Newborns To Geriatrics
RIVERSIDE FAMILY HEALTH PL
Stephane Naoumoff, MD
Marze Boersma, PA-C

1395 N Courtenay Parkway
Suite 100
Merritt Island, Florida 32953
(321) 453-5252
Fax (321) 453-5152

PATIENT INFORMATION	Please complete all sections below.		
Patient's last name:	First:	Middle:	Birth date: / /
Social Security No: - -	Cell Phone ☐ OK to leave message ☐ Primary Contact Number ( )	Home Phone ☐ OK to leave message ☐ Primary Contact Number ( )	Who may we thank for referring you?
Mailing address:	City:		State & Zip
Permanent address (if different)	City:		State & Zip
Preferred Language:	Email: (☐ Sign up for Patient Portal)		Sex at Birth (check one): ☐ Female ☐ Male Current Sex (check one): ☐ Female ☐ Male

Gender Identity (check one): ☐ Identifies as Female ☐ Identifies as Male ☐ Genderqueer ☐ Additional Gender Category/Other
☐ Female to Male (FTM)/Transgender Male/Trans Man ☐ Male to Female (MTF)/Transgender Female/Trans Woman ☐ Patient declined to specify

Marital Status (check one): ☐ Annulled ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Never Married ☐ Polygamous ☐ Unmarried ☐ Patient declined to specify	Sexual Orientation (check one): ☐ Bisexual ☐ Don't Know ☐ Lesbian, Gay, or Homosexual ☐ Something Else ☐ Straight or Heterosexual ☐ Patient declined to specify
Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Patient Declined to Specify	Race (check one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Patient declined to specify

Employment Status (check one): ☐ Active Military ☐ Disabled ☐ Retired ☐ Full Time ☐ Part Time ☐ Not Employed
☐ Self Employed ☐ Student ☐ Patient declined to specify

Occupation:	Employer:	Employer Phone: (☐ OK to leave message) ( )

INSURANCE INFORMATION	Please present INSURANCE CARDS and PHOTO ID to front office staff.		

If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges.
Please be advised that it is your responsibility to be aware of the benefits that your medical plan provides, <u>including whether we are in your plan's network or not.</u>

PRIMARY Insurance Co:	Subscriber Name (if not patient)	Birth date (if not patient): / /	SS# (if not patient):
SECONDARY Insurance Co:	Subscriber Name (if not patient)	Birth date (if not patient): / /	SS# (if not patient):

PRIVATE MEDICAL INFORMATION RELEASE	List below anyone you authorize for us to discuss your personal medical information with, including diagnosis, medication, records, and billing. Dr. Naoumoff's office is not responsible for what happens to the information after provided to a person that you have authorized below. This release remains in effect until terminated by you in writing.

Name	Relationship	Phone
1.		
2.		

******<u>ONLY provide names above OR check box below</u>******

☐ **I do NOT authorize Dr Naoumoff's office to release any of my protected medical information to anyone other than the entities that are discussed in the *Notice of Privacy Practices*, which I have been given the opportunity to review.**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to RIVERSIDE FAMILY HEALTH, PL. I understand that I am financially responsible for any balance. I also authorize provider or insurance company to release any information required to process my claims. I hereby authorize any treatment(s) agreed upon with this provider which may be deemed advisable.

Patient/Guardian signature *Date*

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Test Results

Various tests might be ordered during one of your visits here. They will be ordered for reasons including, but not limited to, diagnosis, treatment, or health maintenance screenings. It is very important that you know the results of each test. Generally, these tests need to be discussed with your provider during a follow up visit.

In the event that your provider decides that a follow up visit is not necessary, we will contact you with your results by phone or through your patient portal account. We make every reasonable effort to check on all tests ordered. However, test results could be missed for various reasons. ***No news is NOT good news. If you do not hear from us in a reasonable amount of time after the test is completed, contact us to obtain the result.***

Preventive Visits

Preventive visits are generally conducted once per year. They consist of several components designed to help your provider identify your status concerning common health risks. These visits are not symptom-driven. Instead, preventive visits are an important tool your provider uses to keep you safe and healthy in your own home, avoid hospital admissions, and identify health issues before they become symptomatic, as often as possible.

Riverside Family Health strongly believes in the importance of preventive visits and screenings. As most insurance companies cover 100% of the cost, we ask that you schedule and keep these appointments in the time frame allowed. We will do our best to remind you when you are due for your preventive visits, and schedule them with you.

This clinic is not a walk-in clinic or an urgent care facility. Our established patients do not miss out on appointments due to a schedule full of walk-ins that are unfamiliar to the practice. We do our best to reasonably accommodate our established patients with same day appointments and minor procedures as needed. Riverside Family Health is a medical home, a primary care office that attends to our patients' chronic, acute, AND preventive needs. ***We ask that you actively participate in your healthcare by scheduling and keeping follow up AND preventive visits.***

I have read and understand the above information:

_____ _____
Print Patient/Guardian Name Patient DOB

_____ _____
Patient /Guardian Signature Today's Date

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Office & Financial Policies

_____ *INITIAL*

Insurance Coverage: Knowing your insurance billing information and benefits is ***your responsibility***. Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. We encourage you to be aware of the coverage and benefits of your policy. Failure to do so could result in you, the patient, being responsible for costs incurred due to limitations in coverage.

_____ *INITIAL*

Copayments: Copayments are due at the time of service. **If you are unable to pay your copay at the time of visit, a $10 charge will be added to your balance.**

_____ *INITIAL*

Deductibles/Co-Insurance: All deductible and co-insurance amounts are patient responsibility. We prefer to collect up front toward anticipated deductible/co-insurance balances. We do understand this is not always possible. In these cases, you will be billed after your insurance has processed the claim.

_____ *INITIAL*

Claims Submission: As a courtesy, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. **Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request.

_____ *INITIAL*

Changes in Insurance Coverage: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefit. ***If your insurance company does not pay your claim in 45 days, the full charge amount will be billed to you.***

_____ *INITIAL*

No-Show/Same Day Cancellation Policy: When you do not call to cancel an appointment in a timely manner, you may be preventing another patient from getting much needed treatment. Someone else's failure to cancel may prevent you from receiving treatment. We perform reminder calls as a courtesy. These are not confirmation calls, as you scheduling the appointment is your commitment to keep it.
A **24-hour notice** is required to cancel or change your appointment. ***Habitual no shows and/or same day cancellations may result in discharge from the practice.***

No-Show:** There will be a **$50 fee.** This fee is not covered by your insurance and is due ***prior to your next appointment.

Same Day Cancellation:** There will be a **$25 fee,** if the appointment is rescheduled at the time of cancellation. There will be a **$50 fee,** if the appointment is NOT rescheduled at the time of cancellation. This fee is not covered by your insurance and is due ***prior to or at your next appointment.

_____ *INITIAL*

Arriving Late for Appointments: We realize that life is not always predictable and can cause you to be late for your scheduled appointment time. We will make every effort to squeeze you into the schedule, but you may have to wait behind patients who have shown up on time for their scheduled appointments. Alternatively, we'll be happy to reschedule you to a more convenient time.

_____ *INITIAL*

Self-Pay Policy: We offer a 20% prompt-pay discount to our normal fees as a courtesy for our patients without insurance. Payment is **due at the time of service** in order to receive this discount. If payment is not made at the time of service, the discount is revoked, and the full visit charge will be due and subject to our normal account balance policies.

_____
INITIAL

Account Balances: ***We require that account balances are paid to zero ($0) prior to receiving further services by our practice,*** except for emergency illnesses. Finance charges of 1.5% (or $.50, whichever is greater) per month will accrue on all accounts 60 days past due to cover expenses due to sending multiple statements. The patient is financially responsible for all charges incurred due to debt collection.

_____
INITIAL

Returned Checks: Should a personal check payment be returned to us from the bank, that payment will be removed from your balance, and a **$25 fee will be assessed**. In addition, we will ask that any future payments are made either by cash or credit card. No personal checks will be accepted.

_____
INITIAL

Payment Plans: Patients who have questions about their bill or who would like to discuss payment options may call 321-453-5252 and ask to speak to our billing manager. **Patients who agree to an Automatic Credit Card Installment Payment Plan can then continue to schedule future appointment as long as all required minimum payments are made** on or before the required payment due dates.

_____
INITIAL

Collections: If your account is over 120 days past due and you have not contacted us to set up an Installment Payment Plan Agreement, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. ***Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be disengaged from this practice.*** If the decision is made to disengage you from the practice, you will be notified that you have 30 days to find alternative medical care, during which time, our physician will only be able to treat you on an emergency basis. After a balance is referred to collections, all payments must be made to the collection agency directly.

_____
INITIAL

Completion of Forms (Medical Equipment, Disability Forms, etc.): We prefer to complete forms as part of an office visit with you for better accuracy. Outside of that, a **$25-50 charge will be assessed for the completion of forms.** The charge varies depending on the length of the form and the time needed to complete, and it will need to be paid before the form will be completed. Please allow up to 3 (three) business days for a form to be completed. You will be contacted when forms are ready to be picked up from our front office.

_____
INITIAL

Referrals and Authorizations: Requests for referrals to specialty care ***will require an appointment.*** We want to make sure that you are referred to the most appropriate specialist for your condition. In some cases, your condition can be managed without the need to see specialists. At your appointment, you can discuss and develop a care plan with your physician. **Please be aware of your insurance benefits, as some plans require prior authorization before being seen by a specialist.** Failure to comply with this could result in you, the patient, being responsible for costs incurred due to limitations in coverage. All **Authorization** requests should come from the Specialist providing the requested service. Requests directly from the patient cannot be processed, as the proper information required is not provided. We process Referral and Authorization requests according to order received, as well as urgency. ***It is your responsibility to ensure that authorizations for your scheduled appointment or procedure are being requested on your behalf in a timely manner***.

_____
INITIAL

These policies are subject to change at any time, without notice. You may ask for a copy to review at any time.

I, _____, have reviewed and understand the above policies.
Print Patient/Guardian Name

_____ _____/_____/_____ _____
Signature of Patient/Guardian Date of Birth Date

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Medical History

Patient Name _____ **Date of Birth** _____ ☐**Male** ☐**Female**

Advanced Directives: ☐None

☐Do Not Resuscitate	☐Durable Power of Attorney	☐Living Will	☐Healthcare Surrogate
Who has a copy?	☐Kept at Home	☐Healthcare Surrogate	☐Attorney

Preferred Pharmacy Name/Location _____ ☐Local ☐Mail Away

Current Medications (ALL Prescription and Over the Counter): ☐None ☐See Attached List

Name Of Medication	Dose And Direction	Refill Needed?	
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No
		☐Yes	☐No

Allergies (All known medication, food, and environmental allergies): ☐None

Source (example: Penicillin)	Reaction (example: Hives)

Medical Problems (Check any conditions you have now or had in the past): ☐None

☐ADD/ADHD	☐Diabetes Type I/II	☐Kidney Disease	☐Stroke
☐Alcoholism	☐Diverticulitis/Diverticulosis	☐Kidney Stones	☐Substance Abuse
☐Allergies	☐Frequent UTIs	☐Liver Disease	☐TBI
☐Anemia	☐Gastric Reflux/GERD	specify _____	☐Thyroid Disorder
☐Anxiety	☐Glaucoma	☐Migraine Headaches	specify _____
☐Arthritis	☐Gout	☐Mental Disorder	☐Ulcers
☐Asthma	☐Hearing Loss	specify _____	specify _____
☐Atrial Fibrillation	☐Heart Attack	☐Neuropathy	☐Vertigo
☐BPH/Hypogonadism	☐Heart Disease	☐Obesity	☐Ulcers
☐Cancer	☐Hepatitis A/B/C	☐Seizures	☐Other _____
specify _____	☐High Cholesterol	☐Paralysis	_____
☐Cataracts R/L/BL	☐HIV/AIDS	specify _____	_____
☐COPD/Emphysema	☐Hypertension	☐Skin Condition	_____
☐Dementia/Alzheimer's	☐IBS/Colitis	specify _____	_____
☐Depression	☐Incontinence Urine/Stool	☐Sleep Apnea	_____

Patient Name_____

Other Doctors or Health Care Providers: ☐None

Specialty	Name	Still Seeing?	
Cardiologist (Heart)		☐Yes	☐No
Dermatologist (Skin)		☐Yes	☐No
Endocrinologist (Diabetes/Thyroid)		☐Yes	☐No
Ophthalmologist (Eye)		☐Yes	☐No
Gastroenterologist (GI)		☐Yes	☐No
Nephrologist (Kidneys)		☐Yes	☐No
Neurologist (Nerves/Brain)		☐Yes	☐No
OB/GYN		☐Yes	☐No
Oncologist/Hematologist (Cancer/Blood)		☐Yes	☐No
Orthopedic (Bones/Joints)		☐Yes	☐No
Pain Management		☐Yes	☐No
Previous PCP		☐Yes	☐No
Pulmonologist (Lungs)		☐Yes	☐No
Psychologist/Psychiatrist		☐Yes	☐No
Rheumatologist (Arthritis)		☐Yes	☐No
Surgeon		☐Yes	☐No
Urologist (Bladder/Urinary)		☐Yes	☐No
Other		☐Yes	☐No

Past Surgical History: ☐None

☐Appendectomy	☐Gallbladder	☐Joint Scope	☐Tonsillectomy
☐Back Surgery	☐Gastric Bypass/Sleeve	Specify _____	☐Tubal Ligation
☐Bladder Surgery	☐Heart Bypass/Stent	☐Knee Replacement R/L/BL	☐Vasectomy
☐Breast Augmentation	☐Heart Valve Repair	☐Mastectomy R/L/BL	☐Other _____
☐Breast Biopsy R/L/BL	☐Hemorrhoid Surgery	☐Neck Surgery	_____
☐Cataract R/L/BL	☐Hernia Repair	☐Pacemaker	_____
☐Colostomy	specify _____	☐Prostate Biopsy	_____
☐Dental	☐Hip Replacement R/L/BL	☐Sinus Surgery	_____
specify _____	☐Hysterectomy Complete/Partial	☐Thyroid Removed	_____

Medical Conditions Running in My Family: ☐Adopted/Unknown **M**-Mother **F**-Father **S**-Sibling **C**-Child **GP**-Grandparent

☐Alcoholism/Drug Addiction	☐Diabetes Type I/II	☐Mental Illness	☐Stroke
☐Arthritis	☐Headaches	specify _____	☐Thyroid Disorder Hyper/Hypo
☐Asthma/Allergies	☐Heart Disease	☐Osteoporosis	☐Ulcer
☐Blood/Clotting Disorder	☐High Cholesterol	☐Other Cancer	specify _____
☐Breast Cancer	☐Hypertension	specify _____	☐Uterine/Cervical Cancer
☐Chronic Lung Disorder	☐Kidney Disease	☐Prostate Cancer	Other _____
☐Colon Cancer	☐Liver Disease	☐Seizures/Epilepsy	_____
☐Dementia/Alzheimer's	☐Obesity	☐Skin Cancer/Melanoma	_____

Patient Name_____

Social History:

Alcohol Use ☐Never	☐Current ☐Former (Year Quit_____)	_____ drink(s) per ☐Day ☐Week ☐Month ☐Year ☐Beer ☐Wine ☐Liquor ☐Other_____
Caffeine Use ☐Never	☐Current ☐Former (Year Quit_____)	_____ drink(s) per ☐Day ☐Week ☐Coffee ☐Tea ☐Soda ☐Other_____
Are you on a specific **diet**?	☐Yes ☐No	specify _____
Drug Use ☐Never	☐Current ☐Former (Year Quit_____)	☐Marijuana ☐Cocaine ☐Heroin ☐Prescription ☐Other_____ EVER SHARED NEEDLES? ☐Yes ☐No
Employment Status ☐Active Military ☐Disabled ☐Retired ☐Full Time ☐Part Time ☐Not Employed ☐Self Employed ☐Student ☐Patient Declined to Specify		
Occupation (Previous/Current):		Exposure to Hazardous Materials? ☐Yes ☐No
Exercise ☐Never	☐Moderate but Regular ☐Vigorous ☐Occasionally	specify _____ _____
Marital Status ☐Annulled ☐Divorced ☐Domestic Partner ☐Legally Separated ☐Married ☐Never Married ☐Polygamous ☐Unmarried ☐Patient Declined to Specify		
Do you have any children: ☐No ☐Yes How Many? _____ Age(s):_____		
Living Situation ☐Alone ☐With Spouse or Other Family ☐With a Friend or Roommate ☐In an ALF/Home ☐I Don't Have a Place to Live		
Tobacco Use ☐Never	☐Current ☐Former (Year Quit_____)	_____ pack(s) per day for _____ years ☐Cigarette ☐Chewing ☐Pipe ☐Cigar ☐Vape

Vaccinations: ☐None

☐Covid	Brand:	When/Where:	When/Where:
☐Flu	When/Where:		
☐Hepatitis B	When/Where:	When/Where:	When/Where:
☐Pneumonia	When/Where:	When/Where:	
☐Shingles	When/Where:	When/Where:	
☐TB Test	When/Where:	Have you ever been exposed to tuberculosis? ☐Yes ☐No	
☐Tetanus	When/Where:		

Preventive Screenings: ☐None When was your last Physical/Wellness Exam? _____

Test	Result	When/Where
U/S for Abdominal Aortic Aneurysm	☐Normal ☐Abnormal ☐Never	
Colonoscopy	☐Normal ☐Abnormal ☐Never	
Cologuard/FOBT	☐Normal ☐Abnormal ☐Never	
Dexa Scan (Bone Density)	☐Normal ☐Abnormal ☐Never	
Diabetes: A1c	Result: _____ ☐Never	
Diabetes: Eye Exam	☐Normal ☐Abnormal ☐Never	
Diabetes: Neuropathy (Foot Exam)	☐Normal ☐Abnormal ☐Never	
Hepatitis C	☐Normal ☐Abnormal ☐Never	
HIV	☐Normal ☐Abnormal ☐Never	
Low Dose CT (Lung Cancer)	☐Normal ☐Abnormal ☐Never	
Lipid Panel (Blood Test)	☐Normal ☐Abnormal ☐Never	
Mammogram	☐Normal ☐Abnormal ☐Never	
Pap Smear/Pelvic Exam	☐Normal ☐Abnormal ☐Never	
Prostate Check	☐Normal ☐Abnormal ☐Never	

Other Testing: ☐None

Test	Result	When/Where
Cardiac Stress Test	☐Normal ☐Abnormal ☐Never	
Echocardiogram	☐Normal ☐Abnormal ☐Never	
EKG	☐Normal ☐Abnormal ☐Never	
Endoscopy	☐Normal ☐Abnormal ☐Never	

Pediatric Patient: ☐N/A

Patient Primarily Resides with: ☐Both Parents in Same Home ☐Mother ☐Father ☐Both Parents Equal but Separate ☐Other specify _____	
Parents' Relationship: ☐Married ☐Divorced ☐Single ☐Separated ☐Widowed	
Childcare: ☐Mother ☐Father ☐Grandparent ☐Sibling ☐Nanny ☐Daycare ☐None	
Mother's Occupation: _____	Father's Occupation: _____
Tobacco Exposure? ☐Yes ☐No	Any Smokers in the Home? ☐Yes ☐No

Other Important Information Concerning Your Health:

_____

_____

_____

_____

_____

Signature:_____ Date:_____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____

SS#_____ Cell Phone_____ Other Phone_____

I authorize Riverside Family Health, PL to ☐ **Obtain From** ☐ **Release To**

Healthcare Provider:_____ Phone:_____

Address, City, State, Zip: _____

Fax:_____ Email:_____

☐ All healthcare information **-OR-**

☐ History and Physical ☐ Care Plan ☐ Immunizations ☐ Lab Reports
☐ Radiology Reports ☐ Pathology Reports ☐ Treatment Record ☐ Operative Reports
☐ Hospital Reports ☐ Medication Record ☐ Other (please specify)_____

____ 1 Year _____ 2 Years ____ Entire Record

Purpose:_____

and to include any Federal and state protected information under Florida Statute 394.459 (9) Psychiatric information, Florida Statute 397.501, and 396.112 Drug and/or Alcohol Abuse Information, and Florida Statute 381.004 and FAC 10D-93.064 Human Immunodeficiency Virus test result (HIV testing, AIDS, and related conditions).

I understand and direct that this authorization remains in effect for a period of twelve (12) months or until I revoke it in writing.

My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I hereby release the above named medical facility, practitioner, and its employees from any and all liability that may arise from the release of this information as I have directed.

Signature: _____ Date: _____
(Patient, Parent if minor, or Legal guardian)

Witness: _____

Records will be provided to **another health care provider at no cost**. There is a copy fee for release of medical records for the patient's personal use. We will require prepayment of $1.00 per page for first 25 pages and $.25 for each additional page. Payment is required before records can be released.