOTICE

I (print your name), _____ , the undersigned, am ware of it is my responsibility to notify the receptionist of any changes to my insurance coverage, before being seen by doctor or having blood work done. If I fail to notify the office prior to being seen or having blood work done, I will be responsible for all charges incurred.

Patient signature: _____
Date: _____

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PREFERRED DISCLOSURE

To our patients,

In general, the HIPPA privacy gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to an address other than your home address.

The physician and staff of Martha M. Rodriguez, M.D., P.A., respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below:

I wish to be contacted in the following manner (check all that apply)

- □ Home telephone:_____
  - □ Ok to leave message with detailed information
  - □ Leave message with call-back number only
- □ Work telephone:_____
  - □ Ok to leave message with detailed information
  - □ Leave message with call-back number only
- □ Written communication
  - □ Ok to mail to my home address
  - □ Ok to mail to my work/office address
  - □ Ok to fax to this number:_____
- □ □ Other individuals (family, friends, etc.) you may speak with about
  - □ My care or treatment □ My bill

_____	_____	_____
Name	Relationship	Telephone

_____	_____
Print Patient Name	Date of Birth

_____	_____
Patient Signature	Date

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Acknowledgement of Receipt of Notice of Privacy Practice

Dr. Martha M. Rodriguez reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of a Notice of Privacy Practices for Dr. Martha M. Rodriguez.

Patient Name: _____
Date: _____

Patient signature: _____

Patient Representative: _____

Signature: _____
(required if patient is minor or adult who is unable to sign this form)

Relationship: _____
(relationship of representative to patient)

Suggested form of a Living Will, Florida Statutes Section 765.303

Living Will

Declaration made this _____ day of _____ 2____, I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_____ (initial) I have a terminal condition.
or _____ (initial) I have an end stage condition.
or _____ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

(Signed): _____

Witness _____ Witness _____
Street Address _____ Street Address _____
City, State & Zip _____ City, State & Zip _____
Phone _____ Phone _____

The principal's failure to designate a surrogate shall not invalidate the living will..

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

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LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQs

The Florida Legislature has recognized that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?
Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is the difference between a Living Will and a legal will?
A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his or her death, and appoints a personal representative or revokes or revises another will.

How do I make my Living Will effective?
Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

After I sign a Living Will, what is next?
Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

What is a Health Care Surrogate?
Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?
Under Florida law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care Surrogate?
The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?
Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

Where can I go to obtain legal advice on this issue?
If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.

Please let us know
How did you hear about us?

- ❑ **Flyer**
- ❑ **Friend** Name of who referred you: _____
- ❑ **Health Fair** Name of Health Fair: _____
- ❑ **Magazine** Name of Magazine: _____
- ❑ **Newsletter** Name of Newsletter: _____
- ❑ **Newspaper** Name of Newspaper: _____
- ❑ **Other** _____

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(Patient copy)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please read carefully.

Use and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Martha M. Rodriguez, M.D., P.A... For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional uses of information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

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(Patient copy)

Notice of Privacy Practices (continued)

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund Raising: Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

☐ Please do not use my information for fund raising purposes

Individual Rights:
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to receive and accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice

Martha M. Rodriguez, M.D., P.A. duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.
