Miami Comprehensive Medicine Group, PA

DATE:_____

PATIENT INFORMATION

Información del Paciente

SOCIAL SECURITY# *Número de seguro social*					
PATIENT'S NAME *Nombre del paciente*			DATE OF BIRTH *Fecha de Nacimiento*		
PERMANENT ADDRESS *Dirección Permanente*					
CITY *Ciudad*		STATE *Estado*		COUNTRY *País*	
ZIP CODE *Código Postal*		tK2yŜ		WORK PHONE *Teléfono del Trabajo*	
CELL PHONE *Celular*		EMAIL			
MARITAL STATUS *Estado Civil*		SEX *Sexo*		ETHNICITY *Etnicidad*	
OCCUPATION *Ocupación de Paciente*		EMPLOYED BY *Empleador*			
BUSINESS ADDRESS *Dirección del Trabajo*					
REFERRED BY *Referido por*		EMERGENCY CONTACT *Contacto de Emergencia*			
EMERGENCY CONTACT PHONE *Teléfono*		RELASHIONSHIP TO PATIENT *Relación*			

INSURANCE INFORMATION

Información del Seguro

MEDICARE NUMBER OR SOCIAL SECURITY NUMBER OF SUBSCRIBER *Numero de Medicare o Seguro Social de Asegurado*					
INSURANCE COMPANY (If Blue Shield, indicate State) *Nombre de su Seguro (Si es Blue Shield, indique el Estado)*					
ADDRESS *Dirección*			PHONE *Teléfono*		
POLICY NUMBER / MEDICARE NUMBER *Póliza o Numero de Medicare*		☐ GROUP *Grupo*	☐ PRIVATE *Privado*		
GROUP NUMBER *Numero de Grupo*		NAME OF SUBSRIBER *Nombre del Asegurado*			
DATE OF BIRTH *Fecha de Nacimiento*		RELATIONSHIP TO PATIENT	☐ SELF *Mismo*	☐ SPOUSE *Esposo/a*	☐ OTHER *Otro*
SECONDARY INSURANCE COMPANY (If Blue Shield, indicate State) *Nombre de su Segundo Seguro (Si es Blue Shield, indique el Estado)*					
ADDRESS *Dirección*			PHONE *Teléfono*		
POLICY NUMBER / MEDICARE NUMBER *Póliza o Numero de Medicare*		☐ GROUP *Grupo*	☐ PRIVATE *Privado*		
GROUP NUMBER *Numero de Grupo*		NAME OF SUBSRIBER *Nombre del Asegurado*			
DATE OF BIRTH *Fecha de Nacimiento*		RELATIONSHIP TO PATIENT	☐ SELF *Mismo*	☐ SPOUSE *Esposo/a*	☐ OTHER *Otro*
PRIMARY LANGUAGE *Primer Idioma*		**PATIENT'S SIGNATURE** ***Firma del Paciente***			

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www.miamedicine.com

Miami Comprehensive Medicine Group, PA

NAME: DOB:

Medications

Please list all prescription and over-the-counter medications you are taking

Name of Medication and Strength	# of doses / day

Other Physicians

Please list any physician(s) you have seen in the past 12 months

Name	Specialty	Office Number

Preferred Pharmacy

Name:	Phone:	
Address:	Fax:	

NAME: DOB:

Miami Comprehensive Medicine Group, PA

Patient Request for Confidential Communications of Protected Health Information

The Health Insurance Portability Act of 1996 ("HIPAA") provides you the right to request that **MIAMI COMPREHENSIVE MEDICINE GROUP., (MCMG)** communicate with you about your health information at an alternative address or phone number, or by an alternative means (for example, by email) that is more confidential for you. **MCMG** must accommodate your request if it is reasonable.

MCMG may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, the Medical Center will make every attempt to communicate with you in the manner you have requested. Your election will remain in effect until you have instructed us in writing to change the manner of communication.

To request confidential communications, please complete the form below and send to:

MIAMI COMPREHENSIVE MEDICINE GROUP. 4689 Ponce De Leon Blvd, Suite No. 200 Coral Gables, FL 33146

Patient Name: _____ Telephone #: _____

Address: _____City:_____State:_____Zip:_____

I am requesting that **MCMG**, communicate with me by an alternative means or at an alternative address or phone number that is more confidential for me. I understand that the Medical Center will not accommodate unreasonable requests.

Describe the alternative means of communication you are requesting:

☑ Text to the following No. _____

☑ Fax to the following No. _____

☐ Other(s): _____

If the alternative address selected by patient is an e-mail, then E-Mail Consent Form MUST be completed.

☑ E-Mail Consent Form

Purpose: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information (PHI).

MIAMI COMPREHENSIVE MEDICINE GROUP., (MCMG) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before granting consent to use e-mail for these purposes. **MCMG** will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, **MCMG** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail between **MCMG** and me and consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that **MCMG** may communicate with me regarding my protected health information by e-mail.

My Consented E-Mail Address is: _____

_____

x_____ Date Signed: _____ _____ _____

Signature of Patient or Legal Representative * May be requested to show proof of representative status

Office Use: Received: ____/_____/_____ Completed: ____/_____/_____ Initials: _____

Miami Comprehensive Medicine Group
345 Palermo Ave Coral Gables FL 33134
Tel. (305) 749-9888 Fax: (305) 749-9964

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

Patient Name: _____ SS#: _____
(Nombre Paciente)
Address: _____
(Direccion)
Telephone #: _____ Date of Birth: _____
(Telefono #) (Nacimiento Fecha)

I authorize **MIAMI COMPREHENSIVE MEDICINE GROUP,** to obtain the health information indicated below:
Yo autorizo a **MIAMI COMPREHENSIVE MEDICINE GROUP,** a recibir la información de salud como se indica:

Dates of Medical Record Requested: _____
(Fechas Requeridas de Expediante Medico)

Reason for Disclosure (Proposito de Entrega):
✔ Continuing Care ____ Insurance ____ Legal ____ Personal Use ____ Other Reason
(Continuidad de la atención) (Seguro) (Legal) (Uso Personal) (Otros Propósitos)

Check box of authorized health Information to be requested:

✔	Complete Record (Record Completo)		Radiology Reports (Reportes Radiologia)
	Therapy Physical/ Occupational (Terapia Fisica/ Ocupacional)		Pathology Reports (Reporte Patologia)
	Lab Reports (Informes de Laboratorio)		EKGs (Electrocariogramas)
	Other (Specify) Otros (Especifique)		Operative Report (Reporte Operativo)

SPECIFIC AUTHORIZATIONS

The Following Information will not be obtained unless you specifically authorize it by marking the relevant box (es) below:
(La siguiente información no puede ser obtenida sin la específica autorización dada marcando la caja (s) siguiente)

☑ Drug/ Alcohol Abuse or Treatment (Abuso o Tratamiento de Droga/ Alcohol)
☑ HIV/ AIDS Test Results or diagnoses (Resultado o Diagnostico VIH/ CIDA)
☑ Genetic Testing Information (Información de Pruebas Genéticas)

☑ Psychotherapy Notes (**The release of Psychotherapy Notes required a separate authorization**)
(Notas de Psicoterapia)(Revelar **Notas de Psicoterapia requiere una autorización por separado**)

I hereby authorize the disclosure of the information instructed above. I understand that this consent is subject to revocation at any time by submitting a written request, except to the extent the action has been taken thereon. This Authorization and consent will expire one year from date of authorization written below.
Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the Recipient may no longer be protected by law.

Por la presente yo autorizo que la información marcada puede ser obtenida. Entiendo que este consentimiento puede ser revocado en cualquier momento por escrito, excepto cuando la acción ya ha sido tomada. Esta autorización y consentimiento vencerá a un año de la firma de la presente forma.
Su cuidado de salud (o pagos por el mismo) no podrán ser afectados firme o no esta autorización. Una vez que su información sea entregada, la misma ya no estará resguardada por las leyes.

_____ Date Signed: _____
Signature of Patient or Legal Representative (Fecha)
(Firma del Paciente o Representante Legal)

_____ Relationship if Not Patient: _____
Printed Name (Nombre en Letra de Molde) (Relación si No es el Paciente)

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care).
(Si no es la firma del paciente, una copia del documento legal verificando que es el representante del paciente TIENE que ser acompañada con este formulario)

Miami Comprehensive Medicine Group

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Tel. (305) 749-9888 Fax: (305) 749-9964

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ SS#: _____

(Nombre Paciente)

Address: _____

(Direccion)

Telephone #: _____ Date of Birth: _____

(Telefono #) (Nacimiento Fecha)

I authorize **MIAMI COMPREHENSIVE MEDICINE GROUP..,** to release the health information indicated below to/from:

Yo autorizo a **MIAMI COMPREHENSIVE MEDICINE GROUP.,** a entregar la información de salud como se indica a:

Person/ Organization: _____

(Persona/ Organizacion)

Address: _____

(Direccion)

Phone: _____ Dates of Medical Record Requested: ____/____/____

(Telefono) (Fechas Requeridas de Expediente Médico)

Reason for Disclosure (Proposito de Entrega):

☐ Continuing Care (Continuidad de la atención) ☐ Insurance (Seguro) ☐ Legal (Legal) ☐ Personal Use (Uso Personal) ☐ Other Reason (Otros Propositos)

Check a Box ☑

☐	Complete Record (Record Completo)	☐	Radiology Reports (Reportes Radiologia)
☐	Therapy Physical/ Occupational (Terapia Fisica/ Ocupacional)	☐	Pathology Reports (Reporte Patologia)
☐	Lab Reports (Informes de Laboratorio)	☐	EKGs (Electrocariogramas)
☐	Other (Specify) Otros (Especifique)	☐	Operative Report (Reporte Operativo)

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:
(La siguiente información no puede ser revelada sin la específica autorización dada marcando la caja(s) siguientes)

☐ Drug/ Alcohol Abuse or Treatment (Abuso o Tratamiento de Droga/ Alcohol)

☐ HIV/ AIDS Test Results or diagnoses (Resultado o Diagnostico VIH/ CIDA)

☐ Genetic Testing Information (Informacion de Pruebas Geneticas)

☐ Psychotherapy Notes (**The release of Psychotherapy Notes required a separate authorization**) (Notas de Psicoterapia) (**Revelar Notas de Psicoterapia requiere una autorización por separado**)

I hereby authorize the disclosure of the information instructed above. I understand that this consent is subject to revocation at any time by submitting a written request, except to the extent the action has been taken thereon. This Authorization and consent will expire one year from date of authorization written below.
Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the Recipient may no longer be protected by law.

Por la presente yo autorizo que la información marcada puede ser revelada. Entiendo que este consentimiento puede ser revocado en cualquier momento por escrito, excepto cuando la acción ya ha sido tomada. Esta autorización y consentimiento vencerá a un ano de la firma de la presente forma.
Su cuidado de salud (o pagos por el mismo) no podrán ser afectados firme o no esta autorización. Una vez que su información sea entregada , la misma ya no estará resguardada por las leyes.

_____ Date Signed: _____

Signature of Patient Or Legal Representative
(Firma del Paciente o Representante Legal)

_____ Relationship if Not Patient: _____

Printed Name (Nombre en Letra de Molde) (Relación si No es el Paciente)

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care).
(Si no es la firma del paciente, una copia del documento legal verificando que es el representante del paciente TIENE que ser acompañada con este formulario)

Miami Comprehensive Medicine Group, PA

Releasing Information / Patient's Rights and
Acknowledgement of Receipt of Notice of Privacy Practices

The Department of Health and Human Services Has established a "Privacy Rule" to help insure that personal health care information is protected for privacy and is only to be used or shared in the minimum necessary fashion. Healthcare providers are to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment, or health care operations. By signing this consent, you understand that your physician may need to provide necessary medical information to other appropriate physicians, pharmacies, hospitals, insurance companies, laboratories, and billing agencies. Refusing to consent to the use or disclosure of your personal health information prohibits the doctor from billing for their services; scheduling your care at a hospital; or calling in a prescription to a pharmacy; or medical need. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Office Manager.

El departamento de Servicios Humanos y de Salud ha establecido una Regla de Privacidad con miras de asegurar que se proteja la privacidad de la informacion sobre la atencion personal de la salud y que se use o se comparta solamente la minima informacion que sea necesaria con el fin de proporcionarles una norma a revelaciones de informacion acerca de la salud de usted para fines de tratamientos, pagos, y operaciones de cuidado de la salud. El negarse a dar su consentimiento al uso o revelacion de informacion personal sobre su salud le prohibe al medico facturar sus servicios, programar la atencion que se le vaya a dar a usted en el hospital, llamar a una farmacia para que le despachen una receta asi como satisfacer otras necesidades medicas. En virtud de esta ley, tenemos el derecho de negarnos a dar tratamiento si usted decide negarse a revelar Informacion Personal sobre la Salud (PHI Personal Health Information por sus siglas en ingles). Si usted decide dar su consentimiento mediante este documento, en algun momento futuro usted tambien podra revocar dicho consentimiento por escrito. No se dara a conocer ninguna otra informacion a partir de la fecha en que usted le presente dicha revocacion al doctor.
Si tiene alguma pregunta acerca del presente formulario, pida hablar con nuestro gerente de oficina.

Patient Consent for use and disclosure of Protected Health Information as required and/or permitted by law.
Consentimiento del Paciente para usar y compartir Informacion Personal sobre la Salud como lo permitad y/o requiera la ley.

_____	_____	_____
Patient's Name / Nombre del Paciente	Patient or Legal Representative Signature Firma del Paciente o Representante Legal	Date / Fecha

And I also acknowledge that I have been provided with the "Notice Of Privacy Practices"
Y tambien confirmo que se me ha proveido la "Noticia De las Practicas de Privacidad"

Compliance Assurance Notification for Our Patient's

The misuse of PHI has been identified as a national problem causing inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government regulations regarding HIPAA with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing service for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

El mal uso de la PHI ha sido identificado como un problema nacional que causa molestias, exasperacion y gasto de dinero. Queremos que sepa que todos nuestros empleados, gerentes y doctores continuamente reciben entrenamiento para que sepan comprender y cumplir las reglas y regulaciones gubernamentales con respecto a HIPAA dandole especial enfasis a la Regla de Privacidad. Nos esforzamos por alcanzar las mas elevadas normas de etica e integridad en la prestacion de servicios a nuestros pacientes. Nuestra politica es el determinar adecuadamente los usos apropiados de la Informacion Personal sobre la Salud en conformidad con las reglas, leyes y regulaciones gubernamentales. Queremos asegurar que nuestra practica nunca contribuya de manera alguna al creciente problema de la revelacion inapropiada de dicha informacion. Como parte de este plan, hemos implementado un Programa de Cumplimiento que creemos nos ayudara a impedir cualquier uso inapropiado de PHI. Tambien sabemos que no somos perfectos, a causa de ello, nuestra politica es escuchar a nuestros empleados y pacientes sin intecion alguna de sancionarlos ni penalizarlos si ellos son de la opinion que un evento compromete nuestra politica de integridad de algun modo. Mas aun, acogemos las ideas que usted tenga acerca de qualquier problema que tenga el servicio para poder resolver esa situacion prontamente.
Gracias por ser nuestro valioso paciente.

Miami Comprehensive Medicine Group, PA

OFFICE POLICY FOR APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Miami Comprehensive Medicine Group. We strive to render excellent medical care to every patient. In order to be consistent with this philosophy, we have adopted an appointment system that sets aside ample time dependent on the patient's need.

If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. Missed appointments can also cause our doctors to wait at the office when he or she could be at the hospital or some other healthcare facility. With that in mind we have adopted the following Medical Appointment Cancellation Policy:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is (305)749-9888.

2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment. There will be a $50.00 charge billed directly to you, for any ***three*** missed appointments that are not cancelled as stated above. *(Please note that your insurance will not reimburse you for these fees).*

3. If you are less than 15 minutes late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length. If you are ***more than 15 minutes*** late, however, the appointment will have to be rescheduled in order to continue to provide the highest level of care to all of our patients.

4. As a courtesy, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact us and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by Its terms.

_____ _____

Signature (Patient/ Proxy) Relationship to Patient

_____ _____

Printed Name Date

345 Palermo Ave, Coral Gables FL 33134 Phone: (305) 749-9888 Fax: (305) 749-9964
www.miamedicine.com

NAME: DOB:

Miami Comprehensive Medicine Group, PA

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign and authorize payment directly to Miami Comprehensive Medicine Group, PA all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for Miami Comprehensive Medicine Group charges, for services rendered by Miami Comprehensive Medicine Group. I request that payment of authorized benefits be made on my behalf to Miami Comprehensive Medicine Group for any services provided to me by Miami Comprehensive Medicine Group.

A copy of this agreement shall be considered effective and valid as the original.

I authorize Miami Comprehensive Medicine Group, PA to disclose, to the extent allowed by law, my medical and other information to (a) any affiliate of Miami Comprehensive Medicine Group, specifically including Miami Comprehensive Medicine Group and its employees and agents, and entities under contract with Miami Comprehensive Medicine Group to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to Miami Comprehensive Medicine Group or to me, or any person or entity responsible for all or part of Miami Comprehensive Medicine Group charges including any insurance company or its agents or employees; (c) any person or entity to whom I have been referred for continued care; (d) any provider treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their agents or employees.

Information Privacy: Miami Comprehensive Medicine Group will use and disclose your protected information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies with regard to your protected health information. The terms of the Notice of Privacy Practices may change with time and we will always post the current notice at our clinics, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

☒ I have received a copy of Miami Comprehensive Medicine Group Notice of Privacy Practices

_____ _____

Signature (Patient/ Proxy) Date

☐ I declined a copy of Miami Comprehensive Medicine Group Notice of Privacy Practices

_____ _____

Signature (Patient/ Proxy) Date

All Miami Comprehensive Medicine Group charges are due and owed at the time of visit. In consideration of the services to be rendered to the extent not expressly prohibited by law or by the contract between Miami Comprehensive Medicine Group and the third party payor: I HEREBY AGREE TO PAY ALL SUMS DUE Miami Comprehensive Medicine Group regardless of whether I am signing as a patient or as a guarantor. Should my account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts may bear interest on the unpaid amount as allowed by law. I understand that I am financially responsible for charges not paid and for charges not covered by this assignment. I understand that if Miami Comprehensive Medicine Group files for reimbursement from my insurer or other payor as a courtesy, and the insurer fails to make payment, I shall not be relieved of my obligation to pay Miami Comprehensive Medicine Group.

I certify that I am the patient and/or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due. I understand that if I have coverage questions, I am advised to call my insurance carrier,

I UNDERSTAND THIS AGREEMENT.

_____ _____

PATIENT Guarantor

_____ _____

WITNESS Date