Miami Gastroenterology Consultants

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: «RefProviderName»
Nombre de su medico ______________________________

Phone Number: «RefProviderPhone»
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.***
- ***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.

HIPPA PRIVACY COMPLIANCE

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 Cellular

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

____