JUAN C. YORDAN, MD PA
FAMILY PRACTICE
929 North US Highway 441/27 Suite 102 Lady Lake, Florida 32159
PHONE 352-633-0473 • FAX 352-775-9562

New Patient Checklist

- ✓ **Packet filled out & signed**
- ✓ **Copy of Insurance cards & I.D**
- ✓ **Medical Records if Available**
- ✓ **Medication bottles & list**

Please arrive 30 minutes prior to the appointment
Thank you.

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Today's Date: _____ SSN#: _____-_____-_____

Name: _____, _____, _____ Title: Mr. Mrs. Ms.
(Last) (First) (MI)

Date of Birth: _____ Sex: _____ Marital Status: _____

Address: _____
Street, City, State, Zip

Home: _____ Cell: _____ Work: _____

E-Mail: _____

✓ **Racial Background:**
___: American Indian or Alaskan Native ___: Asian ____: White
___: Black or African American __: Native Hawaiian or Other Pacific Islander
✓ **Ethnicity:**
__: Hispanic __: Non-Hispanic __: Unknown __: Refuse to Report

Insurance Information

Primary Insurance: _____
ID#: _____ Group #: _____ Effective Date: _____
Subscriber Name: _____ DOB: _____

Secondary Insurance: _____
ID#: _____ Group#: _____ Effective Date: _____
Subscriber Name: _____ DOB: _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

✓ Patient Acknowledgement: I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an advance directive. "Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statement that apply:

__: I have an Advanced Directive __:Living Will __: Durable Medical Power of Attorney

__:Designation of healthcare surrogate form Designatee/ Guardian _____

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Patient Name:_____

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Surgeries

Year	Reason	Hospital

Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind?			
	How many drinks per week?			

MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				

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Patient Name:_____ **Date:**_____

Allergies:

( ) No Known Drug Allergies ( ) Latex - Type of Reaction_____

Name of the drug	Reaction you had

Current Medication List

Medication	Strength	Frequency Taken

Preferred Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

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The Patient Bill of Rights and Responsibility

The goal of Juan C. Yordan Family Medicine is to provide all patients with high quality care in the manner that clearly recognizes individuals' needs and rights. We also recognize that to accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. As a result, the following patient rights and responsibility were written.

As A Patient You Have the Right:

- To receive considerate care that is respectful of your personal beliefs, cultures and spiritual values.
- To have all things explained to you in terms that you can understand and have any questions answered concerning your diagnosis, prognosis, and treatment.
- To appropriate assessment and management of your symptoms, including pain.
- To know who it is that is interviewing and examining you.
- To have explained ways that you can prevent your medical problem from recurring.
- To refuse to be examined or treated by the health practitioners and to be informed of the consequence of such decisions.
- To be Assured of confidential treatment of disclosures records and to have the opportunity to approve or refuse the release of such information except when release of specific information is required by law or is necessary to safeguard you or the community.
- To participate in the consideration of ethical issues that arise in the provision of your care.

As A Patient You Have the Responsibility:

- To provide Dr. Juan C. Yordan with information about your current symptoms, including pain.
- To provide Dr. Juan C. Yordan with information about past illnesses, hospitalization and medications.
- To keep appointments or to call the office at **least 24 hours** ahead to cancel.
- To be respectful of others and others' property while in our facility.
- To keep an up to date medication list and provide the office with any changes.
- To monitor prescription refill status and to initiate the refill process with a minimum of one week remaining. To treat all staff members with common curtesy whether in office or through means of communication.

Print name: _____

Signature: _____ **Date:** _____

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Request for Medical Records

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my records, summary or narrative of my protected health information, to the physician/person/facility/entity Juan C. Yordan, MD. I understand that expiration date of this authorization is one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal Privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand I have the right to receive a copy of this form after I have signed it. I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval photocopying of records and/or supervising inspection of medical records.

Patient Name: _____ **Date of Birth:** _____

Purpose of Disclosure: ( ) Continuing Care ( ) Other

✓ The information you may release subject to this signed release form is as follows:

__: Office visit notes __: Stress Test

__: Labs (last 2 years) __: Echocardiogram

__: Colonoscopy/ Endoscopy Report __: Radiology (X-ray, CT Scans)

__: Specify: _____

I specifically authorize the release of information relating to:
__: Substance Abuse (Including alcohol/drug use)
__: Behavioral Health
__: HIV related information (AIDS related testing)
__: Communicable Disease

Release my protected health information to the following physician/ facility/ entity and/or those directly associated in my medical care to the office of Juan C. Yordan, M.D. Lady Lake, FL.

Patient/ Legal Guardian Signature: _____

Date: _____

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Prescription Refill Policy

Refills for current medications can be accomplished by:

- Requesting through your patient portal account.
- Calling your pharmacy and they will transmit the request
- Keeping an up to date list and requesting at the time of your appointment.

PLEASE NOTE:

- Refill request received through the patient portal will be accomplished within 48 business hours.
- Refill requests received from the pharmacy will be accomplished within 48 business hours.
- Please do not leave multiple request for the same medication.
- If you are completely out of medication please contact your pharmacy for an emergency refill (typically 3-4 days' worth of the medication)
- Drop in and call in request for prescription refills will be manually entered into the system at the end of the business day and subject to a **72 business hour** period from that time.
- Your physician will not be pulled out of a room while seeing a patient to refill any medication, as this is not fair to patients with scheduled appointments.

Patient name: _____ **Date:**_____

Patient/Guardian Signature: _____

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Financial Policy Agreement

Thank you for choosing Juan C Yordan, MD P.A, for your family's medical care. We are committed to providing you with quality, personal health care. We appreciate your commitment to adhere to this Financial Policy Agreement.

Except as indicated below, **payment is required at the time services are rendered** unless other arrangements have been made in advance. We accept cash, VISA, MasterCard, Discover and American Express credit cards, and debit cards.

- **Proof of insurance:** All patients must complete and/or update our Patient Information form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to the time of service. Insurance denials for termination of coverage will be automatically billed to you. Be familiar with your co-pay and be prepared to pay at each visit. Determine if the physicians are network providers prior to first visit.

- **Co-Payments and deductibles:** All co-payments, current balances, co-insurance and deductibles are due and payable **PRIOR** to services being rendered and are required by your insurance to be paid at each visit. Our billing department will bill or credit your account accordingly after your insurance pays their portion.

- **Claim Submission:** We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to pay whether your insurance company has paid.

- **Patient balance policy:** Juan C Yordan, M.D P.A., after filing with insurance companies, will mail you a patient balance statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Past due accounts will be subject to a late feel of $5.00 per month and may be referred to a credit bureau and/or a collection agency. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.

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- **Referrals**: Unless discussed prior and evaluated in the office, all referrals require seeing the doctor to discuss the best treatment plan. If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to referral. We require 48hrs. notice to facilitate a referral request and cannot issue retroactive referrals.

- **Self-Payment:** Juan C. Yordan, M.D P.A., recognizes that some of our patients may be without insurance coverage or may choose to receive care even when we are not 'participating providers' with their managed care plan. We do not believe in, nor do we endorse charging a fee greater that the fees we have agreed to receive from most managed care networks. Please let us know in advance if you are in this situation, so we may determine the best way to handle your account.

Other Services Charges and Patient Responsibilities:

Insurance coverage generally does not include coverage for many administrative services, such as requests for information, prescription refills or after hours medical consultation. The following services may have an administrative services charge that will be billed directly to you and are your responsibility for payment. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

- **Late for Appointments**: If you arrive more that 15 minutes late for your appointment, you will have to reschedule.

- **Missed Appointments**: It is your responsibility to remember your appointment; however, we understand there may be times when you might have to miss an appointment due to other obligations or emergencies. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen at the time we have set aside for you. **We require a 24-hour notice of cancellation to avoid a $25 cancellation fee.**

- **Form Completion Policy:** All forms requiring medial review and physician signature- including school, daycare, and camp physicals, prior authorizations, FMLA, disability or other paperwork- may be subject to administrative fees of $25.00 - $150.00. Please allow 5-7 business days for completion.

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- **Prescription Refills:** Without a scheduled visit, new prescriptions will not be issued without first seeing your physician. Prescriptions for acute care or chronic conditions are usually written with an appropriate number of refills to complete the course of treatment or to last until your next scheduled appointment. These do not require further approval for refills. Please make sure you have enough prescription refills to last until your next appointment. Consult your pharmacist as needed. Request for refills will be handled between 8:30 A.M. and 3:00 P.M., Monday through Friday. Any refill request after 3 P.M. will be handled on the next business day. Please allow 48 hours for prescription refills. Narcotic and antibiotic prescriptions will not be refilled after hours.

- **Request for Medical Records:** Requires written requests for the release of medical records. The administrative fee associated with copying medical records is based on current Florida Law, which allows up to 15 business days to get the requested copies to you. Please take this into consideration when requesting copies of your medical records. Expedited copies will be charged an additional fee.

- **Motor Vehicle/ Workers Compensation:** We do not see patients for any type of motor vehicle or worker's compensation injuries.

- **Returned Check Policy:** If a check is submitted as payment in the mail, there is a $35.00 charge for returned checks added to your original balance. In addition, we may seek all additional legal remedies provided to us under Florida Law.

I have acknowledged, read and understood Juan C Yordan MD PA, Financial Policy Agreement. I agree to assign insurance benefits to Juan C Yordan MD PA, to release information to a credit bureau and/or collection agency. In the event of non-payment or default. I am responsible for all cost and reasonable collection fees. Except for emergency care, patients may be denied services for their failure to agree to this Financial Policy Agreement.

Thank you for understanding our Financial Policy Agreement. Please let us know if you have any questions.

Patient Name: _____ **Date**:_____

Patient/Legal Guardian Signature: _____

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HIPAA Authorization Form

Juan C Yordan Family Medicine has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below.

HIPAA (Health Insurance Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. For Example, another medical office we have referred you to, your insurance company, your pharmacy, or hospital.

Please see receptionist with any questions prior to signing this Authorization Form.

I, _____ am authorizing the person/people listed below to obtain medical information about myself. I understand that Juan C Yordan Family Medicine is not responsible for the information provided if it is given to a person that I have listed below.

1. Name: _____ Date of Birth: _____
2. Name: _____ Date of Birth: _____
3. Name: _____ Date of Birth: _____
4. Name: _____ Date of Birth: _____

I acknowledge and agree that Juan C Yordan, MD P.A. may:

__: Leave a message regarding upcoming appointments.

__: Leave a message regarding lab results, imaging studies, and medication refill on my home answering machine/cell voicemail.
__: Leave a message regarding billing questions on home answering machine/cell voicemail.

I have read and understood the information in this consent. I may receive a copy of this consent if I so choose. I, the patient or the authorized legal guardian of the patient sign this document verifying consent to the above terms.

Patient Name: _____ **Date**: _____

Patient/ Legal Guardian Signature: _____

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Consent to Obtain External Prescription History

I authorize Juan C. Yordan, MD P.A. and its affiliated providers to view my external prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit manages may be viewable by my providers and staff at Juan C. Yordan, MD. P.A and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient Name: _____ **Date**:_____

Patient/ Legal Guardian Signature: _____

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Patient Name: _____ **Date:**_____

Review of Systems

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

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Regenetiq

Patient Name: _____

Date of Birth: _____

Gender: M F

- ❖ Do you have any type of joint, back, or neuropathy pain or discomfort that you deal with on a weekly or daily basis?

  __: Yes __: No

- ❖ Would you like to lose weight, or have you been told by a medical provider that you need to lose weight?

  __: Yes __: No

- ❖ Have you been diagnosed with COPD or do you have breathing issues?

  __: Yes __: No

- ✓ Please check any areas of concern with your face, neck, or décolletage?

  __: Acne or any other scarring __: Fine lines or Wrinkles

  __: Discoloration/Redness __: Lack of lip fullness

  __: Dry Skin or dark circles under eyes __: Skin tone

  __: Face and neck skin tightening __: Skin sagging or elasticity issues

For office use only:

Appointment with case manager: Date:_____ Time:_____

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Patient Name: _____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more that usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

Add columns _____ + _____ + _____

Total:_____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	___: Not difficult at all ___: Somewhat difficult ___: Very difficult ___: Extremely difficult

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Patient Name: _____ **Date:** _____

The Alcohol Use Disorders Identification Test: Self- Report Version

Patient: Because alcohol use can affect your health and can interfere with certain medication and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in on box that best describes your answer to each question.

Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink of alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2.How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8.How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
			Total:		