MARGARITA M. VENDRELL, M.D., P.A.
12276 SAN JOSE BLVD. STE. 608
JACKSONVILLE, FL, 32223
(904) 446-9205

Patient Name:_____Date of Birth:_____Sex:__ Marital Status :_____.

E-mail Address*: _____*required*

Cell Phone* _____*required*

Address:_____City_____State: Zip:_____

Driver's License Number:_____ State of License:_____

Employer's Name & Address:_____

Employer's Phone #:_____Social Security Number: _____

If Patient is a Minor Please Complete This Section:

Father's Name:_____Social Security #:_____Date of Birth:_____

Father's Employer:_____Employer's Phone #: _ Father's Employer

Address:_____

Mother's Name:_____Social Security #:_____Date of Birth: _____

Mother's Employer:_____Employer's Phone #:_

Mother's Employer Address: _____

If Patient is Married Please Complete This Section:

Spouse's Name:_____Social Security #:_____Date of Birth:_____

Spouse's Employer:_____Employer's Phone #:_____

Spouse's Employer Address:_____

Does the Patient have health insurance? Yes_____ No_____

If yes, please list insurance company name(s). Please have your insurance cards available to copy.

Primary Insurance Carrier:_____

Secondary Insurance Carrier(s): _____

Subscriber Name:_____Subscriber DOB: _____

Subscriber Gender: M___F___SubscriberSSN:_____SubscriberID:_____

Subscriber's relationship to patient (mother, father, spouse, etc.): _____

I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Margarita M.Vendrell, M.D., P.A. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature shall be as valid as the original.

Patient/Guarantor Signature:_____***Date:***_____

Emergency Contact: Phone #:_____Relationship:_____

Dr. Margarita Vendrell
MEDICAL HISTORY

NAME:	ALLERGIES:

CURRENT MEDICATIONS:

SURGERY (type and date)	ILLNESSES (requiring hospitalization)
1. 2. 3.	1. 2. 3.

FAMILY HISTORY
Do your parents or siblings have any of the following:

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Obesity				Hypertension			
Diabetes				Heart Disease			
Cancer				Kidney Disease			
Stroke				Arthritis			
TB				Migraine			
Asthma				Depression			
Epilepsy				Other			

PERSONAL HISTORY

Have you ever: (please check each item)

YES	NO		Do you: (please check each item) YES	NO	
		Lived with anyone who had tuberculosis?			Wear glasses?
		Coughed up blood?			Have vision in both eyes?
		Bled excessively after an injury or tooth extraction?			Wear a hearing aid?
		Attempted suicide?			Stutter or stammer habitually?
		Been a sleepwalker?			Wear a brace or back support?

Have you ever or do you now have:

YES	NO	DON'T KNOW		YES	NO	DON'T KNOW	
			Scarlet fever, erysipelas				Tumor, growth, cyst or cancer
			Rheumatic fever				Rupture/hernia
			Swollen or painful joints				Piles or rectal disease
			Frequent or sever headache				Frequent or painful urination
			Dizziness or fainting spells				Bedwetting since age 12
			Eye trouble				Kidney stone or blood in urine
			Ear, nose or throat trouble				Sugar or albumin in urine
			Hearing loss				VD, syphilis, gonorrhea, etc.
			Chronic or frequent colds				Recent gain or loss of weight
			Severe tooth or gum trouble				Arthritis, rheumatism or bursitis
			Sinusitis				Bone, joint or other deformity
			Hay fever				Lameness
			Head injury				Loss of finger or toe
			Skin disease				Painful or "trick" shoulder or elbow
			Thyroid trouble or goiter				Recurrent back pain
			Tuberculosis				Locked or "trick" knees
			Asthma				Foot trouble
			Shortness of breath				Neuritis
			Pain or pressure in chest				Paralysis (including infantile)
			Chronic cough				Epilepsy or fits
			Palpitation or pounding heart				Car, train, sea or air sickness
			Heart trouble or murmur				Frequent trouble sleeping
			High or low blood pressure				Depression or excessive worry
			Cramps in your legs				Loss of memory or amnesia
			Frequent indigestion				Nervous trouble of any sort
			Stomach, liver or intestinal trouble				Periods of unconsciousness
			Gallbladder trouble or gallstones	FEMALES ONLY: HAVE YOU EVER:			
			Jaundice or hepatitis				Been treated for a female disorder
			Adverse reaction to serum, drug or medicine				Had a change in menstrual pattern
			Broken bones	DATE OF LAST MENSTRUAL PERIOD:			

Do you have a Living Will or any form of Advance Directive?

Yes*	No

*Please provide us a copy of your documents as soon as possible.

MARGARITA M. VENDRELL, M.D.,P.A.
12276 San Jose Blvd. Ste. 608
Jacksonville, FL. 32223
(904) 446-9205
(904) 446-9250

PATIENT RECORD OF DISCLOSURES

Margarita M. Vendrell, M.D.,P.A. has a policy of 100% compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the HIPAA Privacy Practices has been given to this patient to review and keep. The following method of operations will be used to insure privacy of your Protected Health Information (PHI).

I wish to be contacted in the following manner: (check all that apply)

1. **Home telephone #**_____
   - D Ok to leave a detailed message.
   - D Leave message with call back number only.

2. **Work telephone #**_____
   - D Ok to leave a detailed message.
   - D Leave message with call back number only.

3. **Cell telephone #**_____
   - D Ok to leave a detailed message.
   - D Leave message with call back number only.

4. **Written Communications:**
   - D OK to mail to my home.
   - D OK to mail to work address.

5. **E-Mail(s): (home)**_____
   (work)_____
   - D OK to e-mail me at my home e-mail address.
   - D OK to e-mail at my work e-mail address.

Our office will provide information and records about your medical condition to other medical providers to whom you have been referred for treatment with this authorization.

Disclosure of PHI may be used without prior consent in an emergency!

6. **If you wish to provide a designated individual(s) access to your medical records, please list the name(s) below. This includes family members that may want to discuss your condition with the physician and / or staff.**

_____

_____

APPOINTMENT CANCELLATION/ NO-SHOW POLICY

Margarita M. Vendrell, M.D
12276 San Jose Blvd. Ste. 608
Jacksonville, FL 32223

EFFECTIVE JANUARY 2, 2008

IN ORDER TO HELP CONTROL THE EXPENSE AND INCONVENIENCE OF NO SHOWS AND SHORT NOTICE CANCELLATIONS, PLEASE BE AWARE OF THE FOLLOWING POLICY FOR THE APPOINTMENT YOU WILL BE MAKING. WE REQUIRE A MINIMUM OF 24 HOURS NOTICE (WEEKENDS NOT INCLUDED) IF YOU CANNOT KEEP YOUR APPOINTMENT.

IF YOU DO NOT GIVE ADEQUATE NOTICE OR FAIL TO KEEP YOUR APPOINTMENT THE FOLLOWING WILL APPLY:

1. THE FIRST TIME YOUR ACCOUNT WILL BE CHARGED **$25.00**. WHICH MUST BE PAID BEFORE YOUR NEXT APPOINTMENT.

2. THE SECOND TIME YOUR ACCOUNT WILL BE CHARGED **$35.00**. WHICH MUST BE PAID BEFORE YOUR NEXT APPOINTMENT.

3. THE THIRD TIME YOUR ACCOUNT WILL BE CHARGED **$50.00**. WHICH MUST BE PAID BEFORE YOUR ENXT APPOINTMENT.

4. THE FOURTH TIME **WE WILL CONSIDER YOU FOR DISMISSAL** FROM THE PRACTICE.

By signing below, I acknowledge that I have read and understand the Cancellation/No-Show policy.

PATIENTS NAME: _____ DATE:_____

Acknowledgement

Of

Receipt of Privacy Notice

For

Margarita M. Vendrell M.D., P.A.

We are required by law to provide you with a copy of our Notice of Privacy Practices.

To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our notice.

_____ _____

Signature of Patient (or Legal Representative) **Date**

_____ _____ _____

Signature of Employee **Title** **Date**

MARGARITA M. VENDRELL, M.D., P.A.
FINANCIAL POLICY

As your family practitioner, I am committed to providing you with the best possible medical care. In order to achieve this goal, I need your assistance and understanding of our financial policy.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a $25.00 service fee and you will lose your privilege to write checks. Margarita M. Vendrell, M.D., P.A. currently uses Check Velocity, a returned check company, who will automatically debit your account for the amount of the returned check plus the applicable service fee.

HMP/PPO INSURANCE COVERAGE

Co-Payment and Deductible must be paid at the time of the service. Because we are under contract with these insurance companies, we will file your insurance.

MEDICARE

Your deductible and 20% of the allowable charges are due at the time of service; however, since we are Medicare providers, we will file your Medicare.

If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare.

Please bring your Medicare Explanation of Benefits to show that you have met your deductible.

LABORATORY BILLING PROCEDURE

I have been informed that all laboratory procedures done outside of the office (blood work, cultures, pap smears, etc.) will not be included in the charges for Margarita M. Vendrell, M.D., P.A.. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Margarita M. Vendrell, M.D., P.A. will send my lab specimens to a laboratory that accepts my insurance.

MEDICAL RECORDS REQUEST

I am aware that should I request a copy of my medical record, I will be charged $1.00 (One Dollar) per page for the first 25 pages and .25 (Twenty-Five Cents) for each additional page thereafter. This cost is NOT covered by insurance and is charged to offset our cost for providing requested records. These costs are in accordance to the Florida Statutes for Medical Records. (Florida Statutes Section 456.057(10); Rule 64B8-10.003, Florida Administrative Code))

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary in the judgment of my physician or his/her designee for myself, my minor child or other. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as a result of treatment or examination performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

CHILDREN OF DIVORCED PARENTS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS REPSONSIBLE BY ORDER OF THE DIVORCE DECREE.

PRIVACY POLICY

I have received a copy of the privacy policy of Margarita M. Vendrell, M.D., P.A. and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals and mole removals).

We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Margarita M. Vendrell, M.D., P.A.

There will be a $25.00 administrative fee for any forms or paperwork that requires assessment and documentation by Dr. Vendrell. (ie: FMLA, Disability, Medical Research, etc)

Signature_____ Date_____

2. **Confidential Communications.** You have the right to reasonably request to receive communication of PHI by alternative means or at alternative locations. However, you are required to provide our office with a daytime telephone number.

3. **Inspection and Copies.** You have the right to inspect and copy the PHI contained in your medical and billing records, except for:

(i) psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) PHI involving laboratory tests when your access is required by law;

(iv) if you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created PHI as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) your PHI is contained in records kept by a federal agency or contractor when your access is required by law; and

(vii) if the PHI was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

We may also deny a request for access to PHI if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested reasonably likely to endanger your life or physical safety or that of another person;
- the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You will be financially responsible for copying charges and postage related to the production of your information. The charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

4. **Requesting an Amendment**. You have the right to request an amendment (correction) to your PHI, but we may deny your request for correction, if determine that the PHI or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records;

(iii) is not available for inspection as set forth above; or

(iv) is accurate and complete.

To request an amendment, your request must be made in writing and submitted to the Practice Office Manager at (904) 778-3389. You must provide us with a reason that supports your request for amendment. Our Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing.

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. **Accounting of Disclosures.** You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;

(ii) to persons involved in your care or for other notification purposes as provided by law;

(iii) made pursuant to your written authorization;

(iv) for national security or intelligence purposes as provided by law;

(v) to correctional institutions or law enforcement officials as provide by law; or

(vi) that occured prior to April 14, 2003.

The first accounting requested within a 12-month period will be provided free of charge. For additional requests during the same 12-month period, you will be charged for the cost of providing the list. The Practice will notify you of the cost involved, so you may decide whether to withdraw or modify your request.

6. **Copy of Privacy Notice.** You have the right to request and receive a paper copy of this notice from us.

This notice is effective as of April 14, 2003.

Margarita M. Vendrell M.D., P.A.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

We are required by law to maintain the privacy of protected health information ("PHI"). PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. A copy of our most current privacy notice will be posted in the office. You can always request a copy of our most current privacy notice from our Practice.

PERMITTED USES AND DISCLOSURES

The following categories describe the different ways in which we may use and disclose your PHI without obtaining your authorization.

- **Treatment** means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

- **Payment** means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your HMO information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the HMO for the services rendered to you, we can provide the HMO with information regarding your care if necessary to obtain payment.

- **Health care operations** means the support functions of our Practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

- We have an indirect treatment relationship with you, that is, we provide health care to you based on the orders of another health care provider. For example, if you have come to us for a diagnostic procedure, we can disclose the results of that test to the physician who ordered the procedure;

OTHER USES AND DISCLOSURES OF PHI

We may contact you to notify you of lab or test results, to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may disclose your PHI only to those people that you have authorized. We will only disclose the PHI directly relevant to their involvement in your care or payment. We may also use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the PHI that is directly relevant to their involvement in your care. When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI with your authorization.

We may contact you as part of our marketing efforts as permitted by applicable law.

Except for the special situations listed below, or as provided by Florida law, we will not use or disclose your PHI for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

SPECIAL SITUATIONS

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces,we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Worker's Compensation.** We may release medical information about you for programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of product, recalls, repairs or replacements;
  - to notify a person who may have been exposed to a disease or be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose PHI to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing persons;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct on our premises; and
  - In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **Serious Threats.** As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOUR RIGHTS

1. **Requesting Restrictions**. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Practice Office Manager at (904) 446-9205 Your request must describe in a clear and concise fashion:
   (a) the information you wish restricted;
   (b) whether you are requesting to limit our Practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.