Letter to Prospective Patients

Thanks for your interest in wanting to become a patient in our office. To expedite your appointment, it is important that you follow the instructions on this page and on the accompanying forms. Our goal is to provide our patients timely appointment and make your visit to our office a pleasant one without undue delays or long waits. You will be seen at the scheduled time so we ask that you arrive to our facility 15 minutes prior to your appointment time.

1. This **Prospective Patient Information Packet** consists of ten sections. By collecting this information prior to your visit to our office, we are able to carry out a more complete evaluation of your medical problems while at the same time allowing the doctor to spend more time face to face with you, the patient, during the visit. By answering any questions you may have and by explaining to you in detail all the ins and outs of your condition, in addition to the treatment that he recommends, you will not feel like you are being rushed and that you are not being listened to. Our goal when you visit our office is to make your experience unlike any other you may have had at a doctors office. Additionally we do not want our patients to just sit and wait for hours on end in our waiting room. So please be on time.

2. In order for Dr. Dieguez to make an accurate initial assessment of your condition, all questions must be answered in full, with all spaces completed. If you do not have, or know, the information requested, please indicate so.

3. Enter your **name, signature, and date**, as indicated, on all the appropriate spaces in the forms.

4. Once you have completed all sections, return them to us as soon as possible and we will call you to arrange a date and time that is convenient to you for your appointment at our office. Our goal is to get you in as soon as possible. We will strive to get you in within 24 hours, schedule permitting.

Sincerely,

Administrative Cordinator
NO INSURANCE? NO PROBLEM!
WE HAVE MADE CARE AFFORDABLE!
WE HAVE AFFORDABLE FLAT RATES AVAILABLE FOR YOU!

We realize that with the introduction of the “Affordable Care Act”, some patients out there are still finding it difficult to afford health insurance coverage. Still many others are now facing much higher deductibles and co-pays. Wanting to avoid turning down those patients in our office just because they do not have insurance or have high deductibles and co-pays, we have decided to offer those patients the care that we provide at affordable flat cash rates.

Additionally those patients that have health insurance policies with insurance companies, of whom we are not participating providers, can also benefit from these flat rates if they so wish and get immediate access to specialist care without a referral from your primary care doctor. Examples that come to mind are Humana, GHI, Aetna, Cigna and many others.

If you or any family members or friends do not have insurance or have an insurance for which we are not participating providers and can benefit from the above rates, please let us know.

Call our office at (904) 827-1455 to get additional information. Please be aware that we will not be providing controlled substance prescriptions of any kind.
In our constant effort to keep you informed about new development and new treatment option that we offer at our office we have created two sources of information for you. We kindly request that you look at this sources of information and share them with friends and family.

1. - The first one is our Office Facebook Page. Here we add information at least weekly and also our patient can ask questions, rate our services and stay in contact with new development or any events planned at our office. Please we encourage you visit us on the web at: www.Facebook.com/WellnessAndRegenerativeMD.com. Visit us and tell us what you think. Look around the site, as we have posted several videos that may interest you. Share with friends and family member that you think may be interested in some of the conditions and the treatment we provide. Please rate us so we know how we are doing or if we need to change anything. Your comments will be greatly appreciated.

2. - The second one is our Office Website. Here you will get an overview of the different modalities of treatments that we offer and different conditions we treat at our office. You will also find an area in our website where you can request appointments at our office. Visit us at: www.WellnessAndRegenerativeMD.com.

Sincerely,

Edward Dieguez Jr. M.D.
Section 1 - General Information/Patient registration

Important Note: Please understand that all questions must be answered in full if possible, with all spaces completed, in order to expedite the process for an appointment. If the information requested is not available please specify so. Please print clearly.

1) PATIENT'S FULL NAME: __________________________________________________________________________________________

   DATE OF BIRTH: ___ __________ SOCIAL SECURITY NUMBER: ________________________________
   (MM/DD/YY)

2) MAILING ADDRESS: __________________________________________________________________________________________

   CITY AND STATE: ____________________________________________ ZIP: ______________________

   ** CURRENT E-MAIL ADDRESS: ________________________________________________________________

3) HOME PHONE (INCLUDING AREA CODE): __________________________________________________________

   WORK PHONE (INCLUDING AREA CODE): _________________________________________________________

   MOBILE PHONE (INCLUDING AREA CODE): _______________________________________________________

4) MARITAL STATUS: SINGLE ___ MARRIED ___ DIVORCED ___ OTHER ______________

5) PERSON TO CONTACT IN EMERGENCY ___________________________________________________________

   PHONE NUMBER (INCLUDING AREA CODE) _______________________________________________________

   RELATIONSHIP TO PATIENT _________________________________________________________________

6) ARE THE SERVICES YOU WISH TO OBTAIN FROM THE DOCTOR ACCIDENT RELATED? YES ___ NO ___
7) ARE YOU EMPLOYED? YES ___ NO ___ IF YES, SPECIFY WHERE:

___________________________________________________________________________

8) IF MARRIED, IS YOUR SPOUSE EMPLOYED? YES ___ NO ___ IF YES, SPECIFY
WHERE?

___________________________________________________________________________

9) **Primary Insurance Information:**

INSURANCE COMPANY NAME

10) **Secondary Insurance Information:**

INSURANCE COMPANY NAME

I understand that in order to have these services properly paid by my insurance company if covered, I am responsible for the accuracy of all the above information. I have answered all of the above truthfully and to the best of my ability and I understand that I am solely responsible for any misrepresentations or errors included herein. If the above information is to change at any time, I will notify this office in writing within ten days. I also understand that the answers to the above questions may have legal implications if I have intentionally supplied false or misleading information. I authorize the release of any medical records required for claim payment. I further assign all benefits payable to Edward Dieguez, Jr., M.D. P.A. Should any insurance company fail to pay these services; I assume full responsibility for any remaining balance due. Please be aware that we do not accept insurance for Acupuncture or Facial Aesthetics or Stem Cell therapy. See our financial policy attached.

PATIENT OR RESPONSIBLE PARTY: _____________________________________________

(Please print)

SIGNATURE: _____________________________________________ DATE: _______________

(Patient’s or Responsible Party’s)
Section 2- Health Questionnaire/New Patient’s Questionnaire

Patient Name: _______________________________ Age: ______

Who referred you to our office: ________________________________

Who is your primary care doctor: ________________________________

(CC) What problem brings you to our office today? ________________________________

_______________________________________________________________________________

HISTORY OF PRESENT ILLNESS (HPI)

Brief description of the pain to include the following:

1) Location: ________________ 2) Duration: ________________

3) Quality: sharp; Y  N  dull; Y  N  aching; Y  N

4) Timing: gradual; Y  N  acute; Y  N  When did it start? ________________________________

5) Modifying factors such as:

Made worse by ________________________________

Relieved by_______________________________

6) Context: such as when it first appeared, associated with etc. ________________________________

_______________________________________________________________________________
7) Severity: Pain score; 0 1 2 3 4 5 6 7 8 9 10

8) Does the pain * Radiates; Y N where to _____________________________

9) Is there: * Numbness; Y N where _________________________________

* Weakness; Y N where____________________________________________

10) How does the pain affect your daily living: ____________________________

___________________________________________________________________

(ROS) DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:
(Please answer yes or no to the following)

* GENERAL: Generalized weakness; Yes___ No___ Weight change: Increased ___ Decreased___

* SKIN: Rashes-Hives: Yes___ No___ Color Change: Yes___ No___

* HEENT: HEAD, EYES, EARS, NOSE AND THROAT

  EYES: Glaucoma: Yes ___ No ___ Cataracts: Yes ___ No ___

  EARS: Ringing in ears: Yes___ No___ Loss of Hearing: Yes___No___

  NOSE: Nose Bleeds: Yes___ No___ Sinus problems: Yes___ No___

  THROAT: Hoarseness: Yes___ No___ Difficulty Swallowing: Yes___ No___

* NECK: Lumps: Yes ___ No ___ Thyroid nodules: Yes ___ No ___

* BREASTS: Lumps: Yes___ No___ Nipple discharge: Yes___ No___ Tenderness: Yes___ No___

* RESPIRATORY SYSTEM: Tuberculosis: Yes___ No___ Asthma: Yes___ No___ Emphysema: Yes___ No___

  Blood when coughing: Yes___ No___ Shortness of Breath: Yes___ No___

* HEART/ARTERIES: Heart attack: Yes___ No___ Chest Pain: Yes___ No___ When: _____ BP: Yes___ No___

  Congestive Heart failure: Yes___ No___ Rheumatic Fever: Yes___No___

  Congenital Heart Disease: Yes___ No___ Heart murmur: Yes___ No___ Artificial Valve: Yes ___ No___

  Clogged arteries: Yes___ No___ Aneurysm: Yes___ No___

  Palpitations: Yes___ No___ Passing out spells: Yes___ No___

* ABDOMEN/ DIGESTIVE SYSTEM:

  Jaundice: Yes___ No___ Bloody Stools: Yes___ No___ Hepatitis: Yes___ No___ Ulcers: Yes___ No___

  Colon Cancer: Yes___ No___ Rectal Cancer: Yes___ No___ Gastric Bypass: Yes___ No___

  Abdominal pain: Yes___ No___ Vomiting: Yes___ No___ Bloody stools: Yes___ No___
**GENITO-URINARY SYSTEM:** Frequent Urination: Yes___ No___ Burning: Yes___ No___ Blood in Urine: Yes___ No___

Kidney Disease: Yes ____ No ____ Urethral Discharge: Yes ____ No ____ Venereal Disease: Yes ____ No ____

Prostate cancer: Yes____ No____ Urinary incontinence: Yes____ No____ Kidney Tumors: Yes___ No____

**BLOOD AND LYMPHATICS:** Anemia: Yes___ No___ Hemophilia: Yes___ No___ Transfusions: Yes ___ No___

HIV: Yes___ No___ Bleeding tendencies: Yes___ No___ Hematomas: Yes___No___

Lymph node enlargements: Yes___ No___

**ENDOCRINE SYSTEM:** Diabetes: Yes___ No___ Thyroid Problem: Yes___No___ Thyroid nodules: Yes___ No___

Goiter: Yes____ No____

**NERVOUS SYSTEM:** Headache: Yes___ No___ Dizziness: Yes____ No___ Strokes: Yes___ No___ Nerve injury: Yes___ No___

Paralysis:Yes___ No___ Tremors: Yes____ No____

**PSYCHIATRIC:** Hx of Depression:Yes___ No____ Suicidal ideation: Yes___ No____

Hx of Anxiety: Yes____ No___ Bipolar: Yes___ No____

**MUSCULOSKELETAL:** Tennis Elbow: Yes___ No___ Golfers elbow: Yes___ No:___ Back surgery: Yes___ No___

Carpal Tunnel: Yes ___ No____

**OTHER:** Radiation Therapy:Yes___ No___ Scarlet Fever:Yes___No___

Mononucleosis:Yes___ No___ Dialysis:Yes___No___

Are you pregnant: Yes___ No___

On hormone replacement: Yes____ No____

Malignant Hyperthermia: Yes____ No____

**ALLERGIES:** Local Anesthesia: Yes___ No___ Penicillin: Yes___ No___

Barbiturates:Yes___ No___ Other Antibiotics: Yes___ No___

Aspirin: Yes___ No___ Codeine: Yes___No___

Latex/Rubber: Yes___ No___ Other Allergies: _________________________________________________
PAST MEDICAL & SURGICAL, FAMILY AND SOCIAL HISTORY (PFSH) PLEASE WRITE ANY NEEDED EXPLANATION:

Past Surgeries (specify type and when)______________________________________________________________

Other medical problems: _________________________________________________________________________

Do you use or ever had one of the following:

Alcohol use: Yes___ No___ If so how much? ______________________________

Smoke: Yes___ No___ How many packs per day? _____ Years smoking? ______

Do you use illegal drugs: Yes___ No___ Which ones?________________________

Do you smoke marijuana: Yes___ No___

Have you ever been hospitalized with a psychiatric condition: Yes____ No____

Have you ever been in prison: Yes____ No____

Living arrangements: Live alone_____ With family_____

Are you presently employed: Yes____ No____ Occupation? ________________________________

Name, address and phone number of family doctor and other doctors that treat you for this problem or other problems at present. _____________________________________________________________

Present medications: (please list all below or add separate paper):

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<th>Name</th>
<th>Dosage and frequency</th>
<th>Purpose</th>
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Medications you have tried before for your condition:____________________________________________________
_____________________________________________________________________________________________________

Are currently involved in or considering a lawsuit in relation to your problem? ______________
______________________________________________________________________________________________

Are you receiving compensation for any medical problem? ________________________________
______________________________________________________________________________________________

Patient’s Signature:________________________________________________ Date:________
Section 3 - Assessment for Patients with Pain

Following are questions given to patients in pain. Please answer each question as honestly as possible. Your treatment will not be determined solely by the answers provided. Thank you.

PATIENT: ____________________________________________
(please print)

Please answer all the questions below by circling the number that most accurately matches your response.
Use the following scale:

0 = Never   1 = Seldom   2 = Sometimes   3 = Often   4 = Very often

1. How often do you feel that your pain is “out of control?”
   0 1 2 3 4

2. How often do you have mood swings?
   0 1 2 3 4

3. How often do you do things that you later regret?
   0 1 2 3 4

4. How often has your family been supportive and encouraging?
   0 1 2 3 4

5. How often have others told you that you have a bad temper?
   0 1 2 3 4

6. Compared to other people, how often have you been in a car accident?
   0 1 2 3 4

7. How often do you smoke a cigarette within an hour after you wake up?
   0 1 2 3 4

8. How often have you felt a need for higher doses of medication to treat your pain?
   0 1 2 3 4

9. How often do you take more medication than you are supposed to?
   0 1 2 3 4

10. How often have any of your family members, including parents and grandparents had a problem with alcohol or drugs?
    0 1 2 3 4

11. How often have any of your close friends had a problem with alcohol or drugs?
    0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem?
   0 1 2 3 4

13. How often have you attended an AA or NA meeting?
   0 1 2 3 4

14. How often have you had a problem getting along with the doctors who prescribe your medicine?
   0 1 2 3 4

15. How often have you taken medication other than the way that it was prescribed?
   0 1 2 3 4

16. How often have you been seen by a psychiatrist or mental health counselor?
   0 1 2 3 4

17. How often have you been treated for an alcohol or drug problem?
   0 1 2 3 4

18. How often has your medication been lost or stolen
   0 1 2 3 4

19. How often have others expressed concern over your use of medication?
   0 1 2 3 4

20. How often have you felt a craving for medication?
   0 1 2 3 4

21. How often has more than one doctor prescribed pain medication for you at the same time?
   0 1 2 3 4

22. How often have you been asked to give a urine screen for substance abuse?
   0 1 2 3 4

23. How often have you used illegal drugs (such as marijuana, cocaine, etc.,) in the past five years?
   0 1 2 3 4

24. How often, in your lifetime, have you had legal problems or been arrested?
   0 1 2 3 4

Please include any additional information you wish about the answers above. Thank you.

____________________________________________________________________________________
____________________________________________________________________________________

PATIENT’S SIGNATURE: __________________________________________________________________ DATE: ___________________
Section 4 - Medical Records Request or Release

I, the undersigned, authorize Edward Dieguez, Jr., M.D. and his staff either to request from, or release to, any and all other entities, such as doctors, hospitals, insurance companies and medical facilities, any and all medical information related to my care. I further authorize Edward Dieguez, Jr., M.D. and his staff to discuss my medical conditions and share information with other physicians or entities that may have participated in my care in the past or that will participate in my care in the future. I also authorize Dr. Dieguez to share the information with me the patient. I understand that some of this information may be transmitted via fax machine [or by any other electronic means].

PATIENT NAME: ____________________________________ DATE OF BIRTH: ____________

(MM/DD/YY)

SOCIAL SECURITY NUMBER: _______________________________________________________

PATIENT SIGNATURE: ____________________________ DATE: ______________________

FOR OFFICE USE ONLY

REQUESTED FROM: __________________________________________________________ DATE: __________

RELEASED TO: ____________________________________________________________ DATE: __________
Section 5 - Our Financial Policy

*ACUPUNCTURE TREATMENTS.* - We do not accept insurance for Acupuncture treatments, unless we are participating providers of your insurance and your particular policy offers coverage for acupuncture. We will verify benefits with your insurance company for you. If that is not the case, payment is then due at time of service. We accept Visa, Master Card, Dinners Club, American Express, Discover card, cash or personal checks that will be processed by Tele-Check. The doctor is willing to make special financial arrangements to accommodate your financial circumstances, so that you can have the treatments. Please inquire about special arrangements to meet your needs. Since at our office services are provided by a medical doctor your initial medical consultation fee most likely will be covered by your insurance policy, at least to some extent. The actual acupuncture treatments will not be covered most of the time.

*FACIAL AESTHETICS AND STEM CELL THERAPY.* - For these services we accept, Visa, Master Card, Dinners Club, American Express, Discover card, cash or personal checks that will be processed by Tele-Check. We can also arrange financing for facial aesthetics through Advance Patient Financing for your convenience.

*INSURANCE PATIENTS* – The percentage of coverage by your insurance company may be based on your insurance company’s own reduced fee schedule for medical services, and may be less than actual charges, resulting in lower coverage for you. However if we are participating preferred providers for your insurance carrier, we are bound to accept their payment as full payment, excluding co-pays, deductible and co-insurance. This situation is outside of our control. Lower coverage and higher deductibles and co-pays are a direct result of the plan selected by you or your employer. Please be advised that we cannot waive co-payments or deductibles. If you have a secondary insurance policy, sometimes they will cover you deductible but not always. Finally, be aware that there are some procedures such as acupuncture and others that are not covered by some insurance because they arbitrarily considered them experimental.

*INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY* – We are not privy to this contract. If we participate with your insurance company, we will inform you and we will handle your claims according to our contract with that company. We file insurance claims as a courtesy to our patients. It is our policy not to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered or non-covered services, or usual and customary allowable charges as per your contract. You are ultimately responsible for timely payment of your account.
*MEDICARE PATIENTS – This office accepts traditional Medicare assignment. Medicare patients are fully responsible for the yearly deductible and 20% co-payment unless your secondary insurance picks that up. Most of the time they do. If not, federal law requires that we collect these amounts. If you have insurance in addition to Medicare, we will submit this for payment. Be aware that Medicare does not cover Acupuncture, facial aesthetics or Stem Cell therapy and some other procedure.

*NO INSURANCE – Other than for Aesthetics procedures or Acupuncture, or Stem Cell Therapy, and Prolotherapy, as the sole form of payment, cash payment is accepted only in very rare occasions. We know that at times patients do not have insurance. If this is the case, the procedure and cost will be discussed prior to making the appointment and rendering the service. At this time a payment plan may be set up. The doctor alone makes the final decision. More importantly, cash payment does not guarantee in no way shape or form a prescription of any kind and it does not guarantee that the doctor will continue to see you after your first consultation. Additionally the fee paid is not refundable.

*MEDICAID – This office accepts traditional Medicaid assignment. We are providers of Medicaid.

*ASSIGNMENT OF INSURANCE BENEFITS - In the event that you are entitled to any benefits of any type whatsoever arising out of a policy insuring you or any other party’s liability to you, you hereby assign said benefits to Edward Dieguez, Jr., M.D. P.A. to be applied towards your bill.

*CHANGES OF INSURANCE COVERAGE – It is your sole responsibility to notify our office of any changes in insurance coverage prior to having any service rendered to you. Failure to do so will automatically make you responsible of all charges. These charges will become due and payable immediately.

*I REALIZE ALL PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE – Failure to keep my account current may result in the doctor not being able to provide additional services. In the case of default on payment of my account, I agree to pay and additional 33% for collection costs, in addition to court costs, and reasonable attorney fees incurred while attempting to collect my account balance or any future outstanding account balances.

SIGNATURE OF RESPONSIBLE PARTY: _________________________________________________

NAME OF RESPONSIBLE PARTY: ___________________________________________________

PATIENT NAME: ______________________________________ DATE: ____________________

(Please print)
Section 6 – Signature on File Document

PATIENT: ____________________________________________________________
(Please print)

HIC#: (Medicare Number) ____________________________________________

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Edward Dieguez, Jr., M.D. for services rendered. I authorize any holder of medical information about me to release to Medicare or other insurance and it’s agents any information needed to determine benefits for related services.

SIGNATURE: ___________________________ DATE: ________________
Section 7 - Prescription Refill Policy

Due to the nature of a medical practice, there may be, on a daily basis, a high volume of requests for refills. Each request requires a comprehensive chart review by a physician, and review of the Florida Prescription Drug Monitoring Program (PDMP) database as indicated. Therefore each patient is asked to adhere to the following protocol:

1. Ten (10)-business days (excluding weekends) prior to needing a refill, call our office at (904) 827-1455. If it is for a controlled substance prescription, you will need to see the doctor before the prescription is issued or refilled.

2. For all prescriptions that can be called to your pharmacy, or prescribed electronically, please check with that pharmacy 2 business days after you have called our office. For all prescriptions that must be written, they will be issue only during a routine office visit. Call our office to make an appointment.

3. Refill messages received after 1:00 pm will be handled on the following business day.

With your cooperation, we will be able to better serve you and all of our patients. Thank you.

I fully understand, acknowledge and agree to abide by the above medication refill policy:

PATIENT’S NAME: ________________________________________________________________
(Please print)

SIGNATURE: ________________________________________________________________ DATE: __________
Edward Dieguez Jr., MD
120 Health Park Blvd.
Reuben J. Plant Building Ste. 4
Flagler Hospital Campus,
Saint Augustine, Florida 32086
Phone: (904) 827-1455  Fax (904) 827-1407
E-mail: info@WellnessAndRegenerativeMD.com
www.WellnessAndAesthetics.com

Section 8 - Pain Distribution Drawing

PATIENT: ___________________________ DATE: ___________________________
(Please print)

On the drawing below, please shade the area where you feel pain
Section 9 - Authorization to Release Medical Information to Patient’s Family or Friends

PATIENT NAME: ____________________________________________________________

(Please print)

I hereby give my consent to Edward Dieguez, Jr., M.D. and his staff to discuss my medical condition—including, but not limited to, laboratory/radiology reports, procedures, treatment plans and medication regimen—with the individual (family or friend) listed below. I understand that this consent will remain in effect until or unless I provide further written notice.

NAME: ________________________________________________________________

RELATIONSHIP: ________________________________________________________

ADDRESS: ____________________________________________________________

PHONE: ________________________________

PATIENT’ SIGNATURE: _____________________________ DATE: __________

WITNESS: ___________________________ SIGNATURE: ___________________________
Section 10 – Acknowledgment

I am aware that all of the information I have provided on this Prospective Patient Information packet (Sections 1 – 10), including the foregoing authorizations for release of information about myself, will be utilized by Dr. Dieguez and staff to do a preliminary evaluation of my case and see if, at his sole discretion, he feels he can be of service to me or not. Additionally this information will expedite my appointment at the moment of arrival at the office avoiding long wait time.

I have provided to the best of my knowledge, truthful information in the foregoing questions and release forms. After a prompt review of the above information by Dr. Dieguez, I will be contacted by Dr. Dieguez office regarding an appointment.

PATIENT NAME: __________________________________________________________________________

PATIENT SIGNATURE: ____________________________ DATE: ______________