7000 Spyglass Court, Suite 300
Viera, FL 32940
321-752-7555, Fax 321-757-9988

Welcome to McKee Family Practice! I am excited that you have chosen me as your primary care physician.

As a board-certified family physician, I offer a broad range of services for patients ages 6 and up. This includes physicals, well woman care (including pap smears) and dermatologic care such as mole removals and skin biopsies. I also offer same day appointments for acute illnesses.

McKee Family Practice uses electronic medical records (EMR), which means your records are computerized and no longer on paper. We also have an online patient portal which provides you with secure access to your lab results, medication lists, and parts of your medical records, as well as electronic communication with the practice for questions and prescription refills. The EMR makes us very environmentally friendly as well as efficient when communicating with specialists.

Office hours for McKee Family Practice are 8:00am to 5:00 pm Monday through Thursday and 8:00am to noon on Friday. After hours calls are forwarded to the answering service.

As a family business, McKee Family Practice strives to put the patient first and make you feel at home. We understand that your health is important to you and it is of utmost importance to us. Our goal is to care for you and make you feel comfortable at the same time. *You are not just a number here.*

Included in this packet are the following necessary forms: Notice of Privacy (HIPAA), Consent to Treat, Financial Policy, Demographics, Medical History, Release of Information (to request records from your previous provider), and a permission form for discussing your care with family members or others of your choice (optional). If you have any questions about these forms, please call the office.

Welcome! We look forward to being your “medical home”.

Sincerely,

Kimberly D. McKee MD

McKee Family Practice Notice of Privacy Practices for Protected Health Information

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to adequate notice of the uses and disclosure of your protected health information (information that discloses your identity or leads to disclosure of your identity) that may be made by McKee Family Practice.

Typical uses and disclosures of medical information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. Outside of our office, we restrict the disclosure to those people, entities, and agencies for whom you authorize disclosure such as other healthcare providers, insurance companies, billing agencies, hospitals, and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- when required by law
- public health activities (death, child abuse, neglect, domestic violence, reactions to medications, disease/infection exposure)
- health oversight activities (audit, investigations, inspections)
- judicial and administrative proceedings (court order)
- appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- decreased person information to coroners, medical examiners, funeral directors
- organ and tissue donation
- research, provided authorization is IRB approved or privacy board approved
- emergencies or to avert serious threat to health or safety
- specialized government functions (military, inmates)
- worker's compensation

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the *Notice of Privacy Practices* and an opportunity to review and understand it.

You (the patient) have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your records. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last 6 years, starting February 2, 2009. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions to the amount of medical information we disclose; you may revoke or restrict consent.
- Request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to John Dionne, privacy officer of MFP, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests.
- Receive a copy of this notice by printing it from our website or with a written request directed to this office. A copy of this notice will be given with all new patient packets as well.

McKee Family Practice responsibilities under HIPAA:

- We are required by law to maintain the privacy of your personal health information and to provide you notice of our legal duties and privacy practice and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of that change. Copies will be available after the changes are made.

You can complain about our privacy policy or its execution, either verbally or in writing, to our Privacy Officer: John Dionne, McKee Family Practice, 7000 Spyglass Court, Suite 300, Viera FL 32940. Phone 321-752-7555.

If you feel you have not achieved resolution, you may contact this office or the Secretary of Health and Human Services of the United States Government in writing.

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES:** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician._____***(Initials)***
2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:** In consideration of services rendered, I hereby transfer and assign to McKee Family Practice all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. _____***(Initials)***
3. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts it terms. _____***(Initials)***
4. **MEDICARE/MEDICAID:** Patient's certification authorization to release information and payment request. I certify that the information given to me I applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Securtiy Administration/ Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me._____***(Initials)***
5. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic._____ ***(Initials)***
6. I understand that certain insurance claims may be filed as COURTESY. However, if the claim is denied for any reason, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay any DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PAYOR WITH A REASONABLE PERIOD OF TIME NOT TO EXCEED 30 DAYS._____***(Initials)***

Patient's signature_____**Date**_____

Subscriber's signature (if different than patient) _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I HAVE RECEIVED ON THIS, OR A PRIOR OCCASION, the McKee Family Practice Notice of Privacy Practice and acknowledge that I have a copy of the notice or that I requested and was given a copy.

Received copy this date: **YES / NO** Previously received copy: **YES / NO**

Patient_____ Witness_____

- ☐ Patient unable to acknowledge receipt of the Notice of Privacy
- ☐ Patient refused to sign acknowledgement

McKee Family Practice Financial Policy

Thank you for choosing Dr. McKee as your primary care physician! Dr. McKee and staff are committed to your well-being and look forward to helping you be as healthy as possible. Please understand that in order for the practice to remain viable, we require prompt payment of services. The following is our financial policy for you to read and sign prior to treatment:

*Copayment is due at the time of service.

*We accept cash, checks, Visa and Mastercard. Checks are processed electronically and the amount is debited from your account immediately.

*We ask that you call 24 hours in advance of cancellation of your appointment. If you miss your appointment and do not give adequate notice, you may be charged a $25 fee.

*If we participate with your insurance, we will file the insurance for you. If we do not participate with your insurance, payment will be expected at the time of service. We will give you a billing summary sheet that you can file with your insurance. Balances from your insurance company not paid after 45 days will be transferred to you.

*Balances for services due will be sent to you. If you fail to pay in a timely fashion, you may be charged a processing fee of $25. This fee may be assessed for every billing period you fail to pay your balance. If your account needs to be sent to collections, you will be responsible for expenses incurred in the collection of your account.

*Please note that some labs or tests may be recommended by your physician but coverage by your insurance company is independent of McKee Family Practice. Coverage of tests/labs is up to your insurance policy. Your insurance policy is a contract between you and your insurance company; McKee Family Practice is not a party to that contract. This means that McKee Family Practice will not always know what is covered *per your insurance policy*. It is recommended that you call your insurance company to verify benefits prior to blood work or any testing.

Signature of responsible party_____Date_____

Printed name_____

PATIENT DEMOGRAPHICS FORM

PATIENT INFORMATION: **Date**_____

Last name_____First name_____MI_____

Address_____

City/State/Zip_____

Soc. Security Number_____ Date of birth_____

Contact info: Home #_____Work #_____

Cell #_____Email address_____

Employer_____Address_____
Please circle one: Single / Married / Divorced

If patient is less than 18 years old, please complete the following information:

Mother's	**Father's**
Name:	Name:
Birthdate:	Birthdate:
Address (if different):	Address (if different):
Home phone:	Home phone:
Work phone:	Work phone:
Cell phone:	Cell phone:
Soc. Security Number:	Soc. Security Number:

Party responsible for payment: Self/ Spouse/ Parent/Guardian

Contact information for party responsible for payment if different than above:

Last name_____First name_____MI_____

Address_____

City/ State/ Zip_____

Social security number_____Phone number_____

INSURANCE INFORMATION:

Primary insurance company_____Phone #_____

Secondary insurance company_____Phone #_____

New Patient Medical History Sheet

Date _____ **Name** _____

Please list any current or past medical problems: *(diabetes, high blood pressure, kidney stones, etc.)*	***Please list any surgeries you have had:***
	Please list any allergies you have:

Please list any meds you take regularly including strength and dosing: *(I.e. atenolol 50 mg one pill twice daily)*

Do any blood-related relatives have any of the following? *(please check if yes, indicate maternal or paternal)*

Yes	Disease	Who (plus ***what type*** for cancers)
	Heart attacks	
	High blood pressure	
	Stroke	
	Diabetes	
	Thyroid problems	
	High cholesterol	
	Depression	
	Cancer	

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REVIEW OF SYSTEMS: Have you ***recently*** had any of these problems? (please check if yes)

General:
- ❑ weight gain/ loss
- ❑ loss of appetite
- ❑ fatigue/ weakness
- ❑ fevers/ chills/ sweats
- ❑ insomnia

Eyes:
- ❑ pain
- ❑ itching/ irritation
- ❑ vision changes/ loss
- ❑ light hurting eyes

ENT:
- ❑ runny nose/ nasal congestion
- ❑ hearing problems
- ❑ ringing in the ears
- ❑ ear pain/ discharge
- ❑ sore throat
- ❑ hoarseness
- ❑ nosebleeds

Cardiovascular:
- ❑ ankle swelling
- ❑ chest pain
- ❑ palpitations
- ❑ short of breath with exertion
- ❑ short of breath with lying down

Gastrointestinal:
- ❑ heartburn/ gas/ indigestion
- ❑ constipation
- ❑ diarrhea
- ❑ nausea/ vomiting
- ❑ abdominal pain
- ❑ blood in stools

Respiratory:
- ❑ wheezing
- ❑ cough
- ❑ shortness of breath at rest

Musculoskeletal:
- ❑ low back pain/ sciatica
- ❑ joint pain/ swelling
- ❑ muscle cramps/ weakness
- ❑ stiffness
- ❑ restless legs
- ❑ leg pain at night/ with exertion

Allergy:
- ❑ hives/ allergic rash
- ❑ hay fever
- ❑ recurrent infections

Dermatology:
- ❑ skin cancers
- ❑ pre-cancerous skin lesions
- ❑ itchy/ dry skin
- ❑ seborrheic keratosis
- ❑ suspicious lesions

Neurology:
- ❑ headaches
- ❑ dizziness/ vertigo
- ❑ difficulty walking
- ❑ frequent falls
- ❑ numbness/ tingling
- ❑ tremors
- ❑ paralysis
- ❑ seizures

Psychiatry:
- ❑ depression
- ❑ anxiety
- ❑ memory loss
- ❑ suicidal thoughts
- ❑ hallucinations
- ❑ paranoia
- ❑ phobias
- ❑ confusion

Endocrinology:
- ❑ heat/ cold intolerance
- ❑ excessive hunger
- ❑ excessive thirst
- ❑ excessive urination

Hematology:
- ❑ abnormal bruising
- ❑ bleeding problems
- ❑ enlarged lymph nodes

Genitourinary:
- ❑ incontinence
- ❑ decreased libido
- ❑ vaginal discharge
- ❑ urinary burning/ frequency
- ❑ urinary urgency
- ❑ blood in the urine
- ❑ changes in your period
- ❑ pelvic pain
- ❑ sores in the genitals
- ❑ erection problems

❑ *NONE OF THE ABOVE*

SOCIAL HISTORY

Do you?: (please circle)

❖ Smoke? **Yes / No**
If yes, _____packs per day

❖ Drink alcohol? **Yes / No**
If yes, how much and often?

_____

❖ Have a history of alcoholism? **Yes / No**

❖ Use recreational drugs? **Yes / No**

I am: (please circle)

❖ Single / married / partnered/ divorced/ widowed

❖ A parent: **Yes / No**
If yes, how many children?

❖ Sexually active **Yes / No**

What is your profession?
(If retired, please note this then list what you did before retiring)

HEALTH MAINTENANCE

Last tetanus shot_____
(recommended every 10 years)

Last pneumonia shot_____
(once at age 65 or earlier with certain medical problems)

Last colonoscopy_____
(every 10 years starting at age 50)

Do you exercise regularly?
Yes / No
If yes, how often?

MALE

Self-testicular exam: **Yes / No**

Last rectal exam_____
(starting at age 40)

Last PSA_____
(starting at age 50)

FEMALE

Last pap smear_____

Self breast exam: **Yes / No**

Last mammogram_____
(starting at age 40, baseline age 35-39)

Last bone density test_____
(starting at age 65)

McKEE FAMILY PRACTICE

Authorization to release medical information

Patient Name_____

I hereby authorize: _____
Facility/Practitioner's Name

_____
Street Address

_____
City, State, Zip

_____
Fax Number

To release information **TO**:

McKee Family Practice
7000 Spyglass Court, Suite 300
Viera, FL 32940
Fax: 321-757-9988
Phone: 321-752-7555

Information to be released: COMPLETE RECORD___**YES/NO**____OTHER_____

Covering the period of treatment: FROM (date)_____TO___**PRESENT/OTHER:**_____
I authorize release of *protected mental health information, infectious disease information including HIV treatment if applicable, and information about drug/alcohol abuse as discussed under Florida Statutes 394.459, 397.053, 396.112, and 381.609* (please circle one): **YES/NO**

Purpose of disclosure: _____

_____

THIS CONSENT WILL BE VALID FOR 90 DAYS AND MAY BE REVOKED BY THE SIGNER AT ANY TIME EXCEPT WHEN ACTION HAS ALREADY BEEN TAKEN

SIGNATURE OF PATIENT_____

DOB_____SS#_____

DATE_____

If additional consent is necessary from a person authorized to give consent other than the patient:

SIGNATURE OF PATIENT'S REPRESENTATIVE_____

RELATIONSHIP TO PATIENT_____DATE_____

WITNESS_____DATE_____

Permission to Discuss Treatment

I, _____, give my permission to the staff at McKee Family Practice to release any medical information pertaining to my treatment and care to any of the following individual/s:

Name	Relationship to the patient	Phone Number
_____		
_____		
_____		
_____		
_____		

Signature of Patient:_____

Date:_____

Signature of Patient's guardian or representative: _____
(if needed)

Date:_____