MIAMI CLINIC, INC.

ADMISSION RECORD

MEDICAL RECORD NO.:	Admission Date:

ADMISSION DATA BASE

Last Name:			First Name:		Middle Initial:
Age:	DOB:	Sex:	Birthplace:	Origin:	Marital Status: S( ) M( ) D( ) W ( )
Address (Permanent):			City, State and Zip Code:		Home Phone No.:
Current Address:			City, State and Zip Code:		Phone No.:
Next of KIN:			Relationship:		Phone No.:

EMERGENCY INFORMATION

Notify in Case of Emergency:	Relationship.	Work Phone No.:	Home Phone No:
Address:		City, State and Zip Code:	

LEGAL STATUS

Admission Status.	Legally Responsible:
(x) Voluntary ( ) Involuntary	(X) Patient ( ) Other

FINANCIAL DATA BASE

Primary Insurance No.:	Social Security No.:
Medicare No.:	Secondary Insurance and No.:
Medicaid No.:	HMO (Subscriber's No. And Group No.):

OTHER PERTINENT INFORMATION

PHYSICIAN RELEASED AND ASSIGNMENT:

I hereby authorize payment directly to of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier.

A copy of this authorization may be used of the original.
I authorize any holder of medical or other information about me to release to the Social Security Administration &Health Care Financial Administration or it's intermediaries or carries any information needed to this or a related claim. I request payment of medical insurance to the who accepts assignment.
I understand what I am signing.

PATIENT

SIGNATURE_____

MIAMI CLINIC, INC.

AFFIDAVIT OF AFFILIATION

DATE:_____

I _____CONFIRM THAT I HAVE NOT HAD ANY LABORATORY (BLOOD) EXAM PROCESSED WITHIN THE LAST 30 DAYS NOR AM I AFFILIATED WITH ANY HMO OR ANY OTHER MEDICAL FACILITY AT THIS TIME.

PATIENT SIGNATURE:_____

WITNESS:_____

WITNESS:_____

WITNESS:_____

WITNESS:_____

MIAMI CLINIC, INC.

AFTER HOURS EMERGENCY
POLICY AND PROCEDURES

PT. NAME:_____

DATE: _____ MR#:_____

POLICY:

In the event that a patient's condition deteriorates after program hours to a level of intensity and security greater than Medical Center indicated, he/she should contact the Medical Center Director for proper disposition.

STANDARD:

The patient can expect to have his or her needs met in the event of exacerbation of physician/ medical symptoms.

PROCEDURES:

1. Should a medical crises arise after program hours, patient and/or family should contact 911.
2. The Primary Care Physician will then contact the patient and/or family inform him/her of the presenting situation. (In the event of a serious emergency, the physician may instruct the patient to seek hospitalization when the physician is not immediately available.) Direct hospitalization is available at the request of the attending physician or the Medical Director for the MEDICAL CENTER.
   If the physician is available and time permits, the physician will assess the patient's situation and take appropriate action and instruct the patient as to which course of action he/she should take.
   The physician will document all pertinent information on patient records and follow-up with patient family members.

X _____ _____

Patient's Signature Date

_____ _____

Witness Date

Note: **Patient's signature indicates he/she has read the above information and understand its context. A copy is given to the patient.**

MIAMI CLINIC, INC.

Anti-Kickback Statement

I, _____ have in no way been compensated for coming to: Miami Clinic, Inc. for treatment either now or in the past and have not been offered or given any compensation for future treatment.

Yo, _____ nunca he sido compensada/o de ninguna manera por venir a: Miami Clinic, Inc. por tratamiento en el presente, pasado y no me han ofrecido compensación por tratamientos futuros.

_____ _____
PATIENT DATE

_____ _____
WITNESS DATE

MIAMI CLINIC, INC.

AUTHORIZATION TO RELEASE INFORMATION

Patient: Name _____ Date of Birth _____
Address _____ Social Security #_____
City _____ State _____ Zip code _____
Day Phone Number _____ Email address _____

Clinic: Information to be released from:
Clinic Name _____ Provider Name _____
Address _____
City _____ State _____ Zip code _____

Recipient: Information to be released to:
Name _____
Address _____
City _____ State _____ Zip Code _____
Information to be disclosed: **Medical Record Release Date of Service Requested** _____

☐ Clinic Visit Notes
☐ Special Tests _____
☐ Consultation/Follow-up Reports
☐ Immunizations
☐ Occupational Health/Worker's Comp
☐ X-Ray Report/Mammography Report
☐ Lab Reports
☐ X-Ray Films
☐ Hospital Reports
☐ Optical
☐ Mental Health/Psychological Testing/Reports
☐ Other _____
☐ All the above (including records relating to HIV, alcohol, drug treatment, records relating to communicable disease and/or those marked confidential).

**Information in your chart that was not originally generated by this clinic will not be released to another facility. Such information must be obtained from the original source.*

Reason for Release:
☐ Legal
☐ Consult/Second Opinion
☐ Insurance Claim Report
☐ Insurance Changed to _____
☐ Out of Town Move
☐ Selected New Physician
☐ Referred by Dr. _____

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature.
I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the redisclosure of that information.

Authorization: I authorize the above provider to release the information marked above to the recipient,

_____ _____
Signature of Patient/Guardian — Relationship to Patient if signed by Guardian

_____ _____
Date of Patient's Signature — Reason Patient Unable to Sign

Records Copied: Date _____ By Whom _____

Medical Record Copies will be: Mailed _____ Picked Up _____

MIAMI CLINIC, INC.

POLITICA Y PROCEDIMIENTOS EN CASO DE EMERGENCIA DESPUES DE HORAS DEL PROGRAMA.

POLITICA

En caso que el comportamiento del paciente se deteriore, después de las horas del Programa. El o ella debe comunicarse con el Médico, o la enfermera de cabecera. del Programa.

El Programa le proveera al paciente la atencion a sus necesidades en caso de empeorar sus sintomas psiquiatricos o clinicos.

PROCE DIMIENTOS

1. Al presentarse un caso de ernergencia despues de las horas del Programa, el paciente y/o familiar debera comunicarse con el 911.

2. El Medico o la enfermera debe comunicarse con el paciente y/o familiar y le informara la situacion actual (de ser un caso de ernergencia, el Medico o]a enfermera le recomendara al paciente la hospitalizacion. El paciente puede ser hospitalizado inmediatarnente por el Medico.

3. De no estar el Medico disponible, el atendera la situacion del paciente y hara las llamadas y referidos pertinentes.

4. El Medico o la enfermera dodumentara toda la informacion pertinente en el expediente del paciente y le dara seguimiento junto al paciente y/o familiar.

AVISO: En el momento de admision, se le ofrecera al paciente informacion sobre esta politica en particular. Sera firmada por el paciente. Una copia sera dada al paciente y la otra copia se colocara en el expediente.

MIAMI CLINIC, INC.

NOTICE OF PRIVACY PRACTICES.
HIPAA

Effective Day Policy: April 14.2003.

We are dedicated to protecting your right to privacy of your medical information while providing the highest quality of medical care. We want you to be aware of new regulations that affect how we use and disclose your medical information, and the rights you have regarding your medical records. New Privacy Rules adopted as part of the Federal Health Insurance Portability and Accountability Act (HIPAA) establish standards for the release of medical information that personally identifies you.

Our Privacy Practices

- We must provide you access to a Privacy Notice that explains how we may use or disclose your medical information,
- We will ask for you to acknowledge that you have received and understood our Privacy Notice.

Your Permission

- Once we have let you know about our Privacy Practices, we may release information about you for purposes of treatment, billing for services, or operational purposes without further permission from you.

Your Rights Regarding Your Medical Records

The Federal Privacy Regulations give you many rights regarding your medical records. They include:

- The right to an accounting of certain disclosures of your medical information in the six years prior to the date of your request.
- The right to Inspect and obtain a copy of your medical information.
- The right to receive confidential communications of your medical information.
- The right to receive confidential communications by an alternative means at an alternative location.
- The right to request an amendment to your medical record.
- The right to submit a complaint to our company about how your medical information is used or disclosed.

Patient Signature _____ Date _____

MIAMI CLINIC, INC.

BOLETIN SOBRE LAS PRACTICAS DE PRIVACIDAD HIPAA

La Poliza Entra en Efecto en Abril 14, 2003.

Nuestra organización está dedicada a proteger los derechos de privacidad que tiene usted sobre su información médica, mientras le proveemos el mejor cuidado médico. Queremos que usted esté informado de las nuevas regulaciones que van a estar en efecto a partir del día 14 de Abril del 2003. Estas regulaciones afectan la manera en como se utiliza su información médica y sobre todo que derechos tiene usted con relación a su expediente médico. Las nuevas regulaciones de Privacidad adoptadas como parte de HIPAA establecen criterios para poder entregar o revelar información médica que lo identifique a usted personalmente.

Nuestras Prácticas de Privacidad

- Nuestra facilidad le tiene que proveer acceso a nuestra Práctica Privada,la cual le explica en detalle como nosotros utilizamos su información médica y con quien compartimos su información médica.
- Nosotros le pedimos que cuando usted reciba esta información firme este papel dando por entendido que le fue explicado a usted en su totalidad como es el funcionamiento de nuestras prácticas de Privacidad y que usted las ha entendido.

Con su Autorización

- Después que le hallamos explicado acerca de nuestras Prácticas de Privacidad, nosotros pademos utilizar su información médica con relación a su tratamiento, para sevicios de cobro o para nuestro, proceso operacional sin requerir autorización suya adicional.

Sus Derechos con Relación a su Expediente Médico

Las Regulaciones Federales de Privacidad le dan a usted muchos derechos con relación a su expediente médico. Estos derechos incluyen:

- El derecho a una contabilidad de ciertas revelaciones de su información médica hasta seis años de antelación a su pedido de contabilidad.
- El derecho de inspeccionar y obtener una copia de su información médica.
- El derecho de recibir comunicación confidencial de su información médica.
- El derecho de recibir una comunicación confidencial por medio de una forma alterna y en una localización alterna.
- Ell derecho de solicitar una enmienda a su expediente médico.
- El derecho de someter quejas a nuestra compañía con relación al manejo de su información médica y como ha sido utilizada o revelada.

(Favor de firmar en la parte del frente, después de haber leído esta forma)

MIAMI CLINIC, INC.

INITIAL HISTORY

Name_____ Gender_____ Age_____ Date_____
Chief Complaints: _____

History of present Illness: _____

Medications - List all medications you are currently taking. Include ALL medications even Over The Counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency	Status
			☐ Chronic ☐ Acute ☐ DC'd
			☐ Chronic ☐ Acute ☐ DC'd
			☐ Chronic ☐ Acute ☐ DC'd
			☐ Chronic ☐ Acute ☐ DC'd
			☐ Chronic ☐ Acute ☐ DC'd
			☐ Chronic ☐ Acute ☐ DC'd
			☐ Chronic, ☐ Acute ☐ DC'd

Allergies - List your allergies including any medications that caused an allergic reaction.

List ALL Allergies	Allergic Reaction

Past Medical History - Please provide a complete history including all illnesses, injuries, hospitalizations and operations.

List all Illnesses, Injuries, Hospitalizations and Operations	Date	Hospital	Treatment	Physician

Family History - Please list all blood relatives with their current health status and any illnesses they have had or now have.

List Blood Relatives	Age If Living	Age At Death	Cause Of Death	State Of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

Social History - Please check the appropriate boxes and fill in the accurate amounts of standard portions.

Mental Work
☐ Heavy ☐ Moderate
☐ Light ☐ None
☐ Omit
No. Hours Per Day_____

Physical Work
☐ Heavy ☐ Moderate
☐ Light ☐ None
☐ Omit
No. Hours Per Day_____

Exercise
☐ Heavy ☐ Moderate
☐ Light ☐ None
☐ Omit Type_____
No. Hours Per Day_____

Alcohol
☐ Beer/Week_____
☐ Liquor/Week_____
☐ Wine/Week_____
☐ None
No. Of Years

Smoking
☐ Current ☐ Previous
☐ None Other_____
No. Of Packs/Day_____
No. Of Years_____
Quit Year_____

Caffeine
☐ Coffee ☐ Tea ☐ Cola ☐ None
☐ Other_____
Cups Per Day_____
No. Of Years_____

Aspirin
No. Per Day_____
No. Of Years_____
Other_____
☐ None_____

Nutritional Information
☐ Low Sodium Diet ☐ Diabetic Diet
☐ Low Fat Diet ☐ Vegetarian Diet
☐ Low Cholesterol Diet
☐ Other_____

Miscellaneous Drugs
☐ Vitamins ☐ Pain Pills ☐ Marijuana
☐ Laxatives ☐ Sleeping Pills ☐ Cocaine
☐ Antacids ☐ Nutra Sweet ☐ Amphetamines
☐ Diet Pills ☐ Saccharin ☐ Other_____

MIAMI CLINIC, INC.

ATTENTION TO ALL PATIENTS

UNDER FLORIDA LAW PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE, YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE. THIS IS PERMITTED UNDER FLORIDA LAW SUBJECTED TO CERTAIN CONDITIONS FLORIDA LAW IMPOSES PENALTIES AGAINST NON INSURED PHYSICIANS WHO FAIL TO SATISFY ADVERSE JUDGEMENTS FROM CLAIMS OF MEDICAL MALPRACTICE THIS NOTICE IS PROVED PURSUANT TO FLORIDA LAW.

YOUR DOCTOR

I HAVE READ THIS STATEMENT AND FULLY UNDERSTAND IT

PATIENTS SIGNATURE: X _____

ATENCION PACIENTES

BAJO LAS LEYES DE LA FLORIDA, SE REQUIERE GENERALMENTE QUE LOS MEDICOS TENGAN SEGUROS DE MALA PRACTICA MEDICA O DE LO CONTRARIO DEMONSTRAR RESPONSABILIDAD FINANCIERA PARA CUBRIR POSIBLES RECLAMACIONES, SU MEDICO HA DECIDIDO NO TENER SEGURO DE MALA PRACTICA MEDICA. ESTO SE PERMITE POR LAS LEYES DE LA FLORIDA SUJETO A CIERTAS CONDICIONES. LAS LEYES DE LA FLORIDA IMPONEN MULTAS A LOS MEDICOS NO ASEUGURADOS QUE NO SATISFAGAN JUICIOS ADVERSOS DERIVADO DE RECLAMACIONES DE MALA PRACTICA MEDICA. ESTE AVISO HA SIDO PROVISTO SIGUIENDO LAS LEYES DE LA FLORIDA.

SU DOCTOR

YO HE LEIDO Y ENTIENDO PERFECTAMENTE ESTE AVISO

FIRMA DE PACIENTE: X _____

MIAMI CLINIC, INC.

Established Patient Progress Note

Date:_____ Name: _____ MR#: _____

Vital Signs:_____ Allergies: _____ _____

BP: P: R: T: Height: Weight:

Chief Complaint (CC)/History of Present Illness (HPI)

Chief Complaint:

Review of Systems (ROS)
Check if WNL; write out all (+) findings

☐ General: _____	☐ GU: _____	☐ Psych:_____
☐ HEENT: _____	☐ MS: _____	☐ Renal:_____
☐ Pulm: _____	☐ Skin:_____	☐ Gyn: _____
☐ Cardio; _____	☐ Neuro: _____	☐ Lymph: _____
☐ GI: _____	☐ Endo; _____	(√) *All systems* negative

Past Medical, Family, and Social History (PFSH)

Family Hx:_____ Medications:_____

Past Hx: _____ _____

Social H)c _____ _____

Physical Examination (PE) Check if WNL; write out all (+) findings

Body Areas	Organ Systems	
☐ Head/Face:	☐ Constitutional;	☐ Skin:
☐ Neck:	☐ Eyes:	☐ Neurological:
☐ Chest:	☐ ENT:	☐ Psychiatric:
☐ Abdomen:	☐ Cardiovascular:	☐ Hematologic/Lymphatic:
☐ Genitalia, Groin.	☐ Respiratory:	☐ Extremity:
☐ Back/Spine:	☐ Gastrointestinal:	☐ Musculoskeletal:

Counseling and Coordination of care
(Check each appropriate Component and list number of minutes spent)

☐ Counseling:____	☐ Nutritional requirements____	☐ Safe sex practices__
☐ Instructions for management and/or follow-up____	☐ Adherence___	☐ Exercise program__
☐ Diagnostic results and or recommended diagnostic studies. ___	☐ Drug side effects____	☐ Social support__
☐ Prognosis____	☐ Psychological support__	☐ Other (specify)__
☐ Risk and benefits of treatment options____	☐ Alternative therapies____	_____

Diagnostics Reviewed / Ordered
(Circle if ordered /check if reviewed)

☐ CBC	☐ Electrolytes	☐ Blood Lipids	☐ Platelet Count	☐ PPD Skin Test
☐ RBC	☐ Hemoglobin	☐ Hemoglobin A I C	☐ MCV	☐ Testosterone
☐ VVBC	☐ Hematocrit	☐ Lymphocytes	☐ Granulocytes	☐ Thyroid Function
☐ CHEM-25	☐ Glucose	☐ Cholesterol	☐ Triglycerides	☐ Amylase
☐ Liver Function Tests	☐ Kidney FunctionTests	☐ Hepatitis Serologies	☐ HIV- I Antibody	☐ Referrals (specify):
☐ Q-PCR	☐ bDNA	☐ Lumbar Puncture	☐ Other (specify)	
☐ Genotype	☐ CT Scan	☐ MRI Scan	☐ Chest XRay	_____
☐ Phenotype	☐ Sonogram	☐ Bone Scan	☐ Sinus Series	_____

Is Counseling and/or coordination of care a factor? **Yes or No**

Total minutes of Patient encounter _____ Number of minutes devoted to counseling and/or coordination of care _____

Physician Signature:_____

MIAMI CLINIC, INC.

RIGHTS OF THE PATIENT

PATIENT NAME:_____
MR#:_____ **DATE:**_____

Your rights as a patient in a Facility are guaranteed by Florida Law. Your rights are summarized below.

1. RIGHT TO BE FULLY INFORMED OF ALL YOUR RIGHTS.
2. RIGHT TO INDIVIDUAL DIGNITY.
   a.)To be respected at all times.
   b.)To have freedom of movement unless restricted as a part of treatment.
   c.)To be free from abuse or neglect.
3. RIGHT TO TREATMENT.
   a.)To receive treatment regardless of your race, creed, sex, national origin, or your ability to pay.
   b.)To receive treatment in the least restrictive setting possible.
   c.)To be transferred to another facility if the hospital cannot meet your needs and or request, if medically permissible and transfer is acceptable by the other facility.
4. RIGHTS TO EXPRESS AND INFORMED CONSENT.
   a.)To be informed about the nature of your treatment.
   b.)To consent or not consent to treatment unless restricted by a judge or in an emergency.
   c.)To be provided through the court a Guardian Advocate, if necessary, to help with decisions regarding your treatment.
   d.)To be informed about the professional staff responsible for your care, their professional status and staff relationship.
   e.)To be informed of the reasons for any proposal change in the professional staff responsible for your or for your transfer, either within outside the facility.
   f.)To receive an itemized and detailed explanation of your total bills for services rendered in the hospital.
   g.)To receive notice prior to the determination of any party payer benefits.
   h.)To be informed of the facility's rules and regulations applicable to your conduct as a patient.
5. RIGHTS TO QUALITY TREATMENT.
   a)To receive treatment that is skillfully, safely, and humanly administered.
   b)To receive such medical, vocational social, educational and rehabilitative services and rendered.
6. RIGHTS TO PRIVACY.
   a)To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
   b)To expect that all communications regarding your care, including the source for payment for treatment, be held in the strictest confidence by all of the staff.
   c)To be place in protective privacy when considered necessary for YOUR PERSONAL SAFETY.

MIAMI CLINIC, INC.

RIGHTS OF THE PATIENT

PATIENT NAME:_____
MR#:_____ **DATE:**_____

7. RIGHTS TO CONSULT A SPECIALIST
   a)To request at your expense, an opinion from a consultant as to your treatment at the hospital.
8. RIGHTS TO COMMUNICATION, ABUSE REPORTING, AND VISITS.
   a)To have visitors at reasonable hours, unless such visitations is restricted as part of your treatment.
   b)To have access to a telephone at any time to report abuse or neglect (1-800-96-ABUSE)
   c)To initiate a grievance procedure or complaint if you feel your rights have been denied.
9. RIGHT TO CLINICAL RECORD THAT IS CONFIDENTIAL.
   a)To designate, if legally competent, who or which agencies shall receive information about your treatment.
   b)To know that only a court can get information from your clinical record.
10. RIGHT TO PETITION FOR A WRITE HABEAS CORPUS
    a)To question that cause and legality of your detention.
    b)To ask the Circuit Court to order your release.
11. RIGHT OF TRANSPORTATION
    a)To be transported to and from the treatment facility if you are unable to provide or pay for Such transportation.
12. RIGHT TO DESIGNATE REPRESENTATIVES.
    a)To designate a person to receive notices.
13. RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE.
    a)To help make decisions about your Treatment.
    b)To help make plans for your discharge.

We, the undersigned, hereby state that we have been fully informed of the Patient Rights that apply to _____ We received a copy of the Rights and do hereby agree to and understand the above rights as they pertain to the facility.

X_____ _____
Signature of Patient Date/Time a.m./p.m.

_____ _____
Signature of Legal Guardian Date/Time a.m./p.m.

_____ _____
Witness Date/Time a.m./p.m.

DAMAR MEDICAL CENTER, INC.

INITIAL HEALTH ASSESSMENT

Date: ____ / ____ / ____

Name: _____ D.O.B. ____ / ____ / ____ /
Age: _____ WT: _____ HT: _____ Temp: _____ Bp: _____ Pulse: _____

Chief Complaints: _____
_____
_____

History of Present Illness: _____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Childhood Illness: _____
Surgery: _____
Hospitalization: _____
Accidents: _____
Hospitalizations: _____
Allergies: _____
Current Medicines: _____
_____
_____

SOCIAL HISTORY

Smoke: □ No □ Yes Amount: _____
ETOH: □ No □ Yes Amount: _____
Drugs: □ No □ Yes Amount: _____
Religion: _____

Marital Status:
Single □ Divorced □ Separated □
Married □ Widowed □
Other: _____

IMMUNIZATIONS

Pneumococcal: ____ / ____ / ____ /
Influenza: ____ / ____ / ____ /

Rubella: ____ / ____ / ____ /
Diphtheria: ____ / ____ / ____ /

Tenatus: ____ / ____ / ____ /
Other: ____ / ____ / ____ /

DAMAR MEDICAL CENTER, INC.

MEDICATION RECORD		DRUG PLAN	ABBREVIATIONS
NAME			D- DISCONTINUE MED PD- PT DISCONTINUE MED → CONTINUE SAME DOSE î INCREASE MED. DOSE ł DECREASE MED. DOSE
PHARMACY	PHONE ( )	FAX ( )	
ALLERGIES			

MEDICATIONS	DATES								

DAMAR MEDICAL CENTER, INC.

PROGRESS NOTE

Date: _____ / _____ / _____

Name: _____ D.O.B.: _____

Age: _____ WT: _____ HT: _____ Temp: _____ Bp: _____ Pulse: _____

Chief Complaints: _____

System Review:

Skin: ☐ WNL ☐ Abnormal Heat/EENT: ☐ WNL ☐ Abnormal Respiratory: ☐ WNL ☐ Abnormal Endocrine: ☐ WNL ☐ Abnormal
Cardiovascular: ☐ WNL ☐ Abnormal Gastro-Intestinal: ☐ WNL ☐ Abnormal Genito-Urinary: ☐ WNL ☐ Abnormal
Musculo-skeletal: ☐ WNL ☐ Abnormal Neurological: ☐ WNL ☐ Abnormal Gynecological: ☐ WNL ☐ Abnormal

PHYSICAL EXAMINATION

Skin: ☐ _____
ENT: ☐ _____
Lungs: ☐ _____
Heart: ☐ _____
Abdomen: ☐ _____
Genito-Urinary: ☐ _____
Extremities: ☐ _____
Neurological: ☐ _____
Rectal: ☐ _____

Working Diagnosis: _____

Diagnosis Studies Ordered:

_____
_____
_____
_____
_____

Labs

☐ CBC ☐ Chemistry 14 ☐ Chemistry 8
☐ Cardiak Risk ☐ Liver Function Test ☐ Stool
☐ Thyroid Panel ☐ Urinalysis ☐ Anemia Profile
☐ Arthritis Profile ☐ Glycohemoglobin ☐ H. Pylori QLT
☐ PSA ☐ PT with INR ☐ PTT
☐ Sed Rate ☐ Other:

Side Effects Explained:

Nutrition: _____
Patient Education: _____
Referred To: _____
Reason: _____

Treatment Plan Medication:

_____
_____
_____
_____

Next Appointment: _____ Days: _____ Weeks: _____ Months: _____ PRN

Provider Name: Dario Altamirano, DO **Provider Signature:** _____

FAMILY HISTORY					
	ALIVE		ILLNESSES	AGE AT DEATH	CAUSE OF DEATH
	Y	N			
MOTHER					
FATHER					
SISTERS					
BROTHERS					

REVIEW OF SYSTEMS			
	NEG	POSITIVE (circle all that apply)	REMARKS
GENERAL		weight loss - fever/chills - /nightsweats - change in appetite	
SKIN		rashes	
HEENT		vision changes - decreased hearing - tinnitus	
PULM		dyspnea - cough - hemoptysis - wheezing	
CARDIAC		chest pain - palpitations - orthopnea - edema	
GI		pain - nausea/vomiting - hematemesis - constipation - diarrhea - rectal bleeding	
GU		dysuria - hematuria - frequency/urgency	
GYN		abnormal menses - pelvic pain - vaginal discharge or bleeding	
HEME		abnormal bleeding/bruising	
NEURO		headache - seizures - weakness - numbness - paresthesias faintaing	
RHEUM		pain - swelling - stiffness - limitation of motion of joints	

	Normal	EXAMINATIONS COMMENTS: Description if abnormal
General:		
Head:		
E.E.N.T.:		
Neck/Carotids:		
Chest & Lungs:		
Breasts:		
Heart:		
Abdomen:		
G/U:		
Rectal:		
Extremities:		
Skin:		
Neurological:		
Other:		

WORKING DIAGNOSIS / PLAN

_____
_____
_____
_____
_____

Diagnosis Studies Ordered:

□ EKG □ Vestibular
□ CHEST X-RAY □ PFT
□ MAMMOGRAM □ NCV

Labs

□ CBC □ Chemistry 14 □ Chemistry 8
□ Cardiak Risk □ Liver Function Test □ Stool
□ Thyroid Panel □ Urinalysis □ Anemia Profile
□ Arthritis Profile □ Glycohemoglobin □ H. Pylori QLT
□ PSA □ PT with INR □ PTT
□ Sed Rate □ Other:

TREATMENT PLAN

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

( ) Side effects explained ___ Safety counseling: I, e, : car seats, smoke detectors, pool fence, poisons, bike
Patient Education: ( ) Verbal ( ) Written injuries, uv exposure, fire arms.
Nutrition : ( ) Regualar ( ) Low Fat ( ) Diet
Next Appointment: ___ Days ___ Weeks ___ Counseling on use/abuse of smoking, alcohol and drugs
___ Counseling on high sexual behavior
DIET: ( ) Regular ( ) Diabetic (ADA _____ Cal) ( ) Low Salt ( ) Low Fat ( ) Low Purines ( ) BRATS ( ) Low Protein
( ) Oral Rehydratation
Yes ( ) No ( ) Explanation why each test is ordered Yes ( ) No ( ) Explanation of the diagnostic results
Yes ( ) No ( ) Life Styles Modifications Yes ( ) No ( ) Risk and benefit treatment
Yes ( ) No ( ) Instruction for management & F/O Yes ( ) No ( ) Understanding & Agreement
Yes ( ) No ( ) What to expect from treatment Yes ( ) No ( ) Importance of compliance w/ treatment
Yes ( ) No ( ) BSE/TSE Yes ( ) No ( ) Discussion of other treatment options
Yes ( ) No ( ) Coordination of care w/ other supplier Yes ( ) No ( ) Instruction in case of emergency
Yes ( ) No ( ) Patient and Family instruction Referral to: _____
Prognosis: Good ( ) Fair ( ) Poor ( ) Visit Level: ( ) 99211 ( ) 99212 ( ) 99213 ( ) 99214 ( ) 99215
Next Visit: ____ Days ____ Wks ____ Mo

Next Appointment: _____ Days: _____ Weeks: _____ Months: _____ PRN

Provider Name: Dario Altamirano, DO **Provider Signature:** _____

An H. Maez, M.D.
59160 NW 78 Street.
Suite B
Miami, Fl 33126

ph: 305-261-6588
fax: 305-262-7858

SUPER BILL FORM

Code	Description	Charge
OFFICE VISITS - New		
99201	Level I	60.00
99202	Level 2	70.00
99203	Level 3	80.00
99204	Level 4	200.00
99205	Level 5	250.00
OFFICE VISITS - Established		
99211	Level 1	50.00
99212	Level 2	60.00
99213	Level 3	75.00
99214	Level 4	100.00
99215	Level 5	130.00
OFFICE CONSULTATIONS		
99241	Level I	100.00
99242	Level 2	150.00
99243	Level 3	175-00
99244	Level 4	200.00
99245	Level 5	250.00
MD SUPERVISION		
99375	Home Health	150.00
CARDIOVASCULAR		
93000	EKG	75.00
93040	Rhythm Strip	26.00

Code	Description	Charge
CARDIOVASCULAR (continued)		
93224	24 Hour Holter	250.00
93307	Echocardiogram	500.00
93320	Doppler Echo	280.00
INFILTRATIONS		
INJECTIONS		
IMMUNIZATIONS		
90724	Influenza Vaccine	10.50
G0008	Administration Flu Vaccine	20.00
90746	Hep B Vaccine	75.00
G0010	Administration Hep B Vaccine	20.00
90732	Pneumo Vaccine	30.00
G0009	Administration Pneumo Vaccine	15.00
88585	TB Tine Test	25.00
J3180	TetanusToxoid	20.00

DIAGNOSIS

995.3	Allergic Reaction	436	CVA	244.9	Hypothyroidism
285.1	Anemia - Iron Deficiency	309.0	Depressive Reaction	780.52	Insomnia
413.0	Angina Pectoris	250.00	Diabetes Mellitus NID	584.1	Irritable Colon
300.00	Axiety State	250.01	Diabetes Mellitus ID	396.3	Mitral/Aortic Valve Insufficiency
424.1	Aortic Stenosis	009.3	Diarrhea	959.98	Multiple Trauma
447.1	Arterial insufficiency	562.10	Diverticulitis	278.00	Obesity
493.90	Asthma Bronchial	715.90	Diaphragmatic Hernia	785.1	Palpitations
414.00	ASHD	582.10	Diverticulosis	332.0	Parkinson's Disease
427.31	Atrial Fibrilation	715.09	DJD Osteoarthritis	533.90	Peptic Ulcer NOS
724.5	Back Pain	532.9	Duodenal Ulcer	462	Pharyngitis Acute
600.0	Benign Prostatic Hypertrophy	530.11	Esophagitis	V70.0	Physical Exam
466.0	Bronchitis Acute	487.1	Flu Like Syndrome	486	Pneumonia
233.4	CA in Situ Prostate	531.9	Gastric ulcer	788.0	Renal Colic
162.9	CA Lungs	535.40	Gastritis Antral	342.9	Residual Hemipareis
414.9	CAD - Ischemic Heart Disease	558.9	Gastroenteritis	307.81	Tension Headache
786.59	Chest Pain	536.9	GIFD GI Functional DISO	465.9	Upper Respiratory Infection
310.9	Chronic Org. Brain Syndrome	530.81	GERD	599.0	Urinary Tract Infection
571.5	Cirrhosis of Liver	599.7	Hematuria	458.81	Venous Insufficiency
428.0	Congestive Heart Failure	272.4	Hyperlipidemia	386.11	Vertigo
692.0	Contact Dermatitis	401.9	Hypertension		
496	COPD	242.80	Hyperthyroidism		

Comments: _____

_____

_____

Return Visit _____ Days _____ Weeks

ALIREZ, M.D, P.A

815 N.W. 517 Ave. Suite 343, Miami, FL 33126
Ph: 305-2680928 Fax: 305-2691948

LAST NAME	FIRST NAME	MI	AGE	SEX	PATIENT PHONE #

COMPLETE FOR PATIENT AND INSURANCE BILLING

PATIENT ADDRESS	CITY	STATE	ZIP CODE

☐ BILL CLIENT	☐ BILL PATIENT	RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT	RELATIONSHIP TO PATIENT ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

☐ BILL MEDICARE	MEDICARE #	BIRTH DATE:
☐ BILL MEDICAID	MEDICAID #	MEDIPASS #
☐ BILL BLUESHIELD	SUBSCRIBER ID #	GROUP#
☐ OTHER INSURANCE	SUBSCRIBER ID #	GROUP#

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: By signing the release below, I hereby grant my concern for the test performed. I authorize the release of any medical records of other information necessary to process this claim. I also request payment assignment and/or medical benefits to Aliuska Alvarez, MD, PA who accepts assignments.

REFERRING PHYSICIAN NAME:	PHYSICIAN SIGNATURE:	REFERRAL AUTHORIZATION #:

OFFICE VISIT

CODE	PROCEDURE		CODE	PROCEDURE	
99202	NEW PATIENT / EXPANDED	_____	99211	EST. PATIENT / LIMITED	_____
99203	NEW PATIENT / DETAILED	_____	99212	EST. PATIENT / FOCUSED	_____
99204	NEW PATIENT / COMPREH	_____	99213	EST. PATIENT / EXPANDED	_____
99205	NEW PATIENT / COMPLEX	_____	99214	EST. PATIENT / DETAILED	_____
99244	CONSULTATION	_____	99215	EST. PATIENT/ COMPREHEN	_____

CODE	PROCEDURE	UNITS
95816	EEG INCL. RECORDING AWAKE & DROWSY	_____
95819	EEG INCL. RECORDING AWAKE + ASLEEP	_____
95957	DIGITAL ANALYSIS OF EEG	_____
95900	NERVE CONDUCTION	_____
95903	MOTOR WITH WAVE STUDY	_____
95904	SENSORY	_____
95934	H-REFLEX, AMPLITUDE & LATENCY STUDY	_____
95861	NEEDLE EMG 2 EXTREMITIES	_____
95864	NEEDLE EMG 4 EXTREMITIES	_____

DIAGNOSIS: _____

_____

_____

Date of service: _____

Physician signature: _____