Howard T. Tee, M.D., F.A.C.P., F.A.C.C.
Patient Registration

Date:_____

Name: _____ DOB: _____ Sex: □Male □Female

Address: _____

City: _____ State: _____ Zip: _____

Phone:
Home _____ Work: _____ Cell:_____

Email: _____ Race: _____ Social Security: _____

Marital Status: Married Widowed Single Divorced Spouce's Name:_____

Language:
□ English □ Spanish □ French □ Other

Dominant Hand: □ Right □ Left □ Ambidextrous

Emergency Contact: _____ Phone: _____

Primary Insurance:__ _____

(Circle One): PPO POS HMO Indemnity

ID Number:_____ Group Number: _____

Insured's Name:_____ Insured's Date of Birth: _____

Insured's Relationship: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Relationship: _____

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Authorization to Use or Disclose My health Information

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

I. My Authorization

You may use or disclose the following health care information (circle yes or no):

All my health information maintained by Dr. Tee	YES	NO
My health information related to drug abuse	YES	NO
My health information related to alcohol abuse	YES	NO
My health information related to HIV/AIDS	YES	NO
My health information related to psychological or psychiatric conditions	YES	NO

My health information relating to the following treatment or condition _____
My health information for the date(s) _____
Other: _____

You may disclose this information to:

Name or Organization: _____
Address: _____

Check all that apply:

My Spouse Name: _____ Phone: _____
My Son/Daughter Name(s): _____ Phone: _____
My Mother/Father Name(s): _____ Phone: _____
My Friend Name(s): _____ Phone: _____
My Lawyer Name(s): _____ Phone: _____
My Caretaker or Living Facility: _____ Phone: _____
My Power of Attorney Name: _____ Phone: _____
Other Specify: _____ Phone: _____

This Authorization Ends On: Date: _____ When the following event occurs: _____

II. My Rights

I understand that I do not have to sign this authorization in order to get health care benefits 9 treatment, payment or enrollment). However, I do have to sign an authorization form to take part in research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke authorization if its purpose was to obtain insurance. Two ways to revoke authorization are: Fill out a revocation form, which is available from the office or write a letter to the office. Once the office discloses health information, the person or organization that receives it may re- disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature **Date** **Time**

_____ _____

Printed name if signed on behalf of patient **Relationship to Patient**

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Name: _____ DOB: _____ Age: _____

Referring M.D.: _____ Primary M.D.:_____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Have you ever been treated for or do you have any complaints of:

Yes [ ] No [ ] Chest Discomfort
Yes [ ] No [ ] Shortness of breath when walking or lying down
Yes [ ] No [ ] Irregular heatbeats or palpitations
Yes [ ] No [ ] Calf cramps when walking
Yes [ ] No [ ] Heart Failure
Yes [ ] No [ ] Heart murmur or heart valve problem
Yes [ ] No [ ] Heart valve replacement If yes, give date(s)_____
Yes [ ] No [ ] Heart attack If yes, give date(s) _____
Yes [ ] No [ ] Blacking out or passing out
Yes [ ] No [ ] Stroke If yes, give date(s) _____
Yes [ ] No [ ] Rheumatic Heart Disease
Yes [ ] No [ ] Coronary Artery Bypass Grafting (open Heart surgery) If yes, give date(s): _____
Yes [ ] No [ ] Coronary angioplasty (PTCA or balloon technique, stents) If yes, give date(s) _____

Yes [ ] No [ ] Have you ever been told you have diabetes or "high blood sugar"?
If yes, how long have you had diabetes?: _____
How is your diabetes treated?: (Circle one) pills insulin

Yes [ ] No [ ] Have you ever been told you have high blood pressure?
If yes, how long have you had high blood pressure?: _____
How long have you received medication for your high blood pressure?: _____

Yes [ ] No [ ] Have you ever been told you have high cholesterol or triglycerides (blood fats)?
What was your last cholesterol level? _____
What were your last triglycerides?: _____
When was the above cholesterol/triglyceride level done?: _____

Women Only:

Yes [ ] No [ ] Are you postmenopausal?
Yes [ ] No [ ] Have you had a hysterectomy?
If yes, give date:_____

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

How many siblings do you have?

sisters _____

brothers _____

Please answer the following:

Relationship	Sex: Male (M) Female (F)	Living (1) Deceased (2)	If deceased, age at death	Heart Attack	Heart Surgery	High Blood Pressure	High Cholesterol	Stroke
Father								
Mother								
Sibling #1								
Sibling #2								
Sibling #3								
Sibling #4								
Sibling #5								
Sibling #6								

Marital Status: [ ] Married, number of years _____ [ ] single [ ] Divorced [ ] Widow

Live with: [ ] Spouse [ ] Children [ ] Alone [ ] Friend [ ] Relative [ ] Other _____

Employment Status:

[ ] Employed [ ] Unemployed [ ] Retired [ ] Homemaker [ ] Other _____

Yes [ ] No [ ] Do you drink alcohol or beer?

If yes, how many drinks per: Day _____ Week _____ Year _____

Yes [ ] No [ ] Do you drink coffee, tea, or soda with caffeine?

If yes, how many cups per day? _____

Yes [ ] No [ ] Have you ever smoked cigarettes?

What age did you start smoking?:_____

How many years did you smoke?: _____

How many packs per day did you smoke?: _____

When did you stop smoking?: _____

How many children do you have?: _____

Do any of your children have heart disease? [ ] yes [ ] No

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Name: _____ DOB: _____ Patient's Age: _____

PMH Describe on the lines below any problems you have had with the following:

ROS

Brain or Neurological Problem(s) _____
Thyroid Disease _____
Carotid Artery Disease _____
Lung/Breathing _____
Stomach/Ulcers/Intestines _____
Blood/Bleeding Problems _____
Liver _____
Kidney _____
Bladder _____
Prostate _____
Peripheral Vascular Disase(Leg blood vessels) _____
Leg Cramps _____
Cancer _____
Glaucoma _____
Arthritis/Gout _____

OP Please list all operations you have had and dates of surgery

_____
_____
_____
_____
_____

Yes [ ] No [ ] Have you ever had a vein stripping of your legs?

Yes [ ] No [ ] Are you allergic to contrast or IVP dyes used in medical tests?
Yes [ ] No [ ] Are you allergic to shell fish?
Yes [ ] No [ ] Are you allergic to any medications?
If yes, describe the reactions you had below.

AL

Medication	Reaction Type

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

MED Please list all medications you are taking. Include the dosage and directions.

Medication	Dosage	How often

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.

☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. **RESEARCH STUDIES:**

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Physician Clinic contact with questions about the Study? _____.

7. **CONSENT TO PHOTO/VIDEO:**

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. **E-MAIL:**

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. **CELL PHONES:**

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. **VIDEOTAPING/RECORDING:**

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

As part of an ongoing effort to enhance care coordination for its beneficiaries, Medicare is pleased to offer a new chronic care management service which will help us better coordinate your care. Chronic care management consists of non-face-to-face care services which our office will furnish to assist in coordination of your care among your different care providers and to help you better manage your chronic conditions. This service would be a complement to face-to-face services you receive, such as office visits.

As part of this service Dr. Howard Tee will work with a team of healthcare providers at our practice to provide care management for your chronic conditions, such as to:

- Create a comprehensive care plan, which will be made available to you either in a written or electronic format and may be periodically revised.
- Coordinate and communicate with other health professionals outside of our practice who are also involved in your care. (Please note, this communication will be done in accordance with all state and federal privacy and security laws.)
- Help you manage care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals or other health care facilities.
- Have a member of Dr. Howard Tee's care team, accessible 24 hours a day, 7 days a week to help you with any urgent chronic care needs and to coordinate with other healthcare professionals involved in your care.
- Review and track your key health information such problems, laboratory results, medications and medication allergies as well as help you know when to receive recommended preventive care services.

By signing this consent form, you agree to:

- Allow Dr. Howard Tee to bill Medicare for chronic care management services on your behalf no more frequently than once a month. This service may be billed even if you do not come into the office that month. Dr. Howard Tee will not bill Medicare for chronic care management during months in which less than 20 minutes of non-face-to-face chronic care management is provided.
- Pay a copayment during months in which this service is provided. Deductibles may also apply. Although there is a fee for this service, it may help you avoid the need for more costly face-to-face services that entail greater cost-sharing. Please note that only one healthcare provider can be paid for these services during a calendar month. If another provider has offered to furnish this service, please let us know.
- Authorize the electronic communication of your medical information with other treating providers as part of these care coordination efforts.

You have the right to stop receiving CCM services at any time (effective at the end of a calendar month) and can do so by notifying Dr. Howard Tee's office of your decision, at which point we will have you sign a CCM termination form.

I permit Dr. Howard Tee to bill Medicare for chronic care management services provided to me and understand I will be responsible for applicable co-payments and deductibles

Signature: _____ Date: _____

Name: _____

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

960 37TH Place, Ste 105 • Vero Beach, FL 32960 • Phone: (772)299-1901 • Fax: (772)299-1904

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____
SSN: _____
DOB: _____
Phone: ( ) _____

I hereby authorize: **(To get records from)**

Facility Name: _____

Facility Address: _____
_____
_____

I hereby authorize: **(To release records to)**

Facility Name: **Howard Tee, M.D.**

Facility Address: **960 37th Place, Suite 105**
Vero Beach, FL 32960
Phone: 772-299-1901
Fax: 772-299-1904

To release any or all: (Please be specific on records requesting) this release is to include any and all HIPAA protected medical records.

_____
_____
_____

I understand and direct that this authorization is to remain in effect indefinitely or until I revoke it in writing.

_____ _____
Patient Signature Date

PAYMENT POLICIES
Please read the following payment policies

Please bring all pertinent insurance information and your insurance cards with you on each visit to our office. Also we recommend that you bring your preferred method of payment (credit card, check or cash) to pay for deductibles or co-pays. Your co-pay or deductible must be paid at the time of service.

Our office files your insurance as a courtesy. We recommend that you should review and understand your insurance policy. Your insurance policy is a contract between you and your insurance company. It is not a contract between you and our Doctors.
Should your insurance carrier withhold payment or partial payment of your claim for any reason, we will be glad to assist you in obtaining an explanation from them. However, we cannot guarantee payment of your claim. Also, we cannot be responsible for negotiating fees or claims with insurance companies or any other entity. Patients are responsible for payment of medical care within a reasonable time, regardless of the status of the claim.
If pre-authorization is needed, then it is your responsibility to notify our staff so we may obtain authorization. If no authorizations are on file we cannot provide the services unless you decide to pay for visit at self-pay rate. Patient balances are expected to be paid in full.
We do not have payment plans for outstanding balances. Partial balance payments through the mail will not be accepted.
If you have any questions or are not prepared to pay for your appointment, please notify one of our staff prior to your appointment. If you are unable to pay for residual balances from previous dates of services, you may be asked to reschedule your appointment.

There is a $50.00 fee for **missed appointments** (unless a 24-hour notice is given) or more than 15min late arrival.

There is a $25.00 fee for **returned checks**.

There is a $ 25.00 for **printing medical records** (first 100 pages then additional 30cents/per page).

There is a **placement fee** of thirty dollars ($30.00) in addition to the balance subject to collection.

By my signature below I acknowledge that I agree with Payment Policies.

Patient Signature: _____ Date: ____/____/____

OFFICE POLICIES

New Patients: New patients to our practice and patients following up from hospital can complete New Patient Paperwork prior to appointment.

We welcome new patients for consultations. You may contact us directly or through a referring physician.

Please make sure to forward copies of your medical records from other physicians before your first appointment, which will be set for the earliest time and date possible.

Please print the New Patient Packet supplied and bring the completed forms with you to our office. Please arrive approximately 15 minutes early to allow for parking and timely arrival.

Prior to your appointment: On your first appointment and all future appointments, please bring a list of all **medicines** you are presently taking (include all herbal and over the counter medication), **photo ID** and your **health insurance card(s)** and **method of payment** for co-pays/deductibles.

Pharmacy: Please call your pharmacy to see if the prescription has been filled prior to calling the office and call pharmacy directly for refills. For refills: pharmacy will fax the request to our office and it will be reviewed immediately. We cannot refill if you are not a current patient or have not come for follow up in more than one year.
Prescriptions will not be filled on weekends/holydays or after 5:00pm Monday – Friday.

Referrals: If a referral has been made to another physician and you do not hear from that physician's office within 2-3 days, please contact our office so that we can assist you in getting your appointment scheduled.

Laboratory Testing: Many times your physician will ask that you have "fasting" blood work .The definition of fasting is: nothing after midnight except water or medications. When the doctor orders blood work, please have it done no less than 1 week prior to your next appointment so that your lab results can be discussed with you when you come in.

After hours: Bringing your concerns to our attention during office hours will ensure the problem is dealt with sooner and a prompt follow-up is scheduled. For urgent matters, you should go to the Emergency Department for any medical emergencies.

Change of information: If you have any changes on your name, address, phone number or insurance, please notify us as soon as possible. We do not want such changes to affect your medical care.

Out of network: If your insurance plan is out of network: we will have to collect full payment at time of service. After service we will send a claim to insurance and insurance will notify you how much of what you payed will be covered or not.

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.

Your Privacy is very important to us. In order for us to speak with anyone other than yourself, we must have your permission.

If you give permission for us to communicate with anyone other than yourself, please complete the list below:

Name/Phone Number	Relationship	Options
1		☐Billing Information ☐Appointment Information ☐Medical/Health Information
2		☐Billing Information ☐Appointment Information ☐Medical/Health Information
3		☐Billing Information ☐Appointment Information ☐Medical/Health Information
4		☐Billing Information ☐Appointment Information ☐Medical/Health Information
5		☐Billing Information ☐Appointment Information ☐Medical/Health Information

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (Print)

Relationship to patient

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

R 0 I

Patient's Name				Date of Birth	Medical Record Number
Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information				
Address	City	State	Zip	Telephone Number
Agency or Individual(s) Authorized to Receive my Health Information				
Address	City	State	Zip	Telephone Number

Health Information that may be used / disclosed is limited to the following:
☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other *(specify)* _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.
☐ **Yes** ☐ **No** If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*			Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf			Interpreter, if Utilized	
Witness's Signature	Date	Time	Expiration Date or Event	

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Howard T. Tee, M.D., F.A.C.P., F.A.C.C.
960 37TH Place, Ste 105 • Vero Beach, FL 32960 • Phone: (772)299-1901 • Fax: (772)299-1904

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____
SSN: _____
DOB: _____
Phone: ( ) _____

I hereby authorize: **(To get records from)**

Facility Name: _____

Facility Address: _____

I hereby authorize: **(To release records to)**

Facility Name: **Howard Tee, M.D.**

Facility Address: **960 37th Place, Suite 105**
Vero Beach, FL 32960
Phone: 772-299-1901
Fax: 772-299-1904

To release any or all: (Please be specific on records requesting) this release is to include any and all HIPAA protected medical records.

_____

_____

_____

I understand and direct that this authorization is to remain in effect indefinitely or until I revoke it in writing.

_____
Patient Signature

_____
Date