THE PICHARDO
CLINIC

Welcome to the Pichardo Clinic

On behalf of our providers and staff, we would like to welcome you to our office and thank you for selecting us as your primary healthcare provider. We are committed to provide you with excellent care by utilizing high-end technology and personalized care. It is our goal to offer outstanding service to all of our patients.

Enclosed find information about our practice that will make your experience easier. We have also included a set of forms that you will need to fill out before your first appointment. Be sure to fill them out to the best of your knowledge. Your insurance card and a government photo id will be required at every visit.

Our goal is to be your provider of choice. We welcome you to our practice and hope this turns out to be a long term relationship.

Welcome Aboard!!

Sincerely,

Nelson M Pichardo MD

Sara J Rodriguez MD

Krista M Brown PA-C

Gladys Rodriguez PA-C

111 Webb Drive, Davenport, FL 33837
(863)421-9447 Fax (863) 421-1806
www.pichardoclinic.com

Getting To Know You:

We would like to help you get the most out of your visit. Your time with your provider is valuable and we have some recommendations:

1) Complete the Patient Information Sheet.
2) Complete the Personal Medical History. Be sure to include all medications, including over-the-counter medications and supplements. Make sure you let your provider know about any refills you may need.
3) Review and Sign the Notice of Privacy Practices.
4) You may optionally fill out:
    a. Authorization for Release of Medical information from your previous doctor.
    b. Advance Directive Forms.
    c. Permission to access your Prescription history from your previous doctors.

If you have questions or would like assistance in completing any of these forms mentioned above, please call our number listed below.

During your First Appointment:

Your first appointment will be the opportunity for us to get to know you. This session lasts approximately thirty minutes. This time will depend on the number of problems you will be discussing with you provider. During this first appointment, you will be asked to provide a brief medical history and discuss any current health concerns you may have. Your provider will want to hear as much symptomatic information as possible to help in making the best decision about your care.

Talk about your medications. It is very important you let us know about all the medications you use, including prescriptions, homeopathic and over-the-counter remedies. It is also important to mention any adverse or allergic reaction you had to any medication.

Talk about serious problems. You should make sure you focus on the serious medical issues, especially the recent ones. They may shed some light on any current problems you are dealing with.

Talk about important health screening. Depending on your age, there are certain tests and exams that should be performed regularly to ensure you are in great shape. Here are some of the most important screenings that you should know about:

- PAP Test (women age 21-64)
- Mammogram (women over 40)
- Cholesterol (men and women age 20 and older)
- Colorectal Cancer (men and women ages 51-80)
- HGBA1c (anyone with diabetes between 18-75)
- Prostate Cancer (men over 50)

During every visit you will be weighted, we will take your temperature, your blood pressure and measure the level of oxygen in your blood. The nurse will update your current medications and discuss any current issues you would like to discuss with your provider. Make sure to be as accurate as possible and come with all your medications or your list updated. If you had labs done, remind your nurse that such labs should be reviewed by your provider.

All our staff and providers utilize computers to access your medical records. This enhances our ability to serve you better and be more precise when discussing your current problems. We also interface with all major laboratories of the area including: QUEST and LABCORP. Laboratories results come automatically into your patient record once they become available. In addition all documents from hospitals, specialists, radiology centers are scanned into your electronic chart.

At the end of each visit your provider will give you a set of sheets that may include:

- Summary of the visit listing the main issues, proposed treatment and medications.
- Lab Scripts if you need to get some labs done. Before getting any labs done make sure that you ask your insurance if they cover for those labs at the lab companies that are nearby.
- Medication Scripts to be brought to the pharmacy. In many occasions, we will send the prescriptions directly to the pharmacy via fax or electronic E-PRESCRIBE.
- Procedure or Diagnostic Test Scripts. These scripts are for studies that will be scheduled in-house: Echoes, ultrasounds, stress test or nuclear studies; or to be scheduled in other radiology centers: i.e. x-rays, mammograms, MRI, CT-scans, etc. Make sure that you get an appointment for these procedures before you leave the office if you were ordered one.
- Referrals to Specialists. As primary care providers we will schedule your specialist appointment in order to ensure that the specialist get all the medical information they need before they see you. If you have a preference of specialists, let our Referral Department know. We encourage you that you have our Referral Department schedule your specialist appointment before you leave the office.

During Check-out, you will also be provided with:

- Summary of the visit if it was not provided by your doctor.
- Receipt of Payment including your charges, co-pay, deductibles and your next appointment.

What we expect from you:

In order to achieve the best quality care we believe that as a patient you have some responsibilities:

- You have the responsibility to be accurate and thorough when providing information about your medical history to our medical staff in order to care for you.
- You have the responsibility to ask for clarification about any aspect of your care which you do not fully understand and to participate in developing mutually agreed upon treatment goals.
- You have the responsibility to follow the agreed upon plans and instructions for your care.
- You have the responsibility to notify your health care provider if you notice any change in your health.
- You have the responsibility to extend reasonable courtesy toward all health care providers during the treatment process.

In order to help you with your medical issues we both, The Pichardo Clinic, and you need to work together to succeed.

MEDICATION REFILLS:

In order to provide quality healthcare and exceptional patient care, you should plan ahead when you need to refill your prescription medications.
Refills will be completed within 24 hours.

You should bring all your current medications or an accurate listing with dosage of them to each visit to our office. Remember to tell your provider about all refills at the office visit.

Refills could be requested at the pharmacy or by calling our office. Medications are usually sent via Electronic RX (E-PRESCRIBE) or by Fax. Make sure we have your preferred pharmacy on file.

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of the medical needs of our patients, please be courteous and call the office promptly if you are unable to attend an

appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our patients.

If it is necessary to cancel your scheduled appointment we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

LATE CANCELLATIONS:

Late cancellations will be considered as a “no show”.

NO SHOW POLICY:

A “no show” is someone who misses an appointment without canceling 24 hours in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients’ chart as a “no show”. The first time there is a “no show”, the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. A copy of the letter will be placed in the patient file. If there is a second “no show” a fee of $20.00 will be billed to the patient’s account.

Patients with frequent no shows or cancellations may be dismissed from the practice.

MEDICAL RECORDS:

There is a copy charge of $1.00 per page for records, as authorized by Florida law. You may be able to reduce the copying costs by requesting a few key documents, rather than the entire medical record. There is NO CHARGE for a patient whose records are copied if it is necessary for the continuation of medical care. This can be demonstrated by having the records sent directly to the treating physician or facility. To obtain a copy of your medical record, you must complete and submit the Authorization for Release of Confidential Medical Records Form. This is in accordance with federal and state laws, to protect the privacy and confidentiality of our patients’ personal medical information.

Financial Policy

PAYMENTS FOR SERVICES

Payment for services provided to you is ultimately your responsibility. For your convenience, we accept cash, personal checks, American Express, Discover, Visa, and MasterCard. In addition, if you have health insurance, we will gladly file a claim with your health insurance company.

Health Insurance

All copayments and deductibles are expected to be paid at the time of the visit. Don't forget that your deductible will be reset by your insurance, every year, usually every calendar year. We accept all major credit cards, checks and cash as method of payment.

If you will be using health insurance to settle your account, you must present your current insurance card at each visit. This is a requirement of your insurance company. It also enables us to have the most current information about billing your insurance company. Your insurance company also requires us to collect any applicable co-payments at the time of service

The Pichardo Clinic has agreements with several insurance companies, which require us to bill them for services provided to you, and accept as payment the amount specified in the agreement. You will be responsible for all amounts not paid by them, including amounts denied, applied to deductible, or considered non-covered as permitted by your insurance company.

We will file an initial claim based upon the information that you have provided to us. Under state law, your insurance company has 30 days in which to process and pay the claim, request more information, or deny the claim and notify us of the decision. If they have not notified us within 90 days of the date of service, it will be assumed that your insurance coverage is no longer in force and the unpaid balance will be your responsibility.

PAST DUE ACCOUNTS:

Past-due accounts cost both time and money; therefore, patients with delinquent accounts will be required to make payment at the time of service. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment.

Seriously past due accounts: Those older than 90 days or those failing to honor agreed-upon payment terms will be sent to a collection agency. If your account is sent to a collection agency you must pay all past due amounts or

make agreeable payment terms before subsequent appointments can be scheduled. Additionally patients can be dismissed from our practice for financial matters and will have to seek their health care elsewhere.

RETURNED CHECKS:

Checks returned due to insufficient funds or closed accounts will be charged $25.00 non-sufficient fund fee. Patient is expected to pay by cash and credit card to cover for the returned check plus fee. Any future checks will not be accepted thereafter.

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

	Current	Past		Current	Past		Current	Past		Current	Past
Allergic rhinitis	☐	☐	Cancer, Melanoma	☐	☐	Epilepsy (seizures)	☐	☐	Kidney Stones	☐	☐
Alzheimer	☐	☐	Cancer, Ovarian	☐	☐	Erectile Dysfunction	☐	☐	Low back pain	☐	☐
Anemia	☐	☐	Cancer, Prostate	☐	☐	Fibromyalgia	☐	☐	Lupus	☐	☐
Anesthesia issues	☐	☐	Cancer, Skin (exc Melanoma)	☐	☐	Gallstones	☐	☐	Lymphoma	☐	☐
Aneurysm	☐	☐	Cardiomegaly	☐	☐	Gastritis	☐	☐	Macular degeneration	☐	☐
Angina	☐	☐	Cardiomyopathy	☐	☐	Glaucoma	☐	☐	Menorrhagia	☐	☐
Anxiety	☐	☐	Carotid artery stenosis	☐	☐	GERD	☐	☐	Migraines	☐	☐
Aortic stenosis	☐	☐	Cataract	☐	☐	Gout	☐	☐	Myocardial Infarction	☐	☐
Arterial thrombosis	☐	☐	Chronic Kidney Disease	☐	☐	Heart Attack	☐	☐	Osteoporosis	☐	☐
Arthritis (Osteo)	☐	☐	Colon Polyp	☐	☐	Hematuria (Blood in Urine)	☐	☐	Peripheral Arterial Disease	☐	☐
Arthritis (Rheuma)	☐	☐	Cong. Heart Fail(CHF)	☐	☐	Hemorrhoids	☐	☐	Overactive Bladder	☐	☐
Atrial Fibrillation	☐	☐	Constipation	☐	☐	Hepatitis A, B, C (circle type)	☐	☐	Pancreatitis	☐	☐
B12 deficiency	☐	☐	Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐	Rectal Bleeding	☐	☐
Back Pain	☐	☐	Depression	☐	☐	High Blood Pressure	☐	☐	Stent, Leg	☐	☐
Cancer, Breast	☐	☐	Diabetes Type 1	☐	☐	Hyperthyroidism	☐	☐	Stent, Heart	☐	☐
Cancer, Colon	☐	☐	Diabetes Type 2	☐	☐	Hypothyroidism	☐	☐	Tuberculosis	☐	☐
Cancer, Lung	☐	☐	Eczema	☐	☐	Irritable Bowel Syndrome	☐	☐	Other	☐	☐

Any other health problem not listed above

Hospitalization

Year	Reason	Hospital

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Surgeries		
Year	**Reason**	**Hospital**
Allergies to medications		
Name the Drug	Reaction You Had	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father ☐ Alive ☐ Dead		☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Prostate Cancer	**Children**	☐ M ☐ F	
Mother ☐ Alive ☐ Dead		☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Breast Cancer ☐ Ovarian Cancer		☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandfather** *Maternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandmother** *Paternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandfather** *Paternal*	☐ Alive ☐ Dead	

HEALTH MAINTENANCE

			DATE OF LAST
Have you ever had an EKG?	☐ Yes	☐ No	
Have you ever had a Colonoscopy	☐ Yes	☐ No	
Have you ever had a blood transfusion?	☐ Yes	☐ No	
Have you ever had a Prostate Exam? (Man Only)	☐ Yes	☐ No	
Have you ever had Mammogram? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Dexa Exam? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Pap? (Woman Only)	☐ Yes	☐ No	

Have you ever had a Blood Work?	☐ Yes	☐ No	

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise (choose one)	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind? ☐ Beer ☐ Wine ☐ Hard Liquor				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No

SPECIFIC CONCERNS YOU WANT TO DISCUSS TODAY

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PREFERRED PHARMACY TO SEND YOUR PRESCRIPTIONS TO		
		Pharmacy Address and Phone #
Pharmacy	☐ COSTCO	
	☐ CVS	
	☐ Publix	
	☐ Target	
	☐ Walmart	
	☐ Walgreens	
	☐ Other (specify)	
Mail Order Pharmacy	☐ AARP Medicare	
	☐ CIGNA TelDrug	
	☐ CVS Caremax	
	☐ Innoviant	
	☐ MEDCO	
	☐ Walmart	
	☐ Other (specify)	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Patient Signature: ____________________ Date: ____________________

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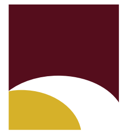

DEMOGRAPHICS FORM

Today's date:	Name of Previous Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email Address:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Cell Phone No:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose this Office because it was referred by:	❑ Dr.	❑ Newspaper	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Drove By (Sign)	❑ Church Ad	❑ Web Search	❑ Billboard	❑ Newsletter	❑ Mail-Out

Name of Person who referred you:	Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Please indicate **primary** insurance	❑ Medicare	❑ BCBS	❑ AETNA	❑ CIGNA	❑ UHC

❑ HUMANA	❑ Great West	❑ Golden Rule	❑ Medicare Replacement *(Write Name)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **secondary** insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I AUTHORIZE NELSON M. PICHARDO, M.D., P.A. TO PROVIDE ANY MEDICAL CARE DEEMED NECESSARY ACCORDING TO THEIR PROFESSIONAL OPINIONS. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NELSON M. PICHARDO, M.D., P.A.. I AUTHORIZE THE RELEASE OF ANY INFORMATION BY. TO MY INSURANCE CARRIER PERTINENT TO MY HEALTH INSURANCE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

I UNDERSTAND THAT SERVICES RENDERED TO ME MAY NOT BE ELIGIBLE FOR BENEFITS UNDER MEDICARE, MEDICAID OR OTHER INSURANCES OR PAYORS. SERVICES NOT ELIGIBLE FOR BENEFITS MAY INCLUDE TESTS AND PROCEDURES THAT ARE NOT COVERED, OR THOSE DELIVERED BY HEALTH CARE PROVIDERS WHO DO NOT PARTICIPATE WITH MY INSURANCE PLAN. NON-COVERED SERVICES MAY ALSO INCLUDE THOSE MY PHYSICIAN DETERMINES MEDICALLY NECESSARY, BUT ARE LATER DETERMINED UNNECESSARY BY MY INSURANCE PLAN. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ANY NON-COVERED SERVICE.

Patient/Guardian signature ______________________ *Date* ____________

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At The Pichardo Clinic, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care or your primary doctor.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information.
- We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy your health information, with a few exceptions: Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact one of the staff members at The Pichardo Clinic at (863) 421-9447.

This notice goes into effect as of April 14, 2003.

Acknowledgement
I have received a copy of The Pichardo Clinic Notice of Privacy Practices.

Print Name: ______________________________ Date: ______________________

Signature: ______________________________

If signing as a parent or guardian, please note the name of the patient: ______________________________