



www.familydoctor.care

Dr. Theresa K. Goebel D.O., P.A.

11786 SE Federal Highway, Hobe Sound Fl. 33455 PH: 772-546-4215 FX: 772-546-8741

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent/Spouse Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Ethnicity:  non Hispanic  Hispanic  Other

Preferred Method of Contact:  Email  Home Phone  Cell Phone  Work Phone

May we text your cell phone or Email you with important information such as appointment dates reminders YES / NO

**Consent for Treatment**

I voluntarily consent to the rendering of medical care by Dr. Theresa K Goebel D.O. and or Kathryn Christenson DNP-C. I understand I am under the care and supervision of my attending physician. It is the responsibility of the staff to carry out the instructions of my physician.

Initials \_\_\_\_\_

**Statement of Financial Responsibility**

I authorize this office to file any participating insurance forms on my behalf and release any medical information necessary to process this claim. I guarantee payment of any and all bills which are not covered by the insurance. Should my account be referred to any agency or attorney for collection, I will be responsible for all attorney, collection, and court fees.

Initials \_\_\_\_\_





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### PRESCRIPTION ORDERS

Due to recent circumstances beyond our control, our office will no longer be refilling prescription orders over the phone or even via fax. All prescription shall be filled electronically through use of the internet.

**Dr. Goebel and Kathryn Christenson will not simply "Call In" a prescription for a new illness without being seen as a patient. This policy includes family and friends.**

An "Office Visit" will be required for review of your medication.

Please remember to discuss the current status of your medications with the attending provider today.

**Please think ahead if you are planning on leaving town for an extended period of time. Many of our patients are on multiple medicines and occasionally we have not seen you within the last year.**

We have implemented this new policy for your protection as well as ours.

We would be happy to discuss this matter today when we see you.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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**Dr. Goebel Office Policies and Procedures**

January 2017

**Appointments:** Please give us 24-hour notice for all cancellations. Missed appointments are subject to a charge of \$50.00 since a broken appointment may keep someone else from receiving treatment.

**Phone Calls:** Every effort is made to return your call quickly, however the doctor will address all non-urgent calls at the end of that business day.

**Prescription Refills:** In an effort to decrease the number of telephone requests for prescriptions, it is our policy that you bring ALL of your medications with you to each visit. Prescription refill requests should be made during normal business *you should always allow 48-72 Hours for prescriptions orders to be filled.*

*Dr. Goebel will not simply "call in" or fill prescriptions over the phone or on weekends for patients suffering from a new complaint or issue. This policy includes all Family and Friends of Dr. Goebel.*

**Referral Services:** We encourage you to be aware of your insurance policy. If you have an HMO that requires written referrals, we remind you that ALL non-emergent referrals take 5-7 business days to process. We will not authorize any referral without previous evaluation for this complaint. Please do not call and request "phone referrals". So If You need a referral unfortunately we must see you as a patient.

**Payment Policy:** Payment is expected at the time of your visit, however we may, or may not, when applicable, we will file Health insurance, Worker's Compensation and accident-related claims. Any co-payments and/or amounts not covered are due at the time services are rendered. There is a \$35 Non-sufficient funds charge for all returned checks. Patients are responsible for services provided which are denied by you carrier for Workers Comp, auto accidents or other health issues.

**Basic Labs and X-ray Results Policy:** We call our patients regarding every "basic" Lab or x-ray result. If you have not heard from us 10 business days after your Labs or x-ray, please call us.

**Labs, Testing and all Other Imaging (Ultra Sound / CT / MRI / Pet Scan) Policy:**

All specialty labs and Imaging will require a follow up visit to our office to review your results. Please allow two (2) weeks or sooner depending upon your circumstances or results.

**Patient Records Request:**

Patients who are requesting copies of their medical record should have the requesting Physician or facility to fax over a copy of the signed request/ release form and our office will provide the requesting facility copies either electronic or on paper within 30 Days at no charge. Patients who are requesting their medical records may do so, Dr. Goebel office may charge a fee of \$1.00 per page and the patients should allow up to 30 days to fulfill this request.

**INSURANCE**

Deductibles must be met before a carrier will cover a portion of the cost of your care. Copays are typically always required even after a deductible has been met by the patient.

Signature of Patient \_\_\_\_\_



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### A Cornerstone Family Practice

#### PATIENT HISTORY

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please check any of the following that apply to you:

- |                            |       |                       |       |
|----------------------------|-------|-----------------------|-------|
| History of Rheumatic Fever | _____ | Diverticulitis        | _____ |
| History of Scarlet Fever   | _____ | Gallstones            | _____ |
| History of Asthna          | _____ | Pancreatitis          | _____ |
| Asthma                     | _____ | Kidney Stones         | _____ |
| Tuberculosis               | _____ | Gonorrhea             | _____ |
| Glaucoma                   | _____ | Syphilis              | _____ |
| Hay fever                  | _____ | Osteoporosis          | _____ |
| Pneumonia                  | _____ | Depression or Anxiety | _____ |
| Bronchitis                 | _____ | Epilepsy (seizure)    | _____ |
| Emphysema                  | _____ | Stroke or paralysis   | _____ |
| Heart Disease              | _____ | Diabetes (sugar)      | _____ |
| Angina                     | _____ | Arthritis             | _____ |
| High Blood Pressure        | _____ | Gout                  | _____ |
| High Cholesterol           | _____ | Thyroid problems      | _____ |
| Stomach ulcers             | _____ | Cancer                | _____ |
| Hepatitis or jaundice      | _____ | Anemia                | _____ |
| Cirrhosis                  | _____ | Sleep Apnea           | _____ |
| Colitis                    | _____ | Snoring               | _____ |

Allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications and strength:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**Surgeries (type and approximate year):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Any other nonsurgical hospitalizations (reason and approximate year):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Screening tests:	Abnormal results?	Most recent year performed:
____ Colonoscopy	_____	_____
____ Stress test or echo	_____	_____
____ Mammogram	_____	_____
____ Pap smear	_____	_____
____ Bone density study	_____	_____
____ Prostate exam	_____	_____

**Smoking History:**

\_\_\_\_ None for \_\_\_\_ years.  
\_\_\_\_ I am presently smoking \_\_\_\_ packs per day for \_\_\_\_ years.  
\_\_\_\_ I smoke \_\_\_\_ cigars/pipe per day for \_\_\_\_ years.



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**Alcohol History:**

Number drinks per day \_\_\_\_\_ or per week \_\_\_\_\_.

\_\_\_\_\_ None for \_\_\_\_\_ years.

History of substance abuse? \_\_\_\_\_

**Family History:**

Father: Living \_\_\_\_\_ Deceased \_\_\_\_\_ Age \_\_\_\_\_ Cause of death \_\_\_\_\_

Other illnesses (circle if applicable) High blood pressure, Diabetes, Heart Attack,

Stroke, Cancer (type) \_\_\_\_\_, others \_\_\_\_\_

\_\_\_\_\_

Mother: Living \_\_\_\_\_ Deceased \_\_\_\_\_ Age \_\_\_\_\_ Cause of death \_\_\_\_\_

Other illnesses (circle if applicable) High blood pressure, Diabetes, Heart Attack,

Stroke, Cancer (type) \_\_\_\_\_, others \_\_\_\_\_

\_\_\_\_\_

**Siblings (ages and health status only):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social:**

\_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Number of children and ages: \_\_\_\_\_

**Occupation:**

\_\_\_\_\_

Women -- Menstrual cycle regular? \_\_\_\_\_ Menopausal \_\_\_\_\_ Hysterectomy \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Miscarriage/Termination \_\_\_\_\_



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**Notice of Privacy Practices HIPAA 2013/2017**

**This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.**

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

**Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices**-We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on our website (www.familydoctor.care).

**You have the right to authorize other use and disclosure**-This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication**-This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI**-This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI**-This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information**-This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability**-This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice**-You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our HIPAA Compliance Officer (Dan Goebel). Contact information is provided on the following page under Privacy Complaints.

Signature of Patient \_\_\_\_\_





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**How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment**-We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices**-We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**Payment**- Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations**-We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization**-The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare** -Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures**-We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule. **Privacy Complaints**

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the HIPAA Compliance Officer at: [Dan Goebel 772-546-4215 or dan@familydoctor.care ]

We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature of Patient \_\_\_\_\_



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NOTICE OF
PRIVACY PRACTICES ACKNOWLEDGEMENT
AND PATIENT AUTHORIZATION FORM

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

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.
• Obtain payment from third party payers.
• Conduct normal healthcare operations.

I have received, read, and understand the Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this practice for an updated copy at any time.

I understand that I may request in writing that you restrict how my medical information is used to carry out treatment, payment, or healthcare concerns.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize you to use or disclose my medical information to the parties below:

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

This authorization is effective \_\_\_\_\_ (date).

I understand that I may revoke this authorization in writing by contacting your office at the above address.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**“New Patient” or “Wellness” or “Welcome to Medicare” patient of the practice.**

Please be aware of the following terms of your insurance carrier including Medicare.

Due to issues related to documentation required for your visit today it is very important that you understand and take into consideration the following before you see a Provider here at this facility, We do not make these rules we are simply informing you of the following information based on a history of providing these services.

1. “New Patients” Your first visit cannot be for wellness or a welcome to Medicare visit, as this is a time to meet the provider. There is a documentation process to review your complete past medical history prescriptions and problems. The documentation required will automatically create this visit to not meet the requirements of one of the types of visits mentioned above.
2. A “Wellness, Annual or a Welcome to Medicare” as a defined as “Wellness” Only. A disease or problem oriented visits in which you have a complaint or concern which requires a work-up, prescription or labs is defined by Medicare as an Evaluation and Management visit. “Wellness, Annual or a welcome to Medicare” visit, focuses only on prevention.
3. If you have a copay or deductible it will be required to be paid in advance of your initial visit today, or at the completion of your visit if this encounter with you becomes a regular visits as defined by insurance and Medicare.
4. I Understand that I am here today for my “wellness”, “annual”, or “welcome to Medicare” and I have no complaints related for today’s visit.

\_\_\_\_\_  
Patient signature:

\_\_\_\_\_  
Date: