SCIDC SPACECOAST INFECTIOUS DISEASE CARE

Saima Abbas MD.

PATIENT INFORMATION
(Please Print Clearly)

REFERRED BY: _____

NAME: _____
LAST FIRST MIDDLE

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SS#: _____ DOB: _____ MARITAL STATUS: _____

Home Phone #: _____ Cell Phone #: _____

SEX: M_____ F _____ RACE: _____ ETHNICITY: _____

LANGUAGE: _____ EMAIL: _____

PCP: _____ PCP PHONE # _____

Pharmacy(s): _____ RX Count Preference 30 day or 90 day
Mail order Pharmacy: _____ (circle one)

Lab facility of Choice: (Blood work, Imaging, Urine & or Stool): _____

INSURANCE

INSURANCE (PRIMARY): _____ Specialty Co-Pay: _____
POLICY HOLDER: _____ DATE OF BIRTH: _____

INSURANCE (SECONDARY): _____ Specialty Co-Pay: _____
POLICY HOLDER: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT

Person to contact in emergency: _____
Phone #: _____
Relationship to patient: _____

****

Person to contact in emergency: _____
Phone #: _____
Relationship to patient: _____

Office: 1019 Harvin Way Suite 120. Rockledge Fl, 32955
Phone: 321-349-3896 Fax: 321-349-3936

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Saima Abbas MD.

What medical problems do you have? (Example: Diabetes, Hypertension, Congestive Heart Failure, Chronic Low Back Pain, Arthritis of the Right Knee, Cancer of the Breast). Please indicate all problems below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What surgery have you had? What date was it done? (Example: Gallbladder removed by laparoscopy, Feb. 2004; Coronary artery bypass graft – 5 vessels, Summer 2006; Splenectomy, vaginal hysterectomy and both ovaries removed, 5/1/02; Abdominal hysterectomy and the right ovary removed, 1970).

Surgery	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you ever been admitted to the hospital? ☐ Yes ☐ No If Yes where, date and Reason- Last 5 years

Where	Date	Reason
1.		
2.		
3.		
4.		
5.		

What medications do you take? Include all over-the-counter medications. (Example: Atorvastatin 40 mg once a day, Lisinopril 20 mg once a day, Aspirin 81 mg once a day, Vitamin C 500 mg twice a day)

MED	DOSE	How Often	Who Prescribed
Example: Atorvastatin	40 mg	Once a day	Dr Smith
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

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What allergies do you have? What happens? (Example: Penicillin – shortness of breath, Sulfa–rash, Latex, rash).

ALLERGIES	Reaction
1.	
2.	
3.	
4.	
5.	

List all the Physicians you see. (Example: Dr. Wesley Driggers - Family Medicine, Dr. Stephen Minor - Cardiology, Dr. Pamela Carbiener – OB/GYN). Last 5 Years only

1.
2.
3.
4.
5.
6.
7.
8.

Please tell us about specific family members below: ☐ Adopted – Family History Unknown

This will help us evaluate your future risk factors. Important diseases to include are Hypertension, Diabetes, Heart Disease, Kidney Disease, Types of Cancer, Bleeding Problems, Endocrine Problems, Neurologic Disease, Mental Health Diseases or Rheumatology Diseases like Lupus or Rheumatoid Arthritis.

	Living	Deceased	DOB	Age at Death	Medical Problems	Cause of Death
Father	☐	☐				
Mother	☐	☐				
Brother/ Sister	☐	☐				
Brother/ Sister	☐	☐				
	☐	☐				

Children _____ Medical Problems: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent **Spacecoast Infectious Disease Care** may use, request and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to SCIDCARE's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, **Spacecoast Infectious Disease Care** may call my home or other designated location and leave a message on voicemail, email or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my clinical care including lab results among others. With my consent, **Spacecoast Infectious Disease Care** may also mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

By signing this form, I am consenting **Spacecoast Infectious Disease Care** to use, request and disclose my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient/Legal Representative **Date**

****

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatments and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at their address to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

_____ _____

Signature of Patient/Legal Representative **Date**

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ASSIGNMENT OF BENEFITS & WAIVER OF LIABILITY

I hereby authorize the release of medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further authorize payment for all billed services to be made directly to **Spacecoast Infectious Disease Care.** I understand and agree to be financially responsible for any balance not covered by my insurance plan. I understand that Self Paying patients are responsible for payment in full on the day services are rendered.
This assignment of benefits will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I hereby authorize the assignee to release all information necessary to secure payment.

_____ Date: _____

Signature of Patient/Legal Representative

PATIENT CONSENT FOR IMAGE & PHOTOGRAPHY USAGE

With my consent **Spacecoast Infectious Disease Care** may take, use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to SCIDCARE Notice of Privacy Practices for a more complete description of such uses and disclosures.

By signing this form, I am consenting to **Spacecoast Infectious Disease Care** to take, use and disclosure of these images to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ Date: _____

Signature of Patient/Legal Representative

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MISSED APPOINTMENT AND CANCELLATION POLICY

MISSED APPOINTMENT POLICY:
Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

CANCELLATION OF AN APPOINTMENT:
In order to be respectful of the medical needs of other patients, please be courteous and call Dr. Abbas's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care. To cancel your appointment, please call 321-349-3896. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

LATE CANCELLATIONS: A CANCELLATION IS CONSIDERED TO BE LATE WHEN THE APPOINTMENT IS CANCELLED WITHOUT A 24-HOUR ADVANCE NOTICE.

No Show Policy: A "no-show", is a patient who misses an appointment without canceling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". 30 minutes late arrival without calling in advance will be considered "no show". Dr Abbas will only be able to accommodate after seeing the on-time scheduled patients.

NO SHOW FEE $75, SAME DAY CANCELATION FEE $75

I have read & I understand the cancellation policy:

_____ Date: _____

Signature of Patient/Legal Representative

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