# Kenneth B. Shephard M.D.,P.A.

Diplomate American Board of
Endocrinology, Diabetes and Metabolism

## 1. PATIENT INFORMATION / INFORMACION DEL PACIENTE

Patient Name:______________________________________________
Nombre Del Paciente

Home Address: ____________________________________________
Direccion Del Hogar

City: ________________ State: _____________ Zip Code: _________
Ciudad Estado Codigo Postal

Employer / Occupation: ____________________________________
Empleo/ Ocupacion

Name of Spouse or Emergency Contact:______________________
Contacto de Emergencia

Emergency Phone #: _______________________________________
Telefono de Emergencia

Primary Care Provider (PCP): _______________________________
Proveedor Primario (PCP)

Who is Referring you: ______________________________________
Nombre De la persona que lo refiere

Email Address: ____________________________________________
Correo Electronico

Home Phone: _________________________________
Telefono Del Hogar

Cell Phone: __________________________________
Numero Del Celular

Work Phone: _________________________________
Telefono Del Trabajo

Date of Birth: ________________________________
Fecha de Nacimiento

Pt.Social Security#:____________________________
Numero de Seguro Social

Marital Status: _______________________________
Estado Civil

Gender: _____________________________________
Sexo

Primary Language: ____________________________
Idioma Principal

## 2. INSURANCE INFORMATION / INFORMACION DE SEGURO

Name of Primary Insurance: _________________________________
Nombre Del Seguro

Name of Subscriber: _______________________________________
Nombre Del Asegurado

Relation to Patient: ________________________________________
Relacion al Paciente

Subscriber's Employer: _____________________________________
Empleo Del Asegurado

Name of Secondary Insurance:_ ______________________________
Nombre Del Seguro Secundario

Name of Subscriber:________________________________________
Nombre Del Asegurado

Relation to Patient: ________________________________________
Relacion al Paciente

Subscriber's Employer: _ ____________________________________
Empleo Del Asegurado

Insured ID: ___________________________________
Numero de indentificacion de Asegurado

Subscriber's SS#:_ ______________________________
Numero de Seguro Social del Asegurado

Subscriber's Date of Birth: _______________________
Fecha de Nacimiento Del Asegurado

Subscriber's Work Number: _____________________
Telefono de Trabajo del Asegurado

Insured ID: ___________________________________
Numero de indentificacion de Asegurado

Subscriber's SS#:_ ______________________________
Numero de Seguro Social del Asegurado

Subscriber's Date of Birth: _______________________
Fecha de Nacimiento del Asegurado

Subscriber's Work Number: _____________________
Telefono de Trabajo Del Asegurado

## 3. PHARMACY INFORMATION / INFORMACION DE FARMACIA

Pharmacy Name: ___________________________Address:_________________________Phone Number:___________________
Nombre de la Farmacia Dirección Número de Teléfono

## 4. PAST MEDICAL HISTORY / HISTORIA MÉDICA PREVIA (CIRCLE / CIRCULE)

Hypertension Diabetes Cancer HIV Hepatitis Osteoporosis Other/Otra: ________________________________

Have you had any surgeries? / ¿Ha tenido cirugias? __________

List Type of Surgeries / Describa el tipo de cirugias: ______________________________________________________

## 5. FAMILY HISTORY / HISTORIA MÉDICA DE FAMILIA (CIRCLE / CIRCULE)

Hypertension Diabetes Cancer HIV Hepatitis Osteoporosis Other/ Otra: __________________________________

## 6. SOCIAL HISTORY / HISTORIA MÉDICA SOCIAL (CIRCLE / CIRCULE)

Do you Smoke? / ¿Fuma? ________________ How many daily? / ¿Cuántas veces al dia? ___________________________

Do you consume Alcohol? / ¿Consume Alcohol? _____________

How Often? / ¿Con qué Frecuencia? _________________________

Do you Have Children? / ¿Tiene hijos? _____________ How Many? / ¿Cuántos? ____________

## 7. ALLERGIES / ALERGIAS

No Known Allergys / No hay alergias conocidas _____________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

## 8. MEDICATIONS (CURRENT) / MEDICAMENTOS (ACTUALES)

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

# Kenneth B. Shephard M.D.,P.A.

Diplomate American Board of
Endocrinology, Diabetes and Metabolism.
Office: (305) 273-1919  Fax: (305) 273-1929

## AUTHORIZATION AND REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: ______________________________

Patient's Name: ____________________

Date of Birth: ______________________

Holder of Medical Record ( Primary Care Physician, Specialist, Hospital, Outpatient Facility):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I hereby request and authorize the above mentioned holder to release to Dr. Kenneth B. Shephard the Following Information:

O Bloodwork

O Radiology Reports

O Pathology Reports

O Consultation

O Hospital Records

Patient/ Guardian signature: _______________________________________ Date: ___________________

# Office Policies

Office Hours: Monday – Friday   07:00 AM to 03:00 PM

✓ I acknowledge that I have been candid in revealing any condition which may have an effect on my treatment, such as: medications, surgery, allergies, hormones, pregnancy or breastfeeding.

✓ I acknowledge that I will notify the office immediately with any changes in my medical condition such as pregnancy. Medication, recent surgeries, or hospitalizations.

✓ I understand that any test results will be discussed with me at the time of my next visit, and not over the phone.

✓ I understand that is my responsibility to schedule a follow up appointment 1 week after any procedure, test or surgery.

✓ I understand that payments for services are due when the treatment is rendered. The office visit and any outstanding balance on the account are due and payable in full at the time of the visit.

✓ I understand that is my responsibility to bring the referral (if applicable) with me at the time of the visit. If we do not have a referral you may be asked to reschedule your appointment, or you may be ask to sign a waiver accepting full financial responsibility for the services you receive.

✓ I understand that I am responsible for all charges regardless of what the insurance company pays or designates as "usual and customary".

✓ I understand that any balance that is older than 60 (sixty) days is subject to a 1.5 %( 18%/year) finance charge; regardless if the insurance company has paid. If for any reason you are unable to make payments, please contact our office manager to discuss your account. If it becomes necessary to seek legal means to collect on an overdue account, you will be billed for any legal services at the standard fee plus any court cost, plus any additional collection agency costs.

✓ I understand that returned checks are subject to a fee. Checks returned by the bank for any reason will be assessed a $30.00 processing fee per check. Payments for continued care will only be accepted in cash, money order or a valid credit card.

✓ I understand that broken appointments are subject to a fee of $30.00. If you are unable to keep an appointment, we ask you to kindly provide us with at least a 24hrs notice. This courtesy, on your part will make it possible to give your appointment to another patient.

✓ As a courtesy to others we reserve the right to reschedule your appointment if you are more than 15 minutes late, unless the physician schedule can still accommodate you.

✓ I understand that after 3 "no show" or 3 "rescheduled" appointment we will no longer be able to provide you with and appointment and you would need to seek care from another physician.

✓ I acknowledge that I have read, and that I fully understand the office policies.

| ____________________ | ____________________ | ______________ |
| --- | --- | --- |
| **Patient Name** | **Patient Signature** | **Date** |

## Notice of Office Policy Change

- Due to the large number of same day appointment cancellations, and patients not showing on appointment date; we are forced to make the following change in our office Policy. Effective immediately, a $35.00 fee will be charged to you, if you miss or cancel with less than 24 hours notice your appointment more than once. Other appointments will not be issue unless this fee is paid.

- After 3 Consecutive No shows or cancelations you will automatically dismiss from the practice for non compliance with appointments.

In signing this form, I understand that I am responsible for the above mentioned charge for any missed or cancel within 24 hours more than once.

______________________________________________

**Patient Signature**

- Debido a la gran cantidad de cancelaciones de citas el mismo dia,y de pacientes que no atienden a sus citas; nos vemos obligados a hacer el siguiente cambio en nuestras regulaciones. Efectivo inmediatamente, un costo de $35.00 se le cobrara a Ud si omite o cancela con menos de 24 horas de antelacion su cita , más de una vez. Otra cita no se ofrecera a menos que este cargo sea pagado.

- Después de 3 erdidas consecutivas o cancelaciones de citas Ud será automáticamente expulsado de la practica debido al incumplimieto de sus citas medicas.

Al firmar este formulario, entiendo que soy responsable de los cargos ocasionados por citas canceladas o perdidas sin previo aviso y con menos de 24 Hrs. de notification a nuestra oficina.

______________________________________________

**Firma del Paciente**

***I certify that the information provided above is complete and accurate to the best of my knowledge.***

______________________________________________ ______________________

**Signature of Patient or Patient Representative** **Date**

## HIPPA NOTICE OF PRIVACY PRACTICE

I, ________________________________ have read and received a copy of the notices of privacy practice’s.

**Signature of Patient**: ______________________________ Date______________

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of Florida law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the Florida Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services.

Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: ______________________________
Patient's Signature (Date)

Print Patient's Name

By: ______________________________
Kenneth Shephard, M.D. (Date)

By: ______________________________
Patient's Representative's Signature (Date)

Print Name and Relationship to Patient