



GARDENS FAMILY PRACTICE
Phone (561) 627-7433
Fax (561) 775-1055

Welcome To Gardens Family Practice! We are happy to have you join our family and would like to give you some general information regarding our office and staff.

Our office is located at: 3365 Burns Road, Suite 217
Palm Beach Gardens, FL 33410

Our office hours are: Monday-Tuesday-Thursday
8:30am-4pm
Friday 8:30am- Noon

We are "on Service" from 12N-1pm each day

Our Doctor: Prabha Viralam, M.D.
Board Certified Family Practice Physician

Our Staff: Fran, Receptionist
Julie, Medical Assistant
Kim, Office Manager, Referral Coordinator,
Billing Specialist

OFFICE POLICIES

WE SEE PATIENTS BY APPOINTMENT ONLY

WE MUST HAVE 48 HOURS NOTICE ON ALL REFERRALS

MEDICATIONS WILL BE REFILLED THROUGH YOUR PHARMACY, PLEASE CALL THEM AND THEY WILL FAX THE REQUEST TO OUR OFFICE. PLEASE CALL A FEW DAYS BEFORE YOUR MEDICATION RUNS OUT.

APPOINTMENTS ARE SCHEDULED AS FOLLOWS:

- URGENT/SAME DAY
- ILLNESS/WITHIN 3 DAYS
- ESTABLISH W/DR/WITHIN ONE MONTH
- WELL EXAM/ WITHIN ONE MONTH

Our staff is always available to answer any question you may have. On Monday mornings, Please limit calls to urgent matters only. We handle each request to the best of our abilities and as efficiently as possible. AS A COURTESY TO OTHERS, PLEASE DO NOT USE CELL PHONES IN OFFICE!

Prabha Viralam, MD
&
Staff

Gardens Family Practice
Prabha Viralam M.D
3365 Burns RD., #217
Palm Beach Gardens, FL 33410
Telephone: (561) 627-7433
Fax: (561) 775-1055



PATIENT INFORMATION

DATE _____ SOCIAL SECURITY # _____

LAST NAME _____ FIRST _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK _____ CELL _____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____

MARITAL STATUS: M _____ D _____ S _____ W _____

INSURANCE INFORMATION

PRIMARY POLICY HOLDER (IF OTHER THEN SELF) _____

PRIMARY POLICY HOLDERS (IF OTHER THEN SELF) DATE OF BIRTH _____

PRIMARY POLICY HOLDERS SOCIAL SEC. # (IF OTHER THEN SELF) _____

EMERGENCY CONTACT INFORMATION

NAME _____

PHONE NUMBER _____ ALT PHONE NUMBER _____

PRIMARY LANGUAGE SPOKEN AT HOME _____

PRABHA VIRALAM M.D

Gardens Family Practice
Board Certified in Family Practice

Dear Patient:

Due to the high cost of medical billing, payment is requested at the time of treatment, unless payment plan arrangements are made with the doctor or billing manager, your signature indicated agreement with the following stipulations:

1. Payment in full at time of visit. (If no insurance coverage at all) including applicable insurance co-payment. Patients with indemnity coverage (80/20 plans) will be responsible if deductible has not been met and/or their 20% at time of service.
2. If payment is not received by your insurance company for any reason within 90 days, you will be responsible for the full amount due.
3. The signing party will incur all costs including collection fees, court costs, and reasonable attorneys' fees, if payment not received as described.
4. Any secondary or supplemental insurance claims that need to be filed will be done as a courtesy to our patients. **All remaining balances after claims are processed are the sole responsibility of the patient!**
5. Managed care subscribers (HMO, PPO, POS) Florida State Law requires payment by your insurance carrier to the participating provider within 60 days of the submission of the medical claim. If the claim is not paid, your insurance company has broken its contractual agreement. Since this is your insurance; If the claim is not paid by your insurance carrier, then it is your responsibility to pay the claim or have it paid by the insurance company.

Thank you very much for your understanding and cooperation.

CONSENT FOR TREATMENT.

I voluntarily consent to the rendering of medical care by Dr. Prabha Viralam. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry out the instructions of the physician.

AUTHORIZATION TO RELEASE INFORMANTION:

I authorize Dr. Prabha Viralam to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, workman's compensation or Medicare benefit payments.

Patient Signature: _____ Date: _____

Gardens Family Practice
Prabhavathi K. Viralam

We need you to know your past medical records to best understand how we can help you. The information you give us on this form will be kept confidential, for our files, in this office only. The information will not be released to anyone else unless you request the **release in writing**.

Date _____

1. What is your full name?

Last	First	MI
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2. Do you have any **Drug Allergies**? _____

3. When was your last Medical check up? _____

Month Day Year

4. Why are you here to see the Doctor? _____

5. What are if any significant illness or injury's you had in you life time?

Illness or Injury

When

6. Have you ever been hospitalized or had any surgeries in your life time?

Hospitalization/ Surgeries

When

7. Please list any medication's you are on currently. _____

8. **Review of Systems** (circle below only the conditions that you know you have)

ENT: Eye disease | Glaucoma | Glasses | Sinus trouble | Hay fever |
Nosebleeds | Ringing in the ears | Deafness | Postnasal drip |
Broken ear Drum

Lungs: Coughing blood | Persistent Cough | Shortness of Breath | Emphysema |
Asthma | Frequent Chest Infections | Pneumonia | Pleurisy

Heart: Heart trouble | Murmurs | Enlarged Heart | Irregular Heart Beat | Fluttering |
Chest Pains | Severe Swelling | Heart Attack | High Blood Pressure

Intestines: Difficulty Swallowing | Indigestion | Ulcer | liver Disease | Cirrhosis | Hepatitis |
Gallbladder Trouble | Vomiting Blood | Black Bowel Movement | Hemorrhoids |
Blood in the Bowel Movements | Yellow or Jaundice

Kidneys: Painful Urination | Frequent Urination | Waking in the Night to Urination | Pus |
Blood | Stones | Albumin | Loss of Control with Cough or Laugh | Prostate
Trouble in Men | Do you have impotency or Ejaculation problems

Nervous System: Headaches | Convulsions | Epilepsy | Head injury | Fainting | Paralysis |
Double Vision | Blurred Vision | Staggering | Unconsciousness | Persistent
Numbness

10. **Miscellaneous History**

Have you had a Blood Disorder or Bleeding problems? YES _____ NO _____

Do you take Aspirin? YES _____ NO _____

Menstrual Periods: Began at age _____ Ceased at age _____

Occurs Every _____ Days | Lasts _____ Days

Pain in Periods _____

Number of Pregnancies _____

Number of Births _____

11. Social History:

Do you smoke or ever smoked _____ How Much _____ How Long _____
When did you Stop Smoking? _____

Do you Drink Alcohol or ever Drank Alcohol _____ How Much _____ How
Long _____
When did you Stop Drinking Alcohol? _____

History of Alcoholism? Yes _____ No _____

History of Drug Abuse? Yes _____ No _____
If so What? _____

Work History? Has you job had you exposed to anything? _____

12. Family History:

Mother Living _____ Age _____ or Died at Age _____ Cause of death _____
Father Living _____ Age _____ or Died at Age _____ Cause of death _____
Brothers - Number living _____ Number Deceased _____ Died at Age _____
Cause of death _____
Sisters - Number living _____ Number Deceased _____ Died at Age _____
Cause of death _____

CIRCLE ONLY THOSE CONDITIONS ANYONE IN YOUR FAMILY HAS HAD?

Heart Trouble | Diabetes | Gout | Tuberculosis | Cancer | High Blood Pressure | Glaucoma |
Kidney Disease | Heart Disease

Gardens Family Practice Privacy Notice

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

Gardens Family Practice Privacy commitment to you

We understand that the information about you and your family is personal. We are committed to protecting your information. This notice tells you how Gardens Family Practice uses and discloses information about you. It tells you about your right and about Gardens Family Practice requirements about medical information.

Understanding the information that Gardens Family Practice has

You provided certain information to Gardens Family Practice when you needed services from us. This information included you name, address, date of birth, phone number, social security number and health insurance policies. It may also have included health information. For some medical treatments, other health care providers send additional medical information such as doctor's statements, x-rays or lab test results.

Your health information rights

You have the following rights regarding the health information that Gardens Family Practice has about you. (Note: These rights may be limited by Florida law or by court orders.)

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to Gardens Family Practice.
- You have the right to ask Gardens Family Practice to change health information that is incorrect or incomplete. Gardens Family Practice may deny your request under certain circumstances. You have the right to request a list of the disclosures that Gardens Family Practice has made of your health information. Beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information Gardens Family Practice is not legally required to agree with your request.
- You have the right to request that Gardens Family Practice communicates with you about your health in a way or at a location that will help you keep the information confidential.
- You have the right to receive a paper copy of this notice. You may ask Gardens family Practice staff to give you another copy of this notice.

Privacy law's requirements

- Gardens Family Practice is required by law to
- Give you this notice of Gardens Family Practice legal duties and privacy practice regarding the information that Gardens Family Practice has about you.
- Follow the terms of this notice
- Not use or disclose any information about you without your written permission, except for the reason given in this notice. You may take away your permission at anytime, in writing, except for the information that Gardens Family Practice disclosed before you stopped your permission

In the future, Gardens Family Practice may change its privacy practices. If its privacy changes significantly Gardens family Practice will provide a new notice to you.

How Gardens Family Practice uses and discloses health care information

There are some services Gardens Family Practice Provides through contracts with other agencies and private companies. For example, the Gardens Family Practice billing services sends your insurance claims. When services are contracted, Gardens Family Practice may disclose some or all of your information to other agencies or companies so that they can perform the job for Gardens Family Practice has asked them to do. To protect your information, Gardens Family Practice requires the other agencies or company to safeguard the information in accordance with the law.

The following categories describe different ways that Gardens Family Practice uses and discloses your health information. For each category, we will explain what we mean and give an example.

For payment:

Gardens Family Practice may use and disclose information about you so that it can pay for the health services that you received. For example, when you receive services at Gardens Family Practice, the provider sends a claim for payment to the insurance for payment. The claim includes information that identifies you, as well as your diagnoses and treatment.

For medical treatment:

Gardens Family Practice may use or disclose information about you to ensure that they receive necessary medical treatment and service. For example, V may send you reminders about medical appointments.

For healthcare operations:

Gardens Family Practice may use disclose information about you to ensure that they receive quality care. For example, Gardens Family Practice may contact with a company that reviews records to check on the quality care that you received and the outcome of that care.

To other government agencies Providing Benefits or Services:

Gardens Family Practice may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services.

To keep informed:

Gardens Family Practice may mail information to you about you health and wellbeing. Examples are information about managing a disease, information about your managed car choices, and appointment reminders for your medical services.

For Research:

Gardens Family Practice may disclose information about you for a research project that has been approves by a review board, as permitted by Florida law. The review board must review the research project and its rules to ensure the privacy of your information.

As required by law:

Gardens Family Practice will disclose information about you when required by law or court order.

For more information:

If you have questions and would like additional information, you may contact Gardens Family Practice at (561) 627-7433.

To report a problem

If you believe your privacy rights have been violated

- You can file a complaint with Gardens Family Practice by contacting Privacy Officer.

There will be no retaliation for filling a complaint or grievance.

Effective Date

The privacy practice described in this notice will be affective April 14, 2003

Notice of privacy practice acknowledgement and consent

I have received a copy of the Gardens Family Practice notice of Privacy Practice.

Signature: _____ Date: _____

Consent:

I consent ton the use and sharing of my health records for treatment, payment and operation purposes as described in the notice of Privacy’s Practices. I know that if I do not consent, you can not provide services to me.

Signature: _____ Date: _____

Request For Release Of Medical Records
Please Fax Or Mail At Your Earliest Convenience

TO: _____

I Hereby Request That Medical Records Be Released To:

Gardens Family Practice
Prabha Viralam MD
3365 Burns RD Suite 217
Palm Beach Gardens, Fl 33410
Phone 561-627-7433
Fax 561-775-1055

Date _____

Patients Signature

Print Name

Social Security Number

Date Of Birth

**GARDENS FAMILY PRACTICE
3365 BURNS RD STE: 217
PALM BEACH GARDENS, FL 33410**

CONSENT TO RELEASE INFORMATION TO FAMILY

To Whom It May Concern:

This letter is to certify that I give permission to Dr. Prabha Viralam, or any member of her staff to give any or all of my personal medical information to _____ . This includes consults from other physicians, test results and any information pertaining to my medical care.

Print Name _____

Signed _____

Date _____

Witnessed _____

Gardens Family Practice

Dr. Viralam

3365 Burns Rd. Suite 217
Palm beach Gardens, Fl 33410
PH: 561-627-7433
FX: 561-775-1055

Health Care Advance Directive

Date _____

I _____ I have been asked if I have an advanced directive,

(Please check one)

_____ I will provide the office with my Health Care Advance Directive I have already completed.

_____ I do have an Advance Directive but, I am unable to provide a copy of it.

_____ I do not have a Health Care Advance Directive at this time.

Patient Name

Patient Signature

Patient Date of Birth

Date