Miami Gastroenterology Consultants, P.A.

PATIENT INFORMATION *Informacion del paciente*

Patient Name:
Nombre del paciente ______________________________

Date of Birth:
Fecha de nacimiento ______________________________

Address:
Direccion del Hogar ______________________________

Social Security #:
Numero de Seguro Social ______________________________

Home Phone:
Telefono del Hogar ______________________________

Work Phone:
Telefono del Trabajo ______________________________

Cell Phone #:
Numero de Cellular ______________________________

Spouse or Emergency Contact :
Contacto de Emergencia ____________________ *Phone#:* ____________________

Patient Email Address:
Correo Electronico ______________________________

Marital Status:
Estado Civil ______________________________

Ethnic Group: __________ Race: ______ Primary Language: ___________
Groupo Etnica *Raza* *Idioma Principal?*

*Pharmacy: __________________________ *Pharmacy Number: ___________________________
Farmacia *Telefono de su Farmacia*

Referring Physician:
Nombre de su medico ______________________________

Phone Number:
Telefono ______________________________

INSURANCE INFORMATION *Informacion del Seguro*

Name of Primary Insurance:
Nombre del Seguro ______________________________

Insurance ID#:
Numero de Identificacion del Asegurado ______________________________

Name of Subscriber:
Nombre de Asegurado ______________________________

Subscriber DOB#:
Fecha de nacimiento del Asegurado ______________________________

Secondary Insurance:
Nombre de Seguro Secundario ______________________________

Insurance ID#:
Numero de Identificacion del Asegurado ______________________________

Name of Subscriber:
Nombre de Asegurado ______________________________

Subscriber DOB#:
Fecha de nacimiento del Asegurado ______________________________

Patient Name:
Date of Birth:

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card, American Express and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Some Insurance companies require that you have a referral from your PRIMARY CARE PHYSICIAN, and it is the patient's responsibility to obtain and bring referral before our services can be rendered. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any collection fees incurred, including attorney's fees, interest, and court costs.

IMPORTANT NOTICE:

- **YOU MUST NOTIFY OUR OFFICE 48 HOURS IN ADVANCE OF ANY SCHEDULED APPOINTMENT CANCELLATION IN ORDER TO AVOID CANCELLATION FEES. OFFICE NO SHOW FEE $ 25.00 / PROCEDURE NO SHOW FEE $ 100.00**
- **IF YOU DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, YOU WILL BE CHARGED A NO SHOW FEE. I UNDERSTAND THAT THIS FEE IS NOT COVERED BY MY INSURANCE AND I WILL BE RESPONSIBLE TO PAY THIS FEE.**

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. Muchas compania de seguro requieren un referido de su MEDICO FAMILIAR, es la responsabilidad de el paciente de traer su referido a la hora de la visita. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta dueda, usted es responsable de los gastos legales.

AVISO IMPORTANTE:

- ***USTED DEBE NOTIFICAR A NUESTRA OFICINA 48 HORAS ACTICIPACION DE CUALQUIER CANCELACIÓN DE SU CITA PARA EVITAR CARGOS DE CANCELACIÓN.***
- ***SI USTED NO SE PRESENTA A SU CITA, USTED TENDRÁ UN CARGO DE NO SHOW. YO ENTIENDO QUE ESTE CARGO NO ESTA CUBIERTO POR MI SEGURO Y YO SERE RESPONSIBLE POR PAGAR ESTE CARGO.***

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby assign payment directly to Miami Gastroenterology Consultants, P.A. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by PA. I understand that I am financially responsible to PA for any and all charges that the carrier declines to pay (including but not limited to: Not a covered benefit; Disallowed by plan). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente Miami Gastroenterology Consultants, P.A. todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PAPER CLAIM DISCLAIMER

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. <X> will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

FORMULARIO DE DOCUMENTO DE RENUNCIA

Tenga en cuenta que completar cuestionarios seguros y salud preliminar no establece una relación médico-paciente con esta práctica. El Dr. revisará su historial de salud y llevar a cabo una evaluación inicial para determiner si usted es un candidato adecuado y si la practica lo aceptara como paciente.

HIPPA PRIVACY COMPLIANCE WITH HITECH UPDATES

PLEASE NOTE OUR HIPPA COMPLIANT PATIENT PRIVACY NOTICES IS POSTED IN OUR WAITING ROOM FOR EVERYONE TO REVIEW; YOU MAY REQUEST A COPY FOR YOUR RECORDS.

NOTICE OF PRIVACY ACKNOWLEDGEMENT: I have read and understand the Privacy Act:

EN NUESTRA SALA DE ESPERA SE ENCUENTRA UNA COPIA VISIBLE PARA QUE EL PACIENTE PUEDA LEER DE QUE ESTAMOS EN CUMPLIMIENTO DE SUS DERECHOS DE PRIVACIDAD, SI NECESITA COPIA PARA USTED PORFAVOR PEDIRLA.

YO HE LEIDO Y ENTIENDO LOS DERECHOS DE PRIVACIDAD AL PACIENTE:

Signature:____ **Date:**____________________

Firma del Paciente ***Fecha***

Patient Name:
Date of Birth:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND OTHERS

"I authorize disclosure of my protected health information for purposes of communicating results, findings, and care decisions to my family members and others as indicated below.

I acknowledge that no information regarding my healthcare can be communicated without my permission unless I become incapacitated. If I become incapacitated, healthcare providers will communicate to individuals assigned in advance directives previously designated by me. If no advanced directive has been designated, I acknowledge that healthcare providers will communicate to my nearest next of kin."

AUTORIZACION PARA DIVULGAR INFORMACION MEDICA PROTEGIDA A FAMILIARES O A OTRAS PERSONAS

"Yo doy mi autorización para divulgar mi información medica protegida con el objetivo de comunicarle a mis familiares y a las otras personas abajo indicadas los resultados y las decisiones a tomar respecto al cuidado de mi salud.

Yo entiendo que ninguna información relacionada con el cuidado de mi salud puede ser divulgada a no ser que yo este incapacitado/a. Si yo estuviera incapacitado/a, los proveedores del cuidado de mi salud se lo comunicarían a las personas que yo nombre en las instrucciones previas. Si yo no tuviera instrucciones previas, yo entiendo que los proveedores del cuidado de mi salud se lo comunicarían a mis familiares mas allegados."

Name/Nombre	**Relationship /Parentesco**	**Phone #/ # telefono**

Doctor/Doctores	**Specialty/Especialidad**	**Phone# / # telefono**

Signature of Patient/ Firma del Paciente   Date and Time/ Fecha y hora

Witness (office use only) Testigo (solo para uso de oficina)   Date and Time/ Fecha y Hora

Contact Authorization

Patient Name:
Nombre del paciente
Date of Birth:
Fecha de nacimiento
Address:
Direccion del hogar
Social Security #:
Numero de Seguro Social
Home Phone:
Telefono del hogar
Work Phone:
Telefono del trabajo
Cell Phone #:
Numero de Celular

All calls regarding your care, test results and appointments will be made to your home phone. If you would like us to contact you at an alternate phone number, please indicate that number here:

#1_____________________________ 2: ______________________________

____ I hereby authorize this practice to contact me by phone or email and if I am not present, they **MAY** leave a message on my answering machine.

____ I hereby authorize this practice to contact me by text message to my cell phone.

____ I prefer that this practice **DO NOT** leave a message if I am not present.

The following people, other than a duly designated guarding or conservator, are authorized to discuss my ________ medical condition and/or __________ billing information with a healthcare professional in this practice:

_____________________ _______________ _______________________
Name Relationship Phone number

______________________ _______________ ________________________
Name Relationship Phone number

Signature
____

Miami Gastroenterology Consultants, P.A.

Specializing in Digestive and Liver Diseases Gastrointestinal Endoscopy

Miguel J. Rodriguez, M.D.

MEDICAL RECORD RELEASE AUTHORIZATION

Date: ___________________________

Patient: SS#: DOB:

Patient or Guardian Signature: ____

I hereby authorized and request the release of all my complete medical history records, including abstract, emergency room, discharge summary, imaging studies report, operative record, pathology report, consultation, progress notes, physician orders, laboratory, pathology slides, cath lab, mental health, Hiv/Aids, substance abuse and imaging films.

____

Name of Physician or Facility

____

Address

____

Phone Number/Fax Number

TO BE SENT TO:

Miami Gastroenterology Consultants, P.A.
8525 S.W. 92 Street
Suite C-10
Miami, Florida 33156
Phone: (305) 274-7800
Fax (305) 270-1246

MIAMI GASTROENTEROLOGY CONSULTANTS

Name **DOB** **Date** **NEW CONSULT**

HISTORY - COMPLETED BY PATIENT, STAFF, OR PROVIDER

1. Reason for your visit today____

2. Please indicate if you are having any current problems signs or symptoms in any of the following areas:

√		√	
	General Wellness		Neurological
	Eyes		Allergies
	Skin		Reproductive/Urinary
	Ears, Nose, Throat		Thyroid/Endocrine
	Stomach/Digestion		Psychiatric
	Lungs/Breathing		Blood/Lymph
	Heart/Circulation		Other
	Muscles/Joints/Bones		Other

Physician Comments - Review of Systems

AII other systems negative

ROS: 1 prob. pertinent, 2-9 extended, 10+complete

3. Medication(s) (drugs, pills):

4. Previous Surgeries/Dates:

5. Allergies

6. What is your Social History?

Marital Status: Single , Divorced , Married , Widow/Widower , Who lives with you________________________________

Current Occupation/Employer ____________________________What kind of work_________________________________

Do you smoke? __________ How many packs a day? _____________ For how many years? ____________________

Do you drink alcohol?____________ How many drinks per day?_____ per week?______ per month?_________

Are you sexually active? ___________Do you use illicit drugs? ___________If yes, what kind?_______________________________

7. What is the Health Status of Your Family?

Mother:____ Father:____

Brothers/Sisters:____

Family Illnesses:

History of Heart Disease (heart attack, heart failure) yes no History of strokes? yes no

History of high blood pressure? yes no History of diabetes? yes no History of cancer? yes, site _______________ no

HISTORY - COMPLETED BY PROVIDER

Patient evaluated at the request of: ____

Chief Complaint: ____

History of Present Illness: *(Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms)*
(1-3 brief, 4+ extended)

ORStatus of Chronic or Inactive Conditions (3 *or more = extended w/o HPI)*

I have reviewed the History as documented above and personally noted the Chief Complaint and HPI.

____ ________________

signature of provider (attending) ***date***