Dear Patient:

Thank you very much for selecting me as your Primary Care Physician. Please take the time to read this letter carefully as it addresses the policies and protocols of this practice while providing answers to many frequently asked questions. I am Board Certified in Internal Medicine, with a focus in the care of adults and geriatrics. I have privileges at all the local area hospitals including HCA, Advent Health and Orlando Health.

**OFFICE HOURS AND APPOINTMENTS**

Office Hours are subject to vary based on your needs. Our goal is to provide you with the most flexible way to access us. Please call our office for most up to date info on hours of operation and making appointments. IF YOU HAVE AN EMERGENCY CALL 911. It is your responsibility to make and keep the follow-up appointments. We try to call or text for appointment reminders. If you are unable to keep the appointment, we require that you give us 24-hour notice to avoid last-minute cancellation or no-show charge. Depending on the circumstances we may waive this charge at our sole discretion.

**COMMUNICATION**

Please understand that I am spending most of my day with the care of patients in my clinic or admitted to the hospital. Most of the communication that you will have will be with my office staff. It is extremely important that you give detailed information to my staff so that your questions and concerns can be properly addressed. If you leave a message with my staff, rest assured that it will be reviewed by me within 24 hours. If I feel the situation requires you to come in, I will have my staff contact you to schedule an office visit, or I will personally call you to discuss. For after-hours needs you may call and leave a message which will be checked the next morning when we open. My staff will try to review these calls non-emergently and respond as needed. However, for an EMERGENCY please immediately call 911 or GO TO THE ER.

**MEDICATION REFILLS**

Please bring all medicines in their original containers and/or a current drug list during each office visit and try to get them refilled at the same time. If you happen to need a refill and you are unable to schedule an appointment, then please have your local pharmacy fax a refill request to our office. I will review these requests and address appropriately. For some refills, please know that it is possible you may have to be seen by me.

Dr. Mihir Faldu

Frontline Primary Care

**OFFICE POLICIES AND PROCEDURES**

We ask out of courtesy that all patients arrive 15 minutes PRIOR to your scheduled appointment time. If you arrive more than 15 minutes LATE to your appointment, you may be asked to reschedule your appointment. Please know that while we do our best to get you seen by me as soon as possible after your arrival, due to many factors that are out of our control there is a possibility you may wait for some time before you are seen. Please have your insurance cards and photo ID available for each appointment. Please be prepared to verify demographic and insurance information at each appointment and complete paperwork as necessary. It is important to ensure the best and safest care possible that we update these forms as necessary. You are responsible for advising the office staff of any insurance, address, or phone changes as soon as possible. Payment for services is due and payable at the time of service, including co-payments, co-insurance, deductibles, self-pay balances, and any outstanding or past due balances on your account.

**Medication Refills**: If you need refills on your medications outside of your clinic appointment, please call your pharmacy directly to request.

* Refills will be addressed within 3 business days of pharmacy request, so please be mindful of this when you are running low on your medications.
* Certain medications may require an office visit prior to being filled in by your provider.
* Controlled medications are prescribed in select cases depending on the reason. Prior to prescribing any controlled substance, it is mandated by state law to check Electronic-Florida Online Reporting of Controlled Substance Evaluation (EFORCSE) record on every patient. As per the FL State law guidelines we will not be prescribing more than 3 days’ worth of Opiates prescription under any circumstance.

Please allow one (1) full business day for messages left for provider teams to be returned. If you must cancel or reschedule your appointment, please do so with at least 24 hours' notice. Appointments that are cancelled or rescheduled with less than 24 hours' notice (or a no-show) may be subject to a $25.00 fee. Patients with no-show 2 or more times in a 12-month period may be dismissed from the practice and therefore denied future appointments. Understanding that certain circumstances are unavoidable, this policy may be waived with the approval of management.

By signing below, you agree that you have read and understood the Office Policies and Procedures.

Name of Patient or Representative Signature of Patient or Representative Date

**PATIENT CONSENT TO TREAT**

**Consent to Medical Treatment and/or Procedures**: The undersigned consents to the medical and/or surgical care and treatment as may be deemed necessary or advisable as per the judgment of my physician or other provider.

**Assignment of Insurance Benefits and Authorization to Release Information**: In consideration of services rendered, I hereby transfer and assign to Frontline Primary Care all rights, title, and interest in any payment due to me for services rendered. Frontline Primary Care may disclose all or any part of my record to any part, person or corporation which is or may be liable under a contract to my family member or employer for all or part of Frontline Primary Care's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or my employer.

**Use of Copies**: I permit a copy of these authorizations and assignments to be used in place of the original, which is on file with Frontline Primary Care. This assignment will remain in effect until revoked by myself or an agent in writing.

**Medicare/Medicaid**: I certify the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to Frontline Primary Care.

**Payment Responsibility**: I understand certain insurance claims may be filed as a courtesy, however, if a claim is denied and deemed patient responsibility by the insurance company, I am responsible for payment. If a claim is denied due to my failure to provide up-to-date and accurate information regarding changes in my insurance coverage, I understand that it is my responsibility to pay. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of charges. I understand it is my responsibility to pay any co-pay, deductible, co-insurance, or any other balance not paid for by my insurance or third-party payer within a reasonable period, not to exceed 60 days. I understand that if I do not have insurance or if I choose to withhold my insurance information, that I will be considered self-pay and I am responsible for payment in full. I agree that I will be charged **$30 plus the amount of the payment for any returned checks** or stop payments. Furthermore, should I default on payment for services rendered, I agree to pay all collection costs including reasonable attorney's fees.

I authorize Frontline Primary Care and all its affiliates, employees, and independent contractors’ permission to call me using dialing equipment, artificial voice, or similar technology, even if I am charged for the call. I expressly agree that such automated calls may be made by Frontline Primary Care and all its affiliates, contractors, and agents. I expressly consent to such automated calls and with such consent, I specifically waive any claim I may have against Frontline Primary Care and all its affiliates, contractors, and agents for making such calls, including any claim under the Telephone Consumer Protection Act. I also expressly agree that this provision applies to the use of text messaging. I authorize Frontline Primary Care and all its contractors, affiliates, and agents to use any cell phone or other telephone number to contact me for any purpose, including outstanding bills.

Name of Patient or Representative Signature of Patient or Representative Date

**PATIENT DEMOGRAPHIC INFORMATION**

First name:                                   Middle name:                                Last name:

DOB:                                  Social security number:

Sex: Male OR Female

Marital Status (circle one): Single Married Separated Divorced Widowed Other

Race/Ethnicity (circle one): Caucasian Hispanic African American Asian American Indian

Address (Street, City, State, Zip):

Cell Phone:                                    Home Phone:                                    Work Phone:

Email address:

Emergency contact information:

Name:                                                Address:

Relationship:                                   Phone:

Employer Information:

Name:                                          Address:

Phone:

Preferred Pharmacy:

Name:                                   Address:                                                      Phone:

Insurance Info – Primary:

Insurance co:                                   Policy #:                                     Group#:

Policy Holder Name:                                                        DOB:                                SSN:

Insurance Info – Secondary:

Insurance co:                                   Policy #:                                     Group#:

Policy Holder Name:                                                        DOB:                                SSN:

**PATIENT HISTORY**

Were you referred to us by anyone?

How did you hear about us?

Reason for visit today:

When were you last seen by your previous PCP?

When did you last have your wellness visit with your previous PCP?

**MEDICAL HISTORY**

Please circle any conditions below that you have been diagnosed with or received treatment for:

Easy Bruising Asthma High Cholesterol Blood Clots

High Blood Pressure COPD Kidney Issues Anemia

Heart Disease Liver Disease Diabetes STDs

Heart Valve Problems Stroke Thyroid Disorders Joint Problems

Sleep Apnea Anxiety/Depression Skin conditions Allergies

Cancer (type) Psychiatric conditions UTIs Seizure disorder

GI Issues Eye conditions Sinus Issues Pneumonia

Hormonal disorders Neurological disorders Psychiatric disorders Insomnia

Other Medical Conditions: (please list all the conditions you have been diagnosed with)

**SURGICAL HISTORY**

Surgery Year Hospital/Doctor

1.

2.

3.

4.

5.

Other major surgeries: (Please list year, name of surgeon and hospital)

**MEDICATIONS**

 Name Dosage Frequency

Any additional meds not listed above, OTC meds, Vitamins, Herbal supplements:

**ALLERGIES** (Please list reaction with each)

**SOCIAL HISTORY**

Do you currently smoke? Yes / No Packs/day? How many years?

Previous smoking? Yes / No Packs/day? How many years?

Do you drink Alcohol? Yes / No What type? Amount?

Caffeine intake? Yes / No Amount?

Illicit drugs? Yes / No What type?

Are you sexually active? Yes / No

Your current occupation?

**WOMEN ONLY**

Menstrual cycle length?                Days

Flow? Light / Moderate / Heavy

Pain/discomfort with menstruation?

Regular/Irregular

Date of last period?

Last PAP smear? (Please list month and year)

Last Mammogram? (Please list month and year)

Are you currently pregnant? Yes / No

Are you planning to be pregnant? Yes / No

Are you on any form of birth control? If so, what type?

**FAMILY HISTORY**

(Please place “✔” where appropriate)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ALIVE/DECEASED | AGE | HIGH BLOOD PRESSURE | HEART DISEASE | STROKE | CANCER (Type?) | DIABETES |
| FATHER |  |  |  |  |  |  |  |
| MOTHER |  |  |  |  |  |  |  |
| SIBLINGS |  |  |  |  |  |  |  |
| CHILDREN |  |  |  |  |  |  |  |

Additional pertinent family history:

**REVIEW OF SYSTEMS**

(Please circle below the symptoms you are having currently)

**CONSTITUTIONAL**: Fevers Chills Night Sweats Weight Loss

**EYES**: Blurred Vision Double Vision Eye pain/discharge Redness

**EAR/NOSE/THROAT**: Ear pain/discharge Sore throat Sinus issues Nosebleed/discharge

**CARDIOVASCULAR**: Chest pain Palpitations/Arrhythmias Dizziness Leg Swelling

**RESPIRATORY**: Wheezing Shortness of Breath Cough Coughing up blood

**GI**: Abd pain Nausea/vomiting Bleeding Changes in stool

**GENITOURINARY**: Urinary retention Painful urination Incontinence Blood in urine

**MUSCULOSKELETAL**: Neck/Back Pain Joint Pains Muscle Aches

**PSYCHIATRIC/NEUROLOGICAL**: Anxiety/Depression Focal weakness Sensory deficits

**ENDOCRINE**: Hot/cold intolerance Excessive thirst/hunger Weight loss/gain Hair loss/abnormal growth

**HEMATOLOGIC**: Enlarged lymph nodes Easy Bruising Anemia Clotting disorders

**OTHER SYMPTOMS**:

**NOTICE OF PRIVACY PRACTICES**

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice takes effect on Mav 1, 2021 and remains in effect until we replace it.*

**OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

**OUR LEGAL DUTY**

**Law Requires Us to:**

1.Keep your medical information private.

2.Give you this notice describing our legal duties, privacy practices and your rights

3.Follow the terms of this notice that is now in effect

**We Have the Right to**:

1.Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

2.Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

The following section describes different ways that we may use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**For Treatment**: We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to other caregivers that are involved in your care at other facilities, including hospitals.

**For Reimbursements**: We may use and disclose your medical information for purposes of reimbursements, as required by your insurance carriers

**For Health Care Operations**: We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

**Additional Uses and Disclosures**: In addition to using and disclosing your medical information for treatment and healthcare operations, we may use and disclose medical information for:

**Notification**: Medical information to notify or help notify: a family member, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity · to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment.

**Disaster Relief**: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Funeral Director, Coroner, Medical Examiner**: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions**: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings**: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials.

**Public Health Activities**: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence**: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation**: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities**: We may disclose medical information to an agency providing health oversight for-oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

**Law Enforcement**: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws pursuant to certain subpoenas or court orders, concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies

**YOUR RIGHTS**

**You Have a Right to**:

Request or get copies of your medical information. You may get the form to request access by contacting us directly. If you request copies, you may incur a charge for each page, and postage if you want the copies mailed to you.

Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name:                                                 DOB:

Signature of Patient or Legal Representative:

Date:

**Request for Release of Medical Records**

**Patient Information:**

Name:

Address:

Phone:

Birthdate:

**Records Release From (Please make sure to enter your previous PCP or Clinic name or any other specialists you would like us to request records from):**

PCP/Specialist(s)/Clinic:

Address:

Phone:

Fax:

**Records Release To:** Frontline Primary Care

Please Release the following records for last 3 visits only:

 Clinic Notes Lab Reports Radiology reports All Records

I acknowledge that I have read and fully understand this authorization. I hereby authorize copies of my medical records to be released to Frontline Primary Care. I understand that this may include information regarding medical, surgical, psychiatric treatment, drug treatment, HIV testing, and other confidential information.

 (Patient signature) (Date of Authorization)

**Authorization for Release of Medical Information to Family Member**

I hereby authorize the release of all my protected health information (PHI) to the following person(s):

Name:
Relationship:
Contact Information:

I understand that I have the right to revoke this authorization at any time by providing written notice to Frontline Primary Care.

Patient (or POA) Full Name:

Patient (or POA) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: