INSTITUTE FOR RHEUMATOLOGY & INTEGRATIVE MEDICINE
160 S FLAMINGO ROAD, PEMBROKE PINES FL 33027
www.GoIRIM.com PHONE 954.620.0011 FAX 954.620.0238

PATIENT COVID-19 ACKNOWLEDGMENT

1. Have you or anyone in your household in the last 10 days had any of the following NEW symptoms listed that is not due to another health problem?
Sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?
_____ YES or _____ NO

2. Have you or anyone in your household been tested for COVID-19 in the last 10 days?
_____ YES or _____ NO

What was the result of COVID-19 test?
_____ POSITIVE _____ NEGATIVE _____Still waiting for results

3. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 15 days?
_____ YES or _____ NO

4. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?
_____ YES or _____ NO

5. In the last 2 weeks have you been in close contact (within 6 feet for longer than 15 minutes) to any individual who tested positive for COVID-19?
_____ YES or _____ NO

6. Have you had the Covid Vaccine? _____ YES or _____ NO

If yes, how many doses have you received?
____ 1 dose or _____ 2 doses

Thank you for your honesty and keeping our physicians and staff safe!

PRINT Patient name: _____

Date of service: _____

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WELCOME TO OUR OFFICE

Please complete this form legibly. If you need assistance, please feel free to ask. We are happy to help you.

Date: _____

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please check box for which phone number will be your best contact:

☐Home: _____ ☐Cell: _____ ☐Work: _____

Sex: ☐ M ☐ F Date of Birth: _____ Social Security # (Not Required): _____

Marital Status (check box): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race (check box): ☐ Asian ☐ African American or Black ☐ Native American or Native Alaskan ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Ethnic Group (check box): ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Pharmacy phone and address: _____

Primary Name on Insurance: _____ or ☐ Self

If not self, Relationship to Patient: _____ Date of Birth: _____

Occupation/Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Primary Language Spoken: _____

Primary Care Provider (PCP): _____ Phone: _____ Fax: _____

PCP Mailing Address: _____

Please give your insurance card and Photo ID card(s) to the receptionist so we may make a copy. Thank You!

CONSENT FOR TREATMENT

I, hereby authorize **Institute for Rheumatology & Integrative Medicine (IRIM),** DBA: as: Alex M. Lam, M.D., P.A., to examine and treat me as a patient. I also authorize such treatment and procedures, as deemed necessary by the physician, including but not limited to, medications, blood samples, urine samples and other therapies. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment. I hereby certify that I understand the above authorization.

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Patient / Guardian Name Relation to Patient

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OFFICE PHILOSOPHY/ FINANCIAL POLICIES / MISSED APPOINTMENTS / REFERRAL POLICIES

OFFICE PHILOSOPHY

We would like to take this opportunity to inform you that we will spend as much time as necessary with you to fully address your medical problems. This enables us to explain our suggestions and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly and we try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassured that we value your time. However, given the unpredictable nature of our work, it is not uncommon to have a prolonged waiting period. On many occasions, we are delayed for such matters as patients' medical problems that require immediate attention, hospital calls, physician calls, and/or emergencies. These issues are unforeseen and need to be addressed appropriately. We do not leave this office until all patients are seen and all their medical problems are addressed.

We encourage your comments and suggestions. Thank you.

_____ _____
Initials Date

FINANCIAL POLICIES

We will be sure to discuss our fees prior to the beginning of your treatment. Payment of fees for services rendered is expected at the time services are provided. We file insurance as a courtesy to our patients. However, we do require co-payments to be paid at the time of service. We accept cash, checks, and most major credit cards (Visa, MasterCard, Discover, and AMEX). **Returned checks are subject to a $35 fee.**

I acknowledge and understand the above-stated Policy

_____ _____
Initials Date

MISSED/CANCELED APPOINTMENTS

Since our profession is based on an appointment schedule, we ask that you show consideration by calling well in advance if you are unable to keep an appointment. We would like to offer that appointment to another patient in need of seeing the physician. This notice is to inform you that if you fail to give our office a 24-hour notice of cancellation, there will be a **cancellation fee of $25.00 for each missed appointment** billed to your account that cannot be filled by your insurance. This fee will be asked for payment at the following appointment.
Please be advised repeated checks of your health are required due to the possibility of an adverse outcome. Failure to keep appointments poses risks to our ability to properly treat you and may jeopardize your health.

I acknowledge and understand the above-stated Policy

_____ _____
Initials Date

REFERRAL POLICIES

Unfortunately, our office is unable to actively monitor each patient's referral status. **Patients are responsible for obtaining their referrals from their Primary / Family physician prior to each visit.** Please keep in mind that most offices require a 7-day notice prior to your appointment. If you do not have a referral for your visit, your appointment will be rescheduled. Please make sure to contact our office prior to your appointment to ensure a correctly coded and dated referral has been received. Most plans will require a new referral for each visit.

I acknowledge and understand the above-stated Policy

_____ _____
Initials Date

If your insurance does not require a referral for office visit, please initial to verify that you are informed of policy in the event your insurance changes. Thank you.

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ASSIGNMENT OF BENEFITS / MEDICARE AUTHORIZATION

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to **Institute for Rheumatology & Integrative Medicine (IRIM),** DBA: as: Alex M. Lam, M.D., P.A, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I am responsible for any fees or legal fees that Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A., incur for the full collection of payments.

_____ _____
Patient/Guardian Signature Date

_____
Patient/Guardian Printed Name

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to **Institute for Rheumatology & Integrative Medicine (IRIM)**, DBA: as: Alex M. Lam, M.D., P.A., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

If you do not currently have a Medicare insurance or Medicare plan, please initial to verify that you are informed of policy in the event your insurance changes. Thank you.

_____ _____
Patient/Guardian Signature Date

_____
Patient/Guardian Printed Name

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H.I.P.A.A. Disclosure of Patients Protected Health Information

Patient Name: _____ **Date of birth:** _____

If you would like us to waive your protected rights and provide messages, information, or results to a spouse, significant other, or family member, please indicate below. We will be unable to assist any person(s) who are not listed on this form. **A valid photo ID will be required when picking up in items in office.
Please be sure to update this information as needed, for phone number changes or changes in preferences.

My protected health information may be shared with the following persons:

1. **Name:** **Relationship:**

We are able to discuss:	We are able to release for pick up:
Appointment Information: ☐Yes ☐No	Medical Records ☐Yes ☐No
Billing Information: ☐Yes ☐No	Prescriptions / Sample Medications: ☐Yes ☐No
Medical Information: ☐Yes ☐No	Prescribed Orders: ☐Yes ☐No

2. **Name:** **Relationship:**

We are able to discuss:	We are able to release for pick up:
Appointment Information: ☐Yes ☐No	Medical Records ☐Yes ☐No
Billing Information: ☐Yes ☐No	Prescriptions / Sample Medications: ☐Yes ☐No
Medical Information: ☐Yes ☐No	Prescribed Orders: ☐Yes ☐No

3. **Name:** **Relationship:**

We are able to discuss:	We are able to release for pick up:
Appointment Information: ☐Yes ☐No	Medical Records ☐Yes ☐No
Billing Information: ☐Yes ☐No	Prescriptions / Sample Medications: ☐Yes ☐No
Medical Information: ☐Yes ☐No	Prescribed Orders: ☐Yes ☐No

4. **Name:** **Relationship:**

We are able to discuss:	We are able to release for pick up:
Appointment Information: ☐Yes ☐No	Medical Records ☐Yes ☐No
Billing Information: ☐Yes ☐No	Prescriptions / Sample Medications: ☐Yes ☐No
Medical Information: ☐Yes ☐No	Prescribed Orders: ☐Yes ☐No

5. **Name:** **Relationship:**

We are able to discuss:	We are able to release for pick up:
Appointment Information: ☐Yes ☐No	Medical Records ☐Yes ☐No
Billing Information: ☐Yes ☐No	Prescriptions / Sample Medications: ☐Yes ☐No
Medical Information: ☐Yes ☐No	Prescribed Orders: ☐Yes ☐No

6. **Name:** **Relationship:**

We are able to discuss:	We are able to release for pick up:
Appointment Information: ☐Yes ☐No	Medical Records ☐Yes ☐No
Billing Information: ☐Yes ☐No	Prescriptions / Sample Medications: ☐Yes ☐No
Medical Information: ☐Yes ☐No	Prescribed Orders: ☐Yes ☐No

I verify that I am giving consent to the following individuals to have access to my protected health based on my checked preferences. I am aware that if an individual is not listed on this form, then no information will be provided.

_____ _____

Patient/Guardian Signature Date

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Health Insurance Portability and Accountability (H.I.P.A.A.)
Patient Consent to the Use and Disclosure of Health Information **for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, **Institute for Rheumatology & Integrative Medicine (IRIM),** DBA: as: Alex M. Lam, M.D., P.A.**,** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and will be provided with a *Notice of Information Practices,* (please ask for copy at reception) that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A.**,** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A., reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A.**,** change their notice, they will send a copy of any revised notice to the address I've provided.

Please explain here any wishes to have the following restrictions to the use or disclosure of your health information (for example, not to share information with referring provider or family physician):

_____

_____

I fully understand and accept / decline the terms of this consent.

_____ _____
Patient Name Date

_____
Signature of Patient/Guardian

_____ _____
If Guardian, Guardian Name (Please Print) Relation to Patient

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Patient Health Summary
In order to treat you properly, it is important to answer completely to each question listed below. If a question does not apply, please respond with N/A (not applicable).

PRINT PATIENT NAME: _____

ALLERGIES ☐ **No known allergies**

Please list any allergies that you have. This includes medications, foods, and environmental items. Please also list the reaction to these allergies.

ALLERGIES	REACTION

CURRENT MEDICATIONS/ VITAMINS/ SUPPLEMENTS ☐ **Not currently taking anything**

Name of medication	Dosage	How often do you take?

PAST MEDICAL HISTORY

SURGICAL HISTORY

When?	Why? What was the problem? Part of the body?	What hospital / clinic was the surgery performed at?

FAMILY HISTORY

Please list all Relevant History, Include Grandparents, Parents, Siblings and Children.

Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings	Children

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Patient Health Summary
In order to treat you properly, it is important to answer completely to each question listed below. If a question does not apply, please respond with N/A (not applicable).

PRINT PATIENT NAME: _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐Single ☐Separated ☐Divorced ☐Widowed

Do you have any children? If yes, how many? _____

Do you currently exercise? If so, how many times per week? _____

Do you currently drink coffee, energy drinks, caffeinated beverages?
If so, how many / how often? _____

TOBACCO HISTORY

☐Non-smoker

Smoking Status (please check)	How many times a day? How often per week?	Cigar / Cigarettes / Vaporizer / Recreational
☐ Current Smoker		
☐ Past Smoker		
☐ Social Smoker		

If past smoker, what year or how long has it been since quitting? _____

Are there any additional street / recreational drugs you are currently using? If so, name of drug and how often? _____

ALCOHOL HISTORY

☐Non-drinker

Consummation of alcohol (please check)	How many times a day? How often per week?	Wine / Beer / Liquor
☐ Current drinker		
☐ Past drinker		
☐ Social drinker		

If past history of consuming alcohol, what year or how long has it been since quitting?
_____

PHARMACY INFORMATION

Please provide us with your pharmacy information so that we may be able to electronically prescribe to your pharmacy.
Pharmacy Name: _____ Address: _____ Phone: _____

PATIENT PORTAL

Please provide us with your e-mail address so that we may grant you access to your health information through our Patient Portal. Access to our Patient portal provides you with access to your records, direct messaging services, cancel/confirm appointments, and sending refill requests.

E-Mail address _____ @ _____

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Patient Insurance Summary

Please fill in all fields in order to properly bill your insurance

Please use insurance card to fill out form, please answer all questions.

Patient Name on insurance card:

_____

Any other names for patient (Ex: Legal name / Maiden name / Married name):

_____

Patient date of birth:

_____

Name of insurance:

_____

Name of plan (if unknown, please leave blank):

_____

Type of plan:
☐HMO ☐POS ☐PPO ☐Medicare Advantage ☐Medicaid

Patient Member ID# or Policy #

_____

Group ID#

_____

Primary Card Holder on insurance: ☐SELF ☐SPOUSE ☐CHILD

If you are not the primary card holder, please answer:

Name of Primary Card Holder:

_____

Date of birth of Primary Card Holder:

_____

Address of Primary Card Holder ☐Address is same as patient

_____

_____

Please give insurance card to Check-in desk to make copy of card.

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Informed Consent to Telehealth Services and IRIM Policies

This form describes IRIM's Telehealth treatment and payment policies and includes:

- **Your consent to receive medical treatment from IRIM (and your other rights and responsibilities).**
- **Your agreement to receive services using telehealth technology; and**
- **Your agreement to pay in full any charges that are your responsibility.**

By signing my name "I agree to Terms of Use" for IRIM Telehealth practices. I understand and agree that I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of telehealth services as described below and wish to receive such services, and (ii) I agree to the remaining terms of this Consent, including the terms of the IRIM Privacy Notice described below.

If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

1. By participating in IRIM telehealth, I agree to receive telehealth services. Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my IRIM provider and I will be able to see and speak with each other from remote locations.
2. I understand and agree that:
   - I will not be in the same location or room as my medical provider.
   - My IRIM provider is licensed in the state in which I am receiving services.
   - Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my IRIM provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced

exposure to patients, medical staff and other individuals at a physical location.

- Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold IRIM responsible for lost information due to technological failures.
- I further understand that my IRIM Provider's advice, recommendations, and or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my IRIM provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
- I may discuss these risks and benefits with my IRIM provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to present or future treatment by IRIM.
- I understand that the level of care provided by my IRIM provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest IRIM medical center, hospital emergency department or other appropriate health care provider.
- I have the right to receive face-to-face medical services at any time by traveling to the IRIM medical office.
- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.

3. I consent to, understand, and agree that:

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- I have the right to discuss the risks and benefits of all procedures and courses of treatment proposed by my health care provider(s), together with any available alternatives.
- IRIM will provide care consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.
- Before prescribing any controlled substance to me, IRIM may review information from the Prescription Drug Monitoring Program in my state of residence regarding my prior receipt of controlled substances.
- I have the right to review and receive copies of my medical records, including all information obtained during a telehealth interaction, subject to IRIM's standard policies regarding request and receipt of medical records and applicable law. There is a medical record charge of $1.00 per page up to 25 pages, each additional page will be $0.25 thereafter.
- The laws of the state in which I am located will apply to my receipt of telehealth services.

IRIM Notice of Privacy Practices ("Privacy Notice")

IRIM will protect the privacy of my health information and will not use or disclose it except as permitted by law. IRIM's privacy policies are more fully described in the Privacy Notice, which is available for review and download here: http://goirim.com/appointment-information-forms/. By signing this Consent, I acknowledge receipt of the Privacy Notice and consent to IRIM's use and disclosure of my health information in accordance with its terms. I understand that all existing confidentiality protections that apply to in-person treatment apply to telehealth services.

Payment Policy

I acknowledge, understand, and agree that:

1. It is my responsibility to determine whether IRIM's services are covered by my insurer. I will pay the cost of any service that is not covered by my health plan for any reason or are covered but applied to a deductible.

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2. I will pay at time of service any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts.
3. I assign to IRIM all health care benefits to which I am entitled under any insurance policy or benefit plan and authorize payment of benefits directly to IRIM.
4. If I have health care benefits, IRIM will submit a claim to my insurer and allow 60 days for a response. If my insurer does not respond within 60 days, IRIM will assume that the visit is not covered and will, to the extent permitted by law, bill me for the visit charges.
5. By providing my credit card information and receiving telehealth services, I (i) authorize IRIM to charge my credit card for any and all unpaid amounts that IRIM or my insurer determines are my responsibility, and (ii) agree to pay all amounts charged pursuant to this consent and authorization in accordance with the issuing bank cardholder agreement. I agree that IRIM may charge my credit card for such amounts at the end of my telehealth visit or later.
6. I will be billed for all unpaid balances deemed by IRIM or my insurer to be my responsibility and agree to pay such amounts in full. IRIM will charge a $35 fee for returned checks. Delinquent accounts may be turned over to a collection agency at which time I am responsible for all collection's charges and all associated legal fees in addition to the amount owed.
7. IRIM reserves the right to deny non-emergency services if my account is delinquent.

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I understand that I may access and print a copy of this Consent here:
http://goirim.com/appointment-information-forms/

☐ I am approving consent for telehealth

Patient Name : _____

Patient Signature : _____

Date : _____

To deny Telehealth services, please contact our office directly and we will make notation that you have denied services.