Wellington Medical Care Associates, LLC

Pedro Nam, MD, Jose Gonzalez, MD, Abegail Unico, A.P.R.N,
Terryan Douglas, FNP-BC, Maria Mundo, FNP-BC
Board Certified in Internal Medicine
1460 Royal Palm beach Blvd. Royal palm Breach FL 33411
(561)791-7969 • FAX (561) 791-7968

Name:_____ Date of Birth:____ /__ __ /_____
Age:_____ Social Security #:_____-____-_____Sex: _____
Marital Status: __Married __Divorced __Single __Widowed ___Separated
Home phone:( )_____-_____ Cell/Pager Phone: ( )_____-_____
Address:_____
City:_____State:_____ Zip:_____
Mailing Address if different from above: _____
_____State:_____ Zip:_____

Retired?__Yes __No Language Spoken:_____
Employer:_____
Business Address:_____
City:_____State:_____ Zip:_____

Primary Insurance Information
Insured Name: _____Date of Birth: ____/___ /____
Insurance Company:_____
Group #_____ID#_____
Address:_____
City:_____State:_____ Zip:_____

Secondary Insurance Information
Insured Name: _____Date of Birth: ____/___ /____
Insurance Company:_____
Group #_____ID#_____
Address:_____
City:_____State:_____ Zip:_____

Contact in case of an emergency
Name: _____ Telephone #:_____-____-_____
Pharmacy Name:_____ Telephone #:_____-____-_____

Please read the following statements and confirm your agreement by signing below:
- I consent to treatment necessary for the care of the above named patient.
- I allow fax transmittal of my medical records, if necessary.
- I understand and agree that regardless of my insurance status I am ultimately responsible
for the balance on my account for any medical services rendered.
- I certify the information given here is true and correct to the best of my knowledge.
- I will notify Wellington Medical Care Associates of any changes in my health status or in the above information.

Patient Signature:_____ Date:____ /__ __ /_____

Guardian Signature:_____ Date:____ /__ __ /_____
Please furnish us with your insurance card and drivers license so we can have a copy for your chart.

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Patient Personal History & Health Assessment Date: _____

Patient's Name:_____ Date of Birth: ___/____/_____

Allergies: Are you allergic to any medications? YES NO
If yes, please list the medications and the reaction you have to them.
Description: _____
_____
_____

Medications: Please list over the counter medications, doses and vitamins you take:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List each prescribed medication and dose and how often you take them:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Medical History/Diagnosis:

Alcohol Overuse	Dialysis	Hepatitis	Sickle cell anemia
Allergies chronic	Emphysema	High blood pressure	Sleep disorder
Anemia	Epilepsy	Intestinal polyps	Stomach ulcers
Asthma	Frequent kidney/bladder infection		Jaundice
Bleeding tendency	Frequent lung infection	Leukemia/Blood disorder	
Cancer	Gallbladder disease	Measles /Mumps	Thyroid disease
Chicken pox	Goiter	Migraine	Tuberculosis
Colitis	Gout	Nervous breakdown	Whopping cough
Congenital Hear disease	Hay Fever	Radiation treatment	
Depression	Heart Attack	Rheumatic fever	Suicide attempt
Diabetes	Heart Disease	Sexually transmitted disease	Stroke

Other: _____ _____ _____ _____

Past Surgical/Hospitalization History-Please indicate approximate month/year:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Family Medical History-Please include significant pertinent medical history:

Mother:
_____
Father:
_____
Brother:
_____
Sister:
_____

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Medical Equipment-Please circle:
Do you use a cane? Oxygen Catheter Walker Wheel Chair Nebulizer
Do you use Glasses? Hearing Aid?

Social History:

Tobacco: Never smoked____ Quit____Years ago Number of years smoked ____# of packs per day
Alcohol: Never____ Quit____years ago How much do you drink:___ per day___per week___per month
Drugs: Cocaine Marihuana Other

Marital Status: Single Married Widowed Divorced Separated Live Alone

Religious preference (Optional): _____

Women only:
Pregnant Yes No
Date of Last Mammogram:_____ Date of Last PAP Smear:_____

Immunizations-Most recent :
Tetanous_____(Date) Pneumonia_____(Date)
Flu Shot_____(Date) Other_____
Covid-19 Vaccine _____ (Date)

Advance Directives:
A document called a Living Will Advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a living will? Yes___ No___

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HIPAA 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 REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.
For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or
Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations.

You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before August 18, 2021.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ Date:_____

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Insurance Payment Policy

We will accept your insurance assignment as soon as your coverage is verified by our office. As a courtesy to our patients, we will submit your claim forms and assist you in every way we can. You will be responsible for payment at the time services are rendered.

It must be fully understood that your contract is between you and your insurance company and that you are fully responsible for any amount due not paid by your insurance company.

Our office policy regarding insurance payments is:

1. f your deductible has not been met at the time of verification, you are responsible for the deductible amount when you visit our office.

2. You are responsible for the percentage of the amount due not paid by your insurance company at the time of your office visit(s).

3. We do not guarantee that your insurance will pay for the services rendered. Verification is not a guarantee of payment by your insurance company. We will make every reasonable attempt at the beginning of your care to obtain an approximate verification of your policy including the amount of the charge if your insurance company denies the claim or any part of the claim for any reason.

4. You must notify us of changes and updates to your insurance at least twenty-four hours prior to your appointment. Timely notification of changes will assist us in verifying that you have proper coverage and that the charges of your visit will be covered by your insurance company.

I have read, understood and agree with the Wellington Medical Care Associates, LLC Insurance Payment Policy

_____ _____

Patient Signature Date Signed

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RECEIPT OF NOTICE OF OFFICE AND PRIVACY PRACTICES

Written acknowledgement form

Patient Name:_____Date of Birth: _____
Guarantor Name:_____Date of Birth:_____

1. I, _____ have read a Notice of Patient Privacy Practice.

2. I hereby authorize Wellington Medical Care Associates to obtain medical information that may be needed for my healthcare.

3. I authorize one or both of the following persons to make/cancel/or receive any information regarding my appointments.

4. Referrals to specialists may require up to 1 (one) weeks notice to be fulfilled, in case of an emergency the office will try to expedite this service.

5. Medications refills require a 48-72 hour notice. Antibiotics will not be called into a pharmacy without an appointment. Other medications that need refills will not be called in after business hours.

6. **NO SHOW POLICY** – There will be a $25.00 fee for missed appointments or cancellations with less than 24 hours notice. Patients that have a history of repeatedly 'NO SHOWS' may be subject to dismissal for 'non-compliance'.

7. I hereby consent and authorize Wellingon Medical care Associates, LLC to leave voice messages for appointment reminders and other healthcare information/communications

Person #1:_____ Date of Birth:_____

Person #2: _____ Date of Birth:_____

Patient's signature: _____ Date of Birth:_____

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MEDICAL RECORDS RELEASE FORM

Date: _____

To: _____

Fax: _____

I hereby authorize you to release a copy of any inofrmation including the diagnosis and records of my treatment or examination rendered to me.

__ Generel Medical Records

__ Test and laboratory Results

__ Radiology

__ Other _____

Patient's Name:_____ DOB:_____

SSN:_____

_____
Patient's signature