Miami INSTITUTE For Joint Reconstruction

PATIENT INFORMATION

DATE: _____
Fecha

LANGUAGE: _____
Idioma

TO SEE DE: _____ REFERRED BY: _____
A que doctor va a ver? *Referido por?*

PATIENT'S LAST NAME: _____ FIRST: _____ IN'T: _____
Apellido *Nombre*

ADDRESS: _____ ZIP CODE: _____
Direccion *Zona Postal*

TELEPHONE # _____ SINGLE: _____ MARRIED: _____ STUDENT: _____ OTHER: _____
Telefono *Soltero* *Casado* *Estudiante* *Otro*

MALE: _____ FEMALE: _____ DATE OF BITRH: _____ AGE: _____
Masculino *Femenino* *Fecha de Nacimiento* *Edad*

PATIENT'S S.S.# _____ SCHOOL NAME: _____
Seguro Social del Paciente *Nombre del Colegio*

IF MINOR, PARENT'S NAME: _____ PARENT'S S.S.# _____
Si es menor, nombre del padre *Seguro Social del Padre*

PLACE OF EMPLOYMENT (Parent's if minor): _____
Lugar de empleo (Empleo del padre, si es menor de edad)

ADDRESS OF EMPLOYER: _____ OCCUPATION: _____
Dirreccion del Empleador *Ocupacion*

EMPLOYER'S TELEPHONE #: _____ RELATIONSHIP TO PATIENT: _____
Telefono del empleador *Relacion al paciente*

IS THIS CONDITION RELATED TO AN ACCIDENT? YES _____ NO _____ DATE OF ACCIDENT: _____
Es esta condicion relacionada a un accidente? *Dia del accidente*

IF YES, TYPE OF ACCIDENT: AUTO_____ HOME_____ EMPLOYMENT _____
Si es un accidente, Que tipo? *Auto* *Casa* *Trabajo*

OTHER: _____
Otro

DATE OF ACCIDENT OR ILLNESS: _____ IF HOSPITALIZED, DATE: _____
Dia que comenzo el accidente o enfermedad *Si fue hospitalizado, Que dia?*

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ ADDRESS: _____
Nombre del primer seguro *Direccion*

POLICY # _____ GROUP # _____
Numero de poliza *Numero de grupo*

INSURED'S NAME: _____ DATE OF BIRTH: _____ SS# _____
Nombre del asegurado *Fecha de Nacimiento* *Numero Social*

SECONDARY INS. NAME: _____ ADDRESS: _____
Segundo Seguro *Direccion*

POLICY # _____ GROUP # _____
Numero de poliza *Numero de grupo*

INSURED'S NAME: _____ DATE OF BIRTH: _____ SS# _____
Nombre del asegurado *Fecha de Nacimiento* *Numero Social*

RELATIONSHIP TO PATIENT: _____
Relacion al Paciente

PHYSICIAN'S RELEASE & ASSIGNMENT

I hereby authorize payment directly to _____ of benefits due to me from my insurance company other wise payable to me. I further authorize the relase of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization.

PATIENT'S SIGNATURE: _____
Firma del Paciente

Miami
INSTITUTE
For Joint Reconstruction

Arturo Corces, M.D. – Orthopaedic Surgery Director, Joint Reconstructive Surgery, Implant Service.

David Font-Rodriguez, M.D. – Shoulder & Elbow Surgery, Orthopaedic Surgery Director (Shoulder Service).

Mauricio F. Herrera, M.D. – Sports Medicine, Arthroscopic Surgery.

Amar Rajadhyaksha, M.D. – Adult & Pediatric Spine Surgery.

Liam McCarthy, M.D. – Pain Management.

Gary Goykhman, D.P.M. – Podiatry.

Alejandro E. Pino, M.D. – Orthopaedia Surgery, Foot and Ankle Surgery.

OPEN DOOR POLICY

Due to the nature of the practice, the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, has an open door policy.

Treatment areas are kept open and examining rooms doors may be kept open. If you have any questions or objections to this policy, please inform the physician or the designated health care provider.

APPOINTMENT REMINDERS

I acknowledge that this practice/facility may call for appointment reminders and/or cancellations. **If unable to keep appointment, kindly give 24 hrs. notices or a $25.00 fee will be charged.**
I authorize the use or disclosure medical information to contact you as a reminder. This contact may be by phone, in writing, e-mail, or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any questions and/or objections to this policy, please inform us.

CONSENT TO PHOTOGRAPH

I authorize the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, and its affiliates to take pictures of my (or my child's) medical or surgical procedure(s) and condition (s) and to use the pictures for treatment, scientific, educational or research purposes.

PERSONAL VALUABLES

I acknowledge that this practice/facility does not accept responsibility for any personal property. I accept the risk of loss or damage to any of my personal property.

RELATIONSHIP BETWEEN FACILITY AND PHYSICIAN

I understand and acknowledge the relationship between the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION and that of the physicians and surgeons, own and operated this facility.

USE AND DISCLOURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my health care; MIAMI INSTITUTE FOR JOINT RECONSTRUCTION originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results; diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,

- A means of communication among the many health professionals who contribute to my care,

- A source of information for applying my diagnosis and surgical information to my bill,

-A means by which a third-party payer can verify that services billed were actually provided,

- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I am giving my consent for the use and disclosure of Protect Health Information as required and/or permitted by law.

I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

CONSENT AND ACKNOWLEDGEMENT FORM ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment Medicare, Medicaid or other insurance benefits otherwise payable to me for medical service rendered to me or my child directly to MIAMI INSTITUTE FOR JOINT RECONSTRUCTION. These benefits are not limited to individual Policies, Group Polices, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits.

Where MEDICARE/MEDICAID BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made direct

ly to MIAMI INSTITUTE FOR JOINT RECONSTRUCTION on my behalf.

THIRD PARTY BENEFIT COLLECTIONS

I authorize MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, to act in my behalf as attorney in fact in the collection of benefits from any responsible third-party payer through whatever means may be deemed

necessary, and the endorsement of benefit checks made payable to me and/or MIAMI INSTITUTE FOR JOINT RECONSTRUCTION or any of its providers.

RELEASE OF INFORMATION

I authorize the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION to release copies of information in their possession, as acquired in the course of me or my child's examination and/ or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance, Medicare and Medicaid payments:

- This facility and its affiliates
- Utilization review agencies or auditors
- Physician (Attending and Consulting)
- Other allied health professionals

USE OF INFORMATION

I authorized the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, and its affiliates and authorized agents to use the information acquired in the course of me or my child (s) examination and treatment to provide me with information about the MIAMI INSTITUTE FOR JOINT RECONSTRUCTION and its affiliates and other matters that may be of interest to me regarding me or my child's health care.

GUARANTEE OF PAYMENTS

I hereby understand that I am financially responsible for payment to MIAMI INSTITUTE FOR JOINT RECONSTRUCTION, for any charges not covered or allowed by my insurance company, and all deductibles, co-insurance, co-payments, and for any balances remaining after payments have been made by my insurance company. This includes any denial of payments due to lack of medical necessity or pre-qualification/authorization, lack of affiliation with a HMO or any other constraint in posed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collections, I will be responsible for paying the balance owed to the physician plus the cost of collection fees, and/or including reasonable attorney fees if/when applicable.

I further acknowledge that I have read and reviewed the FINANCIAL POLICIES OF THE MIAMI INSTITUTE FOR JOINT RECONSTRUCTION.

CONSENT TO TREATMENT

I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, radiological examination, anesthesia, laboratory procedures, and medications that may be performed, administered or rendered by or under specific or general instructions of my physician.

I hereby voluntarily consent to rendering of medical treatment by MIAMI INSTITUTE FOR JOINT RECONSTRUCTION and/or the medical staff, which may include routine diagnostic and/or surgical procedures, x-rays, administration of injections, therapy and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

_____ _____

Patient signature **Date**

Miami
For Joint Reconstruction
www.miamiorthodoc.com

Financial Responsibility

Arturo Corces, M.D.
Joint Reconstructive Surgery
Orthopaedic Surgery
Director, Implant Service

David Font-Rodriguez, M.D.
Shoulder and Elbow Surgery
Orthopaedic Surgery
Director, Shoulder Service

Mauricio F. Herrera, M.D.
Sports Medicine, Arthroscopic Surgery

Amar Rajadhyaksha, M.D
Adult and Pediatric Spine Surgery

Liam McCarthy, M.D.
Pain Management

Gary Goykman, DPM
Ankle and Foot Surgery

Alejandro E. Pino, M.D.
Orthopaedia Surgery, Foot and Ankle Surgery

I hereby request that my insurance carrier make payment directly to Arturo Corces, *M.* D. PA for any and all services rendered by this practice.

I, the undersigned understand that Arturo Corces, M.D. PA will bill my insurance carrier for service rendered upon verification of coverage by my insurance company. I also understand that should my insurance company fail to render payment for service rendered I am fully responsible for all charges incurred, and will pay, in full, all service. I understand that I am responsible for the payment of any and all deductible, and/or co -insurance amounts, and that interest may be charged on any amounts past due 60 days. Interest may be charged at the rate 1.5 % (percent) per month on the outstanding balance accrued from the date that the service was rendered.

I understand that it is my responsibility to notify the physician, should there be any change in my status, coverage, or carrier and that I will be held financially responsible for any service rendered during the period during which I have failed to do so. Should it become necessary for Arturo Corces, M.D. PA to engage professional collection efforts, I will be held financially responsible for any and all additional costs of collection including, but not limited to agency fees, attorney fees, court costs, and interest.

I further understand that if my injury goes into litigation against a third party, this in no way he relieves me of my obligation to pay for the services rendered. I understand that payments of the fees are not contingent upon settlement of litigation. I however. I hereby instruct my attorney to pay Arturo Corces, M.D. PA in full (including all interest or additional charges as outlined above) directly from the proceeds of my settlement or judgment rendered on my behalf.

Patient Name:	Patient Signature:
Witness:	Date:

KENDALL MEDICAL PAVILION
11801 SW 90 ST
SUITE # 201
MIAMI, FL 33186
PH: 305-595-1317
FAX: 305-270-6813

MIAMI
9299 SW 152st
SUITE #103
MIAMI, FL 33157
PH: 305-595-1317
FAX:305-270-6813

CORAL GABLES
747 PONCE DE LEON
SUITE # 505
CORAL GABLES, FL 33134
PH: 305-595-1317
FAX: 305-270-6813

Miami
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Responsabilidad Financiera

Arturo Corces, M.D.
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Orthopaedia Surgery, Foot and Ankle Surgery

Yo solicito que mi compañía de seguro haga los pagos directamente a Arturo Corces, M.D.PA para cualquier y todos los servicios prestados por esta práctica.

Yo, el abajo firmante entiendo que Arturo Corces, M.D. PA le envié cuenta a mi compañía de seguros por los servicios prestados a la verificación de la cobertura por mi compañía de seguros. También entiendo que si mi compañía de seguros no pagan por los servicios prestados soy totalmente responsable de todos los cargos incurridos, y pagare, en su totalidad, todo el servicio. Yo entiendo que soy responsable por el pago de cualquier y todos los deducibles y / o co-Seguros cantidades, y que se podrán aplicar intereses sobre cualquier cantidad pasada de 60 días. Se podrán aplicar intereses a la tasa del 1.5% (por ciento) mensual sobre el saldo pendiente acumulados desde la fecha en que se prestó el servicio.

Yo entiendo que es mi responsabilidad notificar al médico, sobre cambios en mi estado de cobertura, o compañía de seguro de salud y que voy a ser responsable financieramente por cualquier servicio prestado durante el período el cual no he podido hacerlo.
En caso de que fuese necesario que Arturo Corces, M.D. PA tome esfuerzos de recolección de profesionales, que seré financieramente responsable de cualquier y todos los costos adicionales de la colección incluyendo, pero no limitado a gastos de agencia, honorarios de abogados, costas judiciales, e intereses.

Además, entiendo que si mi lesión entra en litigios contra un tercero, esto de ninguna manera me libera de mi obligación de pagar por los servicios prestados. Yo entiendo que los pagos de las tasas no están supeditados a la solución de los litigios. Yo sin embargo. Presente yo autorizo a mi abogado a pagar Arturo Corces, M.D. PA en su totalidad (incluyendo todos los cargos de interés o adicionales como se indica más arriba) directamente desde el producto de mi acuerdo o sentencia prestados en mi nombre.

Nombre del Paciente _____ Firma del Paciente _____

Fecha _____ Testigo _____

KENDALL MEDICAL PAVILION
11801 SW 90 ST
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MIAMI, FL 33186
PH: 305-595-1317
FAX: 305-279-6813

MIAMI
9299 SW 152st
SUITE #103
MIAMI, FL 33157
PH: 305-595-1317
FAX:305-279-6813

CORAL GABLES
747 PONCE DE LEON
SUITE # 505
CORAL GABLES, FL 33134
PH: 305-595-1317
FAX: 305-279-6813

Miami INSTITUTE For Joint Reconstruction

Arturo Cerces, M.D.
Joint Reconstructive Surgery
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Pain Management

Gary Goykhman, D.P.M
Podiatry

Alejandro E. Pino, M.D.
Orthopaedic Surgery, Foot and Ankle Surgery

Malpractice Notice

Patient Name/Nombre del Paciente:_____

Date/Fecha: _____

Under Florida Law, Physicians are generally required to carry Medical Malpractice Insurance or otherwise demonstrate financial responsibility to cover potential claims for Medical Malpractice.

Your Doctor has decided not to carry Medical Malpractice Insurance. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice.

I Have read this statement and fully understand it.

_____

Bajo las Leyes de la Florida, generalmente se requiere que los Medicos tengan seguro de Negligencia Profesional o demostrar reponsabilidad financiera para cubrir posibles reclamaciones por mala practica medica.

Su medico ha decidido no tener seguro de Negligencia Profesional y lo que es permisible por las leyes de la Florida, sujeto a ciertas condiciones. Las leyes de la Florida imponen multas a los medicos no asegurados que no satisfagan reclamaciones adversas derivadas de reclamaciones de Negligencia Profesional.

Yo he leido y entendido perfectamente este aviso.

_____
Patient's Signature/Firma del Paciente

WEST KENDALL MEDICAL PAVILION
11801 SW 90 ST
SUITE # 201
MIAMI, FL 33187
PH: 305-595-1317
FAX: 305-595-0157

CORAL GABLES
747 PONCE DE LEON
SUITE # 505
CORAL GABLES, FL 33134
PH: 305-595-1317
FAX: 305-595-0157

MIAMI
9299 SW 152 St.
SUITE# 103
MIAMI, FL 33157
PH: 305-595-1317
FAX: 305-595-0157

PATIENT CARE AGREEMENT

PLEASE READ CAREFULLY: THIS AGREEMENT CONTAINS AN ARBITRATION PROVISION. THIS AGREEMENT CONTAINS A WAIVER OF A RIGHT TO A JURY TRAIL. DO NOT SIGN THIS AGREEMENT UNLESS YOU READ AND UNDERSTOOD ALL PROVOSIONS. IF YOU HAVE ANY QUESTIONS REGARDING THIS AGREEMENT, PLEASE ASK THE STAFF FOR ASSISTANCE.

I,_____, in exchange for receiving treatment and care from the Miami Institute for Joint Reconstruction, and its affiliated physicians including _____, MD. (which includes all employees of the Miami Institute for Joint Reconstruction and/or of my physician), hereby acknowledge and accept the following terms (please place your initials by each paragraph):

_____1. That neither the Miami Institute for Joint Reconstruction nor the individual physicians rendering care at or through the Miami Institute for Joint Reconstruction carry medical malpractice liability insurance;

_____2. That I have been given and read the Patient Notification of No Malpractice Insurance as required by Florida Statute;

_____3. That, with the exception of any collections action, any and all controversy or claim, including any claim for medical malpractice or wrongful death, whether in tort or contract, arising from the care and treatment I receive from the Miami Institute for Joint Reconstruction and _____, MD. shall be resolved exclusively by arbitration, that the decision of the arbitrator shall be final and binding resolution which may be entered as a judgment by any court of competent jurisdiction, and that the arbitration will be conducted under the then in force rules of the Florida Arbitration Code;

_____4. That the non-economic damages as defined by Section 766, Florida Statutes, recoverable in arbitration or litigation by the patient shall not exceed under any circumstances Seventy Five Thousand Dollars ($75,000.00);

_____5. That each party shall pay his/her own attorney's fees and costs arising from any legal proceeding, including any arbitration, arising from any and all claims from Medical malpractice, whether in tort or contract, arising from the care and treatment I receive from Miami Institute for Joint Reconstruction and _____, MD.;

_____6. That both I and the physicians at the Miami Institute for Joint Reconstruction, **waive the right to trial by jury for any claim or controversy including any claim for medical malpractice,** whether in tort or contract, arising from the care and treatment I receive from the Miami Institute for Joint Reconstruction and _____, MD. by signing this agreement, **I agree that I am waiving my right to a jury trial should the arbitration provision be determined to be unenforceable by a court of competent jurisdiction.**

_____7. That the Miami Institute for Joint Reconstruction and _____, MD. will submit their fee for services to my healthcare insurance company, Medicaid and /or Medicare, or other third party payer. In the event that the services provided are not covered by any of these third party payers, I remain personally responsible for the fees for services;

_____8. If any provision of this Agreement shall be found by a court of competent jurisdiction to be unenforceable, the validity and enforceability of the remaining provisions shall not be affected.

I understand that I am not required to receive care, treatment, or services from the Miami Institute for Joint Reconstruction or from _____, MD., and that I am free to seek treatment from other qualified physicians in the community. By signing this Agreement, I acknowledge that I have voluntarily and knowingly agreed to all of the above terms in exchange for receiving care, treatment and services from the Miami Institute for Joint Reconstruction or from _____, MD.

_____ _____

Date: Patient Signature:

ACUERDO DE ATENCIÓN AL PACIENTE

POR FAVOR LEA ATENTAMENTE: Este acuerdo contiene una disposición de arbitraje. Dicho acuerdo contiene una renuncia a tener derecho a un sendero jurado. No firme este acuerdo a menos que haya leído y entendido todas las provisiones. Si tiene alguna pregunta sobre este acuerdo, por favor de pedirle asistencia al personal.

Yo, _____, a cambio de recibir tratamiento y atención del Miami Institute for Joint Reconstruction, y sus médicos afiliados incluyendo _____, MD. (Que incluye a todos los empleados de Miami Institute for Joint Reconstruction y / o de mi médico), por este medio reconozco y acepto los siguientes términos (por favor, coloque sus iniciales por cada párrafo):

_____**1.** Que ni el Miami Institute for Joint Reconstruction ni los médicos individuales que prestan atención en o a través de Miami Institute for Joint Reconstruction llevan un seguro de responsabilidad por negligencia médica;

_____**2.** Que se me ha dado y he leído la notificación de no seguro de mala práctica como lo requiere la Ley de Florida;

_____**3.** Que, con la excepción de cualquier acción de colecciones, todas y cada una controversia o reclamación, incluyendo cualquier reclamación por negligencia médica o muerte por negligencia, ya sea en agravio o contrato, derivada de la atención y el tratamiento que recibo de Miami Institute for Joint Reconstruction y _____, MD. será resuelta exclusivamente por arbitraje, que la decisión del árbitro será definitiva y resolución, que pueden incluirse como un juicio por un tribunal de jurisdicción competente vinculante, y que el arbitraje se llevará a cabo bajo la continuación de las reglas de fuerza del Arbitraje de Florida Código;

_____**4.** Que los daños no económicos definidos en la Sección 766, en los Estatutos de la Florida, recuperables por el paciente en el arbitraje o litigio no deberán exceder los setenta y cinco mil dólares ($75,000.00);

_____**5.** Que cada parte pagará los honorarios y gastos derivados de cualquier procedimiento legal, incluyendo cualquier arbitraje, derivadas de su propio abogados y todas las reclamaciones de negligencia médica, ya sea en agravio o contrato, derivada de la atención y el tratamiento que recibo de Miami Institute for Joint Reconstruction y _____, MD.;

_____**6.** Eso sí, yo y los médicos en el Miami Institute for Joint Reconstruction, renuncio al derecho a juicio por jurado para cualquier reclamación o controversia que incluye cualquier reclamación por negligencia médica , ya sea en agravio o contrato , derivada de la atención y el tratamiento que recibo de los Miami Instituto de Reconstrucción conjunta y _____ , MD. mediante la firma de este acuerdo, acepto que estoy renunciando a mi derecho a un juicio con jurado debería la disposición de arbitraje se determinará para ser inaplicable por un tribunal de jurisdicción competente .

_____**7.** Que el Miami Institute for Joint Reconstruction y _____, MD. presentará su cuota por los servicios a mi compañía de seguros de salud, Medicaid y / o Medicare , u otro pagador tercero. En el caso de que los servicios prestados no están cubiertos por cualquiera de estos terceros pagadores, sigo siendo personalmente responsable de los honorarios por los servicios;

_____**8.** Si alguna disposición de este Acuerdo será considerada por un tribunal de jurisdicción competente como no ejecutable, la validez y aplicabilidad de las disposiciones restantes no se verán afectadas.

Yo entiendo que no estoy obligado a recibir atención, tratamiento o servicios del Miami Institute for Joint Reconstruction o de _____, MD. , Y que soy libre para buscar el tratamiento de otros médicos cualificados en la comunidad. Al firmar este acuerdo, reconozco que voluntaria y conscientemente he aceptado todos los términos anteriores a cambio de recibir el cuidado, tratamiento y servicios del Miami Institute for Joint Reconstruction o de _____, MD.

_____ _____

Fecha: Firma Del Paciente:

Miami
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www.miamiorthodoc.com

Pregnancy Notice

The following is to be read and signed by all female patients when scheduled for a diagnostic x-ray.

Arturo Corces, M.D.
Joint Reconstructive Surgery
Orthopaedic Surgery
Director, Implant Service

David Font-Rodriguez, M.D.
Shoulder and Elbow Surgery
Orthopaedic Surgery
Director, Shoulder Service

Mauricio F. Herrera, M.D.
Sports Medicine, Arthroscopic Surgery

Amar Rajadhyaksha, M.D
Adult and Pediatric Spine Surgery

Liam McCarthy, M.D.
Pain Management

Gary Goykhman, DPM
Ankle and Foot Surgery

Alejandro E. Pino, M.D.
Orthopaedia Surgery, Foot and Ankle Surgery

X-rays taken during pregnancy may be extremely dangerous to the unborn child unless adequate safeguards are employed during the first three months of pregnancy. Therefore, you are asked to inform the X-ray technologist if there is any possibility that you may be pregnant.

Please sign the statement below if you are NOT pregnant.

I _____ certify that to the best of
(Patient's name)
my knowledge I am not pregnant at this time.

_____ _____
(Patient's signature) (Date)

_____ _____
(Witness signature) (Date)

Notificacion de Embarazo

La siguiente es para ser leído y firmado por todos los pacientes de sexo femenino cuando se programa para una radiografía de diagnóstico.

Las radiografías tomadas durante el embarazo pueden ser extremadamente peligrosos para el feto a menos que se empleen las garantías adecuadas durante los tres primeros meses de embarazo. Por lo tanto, se le pide que informe al tecnólogo de rayos X si existe alguna posibilidad de que pueda estar embarazada.

Por favor, firme la declaración de abajo si no está embarazada.

Yo _____ certifico que a lo mejor de
(Nombre del paciente)
mis conocimientos no estoy embarazada en este momento.

_____ _____
(Firma del paciente) (Fecha)

_____ _____
(Firma del testigo) (Fecha)

KENDALL MEDICAL PAVILION
11801 SW 90 ST
SUITE # 201
MIAMI, FL 33186
PH: 305-595-1317
FAX: 305-279-6813

MIAMI
9299 SW 152 St
SUITE #103
MIAMI, FL 33157
PH: 305-595-1317
FAX:305-279-6813

CORAL GABLES
747 PONCE DE LEON
SUITE # 505
CORAL GABLES, FL 33134
PH: 305-595-1317
FAX: 305-279-6813

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 INSTITUTE FOR JOINT RECONSTRUCTION (MIJR)** 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. **MIJR** must accommodate your request if it is reasonable.

MIJR may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, **MIJR** 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 INSTITUTE FOR JOINT RECONSTRUCTION **747 Ponce De Leon Blvd, # 505, Coral Gables FL 33134**

Patient Name: _____ Telephone #: _____
(Print)
Address: _____ City: _____ State: _____ Zip: _____

I am requesting that **MIJR** communicate with me by an alternative means or at an alternative address or phone number that is more confidential for me. I understand that **MIJR** 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 INSTITUTE FOR JOINT RECONSTRUCTION (MIJR) 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. **MIJR** will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, **MIJR** 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 **MIJR** and me and consent to the conditions outlined herein. Any questions I may have had were answered.
I agree and consent that ARCPS 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: _____

Patient Request for Confidential Communications of Protected Health Information

The Health Insurance Portability Act of 1996 ("HIPAA") le provee el derecho que **MIAMI INSTITUTE FOR JOINT RECONSTRUCTION (MIJR)** se comunique con usted acerca de su información medica a direcciones alternas o teléfonos, y otras vías alternativas (por ejemplo, correos electrónicos) si esto es mas confidencial para usted **MIJR** hará las adaptaciones necesarias si su pedido es razonable. **MIJR** le puede pedir que especifique la dirección alterna o el método de contacto antes que le podamos proveer este servicio. Si su pedido es aceptado, **MIJR** hará todo intento de comunicación con usted en la forma que usted a pedido. Cambiar otras vías de comunicación no podrá ser efectuada hasta que usted no los haya pedido por escrito.

Para pedir otras vías de comunicación, por favor complete esta forma y envíela a:
MIAMI INSTITUTE FOR JOINT RECONSTRUCTION **747 Ponce De Leon Blvd # 505, Coral Gables FL 33134**

Nombre Paciente:_____ Teléfono:_____

Dirección:_____

Yo estoy pidiendo que **MIJR**, se comunique conmigo vías alternas o a alternas direcciones y teléfonos es confidencial para mí. Yo comprendo que este Centro Medico no podrá acomodar pedidos irrazonables.

Describa el alternativo:

☐ Texto a siguiente No. _____

☐ Fax a siguiente No. _____

☐ Otra(s): _____

Si la dirección alterna pedida por el paciente es un e-mail, entonces el consentimiento para e-mail debe ser completado.

☐ E-Mail Consent Form

PROPÓSITO: Esta forma es usada como consentimiento de usted para comunicarnos vía e-mail en referencia a su Información de Salud Protegida .

MIAMI INSTITUTE FOR JOINT RECONSTRUCTION (MIJR) ofrece a sus pacientes la oportunidad de comunicación vía e-mail. Trasmitir información vía e-mail tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **MIJR** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía e-mail. De todas formas, **MIJR** no podrá garantizarle proteger confidencial y seguro la comunicación vía e-mail y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Paciente Recibió y Acordó

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía e-mail entre **MIJR** y yo y consentimiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.
Yo estoy de acuerdo y consiento que **MIJR** se pueda comunicar en referencia a mi Información de Salud Protegida (por sus siglas en Ingles PHI) vía e-mail.

Mi direccion de E-Mail consentida es: _____

_____

X_____ Fecha Firmada: _____/ _____/ _____
Firma Paciente o Representante Legal * Podemos pedir prueba del estatutos del representante *

Uso de Oficial: Recibido: ____/____/____ Completado: ____/____/_____ Iniciales: _____