Dr. Yovanni Tineo P.A.

90 Cypress Way East, Suite 10
Naples, FL 34110

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New Patient Form

Date: ______________________________ Social Security Number: ____________________________

Patient: ____________________________ Date of Birth: ________________ Age: _____ Sex: _____

☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

If other family members are patients, please give their names: _____________________________________

Parent or Spouse: _________________________________ Relationship: ______________________

Children/Names (please give even if adult): ____

Ages: ________________ Referred by: _____________________________

*Primary Address: ____

City: ____ State: _______ Zip: ________________________

Home #: ____________________Cell #: ___________________ Work #: ______________________

Northern Address: ____

City: _______________________________ State: ________ Telephone: ________________

E-mail: ____

Employer: ___________________Occupation: ___________ Education Completed: ____________________

*Pharmacy & Location: ____

*Emergency Contact: _______________________ *Phone: _____________ *Relation: ___________

Primary Health Insurance Company: __________________ Policy #: ___________ Group#: ____________

Name of Insured: __________________________________ Relationship of Insured: ____________________

Address of Insured: ____

Social Security Number of Insured: _________________________ Date of Birth of Insured: _____________

Secondary Insurance to Medicare: ___________________ Policy #: ____________ Group#: ____________

What are your major health concerns?

____

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Naples, Fl. 34110

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Your New Patient Visit Today:

You are scheduled as a New Patient. The components of a New Patient Visit are not the same as an Annual Physical Visit. Your first visit will be coded "New Patient Visit" and not for an "Annual Physical" visit.

*We **WILL NOT RECODE** this visit at any time in the future. Recoding to suit your insurance policy is Insurance Fraud. If you have a deductible on your insurance, you are responsible to pay for today's visit. It is rendered at time of service.

I understand the office policy for a **New Patient to Establish with the Physician.**

Patient Signature:______________________________________ Date:________________

To my patients:

This is to inform you that due to many changes in insurances as well as individual policies, it is difficult to know every procedure and/or diagnoses that are covered.
Please note certain medical conditions are not covered by all insurances and will be the responsibility of the patient. The following are a few medical conditions: obesity, insomnia, stress, depression, tobacco abuse etc. **It is imperative for you to check your policy manual and be aware of what is or isn't covered.**

Patient Signature: _________________________ Date: _______________________________

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CONSENT FOR PELVIC EXAMINATION FOR MALE & FEMALES

Patients have the right and obligation to make informed decisions concerning their healthcare. Your healthcare provider can provide you with the necessary information and advice, but as the patient or legal representative, you must enter into the decision making process. This form has been designed to acknowledge your acceptance or refusal of treatment recommended or potentially recommended by your healthcare provider.

I _________________________________ hereby authorize **Dr. Yovanni Tineo** (Physician, Advance Practice Registered Nurse, or Nurse) to perform a pelvic examination.

A pelvic examination is a series of tasks that include an examination of the vagina, rectum, testicles, cervix, uterus, fallopian tubes, ovaries, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

The risks and complications associated with a pelvic examination include, but are not limited to:

- discomfort
- bleeding
- infection

The risks associated with failing or refusing to undergo a pelvic examination includes:

- Increased symptom burden including discomfort, itching, constipation, bleeding, or rash
- The inability to obtain a diagnosis and/or a delay in diagnosis and/or treatment of a medical condition;
- The inability of your health care provider to have the information needed to appropriately treat you.

YOU ALWAYS HAVE THE RIGHT TO REFUSE THIS EXAMINATION AT ANY TIME. IT IS YOUR RESPONSIBILITY TO INFORM US IF YOU DO NOT WANT THE EXAMINATION OR WISH TO STOP DURING THE EXAMINATION AFTER IT HAS STARTED.

I certify that the nature and character of a pelvic examination and the anticipated benefits involved have been explained to me.

I, ☐ **DO** authorize, OR ☐ **DO NOT** authorize the above-identified clinician(s) to perform such examination as in his or her professional judgment are necessary.

I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and that I understand its contents.

Patient Name _______________________________________
Patient Signature _________________________________
Date: ___________________________

Revised 09/17/2020

MEDICAL HISTORY

List all surgeries, hospitalizations, injuries or medical problems for which you have been under a doctor's care. Include Pregnancies.

Year	Surgery/Medical Problems/Injuries/Accidents

Current Medications (Include all prescriptions, vitamins, calcium, birth control, and all other frequently used over the counter medications.)

	Medication Name	Dosage	Reason for taking
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Allergies to Medications: ________________________________ **Reaction:** ________________________

Family History	Name	Alive/Deceased	Age	Cause of Death/Medical Problems
Mother				
Father				
Brother(s)				
Sister(s)				

Do any of your blood relatives have a history of any of the following diseases?

Heart Attack	Yes___ No ___	Who?	Strokes	Yes___ No___	Who?
Migraines	Yes___ No ___	Who?	Breast Cancer	Yes___ No___	Who?
Colon Cancer	Yes___ No ___	Who?	Diabetes	Yes___ No___	Who?
Mental Illness	Yes___ No ___	Who?	Bleeding Disorder	Yes___ No___	Who?
Hypertension	Yes___ No ___	Who?	Cholesterol	Yes___ No___	Who
Hyperlipidemia	Yes___ No ___	Who?			
Other					

Check Symptoms You Currently Have

GENERAL
___Chills
___Depression
___Dizziness
___Fainting
___Fever
___Forgetfulness
___Headache
___Loss of sleep
___Loss of Weight
___Nervousness
___Numbness
___Sweats
___ Panic

MUSCULOSKETAL
___Muscle Cramps
___Stiff Joints
____Swelling of Joints
___Generalized Arthritis
___Rheumatoid Arthritis
___Fibromyalgia syndrome
___Osteoporosis
___Neck pain
___Upper back pain
___Lower back pain
___Difficulty with walking
___Pain in feet
___Cold upper extremities

HEPATIC
___liver disease
___Hepatitis
___Jaundice
___Gallbladder problems

GASTROINTESTINAL
___Poor Appetite
___Bloating
___Bowel Changes
___Constipation
___Diarrhea
___Excessive Hunger
___Gas
___Hemorrhoids
___Indigestion
___Nausea
___Rectal Bleeding
___Stomach Pain
___Vomiting
___Vomiting blood

CARDIOVASCULAR
___Chest Pain
___High blood pressure
___Irregular heart beat
___Low blood pressure
___Rapid heart rate
___Swelling of ankles
___Heart attack
___Bypass Surgery
___Angioplasty
___Mitral valve prolapse
___Heart murmur
___Heart failure
___Shortness of breath with walking

ENDOCRINE
___Excessive thirst or urination
___Heat Intolerance
___Cold Intolerance
___Thyroid problems
___Diabetes Mellitus

EYE, EAR, NOSE, THROAT
___Bleeding Gums
___Blurred Vision
___Crosses eyes
___Difficulty Swallowing
___Double Vision
___Earache
___Ear discharge
___Hay fever
___Hoarseness
___Loss of Hearing
___Nosebleeds
___Ringing in ears
___Sinus problems
___Vision-Flashes
___Vision-Halos

URINARY
___Frequent urination
___Difficulty urinating
___Burning
___Lack of bladder control
___Blood in urine
___Kidney Stones

HEMATOLOGIC
___Swollen glands
___Anemia
___Easy bleeding
___Slow to heal
___Enlarged Glands
___Phlebitis
___HIV positive
___On Blood thinners

RESPIRATORY
___Recurrent cough
___Chronic bronchitis
___Emphysema
___COPD
___Bronchial asthma
___Tuberculosis
___Wheezing

PERIPHERAL VASCULAR
___Poor circulation in arm
___Blood clots in arms
___Varicose veins
___Poor circulation in legs
___Blood clots in legs
___Vascular surgery

SKIN
___Bruise easily
___Hives
___Itching
___Changes in skin color
___Changes in hair or nails
___Recurrent rashes

Men Only
___Breast Lump
___Erection difficulties
___Lump in testicles
___Penial Discharge
___Sore on penis

WOMEN ONLY

Last Mammogram ___/___/____Last Pap smear: ___/___/___ Abnormal Pap smear: ______Treatment: _______________

Painful Intercourse ____ Pelvis Pain____ Breast lump _____ Painful Breast_________

Menstrual Cycle: Age of Onset ___ ( ) Regular ( ) Irregular ( ) Heavy ( ) Light ( ) Extreme Menstrual Pain

Pregnancy Total: _____ # of miscarriages/abortions: _____ # of living children_______

Menopause Age: ____ Have you ever taken Hormone Replacements? If so, _____# of yrs

CONDITIONS

___Alcoholism
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorder
___Breast Lump
___Bronchitis
___Bulimia
___Cancer
___Cataracts
___Chemical Dependency
___Chicken pox
___Diabetes
___Emphysema
___Epilepsy
___Glaucoma
___Goiter
___Gonorrhea
___Gout
___Heart Disease
___Hepatitis
___High cholesterol
___Kidney disease
___Liver disease
___Measles
___Migraine headaches
___Miscarriages
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Pacemaker
___Polio
___Prostate problems
___Psychiatric care
___Rheumatic fever
___Scarlet fever
___Stroke
___Suicide attempt
___Thyroid problems
___Tonsillitis
___Tuberculosis
___Typhoid fever
___Ulcers

HABITS

SMOKING: Have you ever smoked? ___ Yes___ No Do You smoke now? ___ Yes ___ No Smoking since ____________________
how many cigarettes per day? _______ Cigars per day _________ Pipe _________

ALCOHOL: Do you drink alcohol? ___ Yes ___ No If yes, how much? ____
Have you ever had a problem with alcohol? ___Yes ___ No If yes, explain ___________________________________

CAFFINE: Do you consume drinks with caffeine? ___ Yes ___ No If yes ___coffee ___ tea ___ colas ___ other
Number of cups per day_______

DRUGS: Do you use any street drugs? ____Yes ___No If yes, explain ______________________________________
Have you ever had a problem with recreational drugs? ___Yes ___ No If yes, explain ___________________________

Dr. Yovanni Tineo P.A.

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Patient Consent Form

I hereby give my consent for **Dr. Yovanni Tineo P.A.** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

(Dr. Yovanni Tineo Practice Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy prior to signing this Consent. **Dr. Yovanni Tineo, P.A.** reserves the right to review its Notice of Privacy Practices at any time.
A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Yovanni Tineo at 90 Cypress Way East, Suite 10, Naples, FL 34110.

With this Consent, **Dr. Yovanni Tineo P.A.** may:

____ **MAIL** to my home or other alternative location
-OR-
Leave a detailed message on:
____ HOME
____ CELLULAR
____ WORK
____ ONLY IN PERSON

I hereby consent to release my medical information to EMERGENCY CONTACT ________________________________, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this Consent, **Dr. Yovanni Tineo P.A.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked **Personal and Confidential**.

By signing this Consent, I am consenting to **Dr. Yovanni Tineo P.A.** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, or later revoke it, **Dr. Yovanni Tineo** may decline to provide treatment to me.

AGREED:

____ ________________________________
Patient's Name **Date**

____
Patient's Date of Birth

____
Signature of Patient or Legal Guardian

Consent for Diagnostic and/or Therapeutic Procedures

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient: ______________________________ **Date:** ______________________

Signature of Parent/Guardian: ____

Patient Consent For The Use of Tele-Health

Telehealth involves the delivery of healthcare services using electronic communications, information technology or other means between a healthcare provider and a patient who are not in the same physical location. Telehealth may be used for diagnosis, treatment, follow-up and/or patient education, and may include, but is not limited to, one or more of the following:

- Electronic transmission of medical records, photo images, personal health information or other data between a patient and a healthcare provider
- Interactions between a patient and healthcare provider via audio, video and/or data communications
- Use of output data from medical devices, sound and video files

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize Dr Yovanni Tineo to use telemedicine in the course of my diagnosis and treatment.

Patient Signature: ______________________________ Date Signed: ____________________

Dr. Yovanni Tineo P.A

Notice of Privacy Practices for Protected Health Information
Effective Date: January 1, 2008

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!

The office/hospital is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

You're Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

    - Is not part of the health information kept by or for the office/hospital;

    - Is not part of the information that you would be permitted to inspect and copy; or,

    - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

Our Responsibilities

Our office is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

Patient Name ____

Patient Signature ______________________________________

Date: ____

Dr. Yovanni Tineo P.A.

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Financial Policy

We are committed to providing you with the best possible care. We are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.
Payment for services is required at the time services are rendered. We accept payment in the form of cash, check, MasterCard, Visa, and Discover and AMEX. **Returned checks** are subject to additional **collection fees**. After we receive two return checks from your bank we will no longer accept your personal checks. **Balances older than 90-days are forwarded to a collection agency with a 25% collection fee added to your balance per payment amount.**

Please realize that:

1. **Commercial Insurance:** Please be aware not all insurance companies cover all of the services provided by our office including your annual physical. You will be responsible for services rendered at the time of service.
2. **Medicare Patients:** We would like you to understand that taking assignment means YOU are responsible for **YEARLY DEDUCTIBLE** and for the 20% (COINSURANCE) of what Medicare allows. You are also responsible for services that your coinsurance does not cover. Please note Medicare does cover annual physicals. The filing of **SECONDARY INSURANCE CLAIMS** is a courtesy that we extend to our patient. We will make every effort to help you in the filing of your claims; however, all charges are ultimately YOUR responsibility after the initial filing with your insurance company.
3. I authorize Dr. Yovanni Tineo, D.O to submit all participating insurance claims on my behalf. I understand that I am responsible for all services not paid in full within 60 days of service, **REGARDLESS** of the reason given by the insurance company.
4. I agree that if **MY ACCOUNT FALLS DELINQUENT,** I will be responsible for ALL collection cost of 35%, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest from the date of service at the rate of 1.5% per month {18% per annum}.
5. For patients under the age of 18 a parent or guardian must accompany the child who will be responsible for payment of the bill at the time of service. We cannot be bound by any divorce or other family relationship contracts.

Please note:

Our CANCELLATION POLICY is as followed: Office Visits need to be cancelled 24 hours in advance. All Ultrasounds/Sonograms needs to be cancelled 24 hours in advance as well.
*****All accounts must be current (have a $0.00 balance) before any medical records are released.**
*****There is a $30.00 charge for the completion of forms (insurance, disability, etc).**
*****You must notify our office within 24 HOURS for any CANCELLATIONS; if not there will be $35.00 charge for "NO SHOW or NO CALL."**

PARTICIPATING INSURANCES AND MEDICARE ASSIGNMENT-SIGN BELOW

I authorize payment of Medical Benefits to be made on my behalf to Dr. Yovanni Tineo, D.O for any services furnished to me. I authorize the release of any medical information held by Dr. Yovanni Tineo, D.O to the health care financing administration and its agents in order to process my claims.

Signature____ Date___________________

SELF PAY PATIENT- SIGN BELOW

I am fully aware payment is due at time of service. Should my account become delinquent I am aware I will be responsible for all collection fees as stated above. Any questions about pricing should be addresses prior to treatment being rendered.

Signature____ Date____________________

Insurance Authorization and Assignment

I request the payment of authorized Medicare/other insurance company benefits be made on my behalf to **Dr.Yovanni Tineo** for any services furnished to me by that party which accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company 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 me or to the party that accepts assignment. I understand it is mandatory to notify the health care provider of any other party that may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 38/01-3812 provides penalties for withholding this information.)

I request that payment under the Medicare or other medical insurance program(s) be made to **Dr. Yovanni Tineo P.A.** for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by **Dr. Yovanni Tineo P.A.** from Medicare and/or other insurance company (ies), I will immediately endorse them and turn them over to **Dr. Yovanni Tineo P.A.** for services rendered.

I understand that I am responsible for payment of all charges and fees to **Dr. Yovanni Tineo P.A** to which they are entitled to collect including ***collection fees*** which is not paid for by Medicare or other insurance.

Signature of Patient: ____ **Date:** _______________

Signature of Parent/Guardian: ____

Prescription Renewal Policy

Dr. Yovanni Tineo P.A. is available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies.

Prescription renewals should be discussed with your doctor during your office visit or by phone with the nurses between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday. We will get back to you within forty eight hours.

Refills are handled more quickly by calling your pharmacy and asking them to fax your request to our office. If you are unable to call your pharmacy, please call our Nurses line at **239-592-0011**

Please do not wait for your medication to run out completely before calling our office!!! By following this policy, we can assure you the highest quality of medical care.

____ ____________________________________

Patient Signature Date

Dr. Yovanni Tineo P.A.

90 Cypress Way East Suite 10
Naples, Fl. 34110
P: (239) 592-5655 F: (239) 592-1370

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____

____

____

to release healthcare information of the patient named above to:

Name: Dr. Yovanni Tineo P.A.

Address: 90 Cypress Way East Suite 10

City: Naples State: Fl. Zip Code: 34110

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED