AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB	Phone#	

I AUTHORIZE Dr. Ambrosio Romero TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:	
METHOD	**CONTACT INFORMATION**
☐ TEXT	
☐ EMAIL	
☐ VIDEO CONFERENCE	

I do not authorize Dr. Ambrosio Romero to communicate with me via electronic means

This Authorization to Communicate PHI via electronic means expires
☐Upon written revocation ☐Other

I understand by selecting the method of communication above and signing below, I authorize Dr. Ambrosio Romero, to share/communicate PHI information via electronic means to myself or my designee described above.
I understand his representatives may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers.
I understand that according to HIPAA Privacy Rule § 164.501, Dr.Ambrosio Romero cannot sell or distribute my communication method or information with any third-party without my prior consent.
I understand that, by federal law, Dr. Ambrosio Romero may not use or disclose my health information without my authorization, except as provided in Dr. Ambrosio Romero's Notice of Privacy Practices.
I hereby release Dr. Ambrosio Romero and his employees from any and all liability that may arise from the release of information as I have directed.
I understand emailing and texting are not secure forms of communication and I release Dr. Ambrosio Romero from any liability.
I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Notice of Billing Efforts Conducted Via Electronic Means

I understand that in its regular course of billing and collection efforts, Dr. Ambrosio Romero may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to Dr. Ambrosio Romero may be used for these purposes. I consent to the use of e-mail, text or automated voicemail communication by Dr. Ambrosio Romero if I have any balances due on my account, regardless of my Preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use of an

"automated telephone dialing system" or "autodialer". I understand that message and data rates may be assessed by my mobile provider. By signing this form, you represent that you are the cellular subscriber or customary user with respect to the cellular number(s) provided and that you have the authority to provide consent..	
Signature	Date
Print Name:	Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative
COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS NOT THE PATIENT	
Name of Representative	
Relationship to Patient (parent, health proxy, etc.)	Phone #
Email Address	

To ensure accurate crediting and avoid errors, please provide the following:

* A copy of your driver's license displaying your current legal address.
* A copy of the front and back of your credit card.

This information is essential for correctly posting transactions to your account.

In addition, please print the following below:

* Your preferred mailing address.

Easy way to complete and sign these intake forms:
1. Go to https://www.sejda.com/en/pdf-editor
2. Upload this blank PDF file.
3. Complete them directly on the website.
4. Download the completed/signed forms to computer.
5. Attach the completed PDF form to an email.
6. Include the date/time of the appt. you need in the email.
7. Send attachment to AmbrosioRomeroMD@gmail.com

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* Emergency contact information, including a phone number: ______________________________

Thank you for your cooperation.

My logo is inspired by the great Leonardo di ser Piero da Vinci, and constructed using artificial intelligence online. See below.

As a private patient, you have the right to consult with me, with reasonable notice, for a reasonable period of time, at mutually agreed-upon appointment times through electronic communication such as video or phone consultations. I do not provide private consultations at my office.

I am licensed in the state of Florida (License # ME 59052), and have been practicing in the state since December 3rd, 1990. I am part of the Orlando Health system with full and active attending privileges.

I am a board-certified Family Physician and a Fellow of the American Academy of Family Physicians (AAFP), with specialties in Family Medicine, Geriatrics, Home Care, and Telemedicine. I offer psychiatric counseling as a telemedicine physician only, and do not do inpatient psychiatric admissions, consults or care. I have been awarded thousands of five-star ratings on social media and Google reviews, and have won numerous awards from WebMD, Vitals, and Medscape. I am generally regarded by my peers as always demonstrating excellence in bedside manner, clinical acumen, and clinical outcomes.

Welcome to my private practice.

Generalized Anxiety Disorder Screening (GAD-7)

Patient Name: ___________________________ Patient Number: _______________ Date :

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

***Total Score*: ______**

Notes on GAD-7

Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 is also suitable for three other common anxiety disorders – panic disorder, social anxiety, and post-traumatic stress disorder (though it is desirable to use additional disorder-specific questionnaires).

Scoring

5-9 Mild Anxiety
10-14 Moderate Anxiety
15+ Severe Anxiety

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several Days	More than A week	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping to much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐

Add columns __________ + __________ + __________

(Healthcare professional: For interpretation of TOTAL, Please refer to accompanying scoring card).

TOTAL: ____________________

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ☐
- Somewhat difficult ☐
- Very difficult ☐
- Extremely difficult ☐

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Credit Card Authorization Form

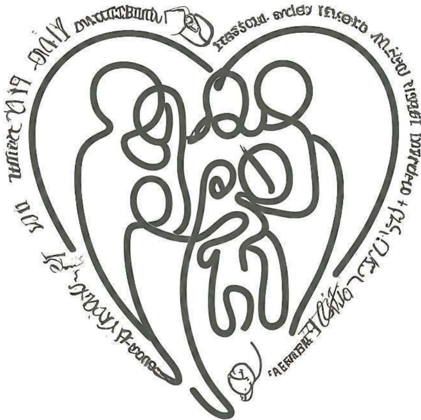
Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other ______________________			What is the number printed on the front of the AMEX card please? ___ ___ ___ ___
Cardholder Name (as shown on card): ______________________				
Card Number: ______________________ CVV: ___ ___ ___ ___				
Expiration Date (mm/yy): ______________________				
Cardholder ZIP Code (from credit card billing address): ______________________				

I, ______________________, authorize Dr. Ambrosio J. Romero, M.D., F.A.A.F.P. to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

______________________ ______________________

Customer Signature Date



As Dr. Ambrosio Romero, I want to assure you your cardholder information is treated with the utmost care and confidentiality. This sensitive data is accessible only to me and will not be shared with any unauthorized individuals or entities.

Your privacy and security are of paramount importance to me, and I adhere to strict professional and ethical standards in handling your personal information. You can trust that your cardholder data remains secure and confidential under my care.

[signature]

Dr. Ambrosio Romero, M.D., F.A.A.F.P., D.A.B.F.M.

Accurate Information Form

To ensure seamless processing of your prescription, please verify that the information provided below matches the details on file with your pharmacy. This will prevent any confusion when your prescription is electronically submitted on your behalf.

Please complete the following form to the best of your ability, ensuring accuracy in all fields:

Full Name

Date of Birth

Phone Number

Address

Height Weight

Email Address

Allergies

Your attention to detail is greatly appreciated, and I thank you for your cooperation in maintaining the accuracy of your pharmacy records.

Default Pharmacy Information

To ensure seamless processing of your prescriptions, please provide the following information regarding your preferred pharmacy:

Pharmacy Name

Address

Phone Number

Additionally, if you have a personal relationship with your pharmacist, please provide their:

Name

Please provide accurate details to facilitate prompt handling and processing of your medications. This information will be used for your initial prescriptions and can be updated at any time if needed. Thank you for your cooperation.

Dr. Ambrosio J. Romero, M.D., F.A.A.F.P., D.A.B.F.M.

Patient Responsibility and Controlled Substance Agreement

Between Patient: ______________________________________ and Provider: _________________________________

The Florida Legislature has laws governing the prescription of controlled drugs. A drug is classified as a controlled substance based on the relative abuse potential of the drug and the likelihood of its causing dependence. Controlled substance medications (ie, narcotics, benzodiazepines, sleep aids, stimulants and barbiturates) are very useful but have a high potential for misuse and are therefore, closely controlled by local, state, and federal governments. They are intended to relieve **pain, psychoactive disorders**, and other medical conditions, thus improving functions and/or ability to work.

The controlled substance my Provider is prescribing is: ____.

To comply with these laws, I acknowledge and agree to the following:

1. I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances. I understand that the long-term advantages and disadvantages of chronic use have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long-term use of controlled substances and that my Provider will advise me of any advances in this field and will make treatment changes as needed.
2. I agree that only my provider will prescribe controlled substance medication. I will not obtain or use any controlled substance from a source other than my provider. I will instruct my other providers to confer with my provider for any changes or need for additional controlled substance medication. If it is discovered that the other providers are prescribing medications for me, my provider reserves the right to discontinue prescribing medications and/or discharge me from the clinic. I understand that my provider **will be** verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Drug Monitoring Program website periodically throughout my treatment period.
3. **At the Providers discretion** refills can be written or sent electronically. Prescriptions for most controlled substance medications can only be written for a 30 day supply. If written, I understand I will need to come in and pick up the prescription. **I or authorized persons must provide proof of identity to pick up my prescription for controlled substance.**
4. All medicine should be filled at the same pharmacy, when possible. The pharmacy I have selected is (Name/Phone):

   ____

5. I must be seen by my primary care provider for Routine blood work and random urine drug NIDA -9 Testing when requested. may be part of my treatment plan. I agree to have them done on the day my provider requests it.
6. ◯ **Option 1:** My provider's office requires a 72 hour notice to refill prescriptions. Prescriptions can only be refilled during normal business hours. They will NOT be refilled at night or on weekends.

   ⓧ Except for emergencies Rx **can only be refilled during scheduled appointments.** They will NOT be refilled in between appointments, at night or on weekends.

   (The selected option will be at the Provider's discretion and based on the drug class and/or scheduled control substance)
7. My provider's office is not responsible for any controlled substance medications that have been misplaced, lost or stolen. Controlled substances cannot be refilled before the renewal date.
8. I agree that I will use my medication at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time and may result in termination from the practice.
9. In the case where my provider feels it is time to stop the medicine; my provider will help me do it safely by giving me clear instructions on how to taper the medication(s) safely and will be available to help me at any time during the tapering process. My Provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. It may be deemed necessary by my Provider that I see a medication use specialist at any time while I am receiving controlled substance medication(s). I understand that if I do not attend such an appointment, my medication(s) may be discontinued or may not be refilled beyond a tapering dose to completion. Also, a drug-dependence treatment program may be recommended. I would also be amendable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary. I understand that if the Provider feels that I am at risk for psychological dependence (addiction), my medication(s) will no longer be refilled.
10. **I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.**
11. I understand that the main treatment goal is to reduce symptoms and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I understand that a successful outcome of my treatment will only be achieved by following a healthy lifestyle.

12. It is a crime to obtain controlled substances under false pretenses. This could include getting medications from more than one provider, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). If my Provider has reason to believe that I have violated this agreement, the provider has the right to notify and cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I understand all confidentiality is waived and these authorities may be given full access to my records.
13. I authorize my Provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room.
14. My provider has the right to discontinue controlled substance medications and discharge me from care if any of the following occur:
    - I trade, sell, misuse or share medication with others;
    - The clinic discovers I have broken any part of this agreement;
    - I do not go for blood work or urine tests when asked;
    - My blood or urine shows the presence of medications that my provider is not aware of, the presence of illegal drugs or does not show medications that I am receiving a prescription for;
    - I get controlled substancesfrom sources other than Dr. Ambrosio Romero;
    - I exhibit any aggressive behavior toward the providers and/or staff;
    - I consistently miss appointments.
15. At the request of my Provider, I will bring any unused controlled substance medicine to every office visit. I will communicate fully with my provider about the character and intensity of my condition, on the day to day functioning, and how well the medicine is controlling symptoms.
16. **I have read this agreement in its entirety and agree to follow these guidelines that have been fully explained to me by Dr. Ambrosio Romero**

    Additionally, I fully understand the consequences of violating this agreement.

I have been fully informed by my Provider and office staff regarding psychological dependence (addiction) of controlled substance medications, which I understand is rare. I know that some individuals may develop a tolerance to the medications necessitating a dose increase to achieve the desired effect and that this is a risk of becoming physically dependent on the medication. This will occur if I am on the medication for several weeks; therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I hold Dr. Ambrosio Romero harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

______________________________	______________________________
Patient/Guardian Signature	Date
______________________________	______________________________
Printed Patient's Name	Date of Birth
______________________________	______________________________
Witness Signature & Date	Provider Signature & Date
______________________________	______________________________
Printed Witness's Name	Printed Provider's Name