GERIATRIC MEDICINE

INTERNAL MEDICINE

LUIS A. BOBEICA M.D., P.A.

16244 S MILITARY TRL, SUITE 220
DELRAY BEACH, FLORIDA 33484
PHONE: (561) 404-1022
FAX: (561) 404-1566

PATIENT INFORMATION

PATIENT'S NAME (last, first, middle): _____

Social Security No: _____ Date of Birth: _____ Sex (M/F): _____

Married _____ Divorced _____ Widowed _____ Single _____ Spouse's Name: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Out of State Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Email: _____ **Voice Message & Email Notifications:** Yes _____ No _____

Race/Ethnicity: White _____ Hispanic/Latino _____ Black _____ Asian _____ Other: _____

Emergency Contact: Name: _____ Phone: (_____) _____

Who referred you to our office or how did you learn about us? _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ Group #: _____

Insured's Name: _____ Date of Birth: _____ Sex (M/F):____ Relationship: _____

(if different than patient)

SECONDARY INSURANCE: _____ ID #: _____ Group #: _____

Insured's Name: _____ Date of Birth: _____ Sex (M/F):____ Relationship: _____

(if different than patient)

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I understand that it is my responsibility to pay any deductible amount, co-insurance, co-payment, or any other amount not paid by insurance or third party payer within a reasonable period of time not to exceed 60 days. If it becomes necessary to effect collections of any amount owned for this or subsequent visits, the undersigned (or personal and/or legal guardian or representative) agrees to pay for all costs associated with said collection, including reasonable attorney's fees. Furthermore, accounts assigned to collections will be assessed a 30% collection fee.

I request that payment of authorized benefits be made on my behalf to LUIS A. BOBEICA, M.D., P.A. for any services furnished to me by this provider. I authorize any holder of medical information about me to release to my insurance carrier(s) or its agents any information needed to determine these benefits or benefits payable for services from this provider.

Name (Patient or Legal Representative): _____

Signature (Patient or Legal Representative): X _____ **Date:** _____

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MEDICAL HISTORY

Patient's Name: _____ **Date of Birth:** _____

Reason for today's visit: _____

Date of last: Primary Care Physician Visit: _____ Annual Wellness Visit: _____ Blood Test: _____

CHECK ALL OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

GENERAL:
- ☐ Weight loss
- ☐ Falls
- ☐ Other: _____

EYES:
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular degeneration
- ☐ Other: _____

ENT:
- ☐ Allergic rhinitis
- ☐ Hearing loss
- ☐ Other: _____

CARDIOVASCULAR:
- ☐ High blood pressure
- ☐ Prior heart attack
- ☐ Heart failure/CHF
- ☐ High cholesterol
- ☐ Heart stent
- ☐ AFib
- ☐ Other: _____

RESPIRATORY:
- ☐ COPD
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Other: _____

GASTROINTESTINAL:
- ☐ GERD (acid reflux)
- ☐ IBS
- ☐ Chronic constipation
- ☐ Chronic diarrhea
- ☐ Stomach ulcer
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Other: _____

MUSCULOSKELETAL:
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Low back pain
- ☐ Sciatica
- ☐ Abnormal gait
- ☐ Other: _____

GENITOURINARY:
- ☐ Kidney failure
- ☐ Dialysis
- ☐ Kidney stones
- ☐ Blood in the urine
- ☐ Recurrent UTIs
- ☐ Genital herpes
- ☐ Other: _____

BREAST/GYN:
- ☐ Breast lumps
- ☐ Dense breasts
- ☐ Abnormal mammo
- ☐ Breast biopsy
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Other: _____

ENDOCRINE:
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes
- ☐ Hyperparathyroid
- ☐ Other: _____

HEMATOLOGIC:
- ☐ Anemia
- ☐ Blood clots
- ☐ Other: _____

ONCOLOGIC:
- ☐ Lung cancer
- ☐ Colon cancer
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Other: _____

SKIN:
- ☐ Rash/eczema
- ☐ Shingles
- ☐ Other: _____

NEUROLOGIC:
- ☐ Stroke
- ☐ Neuropathy
- ☐ Epilepsy (seizures)
- ☐ Dementia
- ☐ Other: _____

PSYCHIATRIC:
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Bipolar disorder
- ☐ Alcoholism
- ☐ Other: _____

SURGERIES:
- ☐ Cataract
- ☐ Cardiac bypass
- ☐ Joint Replacement
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Groin hernia
- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Other: _____

DEVICES:
- ☐ Pacemaker
- ☐ Defibrilator
- ☐ Loop recorder
- ☐ Other: _____

Family Medical History (list significant diseases like cancer, high blood pressure, diabetes, heart disease, stroke):

Father: _____ Mother: _____

Brother(s): _____ Sister(s): _____ Aunt(s)/Uncle(s): _____

Social History (state Yes, No, or Former): Smoking _____ Alcohol _____ Recreational drugs _____

Year of last: Colonoscopy _____ Mammogram _____ PAP smear _____ Bone density _____ PSA _____

Vaccinations (year): Flu _____ Pneumonia _____ Shingles _____ Tetanus _____ COVID _____ RSV_____

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MEDICATION LIST

(list ALL prescription and OTC medications)

Patient's Name: _____ Date of Birth: _____

Pharmacy: _____ Pharmacy Phone: (_____) _____ - _____

Allergies (mention in parenthesis what reaction): _____

_____

MEDICATIONS

No	Name	Dose	Frequency	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				

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HEALTH INSURANCE COVERAGE, BILLING, AND PAYMENT POLICY ACKNOWLEDGEMENT

Patient's Name: _____ Date of Birth: _____

Our practice is committed to the success of your treatment, and we want to remind you that payment of your medical bill is an integral part of your treatment.

Due to the complexity of insurance policies, it's no longer easy to interpret each individual policy. Therefore, we strongly recommend that you contact your insurance company to understand your coverage. It is your responsibility to be aware of your individual coverage and any changes. Failure to do so may result in you being responsible for all costs incurred at our practice. Your health insurance policy is an agreement between you and your insurance company.

We are more than happy to assist you by electronically checking your insurance benefits prior to your initial visit. However, please keep in mind that, as insurance companies often say, "verification is not a guarantee of payment". Some insurances do not allow patients to go out of network, while others may do so at a higher cost to the patient.

After contacting your insurance company, please feel free to call our office if you have any questions or concerns.

If your insurance policy mandates a co-payment, co-insurance, or you have a deductible, we are obligated to collect payment at the time of service.

By my signature below, I acknowledge that I have read and understood the information provided above.

Name of Patient or Representative _____

Signature of Patient or Representative: _____ Date: _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

- ☐ Complete record
- ☐ Records of care from _____ to _____ only
- ☐ Records of care concerning the following condition(s) _____
- ☐ Progress Notes
- ☐ Blood tests results
- ☐ X-ray, MRI, CT, PET/CT, mammogram, bone density reports
- ☐ Cardiology tests reports (EKG, stress test, Echo, Holter, etc.)
- ☐ Colonoscopy, endoscopy results
- ☐ Vaccinations reports
- ☐ Consultation reports
- ☐ Other. Specify: _____

HIV/AIDS: I consent to the release of any positive or negative test result for HIV infection, antibodies to HIV, or infection with any other causative agent of HIV/AIDS, with the rest of my medical records.

Initials: _____ Date: _____

Please send the records to the following person:

LUIS A. BOBEICA, MD
16244 S. Military Trail, Suite 220
Delray Beach, FL 33484
Fax: (561) 404-1566

The reasons or purposes for this release of information are:

- ☐ Continuation of medical care
- ☐ Transfer of care
- ☐ Consultation
- ☐ Second opinion
- ☐ Other

Patient's Name (print):	Legal Representative's Name (print):
_____	_____
Patient's Signature:	Legal Representative' Signature:
_____	_____
Date: _____	Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO RELEASE MEDICAL RECORDS AND INFORMATION

Patient's Name (print): _____ **Date of Birth:** _____

I have received a copy of this medical office's Notice of Privacy Practices.

I consent for Luis A. Bobeica M.D., P.A. to release my medical records and/or information to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name of Patient or Legal Representative (print): _____

Signature of Patient or Legal Representative: _____

Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain acknowledgement of receipt of the Notice of Privacy Practices, but could not be obtain it because:

- ☐ Patient refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining the acknowledgement
- ☐ Other: _____

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CREDIT CARD CHARGE AUTHORIZATION AGREEMENT

Every patient is required to keep a valid credit card on file with our practice at all times and to update credit card information periodically as needed. Under this agreement, the patient authorizes our practice to automatically charge the credit card on file for any outstanding balances, including the transaction fee imposed by our credit card processing vendor.
Please note that the patient always has the option to pay any outstanding balances by check before the due date.

AUTHORIZATION AGREEMENT

I, _____, authorize Luis A. Bobeica, M.D., P.A. to charge my credit card(s) shown below for any balances owed on my account, either as agreed in advance or as a result of overdue balances, as well as the transaction fee in effect imposed by the credit card processing vendor, which is a pass-through charge. This authorization shall remain in full force and effect until Luis A. Bobeica, M.D., P.A. receives my written notification to cancel this authorization.

By my signature below, I state that I am the authorized signer on the credit card(s) per the information listed below.

Patient's Signature: _____ Date: _____

To my credit card company: By signing below, I authorize payments to Luis A. Bobeica, M.D., P.A. as indicated above.

Credit Card #1

☐ VISA ☐ American Express
☐ MasterCard ☐ Discover

Name (as it appears on the credit card): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____ Security Code: _____

Expiration: Month _____ Year _____

Authorized Signature: _____ Date: _____

Credit Card #2 (optional)

☐ VISA ☐ American Express
☐ MasterCard ☐ Discover

Name (as it appears on the credit card): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____ Security Code: _____

Expiration: Month _____ Year _____

Authorized Signature: _____ Date: _____

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OFFICE POLICIES AND PROCEDURES

MEDICAL CONDITIONS RELATED TO ACCIDENTS: Our practice does not provide medical services for conditions related to accidents that may involve litigation (e.g., motor vehicle, work-related, slip and fall, etc.). If you were involved in such an accident, please note that our practice does not engage in third-party billing or work on medical or attorney's liens. We bill only health insurance companies, not auto or liability insurance companies. We do not collaborate with attorneys on liens. Therefore, we advise you to consult a doctor specializing in medical and legal evaluations who can provide treatment for personal injuries and workers' compensation on a lien basis. For more information, please visit www.accidentdoctor.org.

CONTROLLED SUBSTANCES PRESCRIBING: Our practice does not routinely prescribe controlled substances for chronic conditions like chronic pain and chronic psychiatric conditions. Such controlled substances include, but are not limited to, narcotics (e.g. oxycodone, Percocet, Vicodin, Dilaudid, fentanyl, morphine), benzodiazepines (e.g. Xanax, Restoril, Valium, Klonopin, Ativan), amphetamines (e.g. Adderall, Ritalin, Provigil, Focalin, Vyvanse). We can prescribe limited amounts of such medications for acute conditions only. If you require chronic or prolonged treatment with these medications, you would be better cared for by a pain medicine doctor or psychiatrist, and we can provide you with a referral.

WOMEN ONLY: Our practice does not perform pelvic and breast examinations. Please consult your Ob/Gyn doctor for these examinations. If you do not have one, we can provide you with a referral.

CREDIT CARD ON FILE: Every patient is required to maintain a valid credit card on file with our practice at all times, and to update the credit card information periodically as necessary. By doing so, the patient authorizes our practice to automatically charge the credit card on file for any outstanding balances, including the transaction fee imposed by our credit card processing vendor. Please note that the transaction fee may be waived under exceptional circumstances, on a case-by-case basis. **The patient always has the option to pay any outstanding balances by check before the due date.**

MEDICAL LETTER WRITING AND FORM FILL-OUT FEES: Filling out forms or writing medical letters for the patients or their families are not covered benefits under health insurance policies. Therefore, we cannot bill your insurance for these services. A fee will be charged for such services, based on the complexity and/or the time necessary to complete these documents. For simple forms or standard letters the fee may be waved on a case-by-case basis.

SHORT NOTICE OR NO-SHOW CHARGE: Patients must notify our office of appointment cancellations or changes at least two business days in advance. Failure to do so may result in a $50 charge if we cannot fill the allotted time slot with another patient appointment. This charge will be waved in the case of a major personal emergency.

RETURNED CHECK FEE: Writing a bad check is against the law. A $50 fee will be charged for each returned check. If we receive a returned check, the balance, including the fee, must be paid in cash or by credit card only.

Patient's Name: _____ Date of Birth: _____

By my signature below, I acknowledge that I have read and understood the information provided above.

Name of Patient or Legal Representative: _____

Signature of Patient or Legal Representative: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Patient's Copy

THIS NOTICE DESCRIBES HOW YOUR MEDICAL HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the Privacy Practices that are described in this Notice while it is in effect. This Notice took effect on April 14, 2003 and will remain in effect until further notice.

We reserve the right to change our Privacy Practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our Privacy Practices and the new terms of our Notice effective for all health information that we maintain, including health information that we created or received before we made the changes. Before we make a significant change in our Privacy Practices, we will change this Notice and make the new Notice available to you upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone. If you give us an authorization, you may revoke it as long as it is in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

VERBAL REQUEST: when you call our office and request test results to be faxed or mailed to another doctor's office we will be confirming your identity by asking for your date of birth.

To your family and friends – We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person involved in care – We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health – Related Services – We will not use your health information for marketing communications without your written authorization.

Required by Law – We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect – We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or others.

National Security – We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to a correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders – We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access – You have the right to look at or get copies of your records with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure accounting – You have the right to receive a full list of insurances in which we or our business associates discloses your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction – You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by your agreement (except in an emergency).

Alternative Communication – You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations you request.

Amendment – You have the right to request that we amend your health information. Your request must also be in writing, and it must explain why the information should be amended. We may deny your request under any circumstances.

Electronic Notice – if you receive this Notice on our website or by electronic means (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services, address provided upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

CONTACT INFORMATION

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