Gardens Family Practice PA

Phone (561) 627-7433 Fax (561) 775-1055

www.gardensfamilypractice.com

Welcome to Gardens Family Practice! We are happy to have you join our family and would like to give you some general information regarding our office and staff.

We have one location and two doctors. Prabha Viralam MD is a Board Certified Family Practice physician who has been practicing in Palm Beach Gardens since 1995. Eduardo Sequeira MD is a Board Certified Internal Medicine physician who has been practicing since 1984.

Location: 3365 Burns Rd. Suite 217 Palm Beach Gardens, Florida 33410

Office Hours: **Monday- Thursday** 8:30am-4:00pm

Friday: 8:30am-12 noon

Lunch: between 12 noon-1:00 pm

You can contact us by:

(You can always reach the doctor by phone 24 hours a day)

Phone (561) 627-7433

Fax (561) 775-1055

E-mail: info@gardensfamilypractice.com

Office Policies:

We see patients by appointment only unless it is an emergency.

Referrals must be requested **48 hours** in advanced.

Medication refills must be requested **1 week prior** to running out of medication please.

Notice of Privacy Policy's is available upon request. You can also download a copy on or website listed above.

Appointments are scheduled as follows:

Appointment times are 9am-11am & 1pm-3pm: Monday, Tuesday, Thursday AM and PM available Wednesday PM only Friday AM only. We can accommodate some special requests.

- Urgent/Same Day
- Illness/within 3 days
- New patients/Within One Month
- Well Exam/ Within One Month

All **Co-pays** are due at the time services are rendered we accept Visa, MC, Discover, Checks & Cash

Our staff is always available to answer any question you may have. On Monday mornings, please limit calls to urgent matters only because we have a large call volume on that day. All Calls are returned SAME DAY. We handle each request to the best of our abilities and as efficiently as possible.

PRABHA VIRALAM M.D
Eduardo Sequeira MD

Gardens Family Practice PA
Board Certified in Family Practice

Dear Patient:

Due to the high cost of medical billing, payment is requested at the time of treatment, unless payment plan arrangements are made with the doctor or billing manager, your signature indicated agreement with the following stipulations:

1. Payment in full at time of visit. (If no insurance coverage at all) including applicable insurance co-payment. Patients with indemnity coverage (80/20 plans) will be responsible if deductible has not been met and/or their 20% at time of service.

2. If payment is not received by your insurance company for any reason within 90 days, you will be responsible for the full amount due.

3. The signing party will incur all costs including collection fees, court costs, and reasonable attorneys' fees, if payment not received as described.

4. Any secondary or supplemental insurance claims that need to be filed will be done as a courtesy to our patients. **All remaining balances after claims are processed are the sole responsibility of the patient!**

5. Managed care subscribers (HMO, PPO, POS) Florida State Law requires payment by your insurance carrier to the participating provider within 60 days of the submission of the medical claim. If the claim is not paid, your insurance company has broken its contractual agreement. Since this is your insurance; if the claim is not paid by your insurance carrier, then it is your responsibility to pay the claim or have it paid by the insurance company.

Thank you very much for your understanding and cooperation.

CONSENT FOR TREATMENT.

I voluntarily consent to the rendering of medical care by Dr. Prabha Viralam. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry out the instructions of the physician.

AUTHORIZATION TO RELEASE INFORMANTION:

I authorize Dr. Prabha Viralam to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, workman's compensation or Medicare benefit payments.

Patient Signature: _____ Date: _____

New Patient Registration Form

Date:_____

Patient Information

First Name _____ Last Name _____

Address _____ City _____ Zip _____

Date of Birth: _____ SSN: _____ Preferred Contact: Home Cell

Home Number: _____ Cell _____ Other _____

Email _____

Sex: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Race: ○ White ○ White/ Non Hispanic ○ Black/African American ○ Asian ○ Other ○ Hispanic

Ethnicity: ○ Hispanic ○ Non Hispanic

Insurance Information

Insurance Name _____

ex: BCBC Humana etc.

Policy Number _____

Pharmacy Information

Pharmacy Name _____

Pharmacy Phone_____

Address: _____

Emergency Contact Information

Name: _____ **Relation:** _____

Phone Number: _____

Consents:

Medication history from Pharmacy: ○ Yes ○ No

Receive Electronic Correspondence: ○ Yes ○ No

Receive health information on Voicemail: ○ Yes ○ No

Who referred you to the Office? _____

Previous Physician: _____

Address, Phone Number: _____

Past Medical History

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Why are you here to see the doctor: _____

ALLERGIES

(List any allergies to medicines or other substances) ○ None

MEDICAL PROBLEMS

(List any chronic or recurrent medical problems) ○ None

LIST ALL MEDICATION YOU TAKE REGULARLY

(Prescription and Non-Prescription) ○ None

Name	Dose	How Often

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE

ENT			
	Difficulty Swallowing		Hearing Problems
	Frequent Sore Throat		Nosebleeds
	Frequent Earaches		Ringing in the Ears
	Frequent Sinus Problems		Sinusitis
Respiratory System			
	Asthma		Pleurisy
	Bronchitis-Recurrent		Pneumonia
	COPD		Shortness of Breath
	Coughing Blood		Sleep Difficulties
	Cystic Fibrosis		Sleep Apnea
	Emphysema		Wheezy Chest
	Frequent Chest Infections		
Cardiovascular			
	A-Fib		Heart Murmur

SURGERIES

Date:	Reason:	○ None

	Abnormal EKG		Heart Disease
	Congestive Heart Failure		High Blood Pressure
	Chest Pain		Low Blood Pressure
	Fluttering		High Cholesterol
	Heart Attack		Irregular Heartbeat
Gastrointestinal			
	Abnormal Colonoscopy		Gallbladder Disease
	Blood in Bowel Movements		Gallstones
	Bowel or Colon Disease		Hepatitis
	Cirrhosis		Irritable Bowel Syndrome
	Colitis		Pancreatitis
	Constipation		Ulcer
	Crohn's Disease		Vomiting Blood
	Difficulty Swallowing		Yellow Jaundice
Kidneys			
	Bladder infections		Kidney Disease
	Breast Lumps		Kidney Stones
	Diabetes		Urinating Frequently
	Frequent/Painful urination		Urinary Incontinence
	Blood in urine		Sexual Problems/Concerns
Nervous System			
	Blurred Vision		Migraine Headaches
	Convulsions		Meningitis
	Epilepsy		Stroke
	Fainting		Seizures
	Headaches		Persistent Numbness
	Head Injury's		Paralysis
Other			
	Anemia (low Iron)		Deep Vein Thrombosis
	Arthritis		Pulmonary Embolism
	Gout		Clotting Disorder
	Lupus		Personal History of Cancer

	Rheumatoid Arthritis		List
	Thyroid Disease		
	Unexpected Weight loss		

IMMUNIZATION HISTORY

	Date of last shot
Flu Vaccine	
Pneumonia Shot	
Tetanus Shot	
Shingles Shot	

FAMILY HISTORY

○ None ○ Adopted ○ Unknown

Condition (Blood Relative)	Who
Alcohol/Drug abuse	
Asthma	
Allergies	
Diabetes	
Glaucoma	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Sickle Cell Condition	
Thyroid Disease	
List All Cancers	
Other	

SOCAL HISTORY

You're Occupation?

Exposure to Hazardous condition/substance at work?

○ Yes ○ No

Do you have a living will? ○ Yes ○ No

(A legal document that makes known your wishes regarding life prolonging medical treatments.)

TOBACCO USE

Do you smoke: ○ Yes ○ No ○ Ex-Smoker

How much do or did you smoke per day:

How long did or have been smoking:

ALCOHOL USE

Do you drink alcohol: ○ Yes ○ No ○ Recovering Alcoholic

How much do or did you drink alcohol per day:

How long did or have been drinking alcohol:

History of Alcoholism: ○ Yes ○ No

Drug Abuse

History of Drug Abuse, If so what?

NAME_____

PERSONAL HISTORY

For Woman Only:

MENSTRUATION:

Age periods began: How Often:

Date of last menstrual period:

Now Pregnant? ○ Yes ○ No

Menopause?

Unexplained Vaginal Bleeding? ○ Yes ○ No

Date of Last Pap Smear?

PREGNANCIES

Total number of pregnancies?

Total Births?

Miscarriages?

For Men Only:

Prostate Trouble? ○ Yes ○ No

Discharge from Penis? ○ Yes ○ No

Sore on Penis? ○ Yes ○ No

PREVENTIVE CARE

	Yes	NO	Where
Colorectal Disease Screening			
Colonoscopy			
Stool Cards			
Diabetes Management			
Diabetic blood work			
Diabetic Eye Exam			
Diabetic Foot Exam			
Other			
Yearly Eye Exam			
Mammogram			
Bone Density			
Prostate Cancer Screening			

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Gardens Family Practice PA

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW
Patient Name:_____
Please Print Name
Patient's Date of Birth:_____

A. Person(s) or Organization(s) authorized to receive the information:
E.G., Spouse's Name and Phone Number, Family member's Name and Phone Number, Employer

_____

B. Specific description of the information that may be used or disclosed (including dates):
E.G., Full Chart, Specific Date of Service

_____

HOME # _____, CELL # _____, and/ or

WORK # _____

1) I understand that this authorization will expire one year from today's date.

2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Fairfax Family Practice Centers, PC in writing.

3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).

4) I may inspect or copy any information used or disclosed under this agreement.

5) I understand that, if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative *Date*

_____ _____

Printed Name of Patient's Representative *Relationship to Patient*