Family Medical Centre

PATIENT INFORMATION SHEET / *Informacion del Paciente*

LAST NAME:_____ **DATE:**_____
Apellido

FIRST NAME / MI: _____ **EMAIL:**_____
Nombre / Inicial

ADDRESS:_____ **CITY/STATE**_____ **ZIP:**_____
Direccion *Ciudad / Estado* *Zona Postal*

PHONE:_____ **BIRTHDATE:** _____ **SEX: M F**
Telefono *Fecha de Nacimiento* *Sexo*

SOCIAL SECURITY #:_____ **MARITAL STATUS:** **S M D**
Numero Social *Estado Civil* *Soltero Casado Divorciado*

NATIVE LANGUAGE:_____
Idioma Nativo

OCCUPATION / EMPLOYER:_____
Empleo

EMPLOYER'S ADDRESS:_____
Direccion del Empleo

CITY:_____ **STATE:**_____ **ZIP:**_____
Ciudad *Estado* *Zona Postal*

WORK PHONE:_____ **EXT.:**_____
Telefono del Empleo

EMERGENCY CONTACT NAME:_____ **PHONE:**_____
Contacto de Emergencia

REFERRED BY:_____
Quien lo refirio a esta oficina

GUARANTOR INFORMATION: WHO IS RESPONSIBLE FOR PATIENT BILL: _____
Persona responsable de la cuenta

RELATIONSHIP TO PATIENT:_____
Relacion al Paciente

LAST NAME:_____ **FIRST NAME / MI:**_____
Apellido *Nombre / Inicial*

ADDRESS:_____ **DOB:**_____ **SS#:**_____
Direccion *Fecha de Nacimiento* *Numero de Seguro Social*

CITY: _____ **STATE:**_____ **ZIP:**_____
Ciudad *Estado* *Zona Postal*

HOME PHONE:_____ **WORK PHONE:**_____
Telefono *Telefono del Empleo*

- **DRIVERS' LICENSE:** PLEASE PRESENT CARD FOR COPYING. *Favor de presentar su tarjeta de licencia de manejar.*
- **PRIMARY INSURANCE INFORMATION:** PLEASE PRESENT INSURANCE CARD. *Favor de presentar su tarjeta de seguro.*
- **SECONDARY INSURANCE INFORMATION:** PLEASE PRESENT INSURANCE CARD. *Favor de presentar su tarjeta de seguro.*

I acknowledge full financial responsibility for all services rendered by Family Medical Centre. I understand that payments are due at the time of service (including co-payments) unless charges are being filed with my insurance company. I authorize that insurance payments be made directly to Wayne H. Case, M.D., P.A. I agree to pay all responsible attorney fees and collection costs in the event of a default of payment of my charges.

Yo reconozco completa responsabilidad financiera por todos los servicios recibidos por Family Medical Centre. *Yo entiendo que los pagos son hechos al momento de la visita (incluyendo co-pagos de seguro) a menos que los cargos sean cubiertos por mi compañía de seguro. Yo autorizo que los pagos del seguro sean hechos directamente a Wayne H. Case, M.D., P.A. Yo estoy de acuerdo con hacer todos los pagos rasonables de abogados y costo de colación en evento de falta de pago por mis cargos.*

_____ _____
DATE **SIGNATURE**

Please Complete Other Side.

Family Medical Centre

ADVANCE DIRECTIVES RECORD FORM

(LIVING WILL OR HEALTH CARE SURROGATE DESIGNATION)

Living Will

A living will is a legal document that allows a competent person to accept, refuse, stop or otherwise decide about medical care. It is prepared in advance and used when the person's condition is terminal and cannot decide about his or hers own medical care.

Testamento vital

Un testamento en vida es un documento legal que permite a una persona competente aceptar, rechazar, detener o decidir sobre la atención médica. Se prepara con anticipación y se usa cuando la condición de la persona es terminal y no puede decidir sobre su propia atención médica.

Health Care Surrogate Designation

A health care surrogate designation allows someone else to make healthcare choices for you if you cannot. He or she must follow directions stated in your health care surrogate designation and/or living will.

Designación sustituta de atención médica

Una designación sustituta de atención médica le permite a otra persona tomar decisiones de atención médica en su nombre si no puede hacerlo. Él o ella debe seguir las instrucciones indicadas en su designación sustituta de atención médica y / o testamento vital.

Please indicate below if you have previously prepared one of these documents:
Indique a continuación si ya ha preparado uno de estos documentos:

NAME:_____
Nombre

SOCIAL SECURITY #:_____
Numero de Seguro Social

EFFECTIVE DATE:_____
Fecha efectiva

PRIMARY CARE PHYSICIAN: _____
Médico de atención primaria

PLEASE CHECK ONE OF THE FOLLOWING: *POR FAVOR MARQUE UNO DE LOS SIGUIENTES:*

[ ] I have executed advance directive documents. *He ejecutado documentos de directivas anticipadas.*

[ ] I have not executed advance directive documents. *No tengo documentos de instrucciones anticipadas ejecutados.*

_____ _____

Signature (*Firma*) **Date (*Fecha*)**

_____ _____

Witness (*Testigo*) **Date (*Fecha*)**

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (Name and information of person whose health information is being disclosed):

Name (First Middle Last) _____
Apellido

Date of Birth (mm/dd/yyyy): _____
Fecha de Nacimiento

Address**:**_____ City: _____ State: _____ Zip:_____
Direccion *Ciudad / Estado* *Zona Postal*

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical services, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntary authorize, give my permission, and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) (See page 2 for details)

FROM WHOM: ALL Information sources (See page 2 for details)

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: _____ Phone: _____

Address: _____ Fax: _____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other persons (See page 2 for details).
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization and permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

X_____ _____
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____
Print Name of Legal Representative (if applicable)

Check to describe the relationships of Legal Representative to Patient (if applicable):

□ Parent of minor

□ Guardian

□ Other personal representative (explain: _____)

Note: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization of permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to**:
    a. Drug, alcohol, and substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis.
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including individualized Education Programs, assessments, psychological speech evaluations, immunizations, recorded health information (such as height, weight) and information about injuries or treatment**.
3. Information created before or after the date of this form.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health providers (such as nurses) and medical staff who are involved in your medical are at the organization's facility or that person's office, and health care providers who are covering or on call for the specified persona or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic exchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal laws, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: if you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Family Medical Centre

Family Practice

Wayne H. Case, M.D.

Cheryl Case-Diaz, M.D.
Michael J. Paritzky, P.A.
Yenma Vidal-Carmona, ARNP
Olga T. Perez, M.D.
Maydelis Mesa-Mendez, P.A.
Lianet Suarez Garcia, N.P.-C.

Hialeah/Miami Lakes Office
3410 W 84 St. Bldg. F, Suite #110
Hialeah, FL 33018
305-558-3571
Fax: 305-558-3682

Doral Office
3470 NW 82 Ave, #118
Doral, FL 33122
305-398-1991
Fax: 305-398-1994

Pembroke Pines Office
17933 NW 7th St., Suite #102
Pembroke Pines, FL 33029
954-436-1927
Fax: 954-436-0463

Authorization for Insurance Benefits

I understand that Family Medical Centre will not be responsible for any restrictions, limitations, co-insurance or deductibles being imposed by my insurance company.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered.

I request that payment of authorized medicare and/or other insurance company benefits be made to Family Medical Centre on behalf of my insurance company for any services furnished by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I hereby grant the doctor to release all information necessary to secure the payments of benefits.

I authorize the use of this signature for all insurance submissions.

I understand it is mandatory to notify the provider of any other party who may be responsible for payment of my treatment.

_____ _____

SIGNATURE (*Firma*) **DATE (*Fecha*)**

_____

PRINT NAME

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Autorización Para Beneficios de Seguro

Yo entiendo que Family Medical Centre no será responsable de ningún tipo de restricciones, limitaciones, co-seguros o deducibles impuestos por mi compañía de seguros.

Entiendo y acepto que yo soy últimamente responsable por el saldo de mi cuenta por cualquier de los servicios profesionales prestados.

Solicito que el pago autorizado de Medicare/o de otras compañías de seguros sea pagado a Family Medical Centre en mi nombre para cualquier servicio proporcionado por la parte que acepta la asignación. Los reglamentos relativos a la asignación de beneficios de Medicare se aplican.

Por la presente autorizo al médico poder enviar toda la información necesaria a mi seguro para asegurar el pago de las facturas.

Autorizo el uso de esta firma en todas las presentaciones de facturas al seguro.

Entiendo que es obligatorio notificar al proveedor de cualquier otra parte que puede ser responsable por el pago de mi tratamiento.

_____ _____

FIRMA **FECHA**

_____ _____

NOMBRE **FECHA**

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Financial Responsibility Statement

I understand that the medical services I will receive today may not be covered by my insurance and/or that I do not have insurance coverage at this time.

Therefore, I will be financially responsible for any and all services provided by Family Medical Centre in my behalf.

Other charges may be added as follows:

- Additional visit (99213) will be charged for other symptoms addressed at the time of physical exam.

- Additional charges for missed appointments
  - Office visit or bone density study: $25.00
  - Ultrasounds, Holter Monitor*, NCV's: $100.00
  - *Holter Monitor not returned on time: $25.00 / day

I agree to make full payment for all services received to myself or any other family member for which I may be signing this financial responsibility statement.

_____

PATIENT'S NAME

_____

ADDRESS

_____ _____

DATE *(Firma)* **PATIENT/GUARANTOR SIGNATURE**

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Declaración de Responsabilidad Financiera

Yo entiendo que los servicios médicos que voy a recibir hoy pueden no estar cubiertos por mi seguro y/o que no tengo cobertura de seguro en este momento.

Por lo tanto, voy a ser financieramente responsable por cualquier y todos los servicios proporcionados por Family Medical Centre en mi nombre.

Otros cargos pueden añadirse como:
Una visita adicional (99213) será cobrada por otros síntomas tratados en el momento de la cita para un examen físico.

Cargos adicionales por citas perdidas:

Visita al consultorio o estudio de densidad ósea……..	$25.00
Ecografia, *monitor de Holter, NCV's……..	$100.00
*Monitor de Holter no devuelto a tiempo……	$25.00 por/día

Me comprometo a hacer el pago completo por todos los servicios recibidos, a mí/o a cualquier otro miembro de la familia para cual yo este firmarmando esta declaración de responsabilidad financiera.

_____

NOMBRE DEL PACIENTE

_____

DIRECCION

_____ _____

FECHA **PACIENTE / GERENTE FIRMA**