D.R.MEDICAL CARE
PATIENT OFFICE POLICIES

FEES FOR MEDICAL COPIES/FORMS/REPORTS

- $15.00 Processing fee(cost of supplies, labor and postage)
- $1.oo per page for copies up to 25 pages. $0.25 per page for copies of pages 26 and greater.
- $25.00 minimum for all forms (FMLA, Special forms, Medical Reports, physical forms, disability forms)
- Request of medical records/forms a minimum of seven days.
- Request of medical record review requires an appointment with a minimum of seven-business days notice

APPOINTMENT POLICY

1. Minimum of 24 hour notice to reschedule or cancel appointment
2. **If the proper notice is not given to cancel or reschedule an appointment there is a charge of $25.00 for a (15) minute appointment and $45.00 for (30) minute appt.**
3. Arriving late for an appointment, staff will contact physician to see if there is sufficient time to complete visit. Patient may be asked to reschedule appointment.
4. **Urgent appointments that do not show will have a $35.00 no show charge.**

TELEPHONE MESSAGES POLICY

- Telephone messages will have a 48 hr turn around time.

PRESCRIPTION REFILLS POLICY

- Prescription refills require five business days notice.
- It is important to keep your scheduled appointments to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.
- **All controlled substance refill request require a follow up appointment every 3 months, and for any other non-controlled substance request, every 3 to 6 months.**

REFERRAL POLICY

- Referrals require a seven business days notice.
- Appointments are required for a referral request.

I understand that I am responsible for all charges incurred whether or not paid by my health Insurance Company. I hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. I hereby authorize and direct payment to D.R.MEDICAL CARE office for the medical and surgical benefits. I agree and understand that I may be charge 1.5 % interest rate per month on any unpaid balance and that I am responsible for any cost incurred in collection of said balance should that become necessary. I have read and understood the above information and agree to comply.

Patient signature_____Date_____

D.R. MEDICAL CARE

PATIENT NAME_____LAST NAME_____

ADDRESS_____CITY_____ST_____ ZIP CODE_____
(REQUIRED)

PHONE _____ _____ _____
(HOME) (MOBILE) (WORK)

DATE OF BIRTH_____ SEX_____ SS#_____ RACE _____

DRIVER LICENCSE_____ MARITAL STATUS_____
(PHOTO ID REQUIRED)

EMAIL _____@_____._____

GUARANTOR/SPOUSE/ PARENT INFORAMTION REQUIRED

NAME_____

ADDRESS_____

TELEPHONE NUMBER_____CELL NUMBER_____

POLICY HOLDER'S INFORMATION REQUIRED

POLICY HOLDER'S NAME_____

ADDRESS_____CITY_____ST_____ZIP CODE_____

TELEPHONE NUMBER_____ CELL PHONE _____

SOCIAL SECURITY NUMBER____-___-_____ DATE OF BIRTH_____

EMPLOYER NAME_____PHONE NUMBER_____

EMPLOYER ADDRESS_____

INSURANCE COMPANY_____
(INSURANCE CARD REQUIRED,PRESENT TO FRONT DESK)

I AUTHORIZE D.R. MEDICAL CARE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS, COORDINATE CARE, REFERRALS AND FOR QUALITY MANAGEMENT AND/OR UTILIZATION ACTIVITIES. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO D.R. MEDICALCARE FOR SERVICES RENDERED.

SIGNATURE_____**DATE**_____

D.R. MEDICAL CARE, LLC.
10841 PARK DRIVE
RIVERVIEW, FL 33569

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & PERMISSION TO SHARE HEALTH INFORMATION.

I have received a copy of the D.R. Medical Care Office Notice of Privacy Peactices.

PRINT NAME _____

SIGNATURE _____

NOTIFICATION OF FAMILY AND FRIENDS

1) _____

2) _____

3) _____

4) _____

DATE_____ EXP DATE_____

OFFICE STAFF WITNESS _____

D.R. MEDICAL CARE, LLC.

PHARMACY OF CHOICE/FARMACIA DE PREFERENCIA

Please provide the name and location of the pharmacy where you like to pick up your prescriptions.

Por favor provea el nombre y la localizacion de la farmaciadonde le gustariarecogersureceta.

Name of pharmacy (Nombre de la farmacia):_____

Location (localizacion):_____

D.R. Medical Care, LLC **Diana Roque M.D.**

10841 Park Drive
Riverview, Florida 33569
www.drmedicalcare.com
(813) 677-6900
(813) 677-6903 Fax

AUTHORIAZATION TO RELEASE HEALTCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous name: _____ Social Security #:_____

I request and authorize
My previous Physician or
Specialist

_____ to
Release healthcare information of the patient named above to:

D.R. Medical Care, LLC
10841 Park Drive
Riverview, FL 33569

This request and authorization applies to:

All healthcare information

Healthcare information relating to the following treatment, condition, or dates:

_____

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drugs, alcohol or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED

Notice of Privacy Practices: DR Medical Care, LLC

Please Read and Sign

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to the appropriate staff members to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military service.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

DR Medical Care, LLC
Attn: Wilfredo Trinidad
10841 Park Drive
Riverview, FL 33569

Email: drmedicalcare.com

HIPAA South Carolina
USDHHS
Atlanta Federal Center
Suite 3B70
61 Forsyth Street
Atlanta, GA 30303-8909

Patient Acknowledgement

My signature verifies that I have been provided a copy of DR Medical Care, LLC "Notice of Privacy Practices" to review. I understand that if I would like a copy of this Notice, DR Medical Care, LLC will provide me with a copy of this documentation.

Patient's Name (please print)	Date of Birth	Signature	Today's Date

Authorization for Release of Information

Patient Name: _____ DOB: _____

DR Medical Care, LLC _____ Is authorized to release protected
health information about the above named patient to the entities named below. The purpose is to inform

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other: _____
☐ Spouse (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Email communication (provide email address)* _____	☐ Financial ☐ Medical ☐ Breach Notification

*In order for email communication to occur, please accept the disclosure below:

Initial _____ I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

X _____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

Financial Policy and Disclosure

Please Sign and Date

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by DR Medical Care, LLC

Self-Pay Policy

- If you are a self-pay patient, you might be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information. It is your responsibility to keep us updated on any changes on your insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Workers Compensation Policy

- If you are a workers compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments by the worker's compensation carrier as per contracted rates based on the mandated FL State fee schedule.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

Overdue Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.

Divorce or Custody Case Policy

- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-out associate or front desk.

Responsible Party's Signature _____ Date _____

Your cooperation is greatly appreciated.

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by DR Medical CareLLC and its associated physician(s), clinician(s) and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at DR Medical Care LLC.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the DR Medical Care LLC Notice of Privacy Practices.
3. I authorize payment of medical benefits to DR Medical Care LLC physician(s) or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice and the Release of Information. ☐ Yes ☐ No Initial_____

X _____ _____
Patient or Authorized Person's Signature Date

Workers Compensation Patients

I hereby authorize DR Medical Care LLC to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

X _____ _____
Patient or Authorized Person's Signature Date

Patient or Authorized Person's Signature Date

D.R Medical Care, LLC

Anti-Kickback Letter

Dear Patient:

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurance, or co-payments please note that these are provisions you have on behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by you carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,

Dr. Diana Roque

_____ _____

Patient's Signature Date

_____

Print Name

Patient: _____

Date of Birth: _____

D.R Medical Care, LLC

Controlled Substance Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medications that have a high abuse potential. This is to help, both your doctor and yourself, comply with the law regarding controlled pharmaceuticals. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship, and that my doctor undertakes, to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing controlled substance medications. In this case, my doctor will taper off the medication over a period of several days, but not to exceed one month as necessary to avoid withdrawal symptoms, also a drug-dependence treatment program may be recommended.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medications, including opioid pain medication, controlled stimulants or antianxiety medications without Dr. Roque's knowledge.

I will safeguard my controlled medication and/or prescriptions from lost or theft. Lost or stolen medication will not be replaced.

I understand that during my treatment with controlled substances I am responsible for making a follow-up appointment with my doctor at least every three months, or sooner at the discretion of the prescriber. I understand that I am required to make the appointment in advance before I run out of the medication. I agree that refills of my controlled medications will be made only during regular business hours. No refills will be available during evening or on weekends.

I agree to use _____ pharmacy, located at _____ telephone number _____, for filling prescriptions for all my pain medication.

I authorize my doctor and my pharmacy to cooperate fully with any city, state or federal enforcement agency, in the investigation of any possible misuse, sale, or other diversion of my pain medications. I authorize my doctor to provide a copy of this agreement to my pharmacy if needed. I agree to waive any applicable privilege or privacy or confidentiality with respect to these authorizations.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

This agreement is entered on this _____day of _____, 20_____.

Patient signature: _____

HIPAA PRIVACY RIGHTS REQUEST FORM

REQUEST FOR CONFIDENTIAL COMMUNICATIONS
REGARDING MEDICAL INFORMATION

In an effort to better serve your medical needs, we are encouranging you to use our new and refined text messages system **(330-977-8914)**, and / or email address **(DRMEDICALCARE677@GMAIL.COM)** as a primary method of communication. You have the right to request that we communicate with you privately about your medical care by alternative means. Please provide us with your private contact information that you would like us to use. **D. R. Medical Care** will then take reasonable steps to accommodate this request.

I request that **D. R. MEDICAL CARE** communicate with me **confidentially** about my medical care in the following manner (check the box of your preferred contact information):

☐ **Address where you can contact me confidentially:**

Street Address:

City:

State:

Zip Code:

☐ **Email address to contact me confidentially:**

☐ **Phone number to contact me during the day via text:**

☐ **Phone number to contact me during the evening:**

☐ **I do not wish to be contacted with any medical information via text or email. I will be scheduling office visits to discuss health issues.**

_____
Patient Printed Name

_____
Patient/Patient Representative Signature

_____
If Patient Representative, Relationship to Patient

_____
Date