Where family is the focus of our care.
KM Family Physician, LLC

Karelina Muguercia, MD
101 W. Kaley Street
Orlando, Florida 32806
Phone: (407) 872-8491
Fax: (407) 872-2454

PATIENT INFORMATION

Name: _____
Last Name First Name Initials

S.S. #: _____ Birth date: _____

Home phone: _____ Cell Phone: _____

Address: _____ Apartment #: _____

City: _____State: _____ Zip Code: _____

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Employer phone number: _____

Contact in case of Emergency

Emergency Contact Name: _____

Emergency Contact Address _____

Emergency Contact Phone #: _____ Relationship to Patient: _____

Medical Insurance

Primary Insurance: _____ Policy/ID #: _____

Insurance Subscriber Information (If is not the patient)

Subscriber Name _____ DOB: _____

Relationship to Patient: _____ Subscriber SS#: _____

Phone Number: _____ Employer: _____

Address: _____

_____ _____
Patient/Legal Guardian Signature Legal Guardian Name

_____ Today Date _____/_____/_____
Relationship to Patient

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PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

PATIENT'S NAME: _____ SOC.SEC#: _____

D.O.B: _____ SEX: _____

Name of Person (If Not the Patient who Completing this Form)_____
Relationship to Patient: _____

Confidential record: Information contained here will not be released unless you have authorized us to do so, except as required by law.

Have you had any of the following illnesses?

	Yes	*No*		*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
Anemia			**Depression**			**Hay Fever**			**Mumps**		
Alcohol Overuse			**Diabetes**			**Heart Attack**			**Nervous Breakdown**		
Allergies (Other than Medications)			**Emphysema**			**Other Heart Disease**			**Rheumatic Fever**		
Arthritis			**Frequent Kidney or Bladder Infections**			**High Blood Pressure**			**Sexually Transmitted Diseases**		
Asthma			**Frequent Lung Infections**			**Jaundice**			**Sickle Cell Anemia**		
Cancer			**Gallbladder Disease**			**Kidney Disease**			**Stomach Ulcers**		
Chicken Pox			**Gout**			**Measles**			**Thyroid Disease**		
Colitis			**Hepatitis**			**Migraine Headache**			**Whooping Cough**		

PERSONAL HABITS:

1) Have you ever smoked (cigarettes, cigars, pipe)? _____Yes _____ No How many years have you or did you smoke? _____
Have you used chewing tobacco? _____Yes _____ No How many years? _____

2) Do you regularly drink alcohol? _____Yes _____ No _____ 1 oz Per day _____ 2 oz Per day _____ 4 oz Per day _____ 6 oz or more
Beer _____1 bottle per day _____2 bottles per day_____3 or more bottles per day
_____1 can per day _____2 cans per day_____3 or more cans per day

3) Have you ever used any recreational/illegal drugs? _____Yes _____ No If yes, what type? _____

OPERATIONS: List and indicate approximate year.

SERIOUS INJURIES: List injuries and give approximate dates.

HOSPITALIZATIONS: (Other than operations)
List reasons and approximate dates.

DIAGNOSTIC X-RAYS: List and give approximate dates.

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FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brother / Sisters	M F				
	M F				
	M F				
	M F				
	M F				
Husband / Wife					
Sons / Daughters	M F				
	M F				
	M F				
	M F				
	M F				

Check if any blood relative has or had any of the following and relationship:

	Yes	No	Relative		Yes	No	Relative		Yes	No	Relative
Arthritis				Goiter				Nervous Breakdown			
Asthma				Gout				Rheumatic Fever			
Bleeding tendency				Hay Fever				Sickle Cell Anemia			
Cancer				Heart Attack				Stomach Ulcers			
Colitis				High Blood Pressure				Stroke			
Congenital heart Disease				Intestinal Polyps				Suicide			
Diabetes				Kidney Disease				Tuberculosis			
Emphysema				Leukemia				Other			
Epilepsy				Migraine							

Are you allergic to any medications? Yes ___ No___
If yes, please list medications and the reaction you had to them:

_____
_____
_____

PLEASE BRING A LIST OF MEDICINES YOU ARE TAKING TO EVERY VISIT!

_____ _____
Signature of Patient/Guardian Date

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RELEASE TO OBTAIN MEDICAL RECORDS

Patient's Name (PRINT) _____

Social Security Number _____ Date of Birth _____

I hereby authorize _____
Physician/Facility Name

Phone Number: _____ Fax Number: _____

To release information specified below from my medical records covering the dates of service between _____ and _____ .**This medical information should be released to physician listed below**:

KM FAMILY PHYSICIAN, LLC.
KARELINA MUGUERCIA, M.D.

Check off items being released:

☐ Most Recent Physical ☐ Immunizations ☐ Clinic Visit
☐ Consultation Reports ☐ Laboratory ☐ X-Ray
☐ Other _____

The patient's express authorization is required to release certain types of records, including alcohol and / or drug abuse treatment and information, HIV testing and treatment, and psychiatric treatment. To authorize release of this information, please read and sign the following:

I, _____, authorize the release of alcohol and /or drug abuse treatment and information. FL Statute 397.053 and 396.112 and the federal Alcohol and Drug Abuse Act protect confidentiality.
Patient's Signature

I,_____, authorize the release of HIV test results and /or HIV treatment information, AIDS and related conditions. Confidentiality is protected by FL Statute 381.609(2).
Patient's Signature

I,_____, authorize the release of psychiatric information. FL Statute 394.459(g) protects confidentiality.
Patient's Signature

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release KM Family Physician, LLC, and its staff from any restrictions or privilege imposed by law in connection with the disclosure or release of any professional record, observation, or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. This authorization may be revoked writing at anytime, except that KM Family Physician,, LLC has already taken action in reliance on it. Letters to revoke this authorization should be addressed to KM Family Physician, LLC, and . - . W. H^ibv Ave Orlando FL 32806. If not previously revoked in writing, this authorization will have not expiration date.

_____ _____ _____
Signature of Patient/Authorized Representative Relationship to Patient Date

****Please fax Medical Record at (407) 872-2454****

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HIPAA

Notice of Privacy Practice to Use and Protected Healthcare Information

This Notice describes how patient medical information may be use and disclosed.

This privacy notice is being provider to you as a requirement of a federal law The Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose you **Protected Health Information (PHI**) to carry out **Treatment, Payment or Healthcare Operations (TPO)** and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any written and oral health information about the patient including demographic data can be used to identify the patient.

With my consent, **KM Family Physician, LLC** may call my home or other designated location and leave a message on voice mail 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 laboratory results among others.

With my consent, **KM Family Physician, LLC** may mail to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, **KM Family Physician, LLC** may e-mail to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **KM Family Physician, LLC,** restrict how it users or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I _____ authorized **KM Family Physician, LLC,** to use and disclose my Protected Healthcare Information (PHI) with:**(Indicated full name, relationship and phone number)**

_____ My Self Only
_____The Following Family or Friends: _____
_____
_____

I _____ have received and review this medical practice's policy and I am consenting to KM Family Physician, LLC to use and disclosure of my PHI to carry out TPO. I also understand the circumstances under which **KM Family Physician, LLC** may use this information. I have the right to withhold consent in writing if I do not want information released for purposes other than this legal requirement. If I do not sign this consent, **KM Family Physician, LLC** may decline to provide treatment to me

_____ _____
Signature of Patient or Legal Guardian Patient Name

_____ _____/_____/_____ _____/_____/_____
Parent/Legal Guardian Name Patient DOB Today Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **KM Family Physician, LLC.,** may use and disclose **Protected Health Information (PHI) a**bout me to carry out **Treatment, Payment and Healthcare Operations (TPO).** Please refer to **KM Family Physician, LLC Notice** of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. **KM Family Physician, LLC reserves** the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

KM Family Physician, LLC.
Karelina Muguecia MD
101 W. Kaley Ave., Orlando FL 32806
Ph: 407.872.8491 Fax: 407.872.2454

With my consent, **KM Family Physician, LLC** may call my home or other designated location and leave a message on voice mail 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 laboratory results among others.

With my consent, **KM Family Physician, LLC** may mail to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, **KM Family Physician, LLC may** e-mail to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **KM Family Physician, LLC,** restrict how it users or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Please note forms of communication or any persons with whom KM Family Physician, LLC .

☐ **MAY NOT communicate regarding patient's personal health information.**

_____

_____

☐ **MAY communicate regarding patient's personal health information**.

_____

_____

By signing this form, I am consenting to **KM Family Physician, LLC use** and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **KM Family Physician, LLC may** decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____/_____/_____ _____/_____/_____
Parent/Legal Guardian Name Patient's DOB Date

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PAYMENT AGREEMENT

Patient Information:

Name: _____ DOB: _____

Social Security #: _____ Phone Number: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Insurance Information:

Insurance Name: _____ Policy/ID #: _____

Phone: _____ Group #: _____

This Payment Agreement (the "**Agreement**") by and between KM Family Physician LLC (the "**Provider**") and the patient named above (the "**Patient**"), is entered into to be effective as of _____ (the "Effective Date").

WHEREAS, the patient understands that the **Provider** was unable to verify the insurance information listed above. And,

WHEREAS, the **Provider**, in a good faith effort, has agreed to provide services to Patient and to bill the insurance company listed above for payment. And,

WHEREAS, the **Patient** will be responsible for any unpaid balance after thirty (30) days from the date service is provided. And,

WHEREAS, if **Patient** fails to pay this claim within ten (10) days from which **Provider** notifies **Patient** verbally or in writing, **Provider** will submit this information to the credit bureaus for collection. And,

WHEREAS, in the event of default of payment on **Patient's** account, **Patient** understands and agrees that any and all costs of collection, including collection agency fees, reasonable attorney fees, court costs and all other costs to collect this debt are **Patient's** responsibility.

WHEREAS, Provider may retain a collection agency to handle delinquent accounts. All necessary legal action will be retained to collect this debt if a default occurs. All delinquent accounts will be reported to the credit bureau.

THEREFORE, in consideration of the foregoing mutual covenants and agreements set forth herein, which covenants and agreements constitute good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree that Provider will provide services to **Patient** and **Patient** will ultimately be responsible for payment of such services.

_____ _____ _____
Patient/Legal Guardian Signature Legal Guardian Name Relationship to Patient

Date: _____/_____/_____

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PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be no covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

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PATIENT MEDICATION LIST

Patient Name: ____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Do you have any Allergies to Medication? ____YES ____ NO If yes, list allergies and reactions to medication:___________________

____

Do you currently take any Medications? ____YES ____ NO If yes, **please list ALL medications you are currently taking**. Include: eye drops, inhalers, contraceptives, patches that contain medication, over-the-counter medication (e.g., aspirin, antacids) and dietary/herbal supplements (e.g., vitamins, gingko biloba). Also include medications taken as needed (e.g., nitroglycerin). Always keep this form with you and share it with your health care providers at every visit.

Name of Medication	Dose (e.g., mg, IU)	Frequency (e.g., times per day)	Reason for Taking Medication	Prescribing MD