

**Brevard Family Walk-In Clinic**

1950 Rockledge Blvd (US1), Ste 101

Rockledge, FL 32955

321-636-0005 \* Fax: 321-636-9030

**Jasen Kobobel, MD**

Board Certified in Family Medicine

**PLEASE SPECIFY HOW YOU HEARD ABOUT US:**

Billboard  
Friend  
Internet  
Local Edge  
Savings Safari Magazine  
Website  
Other \_\_\_\_\_

Family  
Insurance Company: \_\_\_\_\_  
Laser Skin Rejuvenation Center  
The Real Yellow Pages  
Walk-In  
Other Dr.'s Office \_\_\_\_\_

**Patient's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Sex:** M / F    **Marital Status:** S / M / D / W    **Language:** English/Spanish/French/Other: \_\_\_\_\_

**Race/Ethnicity:** White/African American/Latino/Native American/Indian/Asian/Other: \_\_\_\_\_

**Emergency Contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

**Preferred Pharmacy:**

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

**Address and Phone #:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

By providing my e-mail address, I authorize Brevard Family Walk-In Clinic to send Health News Letters, Coupons, or Special Events. Furthermore, Brevard Family Walk-In Clinic will not share, sell or rent your personal information to any third party, for mailing lists or any other reason. If you choose to be removed from our news letter mailing list, your personally identifiable information will be removed automatically.

**Primary Insurance:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Subscriber Address:** \_\_\_\_\_

**Subscriber Phone:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**I acknowledge that all the information provided is accurate and truthful. Also, I recognize that the Patient Bill of Rights has been placed at the front office for me to review.**

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if signed by legal representative)

# Brevard Family Walk-In Clinic's Policies

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## 1. Private Insurance authorization for assignments of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Jasen Kobobel MD for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or the agent, information concerning health care, advice, treatment or supplies provided me. This information will be used for the purpose of evaluating and administering claims of benefits.

## 2. Walk-In/Emergency Patient:

I understand that every appointment not schedule with the office will be considered as an emergency appointment. This includes daily walk-in, after hours and week-end appointments. A fee of \$50.00 office services will be billed to your insurance company. Definition of walk-in/emergency appointment is as follow: Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.

## 3. Late Fees Policy:

I understand that any outstanding balance I have with Brevard Family Walk-In will accrue a 1.5% interest fee per month that will begin when the debt is 45 days past due.

## 4. Drug Contract:

If I am prescribed narcotic pain medications, I agree not to take narcotics from any other physician except for emergency situations. I understand that if I take narcotics from other physicians while I am under Dr. Kobobel's care and fail to disclose the information, I may be discharged from the practice. If I am referred to a pain management clinic, Dr. Kobobel will only give emergency pain medications on a short term basis. NARCOTICS WILL NOT BE CALLED IN OVER THE PHONE FOR ANY REASON.

## 5. Appointment Cancellation Policy:

I understand that I **must** call to cancel or reschedule my appointment at **least 24 hours prior to the schedule time**. If I do not call to cancel or reschedule, I understand I **WILL** be charged a **\$50.00 fee**.

## 6. Medical Records Request:

If you are requesting copies of a medical record for your own use, there will be a fee associated with this service (authorized by Florida Statute 395.3025). The fee is \$15.00 per CD, or \$1.00 per page copied, plus a fee of \$5.00 if needs to be shipped. You will receive an invoice of fees when you submit your request. Payment must be made prior to receiving your copies.

There is no fee for medical records copied for the purpose of continuing medical care. These copies are sent directly to the health care provider.

## 7. Demographic Changes:

It is your responsibility and a necessity to inform us of any changes in regards to your address, phone number, and insurance information.

**I attest that I understand and acknowledge Brevard Family Walk-In Clinic's policies.**

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if signed by legal representative)

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

# Brevard Family Walk-In Clinic's Policies

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## Notice of Privacy Practices

Jasen Kobobel, MD

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION  
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED  
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health facts and to provide you with notice of legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request. As a client of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosure require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency;
- Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug or alcohol abuse;
- Psychiatry test results;
- Medical history;
- Treatment progress;
- Data from the OASIS data set (home health);
- Any other related facts.

We may release the above to:

- Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services in order for us to receive payment;
- Any person from a program or an insurance company, who performs billing, quality risk management tasks, such as insurance auditors and state Risk Management;
- Any hospital, nursing home, or other healthcare facility where you may have testing done or to which you may be admitted;
- An assisted living or personal care facility where you live;
- Any doctor providing you care;
- Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.
- State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, ST/HIV, home health, hospice, etc.
- Other health care people to start treatment.

We may contact you to:

- Provide appointment reminders or news about other health programs we provide;
- Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

- In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
- Where signature barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
- Where we are required by law to provide treatment and we are unable to obtain consent;
- Where the use or disclosure is required by law;
- For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.
- Where we reasonable believe you are a victim of abuse, neglect, or domestic violence to a government healthcare oversight activities;
- Certain legal administration proceedings;
- Certain law enforcement purposes.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if signed by legal representative)

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**Jasen Kobobel, MD**

Board Certified in Family Medicine

**Patient's Health Questionnaire**

Please mark a check by any of the following problems that you have.

- |                                   |  |
|-----------------------------------|--|
| 1. Asthma _____                   | 21. Wheezing _____                           |
| 2. COPD _____                     | 22. Chest Pain _____                         |
| 3. Short of Breath _____          | 23. Smoker's Cough _____                     |
| 4. Cough _____                    | 24. Allergic Rhinitis _____                  |
| 5. Emphysema _____                | 25. High Blood Pressure _____                |
| 6. Bronchitis _____               | 26. Sarcoidosis _____                        |
| 7. Other Lung Disease _____       | 27. Atrial Fibrillation _____                |
| 8. Congestive Heart Disease _____ | 28. Pre Operation Exam Today _____           |
| 9. Pneumonia _____                | 29. Sleep Apnea _____                        |
| 10. Coronary Artery Disease _____ | 30. Cystic Fibrosis _____                    |
| 11. Lump in chest _____           | 31. Routine Yearly Physical _____            |
| 12. Asbestosis _____              | 32. Prior Abnormal Lung Breathing Test _____ |
| 13. Disease of the Trachea _____  | 33. Diabetes _____                           |
| 14. Cholesterol _____             | 34. Anemia _____                             |
| 15. Cancer _____                  | 35. Joint Pain _____                         |
| 16. UTI _____                     | 36. Rash _____                               |
| 17. Abdominal Pain _____          | 37. Boils _____                              |
| 18. Sinus _____                   | 38. Migraine _____                           |
| 19. Ear Infection _____           | 39. Swelling Glands _____                    |
| 20. Lesions _____                 |  |

Have you had a pulmonary function test in the past year? Yes / No

Please mark a check by any of the following that apply to you.

- |  |  |
|--|--|
| 1. Desire Screening for Osteoporosis _____ | 11. Menopausal or Post Menopausal _____    |
| 2. Fracture _____                          | 12. Over the age of 45 and female _____    |
| 3. Back Pain _____                         | 13. Ovarian Failure _____                  |
| 4. Osteoarthritis _____                    | 14. Fracture of the Vertebra _____         |
| 5. Unexplained Loss of Weight _____        | 15. No Period if Female (Amenorrhea) _____ |
| 6. Pain in Hip, Thigh, or Pelvis _____     | 16. Rheumatoid Arthritis _____             |
| 7. Hypothyroid or Hyperparathyroid _____   | 17. Loss of Height _____                   |
| 8. Arthritis _____                         | 18. On Hormone Replacement _____           |
| 9. Osteoporosis _____                      | 19. Curvature of Spine _____               |
| 10. Immunity Disorder _____                | 20. Cartilage or Bone Disorder _____       |

Have you had a DEXA scan in the 2 past years? Yes / No

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Authorization to use and disclose health information**

**(Request of Medical records)**

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information.

Patient Name \_\_\_\_\_ Date (s) of service requesting \_\_\_\_\_

Date of birth \_\_\_\_\_ SSN# \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type of information to be used or disclosed (check the appropriate items and include other information as needed) is:  
 Entire medical record       ER record       Discharge summary       Radiology reports  
 Cardiology reports       Physician orders       Progress notes       History and physical  
 Lab results (specify dates) \_\_\_\_\_  
 Consultation report (s) by \_\_\_\_\_  
 Other (please specify, i.e., vascular lab, pulmonary or other ancillary visits) \_\_\_\_\_
3. I understand the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. I authorize Brevard Family Walk-In Clinic to make the disclosure to the individual or organization identified below:  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_
5. This information for which I am authorizing disclosure will be used for the following purpose:  
 My personal records       Continued care/Dr. \_\_\_\_\_       Legal purpose  
 Other, please describe \_\_\_\_\_
6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation at Brevard Family Walk-In Clinic where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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.
7. This authorization will expired one year from the date signed, which will be (date) \_\_\_\_\_. (If the expiration date of this authorization is not completed, this authorization will expire one year from the date of which it was signed.)
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
10. If I have questions about disclosure of my health information, I can contact Brevard Family Walk-In Clinic where I received treatment.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if signed by legal representative)

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

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**Release of your private healthcare/financial information**

\_\_\_\_\_ **YES, I authorize** \_\_\_\_\_ **NO, I do not authorize**

Brevard Family Walk-In Clinic to discuss my medical history such as diagnosis, treatment, prognosis, or financial status with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS, related illness, mental health and drug, alcohol or chemical abuse.

Spouse \_\_\_\_\_

Children \_\_\_\_\_

Parents \_\_\_\_\_

Other (legal representative) \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if signed by legal representative)

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date