Indian River
INTERNAL MEDICINE, LLC

PATIENT REGISTRATION FORM

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Social Security: _____

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( ) _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Secondary/ Out of State Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

INSURANCE INFORMATION:

Guarantor: Name of person responsible for your insurance policy; if it is yourself, just write "self."

Guarantor Name: _____ Relationship to you: _____ Guarantor DOB: _____

Primary insurance: _____ Policy number: _____

Secondary insurance: _____ Policy number: _____

EMPLOYMENT INFORMATION:

Employer's Name: _____

Employer's Address: _____

Employer's phone: ( )_____ Occupation: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone: ( )_____

Relationship to you: _____

Patient Signature: _____ **Date:** _____

E. LUIS PRIETO, MD, FACP
Board Certified Internal Medicine

7935 Bay Street, Suite 3 • Sebastian, FL 32958 | Office: 772.581.1881 • Brevard: 321.369.9228 • Fax: 772.581.1885
www.IRinternalmedicine.com

Sebastian River
INTERNAL MEDICINE, LLC

FAMILY HISTORY

Do you have any parents, siblings, or children with any of these problems? If so, please indicate which family member(s).

Diabetes? _____ Heart disease? _____

Breast Cancer? _____ Ovarian cancer? _____ Colon cancer? _____

Prostate Cancer? _____ High blood pressure? _____ Stroke? _____

ALLERGIES TO MEDICATIONS

_____

_____

_____

_____

MEDICATIONS

Name	Strength (mg)	How many times per day?

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MEDICAL HISTORY FORM

Name_____ DOB _____ Date_____

What medical conditions do you have currently?	What medical problems or surgeries have you had previously?
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____
6._____	6._____

SOCIAL HISTORY

Do you smoke currently? _____ How many packs per day? ____ For how many years? ____

Did you smoke previously? _____
If yes, how many packs per day? _____
For how many years? _____
When did you quit? _____

How many alcoholic drinks do you ingest per week on average (One "drink" = 2 oz. of liquor or one 12 oz. beer or one 6 oz. glass of wine)?

____ Less than one per week
____ One to 7 per week
____ 7-14 per week
____ > 14 per week

Do you currently use any illicit / illegal drugs? _____
Have you ever had a blood transfusion? _____ If so, when did you receive it?_____

What kind of work do you do? _____
If retired, what kind of work did you do previously? _____
Are you single, married, divorced, separated or widowed? _____

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I hereby request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Indian River Internal Medicine, LLC:

1. Do we have your permission to call you at home and/or cell phone? ___ yes ___no

If yes, can we leave the following information on your answering machine or voicemail:

Appointment information	___yes	___no
Billing information	___yes	___no
Medical information	___yes	___no

2. Do we have your permission to call you at work? ___yes ___no

If yes, can we leave the following information on your work answering machine or voicemail:

Appointment information	___yes	___no
Billing information	___yes	___no
Medical information	___yes	___no

3. Do we have your permission to communicate medical information (i.e. test results, medical records) via email /web portal? ___yes ___no

4. I give my permission to share the following information with the person(s) named below:

Name:_____ Relationship:_____
Appointment: ___yes ___no Billing: ___yes ___no Medical: ___yes ___no

Name:_____ Relationship:_____
Appointment: ___yes ___no Billing: ___yes ___no Medical: ___yes ___no

Name:_____ Relationship:_____
Appointment: ___yes ___no Billing: ___yes ___no Medical: ___yes ___no

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

Print Witness Name:_____

Witness Signature: _____ Date: _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I, _____, have received a copy of the Notice of

Privacy Practices from Indian River Internal Medicine LLC.

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health cre operatios as discussed in the Notice of Privacy Practices.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

- ☐ Patient/Individual refused to sign (Date of refusal)_____
- ☐ Communications barriers prohibited obtaining an acknowledgement
- ☐ An emergency situation prevented us from obtaining an acknowledgement
- ☐ Other (Explain)_____

Attempt was made by: _____ Date: _____

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FINANCIAL POLICY

Welcome to Indian River Internal Medicine, LLC. In order for us to be able to deliver the quality of care that you are accustomed to, we have established these financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. Further it is the patient's responsibility to verify with your insurance that Dr. Prieto is a provider within your network. If you have a change of address, telephone number, or employer, please notify the receptionist and we will give you a form to update.

2. Payment is expected at the time the services are rendered. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, and Discover.

3. Insurance is filed for all primary and secondary insurance companies. If your insurance denies our charges, or does not pay us in a timely manner, you will be responsible for the balance owed.

4. **DELINQUENT ACCOUNTS:** Accounts are sent to collection 90 days from the date the services were rendered. Further, if your account is past due more than 90 days, an appointment will not be scheduled until your account is paid in full. Patients having financial difficulties are encouraged to discuss them frankly with our billing representative before the account becomes delinquent.

4. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.

5. **MOTOR VEHICLE CLAIMS** are not filed.

6. **WORKERS COMPENSATION CLAIMS** are not filed.

7. **SELF PAY PATIENTS:** Patient with no insurance will be expected to pay at the time services are rendered.

8. **NO SHOW/ MISSED APPOINTMENTS: If you miss your appointment without providing a 24 hour cancellation notice, a fee of $30.00 will be incurred. Notice of cancellation must be given during normal business hours Monday through Friday.**

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of the charges for services rendered to you. If you have any questions regarding our financial policy, please contact our billing department at 772-581-1881.

I have read and have a full understanding of the financial policy of Indian River Internal Medicine, LLC.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

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Care Management Consent

(Medicare or Medicare Advantage Patients Only)

- Dr Prieto participates with a Medicare-sponsored service called "Chronic Care Management/Behavioral Health Integration" (CCM/BHI). This means he has an additional medical assistant (MA) that works from home as a care coordinator, assinged to provide extra care to you.

- This additional MA will be a direct point of contact for you in order to communicate any medical issues, concerns, questions, or requests you may have, and is available to you via phone, email, or text. She will then communicate these concerns to Dr. Prieto to be addressed quickly and efficiently. The MA will also reach out monthly on average to check in with you and review your plan of care.

- *The goal of the program is to reduce unnecessary trips to the emergency room or urgent care for issues that can be addressed by Dr. Prieto directly, and to catch problems early before they become bigger problems.*

- If Dr. Prieto feels that you have 2 or more medical conditions that would benefit from closer monitoring, he will ask his care coordinator MA to reach out to you and commence services.

- This extra service is **covered by Medicare and Medicare Advantage plans**

Name:	_____	**Witness:**	_____
Signature:	_____	**Signature:**	_____
Date:	_____	**Date:**	_____

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Dear Patient:

It is the policy of our practice not to prescribe opiate pain medications that are categorized by the DEA as Schedule II (2) or III (3), such as oxycodone, hydrocodone, fentanyl, morphine, Dilaudid, and others for the treatment of chronic nonmalignant pain. If you require treatment with these medications, they must be prescribed by a pain management specialist, or other provider of your choice.

We apologize for any inconvenience this may cause, and we hope that you will continue to use us for all of your other primary care needs.

Sincerely,



Enio Luis Prieto MD FACP

Acknowledged: _____ _____ _____

Patient Name Signature Date

Witnessed by: _____ _____ _____

Name Signature Date