Vanessa Vizcaino, MD Board Certified Family Practice
Lesley N. Glover, MD Board Certified Family Practice
Heather Loguidice, ARNP Board Certified Family Practice

Family Medical and Wellness Center

Bringing Family and Health Together

Patient's First Name:	Patient's Last Name:	Gender: ( ) Male ( )Female	Date of Birth: / /
Home Street Address:	Home Phone:	Social Security Number: ** **	Marital Status: ( )Single ( )Married ( ) Divorced ( )Widow
City: State: Florida Zip code:	Cellular Phone: Email:	Do you have an Advanced Directive or Living Will? ( ) YES ( ) NO *If yes, please provide a copy for office record.	
Emergency Contact:	Contact Phone:		
Relationship to Patient: ( ) Spouse ( ) Parent ( ) Friend	***Consent to Leave Telephone Message Regarding Personal Health Information**** ***( ) I do authorize FMWC to leave results at this phone_____*** ***( ) I hereby give consent to my healthcare provider to discuss or release any medical information to _____*** ***( ) I do not authorize FMWC to leave messages on any phone. I will be Responsible for following-up on my results.*** ***Patient Signature:***		

Health Insurance Information

Person responsible for insurance:
Date of Birth: / /
Relationship to patient: ( ) Self ( ) Spouse ( ) Parent ( ) Guardian

Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and surgical procedures. I understand that I am under the care and supervision of Family Medical and Wellness Center, LLC and it is the responsibility of the staff to carry out instructions of its physicians/providers.

_____ _____
Patient Signature **Date**

Consent for Medical Treatment for a MINOR

Mother's Full Name:		**Father's Full Name:**	
Mother's Date of Birth: / /		**Father's Date of Birth: / /**	
Mother's Employer:	**Mother's Work Phone:**	**Father's Employer:**	**Father's Work Phone:**

I understand that the patient named above is suffering from a condition that requires diagnosis and medical treatment which may require diagnostic procedures to include, but not limited to a clinical evaluation by Family Medical and Wellness Center, LLC as well a further clinical evaluation and treatment of the mentioned patient. With full understanding of all foregoing, I do AUTHORIZE the performance upon the patient of clinical evaluation and diagnostic procedure as ordered by Family Medical and Wellness Center, LLC.

_____ _____
Signature of Parent or Guardian **Date**

Current Complaint

Name:_____ Date:_____

Reason for Visit:_____

Duration:_____ Associated Symptoms:_____ Location:_____

Medical History ( ) check here if you have no medical history

( ) Anemia	( ) Epilepsy/Seizures	( ) Kidney Problems
( ) Asthma	( ) Diverticulitis	( ) Miscarriage (females)
( ) Anxiety	( ) Gout	( ) Pneumonia
( )Cancer_____	( ) Heart Disease/MI	( ) Prostatitis (male
( )Depression	( ) Hepatitis/Liver	( ) Stroke/TIA
( )Diabetes Type-I	( ) High Cholesterol	( ) Thyroid Problems
( )Diabetes Type-II	( ) High Blood Pressure	( ) GERD/Peptic Ulcers

Current Medication List

Name of Drug:	Strength	Frequency

Allergies to Medication ( ) check here if you have no allergies

Name of Drug:	Reaction you Had:

Surgical / Hospitalization History

Year	Surgery/Visit	Hospital

Family History

Father	( ) Alive ( ) Deceased ( )Hypertension ( ) Diabetes ( ) Cholesterol ( ) Cancer ( ) Stroke ( ) Heart disease
Mother	( ) Alive ( ) Deceased ( )Hypertension ( ) Diabetes ( ) Cholesterol ( ) Cancer ( ) Stroke ( ) Heart disease
Brother	( ) Alive ( ) Deceased ( )Hypertension ( ) Diabetes ( ) Cholesterol ( ) Cancer ( ) Stroke ( ) Heart disease
Sister	( ) Alive ( ) Deceased ( )Hypertension ( ) Diabetes ( ) Cholesterol ( ) Cancer ( ) Stroke ( ) Heart disease

Social History

Are you sexually active? ( ) Yes ( ) No	If active, what method of contraception do you use?
Do you currently smoke tobacco in any form? ( ) Yes ( ) No If you do not smoke now, did you used to? ( ) Yes ( ) No If yes, how many years ago?_____	Do you consume alcohol? ( ) No ( ) Socially ( ) Daily ( ) Habitually ( ) Quit

Do you exercise?	Have you traveled outside of the U.S. in the last 12 months?
( ) Never ( ) Rarely ( ) Regularly ( ) Daily	**( ) Yes ( ) No**

Please check all that apply if they have occurred over the last 12months (an empty box indicates a "no" answer)

Constitutional
( ) Weight Loss/Gain
( ) Weakness
( ) Loss of Appetite

Allergy
( ) Itchy Eyes
( ) Sinus Congestion
( ) Scratchy Throat
( ) Runny Nose

Eyes
( ) Blurry Vision
( ) Eye Drainage
( ) Loss of Vision

Ears, Nose and Throat
( ) Headaches/Migraines
( ) Cough
( ) Sore throat/Hoarseness
( ) Ringing in Ears
( ) Hearing Loss

Cardiovascular
( ) Chest Pain
( ) Palpitations
( ) Dizziness
( ) Swelling of the legs

Respiratory
( ) Shortness of Breath
( ) Wheezing

Musculoskeletal
( ) Joint pain, swelling, redness
( ) Loss of range of motion
( ) Muscular cramping

Neurology
( ) Difficult with memory
( ) Numbness/ Tingling
( ) Weakness/Paralysis
( ) Gain abnormality

Hematology/Lymph
( ) Easy bruising
( ) Fatigue
( ) Swollen glands

Dermatology
( ) Rash, itching, dryness
( ) Change in mole size, color

Psychology
( ) Sadness/Crying
( ) Loss interest in activities
( ) Anxiety
( ) Thoughts of suicide

Males Only
( ) Difficulty with ejaculation
( ) Difficulty with erection

Females Only
( ) Abnormal vaginal bleeding
( ) Hot flashes
( ) Pelvic pain
( ) Irregular periods/ Heavy
( ) Vaginal Dryness

Urology
( ) Urinary frequency
( ) Blood in urine
( ) Difficulty urinating
( ) Decreased libido

Any other medical information, please write here:

Family Medical and Wellness Center of The Palm Beaches LLC,
Payment Policy

Thank you for choosing Family Medical and Wellness Center of The Palm Beaches. We are committed to providing you with the best patient care possible. In order to best serve you and to avoid confusion, please review our payment policy and let us know if you have any questions. Thank you!

Patients with Insurance Benefits: If you have insurance benefits that you would like to use for your visit, please review our policies for in-network and out-of-network health plans.

In-Network Health Plans: FMWC currently participates with most major insurance plans, including Aetna, Blue Cross Blue Shield, Cigna, United Healthcare, Tricare, Coventry and Medicare. If you are covered by one of these plans or others in which FMWC is "in-network" FMWC will submit an insurance claim on your behalf. You will be required to pay your copayment at the time of service (i.e. today). We will attempt to collect the full amount allowable from your insurance plan. However, in the event that there are deductibles, co-insurance, or other amounts for which you are responsible, you will be billed. If you have an appointment and a balance due, you will need to pay the balance first before being seen.

Medicaid Patients: FMWC does not accept Medicaid assignment.

Cash Patients/Out-of-Network Health Plans: If you are covered by a health plan in which FMWC is "out- of network" or does not participate, we require that you pay for your charges at the time of service (i.e. today). We will give you a discount off of our standard fees.

Acceptable Forms of Payment: For your convenience, FMWC accepts Visa, MasterCard, American Express, and Discover as well as cash and checks (U.S. banks only).

Patients with Balances: You (the patient) have a **contractual agreement** with your insurance company to pay all co-pays, co-insurances, deductibles and any other balance you might owe. If you have any of these, **we will collect it from you at the time of your appointment**. If you are unable to pay for any balance owed to us, **we will ask you to reschedule your appointment**. **No exceptions will be made.**

I have read and understand this Payment Policy and understand that it is my responsibility to obtain any referrals that may be required by my health insurance plan. I hereby agree to take full responsibility for any and all charges incurred and hereby assign any and all insurance benefits to Family Medical and Wellness Center Of The Palm Beaches LLC.

Patient/Guarantor Signature:_____Date: _____

Privacy Notification

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding the Type of Information, We Have

We get personal and medical information about you when you enroll in a health plan. It includes your date of birth, sex, identification number, and other personal information. We also get bills, reports from your doctor, and other data about your medical care.

Our Privacy Commitment to You

We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and the legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment, payment, business operations, when we are required by law to do so, or for the other reasons listed below.

- **Treatment:** We may use or disclose medical information about you to provide and coordinate your health care. For example, we may notify your regular doctor about care you get in our emergency room.

- **Payment:** We may use and disclose information so the care you get can be properly billed and paid for. For example, we may ask an emergency room for details before we pay the bill for your care.

- **Business Operations:** We may need to use and disclose personal or medical information for our business operations. For example, we may use information to review the quality of care you get.

- **As Required By Law and for Other Government Functions:** We will release information when we are required by law to do so. Examples of such releases would be:
    - for law enforcement or national security purposes
    - subpoenas or other court orders
    - disclosures to the Friend of the Court
    - communicable disease reporting
    - disaster relief
    - review of our activities by government agencies
    - to avert a serious threat to health or safety or in other kinds of emergencies

  Public Health and Safety: We may use or disclose information about you as necessary to prevent or reduce a serious threat to the health or safety of a person or the public. For example, we, or our providers may report information to immunizations diseases registries.

  Family and Friends: We may disclose your information to family members, friends or others you identify to the extent it is relevant to their involvement with your care or payment for your care or to let them know about where you are and your condition.

- **With Your Permission:** If you give us permission in writing, we may use and disclose your personal information. If you give us permission, you have the right to change your mind and take back your permission. This must be in writing, too. We cannot take back any uses or disclosures already made with your permission. Our use and disclosure of your personal or medical information must comply with federal privacy regulations and applicable Florida law. Florida law provides different protections to your personal health information. For example, Florida law more strongly protects sensitive information like information about HIV/AIDS and mental health.

Your Privacy Rights

You have the following rights regarding the health information that we have about you. Your requests must be made in writing to:
Family Medical and Wellness Center of The Palm Beaches

- **Your Right to Inspect and Copy:** ***You have the right to look at or get copies of your medical records. You will be charged for the copies (includes cost supplies and labor). Postage if required is an additional charge.***
- **Your Right to Amend:** You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.

- **Your Right to a List of Disclosures:** You have the right to ask for a list of certain disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your permission. It will not include information released without your name or other data that would identify you.

- **Your Right to Request Restrictions on Our Use or Disclosure of Information:** You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to such requests, but can if we believe it is reasonable to do so.

- **Your Right to Request Confidential Communications:** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. We will do our best to accommodate your request.

Changes to this Notice

We reserve the right to revise this notice. A revised notice will be effective for personal and medical information we already have about you, as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our web site at: http://www.myfmwc.com If the changes to the notice are material, a new notice will be mailed to you before it takes effect.

How to Use Your Rights under This Notice

If you want to use your rights under this notice, you may call us or write to us. If you need help preparing your request, we will help you.

- **Complaints and communications to us:** If you want to exercise your rights under this notice or if you wish to communicate with us about privacy issues or wish to file a complaint, you can call us or write to us at:

Family Medical and Wellness Center of The Palm Beaches

Signature_____ **Date**_____

Notice of Privacy Practices
Family Medical and Wellness Center of the Palm Beaches, LLC

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

12983 Southern Blvd, Suite 102
Loxahatchee, FL 33470

Office: 561-721-1953
Fax: 561-721-2257

Attn: Compliance Contact

2013

The use of Mandatory Arbitration for Dispute Resolutions. In providing Health Care Services it is unlikely but possible that conflicts or disputes may arise. In order to avoid time consuming and expensive legal costs in resolving these disputes, we have decided t use a mandatory arbitration program administered by the fully independent and highly professional American Arbitration Association.

Please review the attached Arbitration Agreement for Health Care Services and sign the agreement if it meets with your approval.

By entering into this agreement, the parties to this agreement are giving up their constitutional and statutory right to have any dispute involving health care services decided before a judge or jury and instead are accepting mandatory and binding arbitration to resolve any dispute.

Arbitration Agreement for Health Care Services

Whereas on this_____day of_____, 20____the undersigned patient or the patient's legal representative has entered into this agreement with Family Medical and Wellness Center of The Palm Beaches, LLC to arbitrate any dispute involving the rendition of health care services by Family Medical and Wellness Center of the Palm Beaches LLC, and its physicians, employees, agents, partners and assigns (Family Medical and Wellness Center of The Palm Beaches LLC) its physicians , employees, agents and partners and assigns shall be called "health care provider" and have agreed to the following terms and conditions.

Article 1. Full Consideration for this Agreement: The undersigned parties agree that this agreement has been made for full consideration, which consideration includes, but is not limited to their mutual desire to have any health care services dispute or controversy resolved in a fair and expeditious manner by use of mandatory and binding arbitration.

Article 2. Health Care Services Are Arbitral: The undersigned parties agree that any and all issues involving health care services rendered by the health care provider including but not limited to disputes or controversy involving malpractice or negligence involving the diagnosis, treatment of care of the patient by the health care provider are arbitrable issues that shall be submitted to mandatory and binding arbitration as provided in this agreement. Further, the undersigned parties agree that any and all disputes or controversy involving health care services rendered prior to the execution of this agreement are also arbitrable and shall also be submitted to mandatory and binding arbitration as provided in this agreement.

Article 3. Agreement to Arbitrate Disputes under Rules of the American Arbitration Association. The undersigned parties agree that any and all disputes or controversy involving health care services provided by the health care provided to the patient shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and the Supplementary Procedures for Large Complex Disputes and judgment on the award rendered by the Arbitrator(s) may be entered in any court having judication thereof.

Article 4. Notice of Demand to Arbitrate. A party to this agreement shall give written notice of demand to arbitrate a controversy or dispute which involves health care services provided by the health care provider to the patient which notice shall specify the allegations or issues in dispute and shall appoint an arbitrator. Within 20 days of receipt of the written demand for arbitration the responding party shall have the right to name an arbitrator (failing to name an arbitrator within this twenty day period shall be considered a consent to the claimant's appointed arbitrator). If the responding party has appointed an arbitrator, then within 20 days of the appointment of an arbitrator by the responding party the two arbitrators shall select a third arbitrator (provided however if the arbitrators are unable or fail to agree upon a third arbitrator, then the third arbitrator shall be selected by the American Arbitration Association). The third arbitrator shall serves as chair of the arbitration panel. Within a reasonable period of time after the arbitrator(s) has accepted his or her appointment, the arbitrator(s) shall provided an oath or undertaking of impartiality. Provided however, whomever is appointed as an arbitrator shall have experience and knowledge of health care services issues.

Article 5. Discovery. Consistent with the expedited nature of arbitration, each party will, upon the written request of the other party promptly provide the other with copies of documents relevant to the issues raised by any claim or counterclaim. Any dispute regarding discovery or the relevance or scope thereof, shall be determined by the chair of the arbitration panel (or arbitrator if only one arbitrator is serving). All discovery shall be completed with 60 days following the appointment of the final appointed arbitrator. At the request of a party the arbitrator(s) shall have the discretion to order examination by deposition of witnesses to the extent the arbitrator deems such additional discovery relevant and appropriate. Depositions shall be limited to a maximum of three per party and shall be held within 30 days of the making of a request. Additional depositions may be scheduled only with the permission of the chair of the arbitration panel and for good cause shown. Each deposition shall be limited to a maximum of three hours duration. All objections are reserved for the arbitration hearing except for objections based on privilege and proprietary or confidential information.

Article 5. Location of Arbitration. The place of arbitration shall be within 25 miles of offices of the health care provider
Article 6. Patient's Right to Cancel Arbitration Agreement. The patient has the right to rescind this agreement by written notice to the health care provider within one (1) calendar week after this agreement has been signed and executed. The patient may rescind by merely writing "cancelled" on the face of one his copies of the agreement signing his name under such word and mailing by certified mail, return receipt requested, such a copy to the health care provider within such one (1) calendar week period.
Article 7. Arbitration as Exclusive Remedy. With respect to any dispute or controversy that is made subject to arbitration under the terms of this agreement no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except to enforce the award of the arbitrators.
Article 8. General Provisions:

A. This agreement shall be governed by and interpreted in accordance with the laws of the state of Florida
B. This agreement shall be binding on each parties' assigns, heirs, personal representative and assigns. Further, the parties intend that this agreement shall bind all parties whose claims may arise out of or relate to treatment or health care services provided by the health care provider, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to the claim
C. The substantially prevailing party shall be entitled to an award of reasonable attorney fees. Further, the arbitrator(s) shall award to the substantially prevailing party, if any, as determined by the arbitrators, all of its costs and fees. "Cost and Fees" mean all reasonable pre-award expenses of the arbitration including the arbitrators' fees, administrative fees, travel expenses, out-of-pocket expenses such as copying and telephone, court costs, witness fees and attorney fees.
D. Except as my be required by law, neither party nor an arbitrator may disclose the existence content or results of any arbitration hereunder without the prior written consent of both parties
E. The damages awardable at arbitration are limited to those available under Florida Law

Both parties to this contract acknowledge that they each have constitutional and statutory rights to have disputes involving health care services decided before a judge or jury and instead are accepting mandatory and binding arbitration to resolve and dispute

Family Medical and Wellness Center, LLC

Dated this____day of_____20____

By_____
Dr. Vanessa Vizcaino
Dr. Lesley Glover

Dated this____day of_____20____

Patient or Patient's Legal Representative

By_____

_____
Print Name

If you decide not to sign this arbitration, both Dr. Vanessa Vizcaino and Dr. Lesley Glover have the right not take you as patient *

Agreement signed: Yes / No Date:_____

Notice Regarding Abusive, Threatening Or Unruly Behavior

To Our Patients and Visitors:

FMWC staff is here to help you. In order to do this, we must ensure a safe environment.

FMWC will not tolerate any actions that threaten patients, visitors or staff, or prevent

Us from providing a safe environment. These actions include:

- Verbal harassment or abusive language
- Physical harassment
- Threats, cursing or sexual language directed at staff or others
- Illegal behavior
- Any disruptive activity

If your behavior threatens any one of our patients, visitors, or staff, we will ask you to immediately stop the behavior. If you do not stop, we will ask you to leave the premises and if necessary, we will call the police. And will result in immediate discharged from our practice.

Please respect our patients, visitors, and staff so we may care for you and your love ones.

Thank You,

FMWC

Family Medical and Wellness Center of the Palm Beaches, LLC
12983 Southern Blvd, Suite 102, Loxahatchee, FL 33470
Tel: 561-721-1953 / Fax: 561-721-2257

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	Persons/organizations receiving the information:
Specific description of information (including dates):	Purpose of requested use or disclosure:

The patient or the patient's representative must read and initial the following statements:

1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

Vanessa Vizcaino, M.D., Lesley Glover, M.D. & Heather Loguidice, ARNP

NO-SHOW POLICY

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor. Please let this notice serve to notify you that if you fail to give us a 12 hour notice of cancellation, there will be a $25 cancellation fee for appointments, billed to your account that cannot be filed to your insurance.

Signature of Patient _____Date:_____

Print Patient Name_____