When you are done with the new patient paperwork, you may email it to deltaimc2@gmail.com or print it and bring it when you come for your New Patient Appointment.

Patient Registration Form

Name (Last, First, Middle) _____

Social Security Number- _____ Age- _____

Date of Birth- _____ Sex _____ Marital Status- _____

Race-_____ Ethnicity – ☐ Non-Hispanic ☐ Hispanic Preferred Language- _____

Mailing address- _____

City-_____ State- _____ Zip Code- _____

Home phone- _____ Cellphone- _____ Work phone-_____

Email address- _____

Primary Insurance- _____

Subscriber Name- _____ DOB- _____ SS#_____

Relationship- _____ Member # _____ Group # _____

Subscribers Address-_____

Secondary Insurance- _____

Subscriber Name- _____ DOB-_____ SS# _____

Relationship- _____ Policy # _____ Group # _____

Emergency Contact- _____ Relationship- _____

Primary# _____ Home# _____Cell# _____

Pharmacy _____ Phone #_____

How did you hear about us: _____

Patient Release- I certify that the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or a fee at the provider's current rate may be charged on all balances owed to the provider that are past due.

_____ _____ _____

Patient Name (Print) Patient Signature Date

Welcome to our practice! We are honored you have chosen us as your Primary Care Provider. Our goals are to provide you excellent care and to treat you with compassion and courtesy. We thank you for your trust and confidence. Below are a few of our office policies.

Appointments: When making an appointment we will attempt to accommodate your schedule. Your appointment time will be an approximate time. Every effort is made to keep your waiting time to a minimum. As with any medical practice, emergencies do occur, hence, delays are unpredictable. When this happens, your patience is appreciated. Due to emergences, there will be times when your appointment will need to be rescheduled. We regret this may happen without advance notice. If you are more than 10 minutes late, your appointment may have to be rescheduled.

No Show: There will be a $25.00 No show fee applied to any appointment not cancelled or rescheduled 24 hours in advance. If a total of three (3) No Show visits are accumulated, the patient may be subject to dismissal from the practice.

Prescription Refills: Please try to have your medications refilled at your office visits. Otherwise, you will need to contact your pharmacy to process refill requests as we only accept refill requests from the pharmacy. Please allow 24-48 hours for prescriptions to be filled. Based on the medication, there may be a restriction on the refill allowances between your visits with the physician. Controlled medications require an office visit every 1-3 months, while other medications are every 6 months.

Medication Prior Authorizations: Our practice does not process prior authorizations for medications. If we have prescribed a medication that is not covered by your insurance, we will prescribe an alternative for you. If you are notified that a medication is not covered, please do one of the following: (a) Contact your insurance company and request they let you know what a comparable alternative medication that is covered on your formulary; (b) Pay out of pocket for your medication that we have prescribed; (c) Request we submit the Prior Authorization for a $25.00 fee which is required to be paid prior to initiating the prior authorization. The turn around time to process your request is 7-10 business days.

Admission to Hospitals: As your primary care provider, we are concerned about your health. If at any point you feel it necessary to seek emergency medical care, it is your responsibility to notify the admitting staff of your primary physician and contact information to better coordinate your care.

Completion of Forms: Our practice charges a fee for completion of forms. The cost is dependent on the complexity of the form. This ranges from $20.00-$50.00. Payment must be made prior to completion of form. Forms are completed as the physician has time. Therefore, please allow 10 business days for completion of forms.

Payment: Patients are responsible for copayments, co-insurance or deductibles at the time of service. It is the patient's responsibility to know their insurance benefits.

Physician-Patient Relationship: The physician-patient relationship is one of mutual respect and understanding. We expect our patients to maintain a level of self-control and courtesy when present in our office. If a patient becomes verbally abusive or uses vulgar language with and employee or physician, they will be discharged from the practice. If a patient does not comply with recommended treatment, he/she will be discharged from the practice.

I have read and agree with the office policies above. I understand that this form must be updated annually.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

Patient Name- _____ DOB- _____

Allergies to Medicine & Reaction

Current Medications you are taking:

Name of Medication	Dosage/Mg	How often?

Screening	Month/Year	Immunizations	Year/Year
Colonoscopy		Pneumonia vaccine	
Bone Density		Influenza vaccine	
Mammogram		Shingles	
Pap Smear		PPD	
Prostate Specific Antigen (PSA)		Hepatitis B vaccine series	
Electrocardiogram (EKG)		Tetanus	

Hospitalizations Surgeries	Approximate month & year

Health & Weight Goals

☐	Lower blood pressure	☐	Decrease junk food	☐	Decrease HbgA1c	☐	Stop smoking
☐	Lower cholesterol	☐	Start eating healthy	☐	Increase physical activity	☐	Increase family time
☐	Decrease eating out	☐	Adequate fluid intake	☐	Control your diseases with diet	☐	Reduce fat intake
☐	Lose weight	☐	Reduce sodium intake	☐	Daily exercise	☐	Have more energy
☐	Maintain weight	☐	Gain weight	☐	Meal planning	☐	Improve sleep

Patient Name- _____ DOB- _____

Your Own Medical History	YES	NO	Family History	YES	NO
Stroke			Stroke		
Heart trouble			Heart Trouble		
High Blood pressure			High Blood Pressure		
Diabetes			Diabetes		
Arthritis			Arthritis		
Phlebitis			Gout		
Stomach trouble/ulcers			Thyroid trouble		
Seizures			Cancer		
Mental Illness			Mental Illness		
Kidney trouble/stones			Kidney Trouble or Stones		
Cancer			Alcoholism		
Bleeding disorders			Bleeding Disorders		
Liver Trouble			HIV/AIDS		
Alcoholism			WOMEN ONLY		
Anemia			Irregular periods		
Lung Disease			Are you pregnant?		
Tuberculosis			Are you nursing?		

Father- ___Living ___Deceased	Age of death?	Cause of death?
Mother- ___ Living ___Deceased	Age of death?	Cause of death?
How many Living brothers?	# Deceased?	Cause of death?
How many Living sisters?	# Deceased?	Cause of death?
How many son(s)?		
How many daughter(s)?		

Review of Systems	YES	NO		YES	NO		YES	NO
Reading glasses			Leg cramps			Burning w/ urination		
Change of vision			Poor appetite			Difficulty urinating		
Loss of hearing			Toothache			Frequent headaches		
Ear pain			Gum trouble			Blackouts		
Hoarseness			Nausea/vomiting			Seizures		
Nosebleeds			Stomach pain			Frequent rash		
Difficulty swallowing			Ulcers			Hot/cold spells		
Morning cough			Frequent belching			Weight change		
Shortness of breath			Loose stools			Nervous exhaustion		
Chills or fever			Blood in stool			Insomnia		
Heart/chest pain			Constipation			Depression		
Abnormal heartbeat			Hemorrhoids			Nervous tension		
Swollen ankles			Frequent urination			dizziness		

	YES	NO	SOMETIMES			
Exercise				**# days per week?**	**What activity?**	
Smoke				**# packs per day?**	**# years?**	**Quit-**
Alcohol				**# drinks per day?**	**# years?**	**Quit-**
Drug Addiction				**How often per day?**	**# years?**	**Quit-**

Financial Policy

We are committed to providing you with the best possible care and to establish a mutual understanding of the financial policies of this practice. Please understand that the payment of your bill is considered part of your treatment.

1. **We will collect your deductible, co-pay, past due balances or percent of your responsibility at the time of your visit. Please be prepared to pay your copay prior to seeing the doctor. We will need to reschedule your appointment if you are unable to pay.**

2. **Please provide us with ALL your insurance information. Bring your insurance card with you and any authorization information you may have. You will be responsible for any unpaid balances due to lack of information. Authorization form your insurance company does not always guarantee payment. The undersigned/patient shall remain responsible for all charges, co-pays and deductible. If we are participating providers with your insurance, we will file your claims, otherwise you are considered self-pay.**

3. **Your insurance company will send you an explanation of benefits that explains what they have paid to our office. This is a record you must keep on file. If you do not agree with their payment, please contact the insurance company.**

4. **If your insurance company denies payment on your account, you will be asked to pay by check, cash or credit card. Should a collection agency become necessary, the patient will be responsible for all collection costs and attorney fees.**

5. **Self-pay patients include those with no insurance and the patients who have insurance plans in which we do not participate. Payment for services is expected on the day the service is rendered. Personal checks are not accepted for the initial visit.**

6. **We do not bill insurance for evaluation requested by third parties. This includes, but not limited to, evaluation for bariatric surgery, adoption, legal proceedings, etc. If you require/request this type of evaluation, the appointment is a self-pay visit and you are responsible for payment at the time of service. Costs for evaluation vary and the doctor reserves the right to decline the request.**

I have read, understand and agree to the Financial Policy.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

Patient Acknowledgment & Understanding of Delta Internal Medicine Center's Privacy Practices

I understand that the patient's health information is private and confidential. I understand that Delta Internal Medicine Center works very hard to protect the patient's privacy and preserve the confidentiality of the patient's health information.

I understand that the health and billing records Delta Internal Medicine Center maintains are the physical property of the doctor's office. The information in it, however, belongs to you and as such may be released to other healthcare providers upon the patient's request. Please note due to the sensitivity of the content, we do not release mental health records directly to the patient under any circumstances.

I understand Delta Internal Medicine Center may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other healthcare operations. (*In general, there will be no other uses in disclosures of this information unless I permit it. I understand sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if the patient threatened to hurt someone*.)

Information regarding your treatment will not be released unless there is- a written consent and/or an indication that clear and immediate danger exists and/or a court order which directs the release of information and/or you disclose sexual abuse, physical abuse or neglect of a child under the age of 18 and/or elder abuse.

Delta Internal Medicine Center has a detailed document called "Notice of Privacy Practices". It contains more information about the policies and practices to protect the patient's privacy. It also contains a complete description of my privacy/confidentially rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law and requesting communications by specific methods of communications or alternative location.

Delta Internal Medicine Center has established procedures to help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgement and authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs, etc. I will assist Delta Internal Medicine Center by following these procedures if I choose to exercise any of my rights described in the Notice of Privacy Practices.

My signature below indicates I have been given the chance to review a current copy of Delta Internal Medicine Center's Notice of Privacy Notices…

Patient Name (Print)	Patient Signature	Date

COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

Delta Internal Medicine Center
220 East Gore Street, Suite 201
Orlando, FL 32806

Patient Name: _____Date of Birth: _____

1. You may contact me via the following methods and I agree to received detailed messages regarding appointments, prescriptions, test results, referral information, billing information, or other information pertaining to my treatment and care:

   ☐ Preferred Phone Number _____
   ☐ E-Mail Address _____
   ☐ Cell Phone/Text Number _____

2. I authorize Delta Internal Medicine Center to release information about my medical condition and diagnosis (including treatment, payment, and health information) to the following family member or other persons (if any):

_____	_____	_____
Full Legal Name	Relationship	Phone Number
_____	_____	_____
Full Legal Name	Relationship	Phone Number
_____	_____	_____
Full Legal Name	Relationship	Phone Number

I understand that these records may contain information from other health care providers, as well as information which is administrative in nature. I specifically consent to the release of any information contained in my medical record which may relate to:

☐ Infection with Human Immunodeficiency Virus (HIV) ☐ AIDS ☐ Mental Health and any other related alcohol and substance use.

I understand that you have no responsibility of the use of distribution of this information by the party to whom it is released. I release you form all liability which may arise from your compliance to release records.

I authorize you to transmit this information by telephone, facsimile transmission (fax) and/or mail, and to release you form any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax. This release is valid for 1 year from the date signed.

_____ _____
Patient / Legal Representative Signature Date

Delta Internal Medicine Center P.A.

Authorization to Obtain/Release of Medical Records

(This form applies only to release and/or disclosure of patient information. It is not a consent for treatment or intended for any purpose.)

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

Home Address: _____ **Telephone Phone:** _____

☐ **Obtain records** from Facility ☐ **Release records** to Facility ☐ **Request copies** of my Medical Records

Name: _____

Address: _____

Phone: _____

Fax: _____

☐ All records: Between dates of: ____ / ____ /_____ to ____ / ____ /_____

-Or-

☐ For the following period ____ / ____ /_____ to ____ / ____ /_____ on the description below:

Information to be release/obtained:

☐ History & Physical ☐ ER/Urgent Care ☐ Lab Reports

☐ Discharge Summary ☐ X-Ray Reports ☐ Itemized Billing Statement

☐ Progress Note ☐ Diagnostic Test Reports

☐ Other (Specify content and dates): _____

Please be aware there is a fee of $1.00 for the first 25 pages and an additional $0.25 per page. Depending on your request, it can take up to 10 business days to receive records, though most request are fulfilled sooner. _____ INITIALS

By signing this form, I authorize DELTA INTERNAL MEDICINE CENTER to use, release or obtain protected health information described above:

I understand that my records are confidential and cannot be disclosed without my written authorization, expect when otherwise permitted by law (F.S 395.3025, F.S. 456.057 45CFR ss164.524). Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has taken in reliance upon the authorization. The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature _____ **Relationship** _____ **Date** _____

DELTA INTERNAL MEDICINE CENTER
Michael Akpeke, M.B., B.S., M.D.
220 E. Gore St., Ste 201, Orlando, FL. 32806
PH: (407) 985-1940 FX: (407) 985-1947

Controlled Substance Agreement

We are committed to doing all we can to treat your chronic condition. In some cases, controlled substances are used as a therapeutic option in the management of your chronic condition, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to Delta Internal Medicine Center, P.A., and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below, or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below, or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, including over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not see prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy you have selected is:

   Pharmacy Name: _____ Phone: _____

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.
5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below, or during his/her absence by the covering physician, as set for in Section 1 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.
10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

_____

PATIENT'S FULL NAME

_____

PATIENT'S SIGNATURE DATE

_____

PHYSICIAN'S SIGNATURE DATE

ALLERGY SURVEY

This allergy survey lists symptoms and other factors most commonly found in people suffering from some form of allergy. Filling out and scoring this survey, should help you and your physician decide if you have an allergy problem, therefore determining whether any allergy testing needs to be done.

Please answer the following:

1. Have you had or currently have any symptoms such as sneezing, nasal discharge, congestion, and/ or nasal itching?	
2. Have you had or currently have any symptoms of inflammation, red, swollen, or itchy eyes?	
3. Do you suffer from asthma, shortness of breath, often or chronic cough?	
4. Have you experienced a fluctuation of weight, emotional change, fatigue, and depression?	
5. Do you have frequent headaches, fatigue, sleeping disorders, and/or muscle aches?	
6. Have you noticed that the symptoms before exposed, appear or worsened with the change of seasons?	
7. Do your symptoms appear or worsen when you come in contact with dust, moisture, or green areas?	
8. Do you wake up coughing in the middle of the night, have to clear your throat when you wake up, or wake up with a sore, congested throat?	

FOR ALLERGY TECHNICIAN USE ONLY

- ✓ If the patient answers **YES** to at least one of these questions, please inform the Allergy Technician and Physician as the patient is a candidate for Allergy Test.

When you are done with the new patient paperwork, you may email it to deltaimc2@gmail.com or print it and bring it when you come for your New Patient Appointment.