Raymond Duong, M.D.

INTERNAL MEDICINE

370 17th Street- Vero Beach, FL 32960

Phone: 772-770-3859 Fax: 772-770-3581

PLEASE PRINT LEGIBLY and COMPLETE all the following forms to the best of your knowledge.

Last Name: First Name: Middle Initial:

Mailing Address with Zip code:

Phone (Home) (Cell) (Work)

Social Security (required) Date of Birth:

Email:

Circle your Gender: Male/Female /Trans Circle your Marital Status: Single/Married/Divorced/Widowed

Spouse or S.O. Name: Spouse or S.O. Phone Number:

Please circle one from each category: ****These questions are now required by the Federal Government

Race: American Indian or Alaskan

Asian

Black

Caucasian

Other _____

Ethnicity: Hispanic

Not Hispanic

Refused

Other _____

Please present insurance cards and valid photo ID to get copied and scanned. Thank you.

I hereby authorize Dr. Duong to furnish necessary information to insurance carriers concerning my present illness or accident. I assign, where applicable, all payments for medical services, but not to exceed stated charges. I agree to accept responsibility for payment to the physician even if my insurance carrier denies or fails payment, or a service is determined to be "not reasonable and necessary" by Medicare or any insurance carrier. A photographic copy of this authorization shall be valid as the original.

Patient Signature: Date:

Raymond Duong M.D./370 17th St./Vero Beach/FL/32960/772-770-3859

Patient Financial Policy

(Please read, print, sign and date at the bottom)

For over 25 years, Dr. Duong has been committed to providing his patients with the best in comprehensive and preventative care. In order to continue this long history of comprehensive care, our practice must collect payment for our services to remain financially viable. Failure to consider and follow Dr. Duong's office financial policies may result in dismissal from our practice.

Patients are responsible for the payment of all services provided by Raymond Duong M.D. and his staff.

Insurance policy

- **It is our policy to file insurances as a courtesy to you if we have accurate and complete insurance information. We are currently in network with traditional Medicare and some Blue Cross plans.**
- **Patients are responsible for keeping their demographic, and health insurance coverage updated, for us to bill accurately.**
- **Failure to file insurance due to not having updated or incorrect information, will result in patient being responsible for outstanding charges.**
- **Deductibles, co-payments, and coinsurance will be collected at time of service. For Medicare patients- if you are enrolled in the CCM program, you will be responsible for your deductible and coinsurance every month you are enrolled if your insurance does not cover them.**
- **Dr. Duong follows current internal medicine standard of care and appropriate-use guidelines in ordering diagnostic tests or procedures as part of your preventative care. Please be aware that some of the tests or diagnostic procedures recommended and ordered for you, may be determined to be "non-covered or not medically necessary" based on your insurance benefits. You are responsible for knowing the covered and non-covered benefits under your plan.**
- **You will be financially responsible for all costs not covered by your insurance.**

Overdue balances policy

- If we have not received payment from your insurance company after 30 days of filing, we may ask you to contact your insurance carrier, or you may be responsible for the balance due.
- All accounts with a balance of over 60 days will be sent to collections unless other arrangements have been made with our billing department.

We accept Visa, Mastercard, Discover, American Express, checks ($35 fee for a returned check) and exact cash (we do not keep cash in the office to give change).

In order to provide the best medical care, we ask that you **do not** discuss your account balance or financial aspects with Dr. Duong or medical staff. Please discuss any account information with our billing department at 321-848-0937.

Patients printed name: _____ Date: _____

Patients signature: _____

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No Call/No Show Policy

Your appointment is very important to us and your health. If you miss an appointment, you may delay the treatment that you need. You may also have to wait longer than you would like for a new appointment date. We do not want to keep you waiting, but our health care providers are heavily booked and may not be able to reschedule you immediately.

If you must change your appointment, please call in at least 24 business hours in advance to cancel the appointment. You must speak to or leave a message on our front desk voice mail. Failure to do so will result in a charge of $80 for **ANY** missed appointment. This charge is not covered by insurance and must be paid before another appointment can be rescheduled.

This policy includes **ALL** scheduled appointments made within our office. i.e., office visits, consultations, annual wellness exams, ear washes, holter monitors, EKG's, ultrasound studies, and any other testing, as well as Biote pelleting's, Emsculpt, Emsella, Emtone, and EmFemme treatments.

We are aware that emergencies do happen. These will be handled on a case-by-case basis and must be approved by the doctor.

We greatly appreciate your understanding and cooperation with this policy.

This fee is subject to change in accordance with future changes in office policies.

My signature below indicates that I have read and understand the above policy.

Refusing to agree to this policy will result in being discharged from the practice.

Patient Signature: _____ Today's Date: _____

Patient Printed Name: _____ Date of Birth: _____

Raymond Duong, M.D.

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NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

A Statement that this practice is required by law to maintain the privacy of protected health information.

A statement that this practice is required to abide by the terms of the notice currently in effect.

Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment, and healthcare operations.

A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

A description of uses and disclosures that are prohibited or materially limited by law.

A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

The right to request restrictions on certain uses and disclose of my protected health information.

The right to receive confidential communication of protected health information.

The right to amend protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Patient Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

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I _____, authorize Raymond Duong M. D. and medical and CCM staff to release all medical records and converse to other physicians as well as the names of spouse, family or friends whom are listed below. We can not acknowledge you being a patient to anyone unless their name is on here.

NAME	**RELATIONSHIP**	**PHONE**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

By my signing this authorization, I authorize release of my medical records to be in effect until I have given written consent to terminate this agreement.

Patient Signature: _____ Date: _____

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Name: _____

Date of Birth: _____

Today's Date: _____

ADULT HEALTH HISTORY FOR NEW PATIENTS

Main reason for today's visit: _____

What are your health goals for the next year? _____

Where were you receiving your care before? _____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have in the past few months.

Read through every and check "no problems: if none of the symptoms apply to you. List other concerns above.

General:
__Fever/chills
__Night sweats
__Unexplained weakness
__Excessive fatigue
__Decreased activity
__Unexplained weight loss/gain
__**No Problems**

Eye:
__Glasses/Contact Lenses
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__**No Problems**

Ear/Nose/Throat:
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Dental Cavities
__Hearing Loss
__Ear Pain
__**No Problems**

Skin:
__Change in nails
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__**No Problems**

Respiratory:
__Shortness of Breath
__Cough
__Wheezing
__Loud snoring
__Short of breath-exercise
__Short of breath-lying down
__Coughing up Blood
__Coughing up Phlegm
__**No Problems**

Cardiovascular:
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__**No Problems**

Gastrointestinal:
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Rectal Pain
__Hemorrhoids
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Excessive gas
__Loss of bowel control
__Problems eating
__Loss of appetite
__**No Problems**

Genitourinary:
__Leaking Urine
__Blood in Urine
__Nighttime Urination
__Urinating more often
__Discharge: Penis or Vagina
__Concerns w/ Sexual Function
__Testicular Pain/Lumps
__**No Problems**

Musculoskeletal:
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__**No Problems**

Hematologic/Lymphatic:
__Bruise Easily
__Bleeding Tendency
__Swollen Gland
__**No Problems**

Endocrine:
__Heat Sensitivity
__Cold Sensitivity
__Excessive Thirst
__Excessive Hunger
__High/Low blood sugar
__**No Problems**

Neurological:
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness
__Unsteady Gait
__Tremors
__Seizures
__**No Problems**

Psychiatric:
__Anxiety/Irritability
__Sleep Problems
__Lack of Concentration
__Change in Behavior
__Change in Personality
__Anorexia
__Binging/Purging
__Stress
__**No Problems**

Women Only:
__Menstrual Symptoms
__Excessive Bleeding
__Hot Flashes/Sweats
__**No Problems**

Breasts:
__Breast Lump/Pain
__Nipple Pain
__Nipple discharge
__**No Problems**

	Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
	1. Little interest or pleasure in doing things	0	1	2	3
	2. Feeling down, depressed or hopeless	0	1	2	3

MEDICATIONS: Please list (or provide your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, inhalers, etc... Use the back of this form and let us know that you wrote there.

☐ I TAKE NO MEDCATIONS Please list your **PHARMACY** of Choice_____

Location and Phone # _____

MEDICATION NAME	DOSE (mg/pill)	HOW MANY TIMES PER DAY	WHO CURRENTLY PRESCRIBES THIS MED

More medications on the back of this form _____

ALLERGIES: Please list all allergies or intolerance to medications: Must include type of reaction/side effect.

NO KNOWN ALLERGIES ☐

ALLERGIES:	TYPE OF REACTION:

More allergies listed on the back of this form _____

PERSONAL MEDICAL HISTORY: Do you currently or in the past, had the following conditions? In the Comments area please give details if needed.

X	CONDITION	COMMENTS	X	CONDITION	COMMENTS
	Alcohol/Drug Abuse			Gout	
	Allergies/Hay Fever			Endometriosis- Women only	
	Anemia			Fibroids- Women only	
	Anxiety			Hepatitis and which Type A B C	
	Arthritis (Rheumatoid) (Where)			High Blood Pressure (Hypertension)	
	Arthritis (Osteoarthritis) (Where)			High Cholesterol	
	Asthma			Inflammatory Bowel Disease	
	Atrial Fibrillation (AFIB)			Irritable Bowel Syndrome	
	Bipolar Disorder			Kidney Disease/Failure	
	Bladder Problems			Kidney Stone	
	Blood Clot (Where)			Liver Disease/ Cirrhosis (Stage level)	

X	CONDITION	COMMENTS	X	CONDITION	COMMENTS
	Blood Transfusion			Lupus	
	Breast Condition (Benign)			Migraine/Tension Headaches	
	Cancer- Breast			Osteopenia/Osteoporosis (Where)	
	Cancer- Colon			Pancreatitis	
	Cancer- Lung			Pneumonia	
	Cancer- Prostate			Prostate Enlarged/Nodules- Men Only	
	Cancer- Other (Where)			Seizures/Epilepsy	
	Cataracts (Which eye/s)			Skin Condition (Which kind)	
	Colon Polyp			Skin Cancer (Where)	
	Coronary Artery Disease/ Heart Attack			Sleep Apnea	
	Depression (Which type)			Stomach ulcer	
	Diabetes Type 2- Are you on medication			Stroke	
	Diabetes Type 1- Are you on insulin			Overactive Thyroid (Hyperthyroidism)	
	Diverticulosis/Diverticulitis			Low Thyroid (Hypothyroidism)	
	Emphysema (COPD)			Urinary Tract Infection (UTI)	
	Fractures in the bones (Where)			Other (List)	
	Gallbladder Disease/Gall Stones			Other (List)	
	Heartburn/Reflux (GERD)			Other (List)	
	Glaucoma			Other (List)	

SURGICAL HISTORY: Please check off any procedures/surgeries and list what kind of surgeries.

Or check the box if you've never had surgery. **NONE** ☐

X	SURGICAL/PROCEDURES	DATE	COMMENTS- What type of surgery and surgeon's name
	Hernia Repair		
	Appendectomy (Appendix removal)		
	Neck/Back/Spine Surgery		
	Biopsy (Location)		
	Breast Biopsy/Surgery/Augmentation (Circle-Right/Left/Both)		
	Cataract (Circle-Right/Left/Both)		
	Colonoscopy/Sigmoidoscopy		
	Endoscopy (EGD)		
	Gastric band/bypass (Weight loss Surgery)		
	Gallbladder Removal (Circle- Open or Laparoscopic)		
	Coronary Bypass/Stent		
	Heart Surgery (Other than Coronary Bypass)		
	Hip Surgery (Circle-Right/Left/Both)		
	Knee Surgery (Circle-Right/Left/Both		
	Hysterectomy (Circle- Total/Partial)		
	Ovary Removal or Ligation (Tubal)		
	Vasectomy		
	Other (List)		
	Other (List)		

Any Additional Comments:

_____

_____

_____

_____

_____

FAMILY HISTORY- Please indicate which blood relative has had the following diseases.

If you were adopted, check the adopted box and skip the family history portion. **ADOPTED** ☐

X	DISEASE	RELATIONSHIP (Father, Mother, Children, Grandparents, Aunt, Uncle, etc.)	COMMENTS
	No significant history known		
	Alcohol/Drug abuse		
	Alzheimer/Dementia		
	Asthma		
	Autoimmune Disease		
	Bleeding or Clotting Disorder		
	Cancer of _____		
	Cancer of _____		
	Colon Polyp		
	Coronary Artery Disease (Heart Attack, Angina)		Age of Onset
	Depression/Suicidal thoughts/Anxiety		
	Diabetes- Type 1		
	Diabetes- Type 2		
	Emphysema (COPD)		
	Genetic Disorder (Explain)		
	Heart Failure (CHF)		
	Hepatitis (Circle- Type A B C)		
	High Blood Pressure (Hypertension)		
	High Cholesterol		
	Hypothyroidism/Thyroid Disease		
	Kidney Disease		
	Migraine/Tension Headaches		
	Osteoporosis		
	Stroke		
	Other _____		

Father ‰Alive (Age _____) ‰Deceased (Age _____) ‰Unknown Cause of Death: _____ ‰Unknown

Mother ‰Alive (Age _____) ‰Deceased (Age _____) ‰Unknown Cause of Death: _____ ‰Unknown

SOCIAL HISTORY:

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How long (Years)	If stopped, when? (Years)
Tobacco- Cigarettes, Cigar, Pipe, Snuff, Vape	Yes/No	Yes/No			
Recreational Drugs-	Yes/No	Yes/No			
Alcohol- beer, wine, liquor	Yes/No	Yes/No			
Caffeine- coffee, tea, soda	Yes/No	Yes/No			

Exercise: How often_____What type of exercise_____

Education: How many years of school have you completed? _____ Highest Level of Education? _____

Occupations: Your current employment status: ‰Retired ‰Unemployed ‰Homemaker ‰Employed

Current Occupation(s): _____ **Previous Occupations/Jobs**: _____

Disability: Are you disabled? Yes/No If yes, please explain_____

Abuse: Have you ever been physically, sexually, or emotionally abused? Yes/No If yes, please explain _____

Sexual Activity: Currently Sexually Active? Yes/No **Spouse/Partners** Name: _____

Women's Health: Number of: Biological Children_____ Miscarriages_____ Grandchildren _____

HEALTH MAINTENANCE SCREENING TESTS:

Test	Last Date performed and where was test performed
Mammogram	
Pap Smear	
Bone Density	
Endoscopy	
Colonoscopy	
EKG	
Chest x-ray	
Lipid Screening	
Prostate Exam	
Eye Exam	

Safety:

Do you use seatbelts consistently? Yes/No

Does your home have a working smoke detector? Yes/No

Is violence at home a concern for you? Yes/No

Do you have firearms in the home? Yes/No

Who lives at home with you? _____

What do you live in? Circle one: House Apartment Assisted Living Facility Other_____

Do you have pets in the home? And what type? _____

IMMUNIZATIONS:

Check this box if you don't know your vaccination information! ☐

Immunizations	Date last received
Tetanus (Td) or (Tdap)	
Pneumonia (Pneumovax 23)	
Prevnar 13	
Hepatitis A	
Hepatitis B	
Hepatitis C	
Meningitis	
Shingles (Zostavax) or (Shingrix-2dose)	
HPV	
MMR	
Chicken Pox (Varicella shot) or (had the illness)	
Influenza (Flu shot)	
Other-	
Other-	
Therapeutic Injections:	
B-12	
Prolia	
Testosterone	
Other-	
Other-	

Who was your previous primary care physician? _____

Do we have your permission to ask for previous medical records from the above? Yes/ No

Patient Signature_____ Todays Date _____

AUTHORIZTION FOR MEDICAL RECORDS

By signing this form, you are authorizing Raymond Duong M.D. to release/receive the following health information.

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

_____

Please note: There is no charge for Raymond Duong M.D. records to be sent directly to another medical facility. However, there is a charge for patients/family/legal professionals to receive a copy of the medical records under the accordance with Florida State law. $1 per page for the first 25 pages and $.25 per page, thereafter.

The above listed patient authorizes the following healthcare facility to release/receive medical records.

Raymond S. Duong M.D., P.A.
370 17th Street
Vero Beach, FL 32960

Phone: 772-770-3859
Fax: 772-770-3581

****We prefer to send/receive records by Fax****

This medical record authorization is to: check one- ☐ RELEASE RECORDS ☐ RECEIVE RECORDS

Type of Information to disclose:

- Last History and Physical
- Last 1 year of lab results
- All previous Radiology Imaging
- All immunization records
- All cardiology records
- Other: _____

To/From the following individual/organization:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Expiration and Revocation: I understand that this authorization will expire 1 year from the signature date. I understand that I may revoke this authorization at any time by notifying Raymond Duong M.D. in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy or when subpoenaed by law. I understand that if the person who is authorized to receive the information is not a health plan or health care provider, and that the released information may no longer be protected by federal or state privacy regulations and may be redisclosed without my knowledge. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

Signature of patient/guardian/personal representative Date

_____

Printed name/relationship and telephone number of authorized representative if not signed by patient.