# Beach Medical Specialist, P.A.

*Alejandro C. Dizon, M.D.*

9860 Beach Blvd. * Jacksom·il1e. FL 32246

Telephone#: (904) 807-9112 * Fax#: (904) 807-9114

## PATIENT INFORMATION

PATIENT NAME: _____SOCIAL SECURITY#:_____

MARITAL STATUS: (S) (M) (SEP) (DIV) (W) DATE OF BIRTH:_____AGE:_____

ADDRESS _____APT#_____

CITY /STATE _____ZIP: _____

HOME PH: _____CELL PH: _____E-MAIL_____

RELIGION_____ RACE_____

YOUR EMPLOYER _____OCCUPATION: _____

* * * * *

(IF APPLICABLE)

SPOUSE_____SS#_____SPOUSE DATE OF BIRTH_____

* * * * *

EMERGENCY CONTACT

NAME _____CELL PH: _____ HOME PH: _____

RELATIONSHIP _____

* * * * *

## INSURANCE INFORMATION

Please make sure we have a copy of your CURRENT INSURANCE CARD and DRIVER'S LICENSE. if you are not the subscriber, we will also need the subscriber's name, date of birth, and social security number.

NOTE: We do NOT file insurance claims for office care unless we are participating physicians with your specific HMO or PPO Plan. A receipt suitable for you to file your insurance claim will be provided at the conclusion of your visit.

We accept CASH, VISA, and MASTERCARD

* * * * *

I authorize release of medical information necessary to process health insurance claims on my behalf. I authorize direct payment to Beach Medical Specialist, P.A. of any insurance benefits payable for their services. **I understand that I am responsible for any account balance not covered by insurance.**

SIGNATURE_____ DATE: _____

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## OFFICE POLICY

- Please allow *24 hours prior notification* for *cancellation/rescheduling* of appointments. Failure to comply with this policy will result in a $20 charge.
- There will be a charge of $100.00-$250.00 for FMLA/Disability documents or any long detailed medical documents. The cha1-ge will be decided by our billing department.
- Jury Duty forms and parking permits have a fee of $25.
- We will only complete FMLA forms for patients that have been getting treated for the condition for 6 months or more in our office and are being treated by a specialist.
- Allow 5-7 business days for medication refills. Do not call for refills when you are already out of medication:
- REFERRALS, DME Supplies & DRUG AUTHORIZATIONS take 5-7 business days.
- Patient is responsible for calling the specialist for referrals after approval from insurance company.
- Patient is responsible for calling the Laboratory, hospitals, or imaging centers for insurance verification prior to completing diagnostic imaging or labs.
- For patient requesting copies of MEDICAL RECORDS, please allow 7-14 business days to process. A fee of $1.00 per page applies for the first 25 pages, then .25 cents per page after that.
- Patient's co-pays and/or payments will be collected at check-in.
- Bounced check fees is an additional charge of $35.00.
- No NARCOTICS will be given repeatedly without medical records from pain management.
- No early refills will be given if controlled medications are lost or stolen.
- Use prescription or medical devices for oneself only.
- Inform the practitioner(s) if one's condition worsens, or unexpected reaction occurs from medications.
- Our office does not participate with Medicaid Share of Cost Plan.
- NO pets allowed, unless ft is a *CERTIFIED SERVICE DOG* (must bring certificate).
- Please only bring necessary individuals to your appointments (*i.e.: Caregivers, Parents, and Translators only*) this is due to our limited space in our wafting room and for courtesy to other patients.
- *VERBALLY ABUSIVE* patient & patient's relatives will be discharged from the practice.

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## FINANCIAL RESPONSIBILITY AGREEMENT

Please notify our office immediately if there is a change in your insurance or any additional insurance coverage. failure to do so may cause denial from the insurance.

Patient will then be financially responsible for the total amount of the services rendered once insurance/provided payers denies the claim.

*** I understand that if I fail to notify BEACH MEDICAL SPECIALIST, PA of any insurance coverage changes, I will be responsible for charges not covered by insurance*** _____ (Initial)

BEACH MEDICAL SPECIALIST Physicians reserves the right to refuse treatment to patients with outstanding balances over 60 days old. _____ (Initial)

CO-PAY SURCHARGE: Any co-pays that are not paid on the day of the visit will be subject to a $10.00 co-pay processing fee. You are obligated by your insurance contract to pay your co-payment at the time of service. _____ (Initial)

Patient's Name: _____Date of Birth: _____

Patient's Signature_____ Date signed: _____

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## PRESCRIPTION POLICY AND AGREEMENT

All patients are required to sign this Prescription Policy and Agreement. Failure to adhere to the rules and regulations of this agreement could n::sult in the dismissal of your care.

I._____. agree to the following conjunction with my pail1 management treatment under the supervision of the physicians of Beach Medical Specialist PA and/or staff designated by the physicians of Beach Medical Specialist. PA.

- Medication refill appointments must be scheduled at least 5-7 days in advance. It is the patient's responsibility to keep track of the amount of medication remaining and to schedule appointments appropriately.
- Refills of medications will be made only during regular business hours. Monday through Friday, in person, once each month during a scheduled office visit. Refills will not be made at night, on holidays, or weekends.
- Take medication as prescribed. Early refills will NOT be given. If you use up all your medications earlier than the scheduled refill date, the remaining days will be endured with no medications.
- Refills will not be made as an "emergency" such as Friday afternoon because “I Suddenly realized I will run out tomorrow”. I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription.
- Refills will not be made if I “run out early”, “lose a prescription”, “spill or mistake my medication”, or for any other reason. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- All medications are to be kept in a safe place, especially away from children. They may be hazardous or lethal, should they be inadvertently taken by any person other than who they are prescribed for.
- The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the dispensing pharmacy for the purposed of maintaining accountability.
- It should be understood that any controlled medication treatment is initially a trial and that continued prescription is contingent on evidence of benefit. If significant demonstrable improvement in patient functional capabilities does not result from this trial of treatment, the prescriber may determine to end the trial.
- All controlled medications must come from one physician. You must notify our doctors of any controlled medication orders made by other physicians while under the care of Beach Medical Specialist, PA.
- Previous medical record should be obtained if necessary, prior to controlled medication refills. It is not guaranteed that refill(s) will be given on the first visit.
- A urine toxicology screening will be performed when a controlled medication becomes necessary.
- Random urine toxicology screening may be done at any time. Failure to comply with random drug screens is reasonable cause for discharge from Beach Medical Specialist, PA.
- Script altering is a Federal offense, and we -will report any violations with the proper authorities.
- Should your prescription need to be changed prior to your "due date", all unused medication must be brought to our office prior to receiving a new prescription.
- We reserve the right to communicate with the previous and present physicians that have cared for you and/or your previous or present insurance carriers.

I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accept all of its terms.

_____ _____

Signature: Date signed

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# OPIATE /PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This agreement is to help you and your provider to comply with the law regarding controlled pharmaceutical medications.

____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

____ In this case, my provide will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

____ I will not share my medication with anyone.

____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider that I have not been referred to by my pcp.

____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

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OPIATE /PAIN MANAGEMENT AGREEMENT CONTINUED

____ I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. 1authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

____ I will bring unused pain medicine to every office visit.

____ 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. A copy of this document has been given to me.

____The pharmacy I agree to use is_____ located at_____

This agreement is entered into on this _____day of_____,2021.

Patient Signature: _____

Patient Name (printed): _____

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## HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination roommate. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4.You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5.You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confident al information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____ Date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

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## REQUEST OF MEDICAL RECORDS

Records to be sent to the following address:
NAME: Beach Medical Specialist P.A.
ADDRESS: 9860 Beach Blvd. Suite 400 Jacksonville, FL 32246
FAX: (904) 807-9114

Records to be obtain from the following Physician/Facility:
PHYSICIAN/FACILITY: _____
ADDRESS: _____
TELEPHONE#: _____ FAX#: _____

Reason for release of records: _____

DATES OF SERVICE REQUESTED ARE: _____

I understand that the records being disclosed contain PHI. Consent is given to disclose the following: (check all that apply)

| | | |
|---|---|---|
| ( ) Treatment Plan(s) | ( ) Laboratory Results | ( ) Accounting of Disclosures |
| ( ) Bio Psychosocial Assessment | ( ) HIV Test Result | ( ) Medication Record/Prescriptions |
| ( ) Hospital Notes | ( ) Sexually Transmitted Diseases | ( ) Other: _____ |
| ( ) Psychiatric evaluation(s) | ( ) Diagnostic Results (X-Ray/CT/MRI) | |
| ( ) Physician's Progress Notes | | |

As a part of the medical record, the following information will be release unless stricken:

SEXUAL ABUSE INFORMATION
DRUG AND ALCOHOL INFORMATION
CHILD ABUSE AND NEGLECTED INFORMATION
PSYCHIATRIC INFORMATION
AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from the date of signature.

Signed: _____ Date: _____
Patient Name/Guardian: _____ DOB: _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.