Palma Ceia Family Care New Patient Agreement

Clinic Information:

Hours: Monday – Wednesday, Friday: 9am – 5pm Thursday 9am - 2pm (Subject to Change)
Address: 2506 S MacDill Ave Ste A Tampa, FL 33629 **Phone Number:** 813-402-8779 **Fax:** 866-257-4368
Website: www.pcfamilycare.com includes link to patient portal.
Phone App: (Iphones and android phones): download "*healow*" app, search for Palma Ceia and click on our office.

After Hours Policy:

If the office is closed you may seek urgent care at:
After Hours Pediatrics located on 3838 W. Neptune Street Tampa, FL 33629. Phone number is 813-254-4209.
South Tampa Immediate Care located on 602 S. Howard Avenue, Tampa 33606. Phone number is 813-253-2113.

Hospitalization:

If you are hospitalized, please let the ER know we are your primary care physician. You may access your healow app to relay any medical records. Our office has a designated hospital doctor that takes care of our patients.

Patient Responsibilities:

- Let us know when you see other providers and what medications they put you on or change.
- When seeing specialist or other physicians please let them know to send us a report about your care.
- Follow the care plan that is agreed upon, if not suitable let us know so we can make adjustments
- Please, make sure to notify us if you change insurance. It is also your responsibility to contact your insurance company to make sure we are in-network with your plan and benefits.

Clinic Policies:

- Prescription Refill Policy: Most refills for prescriptions are handled at the time of the visit. You may also request refills online once the patient portal has been activated for you. However, office visit may be required depending on your situation. For any new medications, that this office has not prescribed before, an appointment is required.. Any refills made on weekend will incur a $25 after hours charge.
- Narcotics Policy: We do not prescribe certain medications for long term daily use including certain pain medications (i.e. Oxycodone, Morphine, Percocet, Vicodin), anxiety medications (i.e. Xanax, Valium, Klonopin) and certain sleep medications (i.e. ambien, lunesta). You will need to be managed by a specialist for these conditions if you need to be on them for daily use.
- No Show and Late Policy: It is the patient's responsibility to keep your appointment as scheduled, or call and let us know when you cannot. We reserve the right to charge $25 if you don't not contact us to let us know 24 hours prior if you cannot make your appointment. In addition if you arrive late to your scheduled office visit, we will let you know if we are still able to see you. You may be required to wait longer. This is done in order to ensure a decreased waiting time for other patients who arrive on time.

The Practice as a whole will continue to:

- Respect you as an individual-we will not make judgments based on race, religion, sex or disability.
- Respect your privacy- your medical information will not be shared with anyone unless you gives us permission unless required by law.
- Provide care given by a team of people led by your doctor based on quality & safety.
- Have a doctor on-call 24 hours a day, 7 days a week for emergency issues.

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Pediatric Health History

Patient Name:_____ Date of Birth:____/_____/_____
Address:_____ Sex: ____M ____F
City:_____ State:_____ Zip:_____Email: _____
Social Security #:_____ Phone: ( )_____
Race/Ethnicity: ___ White ___Black/African American ___ Asian ___ Pacific Islander
___Native American ___ Hispanic/Latino ___ Other ___ Decline
Preferred Language: _____

Parent Name:_____ Date of Birth:____/_____
Mobile Phone: ( )_____ Work Phone: ( )_____
Home Address (if different from child):_____
City:_____ State:_____ Zip:_____

Medications: (please list any prescription medications, over the counter medications, supplements with dosage)

Allergies to Medication: (please list any possible known allergies)

Past History: Has the child had any of the following illnesses? (*please circle)*

Anemia	Frequent Kidney/Bladder Infections	Sickle Cell Anemia
Allergies	Hay Fever	Sexually Transmitted Infections
Asthma	Heart Disease	Thyroid
Chicken Pox	Jaundice	Whooping Cough
Diabetes	Rheumatic Fever	

Operations/Hospitalizations: List reason and indicate the approximate year.

Birth History:
Premature: Yes ____No ____
Any problems at birth? Yes____ No____If yes, please explain: _____

Parents:
Do you leave in a home predating 1978? (Risk for lead base paint in home).
Are you or any household members smokers? Yes or No, If yes, inside or outside the home?

Please list any medical conditions that both parents or siblings have”

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Mother: Father:
Siblings:

CONSENT FOR EVALUATION/TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned health care provider may deem necessary to patient name above.

_____ _____
PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Palma Ceia Family Care. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____
PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. Please check one of the following statements:

( ) I HAVE executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)
Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

( ) I HAVE NOT executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Signature: _____ Date_____

Written Acknowledgement of Receipt

Palma Ceia Family Care Notice of Patient Privacy Practices

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of the Notice of Patient Privacy Practices

_____ _____
Patient or Legal Representative Signature Patient or Legal Representative Name Printed

_____ _____
Relationship to Patient Date

Acknowledgement NOT obtained because:

____ Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

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____ Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement form.

____ Other (briefly describe) _____

Communication: Use and Disclosure Authorization

Patient Name: _____ Date of Birth: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may leave the following messages on answering machines:

Referral Information	Test results
Prescription refill information	Appointment Reminder
Other: _____	

2. You may discuss information regarding my treatment and care with the following family members and/or friends: Please list relationship and contact number.

_____

__

3. You may contact me regarding my treatment and care at the following numbers:

_____

__

Email and Text Messaging Correspondence Authorization: In compliance with the HIPAA privacy rule, by signing below, I am authorizing in advance use of my confidential email to receive Palma Ceia Family Care email notifications regarding future appointments as well as disease-specific health-related products/services. See our privacy policy.
CONFIDENTIAL EMAIL:_____
CELL PHONE NUMBER:_____

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, TEXT, OR PORTAL MESSAGING, CALL 911.
For urgent issues please do not contact via electronic communication. Please call office during normal business hours 813-402-8779 or go to the nearest emergency room. emails and text messages should not be time sensitive, while we try to respond to electronic communication daily, please note it may take up to 3 business days for response.

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Release of Medical Information (Permission to get medical records)

I, (Patient's First Name & Last Name) _____

(Date of Birth) _____

(Social Security) _____

Hereby authorize Palma Ceia Family Care to obtain medical records from:

_____

Address:_____

City :_____ **State :**_____ **Zip :** _____

Phone: _____ **Fax:**_____

to use or disclose my medical information to the following healthcare provider and/or to release information pertaining to medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders and/or any other medical information, including those of a sensitive nature, to the following individuals or organizations(s)

Dr. Ryan Adami – Palma Ceia Family Care

Address: 2506 S. MacDill Ave.

Tampa, FL 33629

Phone: 813-402-8779 Fax :866-257-4368

Please send medical records to: Fax: 866-257-4368 or mail to 2506 S. Macdill Ave Suite A, Tampa, FL 33629

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Permission to get sensitive information

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated). **Types of records we are requesting**

☐ Any and all types of records you have for this patient

☐ Doctor visit notes

☐ Emergency Room notes

☐ Urgent care notes

☐ History and physical

☐ Hospital Progress Notes

☐ Operation or procedure notes

☐ Clinic notes

☐ Pathology reports

☐ Doctors orders

☐ Nurses notes

☐ Discharge Summary

☐ Lab reports

☐ Radiology Reports

☐ Consultations

☐ Other

Patient's Signature/Authorized Representative's Signature _____ **Date**_____

Relationship of Authorized Representative _____

Consent for release of medical records for _____

I understand that if the organization to receive the information is not health plan or healthcare provider the released information may not be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the dated signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing

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and resend my written revocation to the department or facility listed on the authorization. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that photocopy or fax of this form is the same as the original.

Signed _____ Date_____

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