Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE

https://www.scidcare.com

PATIENT INFORMATION

REFERRED BY: _____ DATE OF APPOINMENT: _____

NAME: _____ DOB: _____
LAST FIRST MIDDLE

HOME ADDRESS: _____ CITY: _____

ST: _____ ZIP: _____ HOME Ph: _____ CELL: _____ EMAIL: _____

SEX: ☐ Male ☐ Female ☐ Other _____ RACE: _____ ETHNICITY: _____

SS#: _____ MARITAL STATUS: _____ LANGUAGE: _____

PCP: _____ PCP PHONE _____

Pharmacy(s): _____ Address: _____ City: _____

Mail order Pharmacy: _____

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

INSURANCE

INSURANCE (Primary): _____ Ins # _____ Gr # _____ Co-Pay: _____

POLICY HOLDER NAME : (if not Self) _____ DOB: _____

INSURANCE (SECONDARY): _____ Ins # _____ Gr # _____ Co-Pay: _____

POLICY HOLDER: Name (If not self) _____ DOB: _____

EMERGENCY CONTACTS

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

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

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE

https://www.scidcare.com

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: (Enter NONE if no known diagnosis)

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). (Enter NONE if no surgeries)

	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) (Enter NONE if not taking any medication)

	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.				

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

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE

https://www.scidcare.com

What allergies do you have? What happens? (Example: Penicillin – shortness of breath, Sulfa–rash, Latex, rash). (Enter NONE if no known Allergies)

	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 (Enter NONE if seeing no other Physicians)

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	☐	☐				
Sibling _____	☐	☐				
Sibling _____	☐	☐				
Sibling _____	☐	☐				

Children_____: Boys_____Girls:_____ Medical Problems: _____

_____

_____

_____

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

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

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**

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

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

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

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**

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE
https://www.scidcare.com

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 Initial_____

I have read & I understand the cancellation policy:

_____ Date: _____

Signature of Patient/Legal Representative

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

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE
https://www.scidcare.com

Telehealth Consent Form

I, _____, date of birth_____ hereby consent to receive telehealth services from Board Certified Physician, Saima Abbas MD, an Infectious Disease Specialist, utilizing electronic communication technologies to facilitate my healthcare diagnosis, treatment, and consultation.

Understanding of Telehealth:

- I understand that telehealth involves the delivery of healthcare services via video or audio communication platforms, which may include sharing personal medical information electronically.
- I acknowledge that technical issues may occur during telehealth sessions, and I will discuss any concerns with my provider regarding potential disruptions to my care.

Privacy and Confidentiality:

- I understand that my medical information will be protected according to HIPAA regulations, and that my provider will take appropriate measures to safeguard my privacy during telehealth sessions.
- I am aware that I should access telehealth sessions in a private location to maintain confidentiality.

Responsibilities:

- I will provide accurate and complete information about my health status to my provider during telehealth sessions.
- I will notify my provider if there are any changes to my contact information or health status between appointments.
- I will be responsible for ensuring a stable internet connection and suitable device for telehealth visits.

Right to Withdraw Consent:

- I have the right to withdraw my consent for telehealth services at any time, without affecting my access to future healthcare.

Emergency Procedures:

- In case of a medical emergency during a telehealth session, I will immediately contact emergency services and inform my provider.

Questions and Concerns:

- I have had the opportunity to ask questions regarding telehealth services and have received satisfactory answers from my provider.

_____ Date: _____

Signature of Patient/Legal Representative

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE
https://www.scidcare.com

CONSENT TO USE SCRIBE DURING ENCOUNTERS

Patient Name_____ Date of Birth_____

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you that we are using a “Scribe” during our encounters/appointments. It assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation.

We want to assure you that your privacy is our utmost priority. The Scribe adheres strictly to Health Insurance Portability and Accountability Act (HIPPA) compliance guidelines to endure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

Please sign and date below. If you have any questions, please feel free to discuss them with us.

I, _____, consent to the use of Scribe during my medical encounters/appointments.

_____ Date: _____

Signature of Patient/Legal Representative

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

Saima Abbas MD
INFECTIOUS DISEASE SPECIALIST

SCIDC SPACECOAST INFECTIOUS DISEASE CARE
https://www.scidcare.com

Advance Care Planning Documentation

Date of Encounter: _____

Patient Name:	DOB:

Advance Care Planning Discussion:

Patient's preferences for medical treatment in case of serious illness or incapacity (Check One)

☐ FULL CODE ☐ DNR ☐ Living Will ☐ Surrogate ☐ Medical Power of Attorney

☐ other _____

Do you have an Advance Directive Document in place (living will, durable power of attorney for healthcare, POLST/MOLST form)

Yes ☐ No ☐

Identification of a surrogate decision maker or healthcare proxy:

Do you have a Surrogate: Yes ☐ No ☐ if Yes, Please enter the name of the Surrogate below:

Surrogate decision maker identified: Name _____

FOR OFFICE USE ON LY:

Advance Care Plan Status (check one):

☐ Patient has provided a completed advance care plan or directive document; copy scanned in the medical record

☐ No advanced care plan or surrogate provided; patient declined to complete during this visit

☒ Advance care planning discussion occurred No Documents currently available

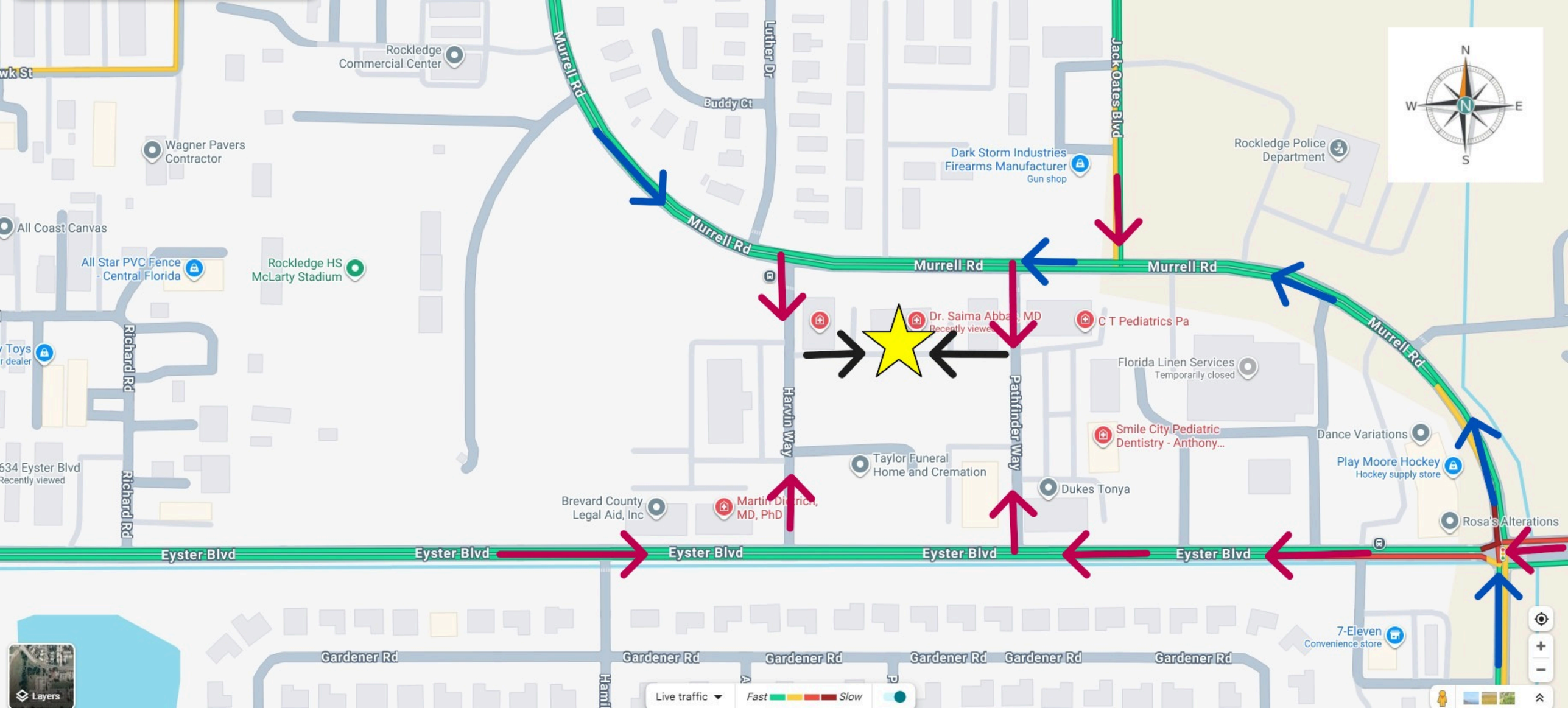
Notes:

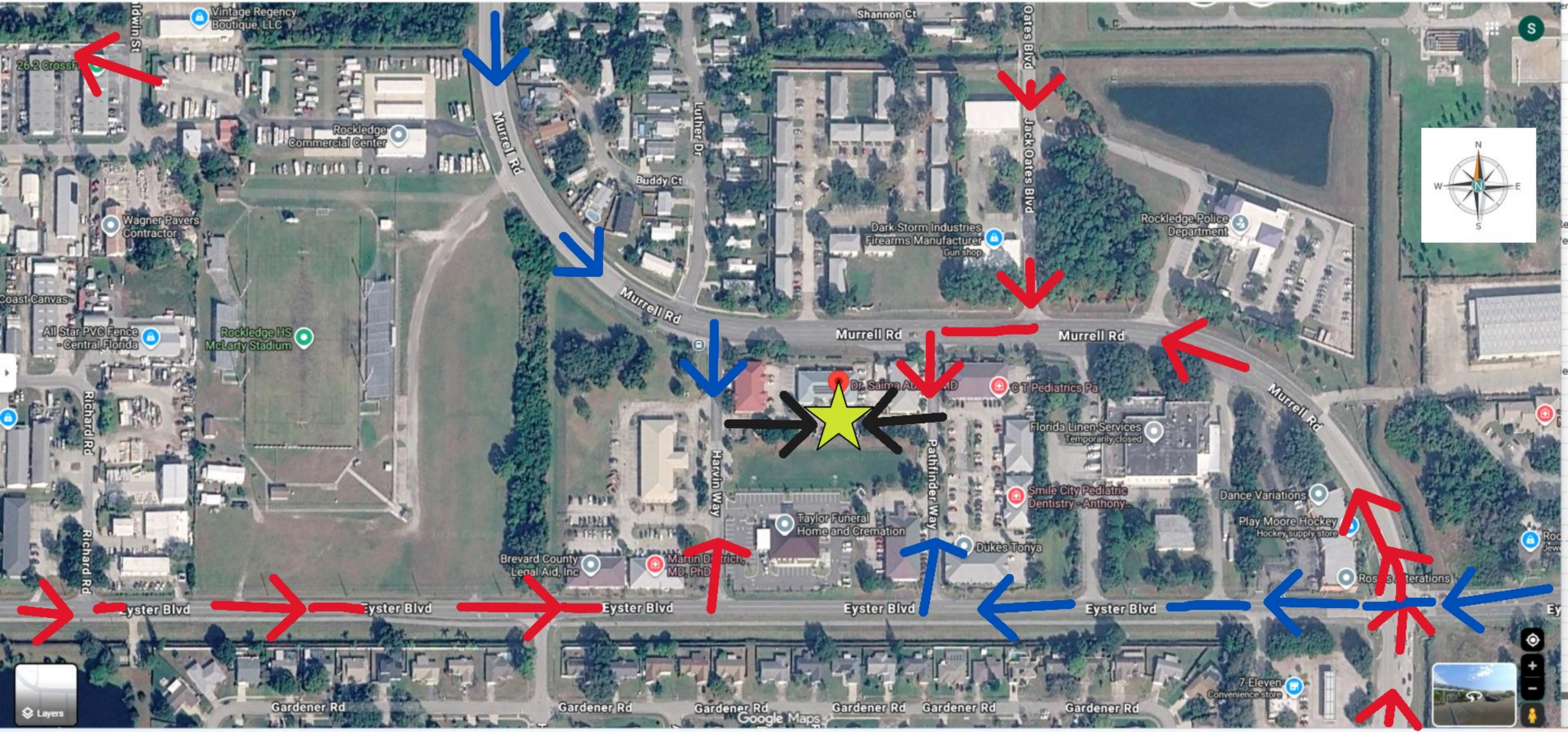
_____

Provider/Provider Representative Signature: Khurram J Khan

Date: _____

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


Murrell Rd
Murrell Rd
Murrell Rd
Murrell Rd
Murrell Rd
Jack Oates Blvd
Luther Dr
Buddy Ct
Rockledge Commercial Center
Wagner Pavers Contractor
All Coast Canvas
All Star PVC Fence - Central Florida
Rockledge HS McLarty Stadium
Dark Storm Industries Firearms Manufacturer
Gun shop
Rockledge Police Department
Dr. Saima Abbas, MD
Recently viewed
C T Pediatrics Pa
Florida Linen Services
Temporarily closed
Harvin Way
Pathfinder Way
Richard Rd
Richard Rd
634 Eyster Blvd
Recently viewed
Smile City Pediatric Dentistry - Anthony...
Dance Variations
Play Moore Hockey
Hockey supply store
Taylor Funeral Home and Cremation
Dukes Tonya
Brevard County Legal Aid, Inc
Martin Dietrich, MD, PhD
Rosa's Alterations
Eyster Blvd
Eyster Blvd
Eyster Blvd
Eyster Blvd
Eyster Blvd
Gardener Rd
Gardener Rd
Gardener Rd
Gardener Rd
Gardener Rd
Gardener Rd
7-Eleven
Convenience store
N
S
E
W
Layers
Live traffic
Fast
Slow


Vintage Regency Boutique, LLC
Shannon Ct
Oates Blvd
Rockledge Commercial Center
Murrell Rd
Luther Dr
Buddy Ct
Jack Oates Blvd
Wagner Pavers Contractor
Dark Storm Industries Firearms Manufacturer
Gun shop
Rockledge Police Department
All Star PVC Fence - Central Florida
Rockledge HS McLarty Stadium
Murrell Rd
Murrell Rd
Murrell Rd
Richard Rd
Florida Linen Services
Temporarily closed
Harvin Way
Pathfinder Way
Smile City Pediatric Dentistry - Anthony...
Dance Variations
Taylor Funeral Home and Cremation
Play Moore Hockey
Hockey supply store
Brevard County Legal Aid, Inc
Dukes Tonya
Richard Rd
Eyster Blvd
Eyster Blvd
Eyster Blvd
Eyster Blvd
Eyster Blvd
Gardener Rd
Gardener Rd
Gardener Rd
Gardener Rd
Gardener Rd
Gardener Rd
7-Eleven
Convenience store
Layers
Google Maps