**Walter Ramirez, MD PA**

11760 SW 40th St. Suite 622A Miami, Florida. 33175

305 559-9860 Fax 305-559-9207

|  |  |
| --- | --- |
| **Name:**  **(Nombre)** |  |
| **Sex:**  **(Sexo)** |  |
| **DOB:**  **(Fecha de Nacimiento)** |  |
| **Address:**  **(direccion)** |  |
| **Telephone No.:** |  |
| **Emergency Contact Person:**  **contacto de emergencia** |  |
| **Telephone No.:** |  |
| **Email:** |  |
| **Social Security:** |  |
| **Pharmacy Phone:** |  |
| **Primary Physician:** |  |
| **Occupation:** |  |
| **Primary language:** |  |

|  |  |  |
| --- | --- | --- |
| **Name of Medications:** | **Dosage: (Dosis)** | **Times a Day: (Al Dia)** |
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| --- | --- |
| **Allergies: (Alergias)** | **Reactions: (Reaciones)** |
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| --- | --- |
| **Past and current Medical Problems:**  **(Problemas de Salud pasados y Actuales)** | **Year: (año)** |
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|  |  |
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| --- | --- |
| **Surgery: (cirugias)** | **Year: (año)** |
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**Health Conditions in your Family: (Historia medica de su familia)**

|  |  |
| --- | --- |
| **Do you Drink Alcohol?** | **How much and How often?** |
|  |  |
| **Do you Smoke?** | **How many cigarettes a day:** |
|  |  |

**Main reason of your consult: (La razon de su visita)**

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

**FROM OTHER HEALTHCARE FACILITIES**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

|  |
| --- |
| Name of Healthcare Facility from which Records are Requested:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Please Print)  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_  Dates of Treatment Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Reason for Disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

MAIL INFORMATION TO:  **WALTER RAMIREZ M.D., P.A.**

**11760 Bird Road, Suite No. 622 A Miami, FL 33175**

Or FAX TO: **305.559.9207 OR 305.357.8037**

I hereby authorize **WALTER RAMIREZ M.D., P.A.,** to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient’s medical record.

|  |  |  |  |
| --- | --- | --- | --- |
|  | History & Physical |  | EKGs |
|  | Physical / Occupational Therapy Reports |  | Radiology Reports |
|  | Laboratory Reports |  | Pathology Reports |
|  | Other (Specify) |  |  |

Check a Box



This consent is subject to revocation at any time except to the extent the action has been taken thereon**. This authorization and consent will expire one year from the 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship if not Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*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). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

\*\*For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

**WALTER RAMIREZ M.D., P.A.**

**11760 Bird Road**

**Suite No. 622 A**

**Miami, FL 33175**

**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 Date / Fecha

Firma del Paciente o Representante Legal

**And** I also acknowledge that I have been provided with the “Notice Of Privacy Practices”

**Y tambien** confirmo haber recibido 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.

**Walter Ramirez, M.D., P.A.**

**Statement of Financial Responsibility**

**Patient Name:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**1. PRIVATE INSURANCE AUTHORIZATION FOR ASSIGMENT OF BENEFITS AND RELEASE OF INFORMATION.**

I hereby authorize and direct payment of my medical benefits to Walter Ramirez, M.D., P.A., for any services furnished to me by the physicians. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to me during the period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines a service to be “not covered”, I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf, including any fees for collection services needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date Signature of Patient (or Responsible Party)

**2. PAYMENT**

I hereby assume responsibility to pay the costs of all services provided by Walter Ramirez, M.D., P.A., and its physicians to the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. AUTHORIZATION OF PAYMENTS**

I understand that Walter Ramirez, M.D., P.A., will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Walter Ramirez, M.D., P.A., and its physicians of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance, co-payments and non-covered services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date Signature of Patient (or Responsible Party)

**4. MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Walter Ramirez, M.D., P.A., for any services furnished me by the physicians. I authorized any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determination these benefits or the benefits payable for related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. MEDIGAP AUTHORIZATION FOR ASSIGMENT OF BENEFITS AND RELEASE OF INFORMATION**

I request that payment of authorized Medigap benefits be made to either to me on my behalf to Walter Ramirez, M. D., P.A.

For any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_