



Physician for Adults, P.A.
1900 N. Central Avenue ♦ Kissimmee, FL 34741

Ph: (407)933-0912, Fax: (407) 933-1034

www.physicianforadults.net

Welcome To Our Practice!



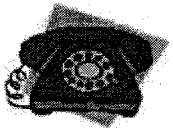
Thank you for selecting Physician for Adults, P.A., as your healthcare provider. You, the patient, are the most important person in our office and we are committed to provide you with the best possible medical care. Please read, understand and accept our policies. Our personnel will be happy to discuss our policy with you at any time. Please do not hesitate to ask us any questions about your health plan or medical care.

Office hours: Monday, Wednesday and Thursday from 8:00 AM to 12:00 AM and 1:00 PM to 5:00 PM. Tuesday from 9:00 AM to 1:00 PM and from 2:00 PM to 7:00 PM. Friday from 8:00 AM to 1:00 PM. Our practice is closed Saturdays and Sundays.

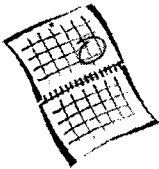
Emergencies: For life- threatening situations, call 911. If you have an urgent problem, please call our office for instructions. After hours, and during lunch break, our answering service will inform you of how to reach Dr. Rodriguez or the physician on call.

Prescriptions: All medications refill should be requested during normal office hours, 48 hours in advance. Please have your pharmacy call the office at **(407) 933-0912** for renewal of medications.

Phones

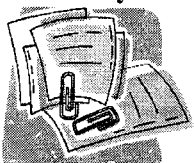


Appointments



- For appointments please call **(407) 933-0912**.
- Please call in advance for routine office visits. Make follow-up appointments as you leave.
- Please come in 15 minutes prior to your appointment time.
- For your first visit, please bring your insurance card and arrive early to complete the necessary patient information forms.
- You must bring with you all medications currently being taken the day of the appointment.
- We make every effort to stay on schedule, although emergencies occur. If we are seriously delayed, we attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.
- 24 hr notice is required for cancelled appointments.
- There is a \$25.00 charge for missed appointments; if we were not notified in advance (This fee may be waived for a medical emergency).
- If you are 15 minutes or more late to your appointment, we reserve the right to reschedule it for another day.
- If you fail to show up for more than two appointments without canceling ahead of time, you may be dismissed from our practice.

Financial Policy

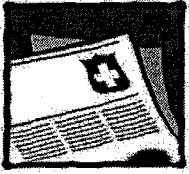


- Unless arrangements have been made in advance, **co-payments, co-insurance, and any outstanding balances are expected at the time of service.** All charges are your responsibility whether your insurance company pays or not. We will bill your insurance company for all services provided. You are responsible for any balance due. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.
- If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company. If we do not have a contract with your insurance carrier, charges are due and payable by you at the time of service.
- We accept: **Visa, Master Card, Discover and American Express.** We reserve the right to accept personal checks with proper identification. Any check returned from the bank will result in an additional \$20.00 charge that will appear in your account.
- If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay within 60 days, you will be responsible for payment. Balances older than 90 days may be subject to collection placement and collection fees. We reserve the right to formally transfer all

associated liability for the claim, to the patient/guarantor. Failure to promptly resolve this balance may result in third party collections and/or legal procedures to be taken.

- We realize that emergencies can happen that may affect the timely payment of your account. If such a case does occur, please call our billing department at **(407) 933-0912**.

Insurance



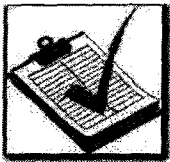
- Please always notify our office of any change in name, address, phone or insurance information.
- Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit. We accept **Medicare**, as well as most major plans, however, please review all insurance information with our staff prior to services being rendered.
- Your health insurance contract is between you and your insurance company. Any complains regarding your coverage should be directed to your insurance carrier.
- Referrals: Please allow 72 hours for referral processing. If you are being referred, please be sure to bring the referral with you at the time of office check-in.

What do we need from you?



- To inform the medical practice staff of any pertinent changes in insurance, employment, demographic information or relationships with other care/service givers.
- To provide payment for services requested and delivered by Physician for Adults, P.A. not covered by Insurance within 90 days.
- To notify the medical practice of any change in your Health Status.
- To follow the recommended treatment plan and inform the medical practice of any physical or mental impairment requiring special accommodation.
- To ask questions if directions and procedures are not understood.

What should you expect from us?



- To be treated with respect, dignity and be informed of your care needs to make appropriate decisions.
- Help plan your care and make changes to it.
- Expect that teaching materials will be provided in a manner you can understand.
- To be informed of the medical practice billing process.
- To have your records keep confidential, except when consent has been given.
- To expect services to be professional, timely and appropriate.
- To communicate your complaints to the medical practice Office Supervisor and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.



Dr. Juan Rodríguez-Rodríguez

Dr. Rodríguez is a Board Certified Internal Medicine Doctor licensed to practice in Florida.

“My goal is to provide the best possible medical service in a professional and respectful environment”

We are located at 1900 North Central Avenue (North Central Avenue intersection with West Columbia Avenue)

I have read and understand the practice’s policies and I agree to be bound by its terms. I also agree that such terms may be amended by the practice from time to time.

Again, thank you for choosing Physician for Adults, PA. We appreciate the opportunity to serve you.

Patient’s Signature

Date

Physician for Adults, P.A.

1900 N. Central Avenue
Kissimmee, FL 34741
Phone: (407) 933-0912

PT ID# _____

Welcome to Our Practice

Please Print

Date: _____

Patient: _____

Last Name

First Name

Initial

#SS: _____ Birth Date: _____ Full Time Student? Y N

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone #: _____

Sex: M F Single Married Divorced Other: _____ Age: _____

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone#: _____

Do you have Medical Insurance? Yes No Subscriber Name: _____

Name of Insurance Company: _____ Subscriber's Date of Birth: _____

ID # _____ # Group: _____ Subscriber's Social Security #: _____

Name of Secondary Insurance Company (if any): _____

#ID: _____ # Group: _____ Subscriber Name: _____

Spouse's Name: _____ Spouse's Social Security #: _____

Spouse Employed By: _____ Business Address: _____

Occupation: _____ Business Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone#: _____ Cell Phone#: _____

Who is responsible for this account? _____ Relationship to patient: _____

Whom may we share information regarding your: Medical Information Billing/payment information?

Relationship to patient: _____

How were you referred to our Practice? Friend/Relative, if so, name: _____

Yellow Pages Internet Physician Referral, if so, name: _____ Newspaper Hospital

Referral Other: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because Insurance Companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your Insurance Company (unless otherwise restricted by law or an agreement we might have made with Insurer). I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I have received notice of this organization's privacy policies.

Signature: _____

Date: _____

HEALTH QUESTIONNAIRE

Patient Name: _____

DOB: _____

Please, indicate (✓) each of your chronic medical problems by marking the appropriate box below:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Cholesterol	Please list any other medical problem
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema/ Lung Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Kidney Problems	

Please, list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins and herbal supplements.

Are you allergic to any medication? Yes No, if yes, please list them and the reaction they cause.

Social History:

Marital Status: _____, # Of Children: _____, Occupation: _____
 Smoke?: Yes No, # Cigarettes a day: _____, # of years smoking: _____, Year quit: _____, Alcohol: _____
 drinks per week, Street Drugs: _____, Caffeine: _____ cups a day, Low fat diet: Yes No,
 Exercise: Yes No, # times a week: _____, Do you have a living will? Yes No, If yes, have you given us a
 copy? Yes No

Family History:

If any blood relative has suffered from the following conditions, check the box and indicate which relative

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Emphysema/ Lung Disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol

Please list any surgeries/hospitalizations (including the year):

Continue in the back...

Are you under the care of any other doctor for any medical problems? Yes No, If yes, who and for what medical problem? _____

Procedures/ vaccines:

Sigmoidoscopy: No Yes, Year: _____, Colonoscopy: No Yes, Year: _____,
 EKG: No Yes, Year: _____, Stress Test : No Yes, Year: _____, Last Flu Shot: No Yes, Year: _____,
 Last Tetanus shot: Year: _____, Last Pneumonia Vaccine: Year: _____

Please place a checkmark (✓) next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

General	<input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unexplained Weight Loss or Gain <input type="checkbox"/> Fatigue
Skin	<input type="checkbox"/> Rashes <input type="checkbox"/> Cancers <input type="checkbox"/> Change in Hair, Skin or Nails
Eyes	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Pain <input type="checkbox"/> Changing vision <input type="checkbox"/> Discharge
Ear, Nose, Throat	<input type="checkbox"/> Ear Pain <input type="checkbox"/> Change in Hearing <input type="checkbox"/> Persistent Runny Nose <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throat <input type="checkbox"/> Change in voice
Heart	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Swelling in Ankles <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart Murmur
Lungs	<input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheeze
Gastrointestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in Bowel Movement
Genitourinary	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Sexually Transmitted Disease Women: <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Change in Menstrual Cycle or Sexual Function Men: <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Decreased Urinary Stream <input type="checkbox"/> Change in Sexual Function <input type="checkbox"/> Penile discharge
Orthopedic	<input type="checkbox"/> Painful joints <input type="checkbox"/> Muscle Weakness
Neuro/Psych	<input type="checkbox"/> Seizures <input type="checkbox"/> Tremor <input type="checkbox"/> Paralysis <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
Allergy	<input type="checkbox"/> Hives <input type="checkbox"/> Hay Fever
Circulation	<input type="checkbox"/> Leg Swelling <input type="checkbox"/> Blood Clots

Women only:

Number of Pregnancies: _____, # of Miscarriages: _____, # of Abortions: _____, # of Live Births: _____, First day of last menstrual period: _____, Contraceptives? Yes No, Type: _____

Test	Date (mm/dd/yr)	Result	Flushing/Menopausal Symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No
Last PAP		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Last Mammogram		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Osteoporosis scan		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Men only:

Date of last Prostate Exam: _____
 Date of last PSA (Prostate blood test): _____

Patient Signature: _____

Date: _____

Physician for Adults, PA
1900 N. Central Avenue ♦ Kissimmee, FL 34741

PATIENT CONSENT FORM

(Please Read and Sign)

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostics procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, authorize **Physician for Adults, P.A.** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered ad valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare Claims. I assign the benefits payable for services to **Physician for Adults, P.A.**

I acknowledge that I have been given the **Physician for Adults, P.A.**' Notice of Privacy Practices. I understand that if I have questions or complains that I should contact the Privacy Official. Patient Initials: _____

Patient (or Responsible Party) Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

For Office Use Only Information

Revision Date: Oct. 1st, 2006

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received a copy
(Print name of Patient)
of Physician for Adults, P.A. Notice of Privacy Practices.

Patient Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to Patient

FOR OFFICE USE ONLY

Patient/Representative Declined to Sign _____ Staff Initials

Physician for Adults, P.A. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

Identify the efforts that were made to obtain the individuals written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.

MEDICAL RECORD REQUEST

To: _____

I _____, hereby request and authorize you to send all of my progress notes, labs, x-rays, and or other tests and hospital discharge summaries that are in my medical records.

Data to exclude and not send is: _____

Reason patient wants information disclosed (Example: Physician Referral):

Please send this information to:

Physician for Adults, PA

1900 North Central Ave.

Kissimmee, Fl 34741

Tel: (407) 933-0912 Fax: (407) 933-1034

Patient's Signature

Date

Print Patient's Name

Patient's Date of Birth

Expiration Date of request will be 1 year from Today's date or as specified on this line: _____

If you wish to request that Physician For Adults, P.A. amend the medical information that we have about you, you should contact the privacy officer listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. Please contact the privacy officer at the end of this notice.

Physician For Adults, P.A. is not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. Our use of protected health information for which you have already given us written authorization.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that Physician For Adults, P.A. restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. But if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI to disclose the PHI to a health care provider to provide you with emergency treatment. Physician For Adults, P.A. is not required to agree to any restrictions you request, but any restrictions agreed to by Physician For Adults, P.A. are binding.

The Right to Obtain a Copy of Paper Notice on Request. Upon request Physician For Adults, P.A. will forward you a copy of this Notice. To make a request please contact the Privacy Officer at the end of this notice.

Revisions to the Notice: Physician For Adults, P.A. reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes

to the Notice will be promptly posted in our facility. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Patient's Legal Rights and Complaints: You also have the right to complain to the Physician For Adults, P.A. privacy officer listed at the end of this notice or to the Secretary the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government.

Marketing/Fundraising: Physician For Adults, P.A. will not use any protected health information for marketing or fundraising purposes.

Research. If Physician For Adults, P.A. engages in any research projects where protected health information identifies individual patients, Physician For Adults, P.A. will obtain the patient's authorization to disclose the patient's PHI.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice please contact:

Physician For Adults, P.A.
1900 N. Central Avenue
Kissimmee, FL 34741
407-933-0912



PHYSICIAN FOR ADULTS, P.A.

IMPORTANT: 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.

Purpose of this Notice: Physician For Adults, P.A. is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Physician For Adults, P.A. is permitted to use and disclose PHI about you.

Physician For Adults, P.A. is also required to abide by the terms of the version of this Notice currently in effect. In most situations we may use information as described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

Permitted Uses and Disclosures of PHI: Physician For Adults, P.A. may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

Effective Date of this Notice: October 1, 2006

For Treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel. It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI by telephone to the hospital or medical director, as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport. Also, this includes information given to a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse. In situations where you are not capable of objecting, we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.

For Payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to healthcare providers, and/or insurance companies, management of billed claims for services rendered, medical necessity determinations, and reviews, utilization review, and collection of outstanding accounts.

For Health Care Operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our federal, state, and local standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, and creating reports that do not individually identify you for data collection purposes.

- To another health care provider (such as the hospital to which you are transported) for the health care operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a public health authority in certain situations, such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement of organ, eye or tissue

transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;

- For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law.

Uses and Disclosures of PHI Requiring Authorization. Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it).

Your may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights. As a patient, you have certain rights with respect to the protection of your PHI, including:

The right to obtain, copy or inspect your PHI. This means you may visit Physician For Adults, P.A., inspect and copy most of the medical information about you that we maintain. Physician For Adults, P.A. will provide you with access to this information within 30 days of your request. Physician For Adults, P.A. may charge you for the cost to copy any medical information that you have the right to access.

The right to amend your PHI. You have the right to ask Physician For Adults, P.A. to amend written medical information that we may have about you. If Physician For Adults, P.A. agrees to amend your information we will generally amend your information within 60 days of your request and will notify you when we have amended the information. Physician For Adults, P.A. is permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct.