



Diverse Medical Care

Date _____

Patient Information.

Name (First, MI, Last) _____ Date of Birth _____ Age _____

Street Address _____

City _____ State _____ Zip _____ Marital Status: M / W / S / D

Email Address _____

If you are *seasonal*, what is the address we should forward to?

Street Address _____

City _____ State _____ Zip _____ Social Security _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Emergency Contact Name _____

Phone Number _____ Relationship _____

Medications/Supplements currently taking _____

Allergies () YES () NO if yes, please list (medication, food, environmental, etc.) _____

Pharmacy Name / Phone number _____

Insurance Information

PRIMARY insurance company _____ () HMO () PPO () POS

Policy/ID # _____ Group # _____

Policy Holder _____ Relationship to patient _____

Policy Holder's DOB _____ Social Security _____

SECONDARY insurance company _____ () HMO () PPO () POS

Policy/ID # _____ Group # _____

Policy Holder _____ Relationship to patient _____

Policy Holder's DOB _____ Social Security _____

TERTIARY insurance company _____ () HMO () PPO () POS

Policy/ID # _____ Group # _____

Policy Holder _____ Relationship to patient _____

Policy Holder's DOB _____ Social Security _____



Diverse Medical Care

Past Medical History (Check all that apply)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic cough | if yes, when? _____ |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> HIV/AIDs | |
| <input type="checkbox"/> History of seizures | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diverticulitis/diverticulosis | if yes, please describe _____ |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Gall bladder disease | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cysts/ Fibroids/ Tumors | |
| <input type="checkbox"/> Prostate Dysfunction | <input type="checkbox"/> Kidney infection/stones | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Water Retention | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Painful urination | |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Bursitis | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Back Pain | |
| <input type="checkbox"/> Rapid/Irregular heart beat | <input type="checkbox"/> Neck Pain | |
| <input type="checkbox"/> Congestive Heart Failure | | |

Surgical History with Dates _____

Smoking

Have you ever smoked cigarettes, cigars or pipes? () YES () NO *if NO, skip to alcohol section*

If you did or do now smoke cigarettes, cigars or pipes, how many per day? _____ () cigarettes () cigars () pipes

If you stopped smoking, when did you stop? _____

Alcohol

Do you drink alcoholic beverages? () YES () NO

() Occasional () Often if often, _____ per week

Do you do Recreational drugs? () YES () NO

if yes, please describe *(We only need this information to better treat you)*

Patient/Legal Guardian Signature

Date

With signing this intake form, you acknowledge all of the information provided is correct to the best of your knowledge



Diverse Medical Care

Phone Message Consent

Unless Diverse Medical Care has your written permission to do so, we will not:

- ❖ Leave messages with anyone except the patient.
- ❖ Leave information on an answering machine.
- ❖ Send emails and/or fax.

I, _____, give **Diverse Medical Care** permission to leave phone messages, send emails or fax information regarding my medical care. I fully understand that this consent will stay in effect until otherwise documented in writing.

Cell phone (_____) _____

Home phone (_____) _____

Work phone (_____) _____

Fax (_____) _____

Email _____

I also give permission for my medical information to be released to the following:

1. _____ at (_____) _____
Name of person / Relationship **Best phone number**

2. _____ at (_____) _____
Name of person / Relationship **Best phone number**

Patient/Legal Guardian Signature

Date



Diverse Medical Care

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse your personal health information.

Diverse Medical Care must use and disclose or share your health information as necessary for treatment, payment and health care operations to provide you with quality health care.

We are permitted to use and release your health information without authorization from you. Treatment includes sharing information with other health care providers involved in your personal care. We may also use your health information as required by your health insurance to determine eligibility or to obtain payment for your treatment.

Your health information may be used for the following purposes unless you otherwise ask for restrictions on specific uses or disclosures:

- Family members or close friends involved in your care or payment for treatment. *
- Disaster relief agency if you are involved in a disaster relief effort. *
- Appointment reminders
- Law enforcement, as required by federal, state or local law.
- Health oversight activities, such as audits, inspections and licensures.
- Lawsuits and disputes, in response to a court or administrative order, subpoena, discovery request or another law request.
- Coroners and medical examiners.

Note: Statements with the asterisk symbol (*) indicate communications about your health information you are able to refuse.

Contact the office if:

- You have any questions about this notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment and/or operations; or
- You wish to obtain a copy of this notice



Diverse Medical Care

Notice of Privacy Practices Acknowledgement

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of services and our healthcare operations.

() I have received and read the Notice of Privacy Practices

Patient/Legal Guardian Signature

Date

FOR OFFICE USE ONLY

Was the patient given a copy of the Notice of Privacy Practices? () YES () NO

Please explain why the Notice of Privacy Practices was not signed and our efforts to try and obtain the patient's signature.

Signature/Title

Date



Diverse Medical Care

CONSENT FOR RELEASE

PURPOSE OR NEED OF RELEASE OF INFORMATION/MEDICAL RECORDS

TO: _____

PHONE: _____

FAX: _____

ATTN: _____

FROM:

Diverse Medical Care, LLC
2310 SE 2nd Street, Suite #2
Boynton Beach, Florida 33435
Phone: (561) 509-9382

FAX: (561) 509-9362

WHAT REPORTS ARE TO BE RELEASED:

- *MRI Report(s) /CT Scan Report(s) / X-Ray Report(s)
- *Pharmacy Records
- *Lab Results
- Initial Medical Examination and / or Progress Notes*Hospital Records*Discharge Summary
- Hospital Record(s)
- Discharge Summary

The above-mentioned has information, including diagnostic and record of any examination or treatment rendered to me during the period of _____ to _____; to include, any federal and state protected examination under Florida Statue 394.459(9) Psychiatric information, Florida Statue 397.053 and 396.112, during and/or alcohol abuse information, and Florida Statue 381.609(2) Human Immunodeficiency Virus results and related conditions.

I understand by approving the release of information in the form of a fax, a confidentiality cannot be assured. I accept the risk of confidentiality may be breached when faxing information. I hereby release Diverse Medical Care, LLC and its employees from any and all liability that may arise from this release of information.

Patient Printed Name _____ DOB: _____

Patient/Legal Guardian Signature: _____ Date: _____

This Authorization may be revoked at any time upon written notification by the patient, but revocation has no effect on any action previously taken.



Diverse Medical Care

Cancellation and NO SHOW Policy

PLEASE READ CAREFULLY

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or reschedule, that you provide at least a 24-hour notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations of less than 24-hour notice, we are unable to offer that appointment slot to other patients.

Office appointments which are cancelled with less than 24-hour notification will be subject to a **\$35.00** cancellation fee. Colonic cancellations with less than 24-hour notification will be subject to a **\$50.00** cancellation fee.

Patients who do not show up for their appointment without a proper call to cancel an office appointment or Colonic will be considered as a ***NO SHOW***. Patients who No Show for an office appointment may also be subject to a **\$35.00** fee and **\$50.00** for a Colonic No Show.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patients next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand and agree to our Cancellation and No Show Policy.

Patient/Legal Guardian (Print Name)

Date of Birth

Patient/Legal Guardian (Signature)

Date