MIDWAY SPECIALTY CARE CENTER
www.midwaycare.org

Claudio D. Tuda, MD / Cynthia I. Rivera, MD / Nicholas S. Camps, DO / Lizy Paniagua, MD
4308 Alton Road, Suite #860, Miami Beach, Florida 33140-2891
(305) 674-2766 tele
(305) 674-2765 fax

New Patient Questionnaire

Last Name, First Name, Middle Initial: | Date:

Date of Birth: | Age: | Social Security #:

Gender at Birth: ☐ Female ☐ Male ☐ Non-Binary ☐ Transgender (F to M)(M to F) ☐ Unsure

Sex Orientation: ☐ Lesbian/Gay/Homosexual ☐ Straight ☐ Bisexual ☐ Do not know ☐ Other ______________________

Family Status: ☐ S ☐ Sig Other ☐ M ☐ Sep ☐ D ☐ W

Address:

Address Line 2:

City, State and Zip Code

Phone Number(s) *Check box representing preferred number for patient reminders, etc.* ☐ Home ☐ Cell ☐ Work

Email Address:

Enable Patient Portal: ☐ Yes ☐ No

Contact Name and # in Case of Emergency / Relationship

Name of Primary Care Provider: | City and State of PCP

Employer Information

Employer Name:

Employer Address:

City, State and Zip Code

Your Occupation:

Insurance Information

Primary Insurance Company

Telephone Number: | Policy Number: | Group Number:

Secondary Insurance:

Telephone Number: | Policy Number: | Group Number:

Policy Holder / Subscriber's Name

Financially Responsible Party:

☐ Self or Relationship to Patient | Initial:

New Patient Questionnaire - Continued

Last Name, First, Middle Initial:

Race:
□ American Indian
□ Asian
□ Native Hawaiian
□ Black or African American
□ White
□ Middle Eastern/ North African
□ Other Race
□ Other Pacific Islander
□ Unreported / Refused to Report

Ethnicity:
□ Hispanic or Latin
□ Not Hispanic or Latin
□ Refused to Report

Preferred Language:
□ English □ Spanish □ Creole

Allergies:

		YES	NO
Medications:	Any allergy to Penicillin?	□	□
	Any allergy to Iodine?	□	□
Medical:	Any allergy to Latex?	□	□
	Any allergy to Tape?	□	□
Other:			

Please list all medications you are currently taking.
Please include Over-The-Counter Medications and/or Supplements.

Have you ever received a dose of COVID-19 vaccine? □ Yes □ No
• If yes, which vaccine product did you receive? □ Pfizer □ Moderna □ Janssen (Johnson & Johnson)

- Date of 1st Dose: ________________________________ Date of 2nd Dose*: ________________________________

	Address	Telephone Number
Name of Your Local Pharmacy		
Name of Your Mail Order Pharmacy		
What Lab Do You Use (Name)?		

I hereby consent to Midway Specialty Care Center, Inc. obtaining my **Prescription History** from any/all sources.

Signature:

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Patient Self Determination Act Questionnaire

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of the Florida Statutes, please answer the following questions by initialing the applicable response:

Declaration to decline Life-Prolonging Procedure (Living Will)

_____I have such a declaration

_____I have NOT made such a declaration

Health Care Surrogate

_____I have a designated health care surrogate

_____I have NOT designated a health care surrogate

Durable Power of Attorney

_____I have appointed a durable power of attorney

_____I have NOT appointed a durable power of attorney

24-Hour Cancellation & No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is unable to receive care. Midway Specialty Care Center, Inc. reserves the right to charge a fee of $25.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

"No-Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple no-shows in any twelve (12) month period by result in discharge from the Practice.

thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have reviewed this notice and understand the policy.

Printed Name:	
Signature	Date:

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Consents

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that we ask your permission before disclosing certain healthcare information to certain people or entities.

In accordance with the Act, I hereby authorize Midway Specialty Care Center, Inc. to release any information regarding my health to the following persons or entities:

Name	Date of Birth	Relationship

Insurance Authorization and Assignment

All Charges are payable at the time of service.

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage, it is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment: I hereby authorize Midway Specialty Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges.

Consent for Communication via E-mail

I hereby consent to have my physician communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

Patient's Name:

Signature:	Date

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. Treatment includes medications currently authorized or approved by the US FDA for treatment of COVID 19 or other emerging communicable respiratory illnesses. Testing includes, but is not limited to physical, radiological, and laboratory testing. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, taking of photographs of my condition and treatment for the condition which has brought me to seek care at this practice.

I consent to allow my laboratory testing specimens (including, but not limited to blood, urine, or sputum samples) to be processed in-house (by MSCC/lab) or sent out to a reference lab as deemed necessary by Midway Specialty Care Center, Inc. I also understand that my specimens may be used for validation purposes.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient (or Personal Representative)_______________________________ Date________________

Printed Name of Patient (or Personal Representative)______________________________Relationship _____________ Printed

Name of Witness: __________________________________Employee Job Title ____________________

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**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT**

I understand that under the Health insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient's Name:	
Signature:	Date
□ Self or Relationship to Patient	

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Authorization for Release of Medical Records

I hereby request and authorize release copies of my medical records to Midway Specialty Care Center, Inc.

Records can be sent to the address above **or sent electronically Physician to Physician.**

I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorize release of the following to Midway Specialty Care Center, Inc.

Type of information to be disclosed:

□ Entire medical record	□ Radiology reports	□ All Hospital records
□ Consultation	□ Billing statements	□ Discharge summary
□ Dental records	□ Pathology reports	□ Laboratory reports
□ Office chart notes	□ Emergency Department reports	□ Other:

Patient Name:	DOB:
Signature	Date:
Last 4 digits of social:	