PHS
POWELL HEALTH SOLUTIONS
HEALTH CENTER

Dr. Michelle C. Powell, D.O, MPH
16400 NW 2 Ave Suite #100
Miami, FL 33169
Tel: (305) 948-4701
Fax: (786) 329-7223

New Patient Appointment Sheet

Patient Information:

Name:_____ **Sex: M / F** **DoB:** ___/___/___ **S.S.#:** ____-___-_____
Address: _____ **City:**_____ **State:**____ **Zip Code:**_____
Home Phone: (**)** _____-_____ **Work: (** **)** _____-_____ **Cell: (** **)** _____-_____

Guarantor Information:

Guarantor:_____ **Patient's Reltionship:**_____ _ **DoB:** ___/___/___
Address: _____ **City:**_____ **State:**____ **Zip Code:**_____
Home Phone: (**)** _____-_____ **Work: (** **)** _____-_____ **Cell: (** **)** _____-_____

Insurance Information:

Primary Ins.:_____ **Phone: (** **)** _____-_____
Address: _____ **City:**_____ **State:**____ **Zip Code:**_____
Policy ID#:_____ **Group #:**_____ **Co-Pay Amt:$**_____

Insurance Verification

How was this insurance verified? **Internet** **Phone** **Verification Machine**

Insurance Type: HMO/PPO/POS/PIP/Other:_____ **Date Verified:**___/___/___ **Initals:**_____

Claims Address: _____ **City:**_____ **State:**____ **Zip Code:**_____

Effective Date:___/___/___ **Policy ID#:**_____ **Group #:**_____

Co-Pay Amt:$**_____ **Deductible Amt:$_____ **Has the deductible been met? Y / N**

Are we Par or Non Par?_____ **Are they any pre-exisitng condiditons? Y / N**

Which lab are they contracted with? **Labcorp / Quest / Lab One / Fin Lay / Other:**_____

Secondary Ins:_____ **Phone: (** **)** _____-_____
Address: _____ **City:**_____ **State:**____ **Zip Code:**_____
Policy ID#:_____ **Group #:**_____

Comments:_____
_____
_____

Occupation:_____ **Status: Full-Time/Part-Time/Retired/Other:**_____

Number of Children:_____ **Age(s) of Children:**_____

Allergies (if any):_____

Name of Spouse/Significant Other:_____

Do you smoke? Yes / No (if no, skip next section)

- Cigarettes / Tobacco / Other:_____
- How many daily?_____

Do you drink? Yes / No (if no, skip next section)

- Beer / Wine / Liquor / Other:_____
- How many daily?_____

Are you using any illicit drugs? Yes / No (if no, skip next section)

- Cocaine / Marijuana / Ectasy / Heroine / Other:_____

Have you had any sort of caffeine? Yes / No (if no, skip next seciton)

- Chocolate / Coffee / Soda / Tea / Other:_____
- How many daily?_____

Current Perscription Medication:_____

_____

_____

Current 'Over-the-counter' Medication:_____

_____

_____

Please list any accidents, hospitalizations, and/or surgeries you have had (include the type and year): ____

_____

_____

_____

Please check off any conditions that you are currently (or have) experienced and list the date(s) they have occured.

Allergies	☐ Yes ☐ No	Date(s):_____
Arthritis	☐ Yes ☐ No	Date(s):_____
Respiratory/Lung	☐ Yes ☐ No	Date(s):_____
Cardiovascular/Heart	☐ Yes ☐ No	Date(s):_____
Weakness	☐ Yes ☐ No	Date(s):_____
Hearing Problems	☐ Yes ☐ No	Date(s):_____
Numbness	☐ Yes ☐ No	Date(s):_____
Diabetes	☐ Yes ☐ No	Date(s):_____
Cancer (specify:_____)	☐ Yes ☐ No	Date(s):_____
Scoliosis	☐ Yes ☐ No	Date(s):_____
Speech Problems	☐ Yes ☐ No	Date(s):_____
Indigestion	☐ Yes ☐ No	Date(s):_____
Constipation	☐ Yes ☐ No	Date(s):_____
Low Blood Pressure	☐ Yes ☐ No	Date(s):_____
High Blood Pressure	☐ Yes ☐ No	Date(s):_____
Vision Problems	☐ Yes ☐ No	Date(s):_____
Poor Memory	☐ Yes ☐ No	Date(s):_____
Fibromyalgia	☐ Yes ☐ No	Date(s):_____
Headaches	☐ Yes ☐ No	Date(s):_____
Dizziness	☐ Yes ☐ No	Date(s):_____
Insomnia	☐ Yes ☐ No	Date(s):_____
Fatigue	☐ Yes ☐ No	Date(s):_____
Hepatitis	☐ Yes ☐ No	Date(s):_____
Preganant	☐ Yes ☐ No	Date(s):_____
Nursing	☐ Yes ☐ No	Date(s):_____
Last Pap Smear	☐ Yes ☐ No	Date(s):_____
Last Menstrual	☐ Yes ☐ No	Date(s):_____

Family History

Mother's Age:_____ (Alive / Dead) Health Status: Poor / Fair / Good / Excellent

Father's Age: _____ (Alive / Dead) Health Status: Poor / Fair / Good / Excellent

Please check off any of the following conditions that are in your family and please specify who as well

Bleeding Disorders	☐ Yes ☐ No	Who:_____
Kidney Disease	☐ Yes ☐ No	Who:_____
Mental Illness	☐ Yes ☐ No	Who:_____
Heart Disease	☐ Yes ☐ No	Who:_____
High Blood Pressure	☐ Yes ☐ No	Who:_____
Epilepsy	☐ Yes ☐ No	Who:_____
Migraines	☐ Yes ☐ No	Who:_____
Rheumatic Arthritis	☐ Yes ☐ No	Who:_____
Thyroid Disease	☐ Yes ☐ No	Who:_____
Diabetes	☐ Yes ☐ No	Who:_____
Stroke	☐ Yes ☐ No	Who:_____
Anemia	☐ Yes ☐ No	Who:_____
Osteoarthritis	☐ Yes ☐ No	Who:_____
Cancer (specify:_____)	☐ Yes ☐ No	Who:_____

Financial Policy

Patient Name:_____ **Date:**_____

BASIC POLICY: Payment for service is due in full at the time of service is provided in our office.
FOR PAYMENT WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also nill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid wihting 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS: We will bill Medicare and secondary insurance carriers for you. All Co-payments and deductibles are due and payable at the time service is provided. If you do not have a secondary insurance, you are responsible to pay a $20.00 co-pay on the date of your appointment due to the 20% non-covered charges by Medicare.
WELFARE PATIENTS: All welfare patients must provide a current, valid insurance card before being seen.
SURGERY FEES: All co-pays, deductibles, and payements for non-covered surgical procedures are due prior to your surgery. Prior authorization amy be required by your carrier.
NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time of services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES: This office only bills for auto accident claims if we receive the proper documentaiton. It is the patient's responsibility to ask for the required documentation before being seen.
WORKER'S COMPENSATION: This office does not bill for worker's compensation.
YEARLY HEALTH CHECKS: Periodic preventive health checks may or may not be covered udner your health insurance policy; however, they may be required by your physician. It is the patient's repsonsibility to pay for any non-covered charges.
MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require ***at least*** 24 hours' notice to cancel appointments. You may be charged for missed appointmentsor dismissed from the practice.

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made by either me or on my behalf to _____ for any services provided to me by the listed provider/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits or the benefits payable to a related service.

I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is repsonsible only for the deductible, coinsurance, and non-covered services. Coninsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature **Medicare No.** **Date**

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance(s), please read and sign below. I hereby assign all medical and/ or surgical benefits, to inlcude major medical benefits to which I am entitled, private insurance, and any other health plans, to _____. This assignment will remain in effect until a written revocation is submitted by me. A photocopy of this assigment is to be considered as valid as an original. I understand that I am financially repsonsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature_____ **Date;**_____

I have read, understood, and agreed to the above financial policy for payment of professional fees. ***The patient is ultimately responsible for all professional fees.***

Signature_____ **Date;**_____

Dr. Michelle C. Powell, D.O, MPH
16400 NW 2 Ave Suite #100
Miami, FL 33169
Tel: (305) 948-4701
Fax: (786) 329-7223

Consent For Use and Disclosure of Health Information

Section A) Patient Information

Name:_____ **Sex: M / F DoB:** ___/___/___ **S.S.#:** ____-___-_____
Address: _____ **City:**_____ **State:**____ **Zip Code:**_____
Home Phone: (**)** _____-_____ **Work: (** **)** _____-_____ **Cell: (** **)** _____-_____

Section B) To the patient: please read the following statements carefully for the purpose of consent:
By signing this form, you will consent to our use and disclosure of your proteceted health information to carry out proper treatment, payment activities, and healthcaare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices beforeyou decide whether or not to sign this consent form. Our Notice provides a descriptionof our treatment, payment activities, healthcare operations, the uses and disclosure of your health information, and other important matters concerning yout protected health information. A copy of our Notice accompanies this consent. We encourage you to review it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised version of the Notice which will contain all said changes. Those changes may apply to any of your protected health information that we maintain. A copy of this Notice may also be requested at any time by contacting our office at **(305) 948-4701**.

Right To Revoke: You will have the right to revoke this cosent at any time by providing a written notice of your revocation submitted to the contact mentioned above. Please udnerstand that revocaiton of this consent will not affect any action we took in reliance on the consent before we recieved the revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

SIGNATURE

I,_____, have had full oppurtunity to read and consider the contents of this consent form and your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____
Patient's Signature **Date**

If this consent is signed by a personal representative on behalf of the patient, complete the following:

_____ _____
Representative's Name **Relationship to Patient**

Dr. Michelle C. Powell, D.O, MPH
16400 NW 2 Ave Suite #100
Miami, FL 33169
Tel: (305) 948-4701
Fax: (786) 329-7223

Consent to Allow Cyber Communciations

I,_____, hereby give my persmission to *Powell Health Solutions: Health Center* to release/obtain information about my health through e-mail and text messages. The e-mail and/or text will be utilized for appointment reminders or to reply to communications which, I, the patient have initiated. I understand that my records are protected under the Federal Confidentiality regulations (42 CFE Part 2) published August 10, 1987 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and cannot be disclosed without my written consent unless otherwise provided for int he regualtions. I am waiving these rights for the aforementioned communications.

I authorize the following cyber comuncaitons (non-Elations Products):

E-mail:_____

Text: ( ) _____ - _____

I understand that the cyber communications are not protected by any firewalls. I am freely waiving my rights for the purposes of my own convenience. I will not hold *Powell Health Solutions: Health Center* or any employee of the *PHS Corporation* responsible for any breach of privacy.

Communication by text and e-mail are NOT protected communcations unless they are performed through the Elations EHR System.

This authorizaiton will expire on:_____ (cannot exceed one year)

I may revoke this authorization at any time upon written notice to *Powell Health Solutions: Health Center*. I acknowledge that such revocation will not be effective if *PHS: Health Center* has already acted in reliance upon this authorization. A scanned copy of this document is to be considered as valid as the original document. Information that is being released under this authorization may be re-disclosed. The privacy of this authorization may not be protected under the federal privacy regulations. I hereby release *PHS: Health Center* from any liability which may arise as a result of the use of the information released in accordance with this authorization.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies.

_____ _____

Patient's Signature Date Witness Signature Date

Dr. Michelle C. Powell, D.O, MPH
16400 NW 2 Ave Suite #100
Miami, FL 33169
Tel: (305) 948-4701
Fax: (786) 329-7223

PHS
POWELL HEALTH SOLUTIONS
HEALTH CENTER

Patient's Office Policy

1. Any patient more than 15 minutes late will be automatically considered a walk-in and/or have their appointment rescheduled

2. Referral requests must be received *at least* five (5) days in advance. Otherwise, your appointment with the specialist will need to be rescheduled

3. All canceled/no show appointments will be charged a $25.00 fee if the appointment is not canceled *at least* 24 hours prior to the appointment

4. Co-Payments must be paid at the time of service along with your co-insurance/deductible, if applicable.

5. Your Co-Payment is required for all doctor visits

6. There is a $5.00 fee for all lab draws appointment(s)

7. There is a $25.00 fee for all return checks/visits

8. Test results shall not be disclosed over the telephone

9. There is a $15.00 fee for any forms to be filled out by the Physician or staff

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies.

_____ _____

Patient's Name Patient's Signature

_____ _____

Witness Date

Powell Health Solutions, Corporation
16400 NW 2ND Avenue, #100
North Miami Beach, FL 33169
(O) 305-948-4701 (F) 786-329-7223

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____
Address Apt # City State Zip Code

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:

- ☐ All medical records Other: _____
- ☐ Recent labs and PAP _____
- ☐ Recent diagnostic tests _____
- ☐ Recent Specialists consultations _____

RECORDS ARE TO BE OBTAINED FROM:

SPECIALIST / FACILITY: _____

Address: _____
Address Unit/ Suite # City State Zip Code

Telephone: _____ Fax: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to the category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this authorization:

- ☐ Information about mental health or mental retardation services
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

RECIPIENT: ***Dr. Michelle C. Powell (Medical Providers)*** of Powell Health Solutions, Corporation

SEND TO:

16400 NW 2ND Avenue, #100, Miami, FL 33169 OR Fax: 786-329-7223

TERM: This Authorization will remain in effect: (Check One)

- ☐ From the date of this Authorization until the_____day of _____, 20_____
- ☐ Until Dr. Michelle Powell and/or Associates fulfills this request,
- ☐ Until the following event occurs:

_____

Signature_____