FAMILY MEDICAL CENTRE

Patient Information Sheet / *Informacion del Paciente*

DATE: _____
Fecha

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

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

PHONE: _____ **CELL**: _____ **BIRTH DATE**: _____ **SEX**: M F
Telefono *Fecha de Nacimiento* *Sexo*

SOCIAL SECURITY #: _____ **MARITAL STATUS**: SINGLE MARRIED DIVORCED
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 *Telefono*

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: _____
Direccion

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

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

DRIVER'S LICENSE: PLEASE PRESENT CARD FOR COPYING. *Favor de presentar su tarjeta de licensia 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 payment is 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 reasonable attorney fees and collection costs in the event of default of payment of my charges.

Yo admito 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 compañia de seguro. Yo autorizo que los pagos del seguro sean pagados directamente a Wayne H Case, M.D.,P.A. Yo estoy de acuerdo con hacer todos los pagos rasonables de abogados y costo de colecion en evento de falta de pago por mis cargos.*

DATE: _____ **SIGNATURE**: _____

PLEASE COMPLETE OTHER SIDE

ADVANCE DIRECTIVES RECORD FORM

(LIVING WILL OR HEALTH CARE SURROGATE DESIGNATION)

LIVING WILL

LIVING WILL IS A LEGAL DOCUMENT THAT ALLOWS A COMPETENT PERSON TO ACCEPT, REFUSE, STOP OR OTHERWISE DECIDE ABOUT MEDICAL CARE. IT IS PERPARED IN ADVANCE AND USED WHEN A PERSON'S CONDITION IS TERMINAL AND CANNOT DECIDE ABOUT HIS OR HER OWN MEDICAL CARE.

HEALTH CARE SURROGATE DESIGNATION

A HEALTH CARE SURROGATE DESIGNATION ALLOWS SOMEONE ELSE TO MAKE HEALTH CARE CHOICES FOR YOU IF YOU CANNOT. HE / SHE MUST FOLLOW DIRECTIONS STATED IN YOUR HEALTH CARE SURROGATE DESIGNATION AND / OR LIVING WILL.

PLEASE INDICATE BELOW IF YOU HAVE PREVIOUSLY PREPARED ONE OF THESE DOCUMENTS.

NAME : _____

SOCIAL SECURITY NO. : _____

EFFECTIVE DATE : _____

PRIMARY CARE PHYSICIAN : _____

PLEASE CHECK THE FOLLOWING:

[ ] I HAVE EXECUTED ADVANCE DIRECTIVE DOCUMENT

[ ] I HAVE NOT EXECUTED ADVANCE DIRECTIVE DOCUMENT

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

Family Medical Centre

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Family Medical Centre may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family Medical Centre's Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Medical Centre reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Medical Centre, Privacy Officer, 3410 West 84th St #110, Bldg. F, Hialeah, FL 33018.

With my consent, Family Medical Centre may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, Family Medical Centre may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential.

With my consent, Family Medical Centre may e-mail to my home or other designated location any items that assist the practice in parrying out TPO, such as appointment reminders and patient statements.

I have the right to request Family Medical Centre restrict how it uses or discloses PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Family Medical Centre's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Family Medical Centre may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient Print Name of Legal Guardian

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign ___ Communication barriers _____Emergency situations

___ Other _____

Family Medical Centre

Patient Consent for Use and Disclosure of Protected Health Information

Con mi consentimiento Family Medical Centre puede utilizar y divulgar información de la salud protegida (PHI por sus siglas en inglés) mía para efectuar tratamiento, pago, y operaciones del cuidado de la salud (TPO por sus siglas en inglés). Favor de referirse al Aviso acerca de las Prácticas de Privacidad de Family Medical Centre para uno descripción más completa sobre dichos usos y divulgaciones.

Tengo el derecho de revisar su Aviso acerca de las Prácticas de Privacidad antes de firmar este consentimiento. Family Medical Centre se reserva el derecho de modificar su Aviso acerca de las Prácticas de Privacidad en cualquier momento. Un Aviso acerca de las Prácticas de Privacidad enmendido puebe obtenerse al dirigirse por escrito a Gerente de la Privacidad de Family Medical Centre a la 3410 West 84th St #110, Bldg. F, Hialeah, FL 33018.

Con mi consentimiento Family Medical Centre puede llamar a mi casa o a otra ubicación designada y dejar un mensaje en el buzón de voz o con una persona respecto a cualquier asunto que les ayude en desempeñar sus TPO, tales como recordarme de citas, asuntos de seguro, y cualquier llamada relacionada con mi atencion clinica, incluyendo resultados de laboratorio, entre otros.

Con mi consentimiento Family Medical Centre puede mandarme cartas que les ayuden a desempeñar sus TPO a mi casa o a otra ubicación designada, tales como recordarme de citas, y estados de cuente, del paciente siempre y cuando estén marcadas Personal o Confidencial.

Con mi consentimiento Family Medical Centre puede enviarme correos electrónicos a mi casa o a otra ubicación designada cualquier asunto que le ayude a la consulta a desempeñar sus TPO, tales como recordarme de citas y estados de cuente del paciente. Tengo el derecho de pedirle a que limiten cómo utilizan o divulgan mis PHI para desempeñar sus TPO.

Sin embargo, la consulta no está obligada a asentir a mi solicitud para los limites de divulgación, pero is lo hace, está sujeta a este convenio. Al firmar este contrato, estoy consinteindo que Family Medical Centre utilice y divulgue mi PHI para desempeñar su TPO.

Puedo revocar mi consentimiento por escrito excepto en el caso que las consulta ya haya hecho divulgaciones por atenerse a mi consentimiento previo. Si no firmo este consentimenito, puedo que Family Medical Centre se niege a darme tratamiento.

_____ _____

Firma del Paciente o Guardián Legal Nombre del Paciente Fecha

_____

Nombre del Paciente o Guardián Legal
en letras de imprenta

Family Medical Centre

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, _____, have reviewed / received a copy of the Family Medical Centre's Notice of Privacy Practices.

_____ _____

Signature Date

Family Medical Centre

Acceptacion de el Aviso de Privacidad de las Practicas

Yo, _____, he revisado / recivido la copia de Family Medical Centre's Aviso de Privacidad de las Practicas.

_____ _____

Firma Fecha