Patient Registration Form

Name: _____ Date: _____
Nombre LAST FIRST MI *Fecha*

Address: _____
Dirreción STREET APT. # CITY STATE ZIP CODE

Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____
Teléfono de casa *Teléfono de trabajo* *Celular*

Social Security No. _____ Date of Birth: _____ Email address: _____
Número de seguro social *Fecha de nacimiento*

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Femenino *Masculino* *Estado civil* *Soltero* *Casado* *Divorciado* *Viudo*

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other_____
Etnicidad

Employer: _____ Occupation: _____
Empleo *Cargo*

Employer's Address: _____
Dirreción STREET CITY STATE ZIP CODE

Primary Care Physician: _____ Phone Number: (_____)_____
Doctor primario *Número de teléfono*

Preferred Pharmacy Name: _____ Phone Number: (_____)_____
Nombre de farmacia *Número de teléfono*

Emergency Contact: _____ Phone Number: (_____)_____
En caso de emergencia: *Número de teléfono*

Relation: _____ Primary Language: _____
Relacion *Idioma principal*

Primary Insurance: _____ Policy #: _____
Seguro Primario *Poliza*

Secondary Insurance: _____ Policy #: _____
Seguro Secundario *Poliza*

ADVANCED DIRECTIVES: A document called a *Living Will* advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare. Have you prepared a living will? ☐ Yes ☐ No
If **yes**, with whom: _____ Telephone: (_____) _____

Lifetime Medical Authorization and Guarantee of Payment

I authorize **Miami-Dade Cardiology Consultants, LLC.** to submit a claim to my insurance carrier for services rendered to me. I also request that benefits payable for these services be assigned to **Miami-Dade Cardiology Consultants, LLC.** and be paid directly to **Miami-Dade Cardiology Consultants, LLC.**

I authorize and holder of medical information of other information about me to be released to my insurance carrier of its intermediaries, and information needed for this claim, or any future claims for services rendered by **Miami-Dade Cardiology Consultants, LLC.**

In consideration of Miami-**Dade Cardiology Consultants, LLC.** providing services to me, I agree that I will not cancel, revoke or limit this authorization for any reason, as long as my insurance company, my attorney, or I, if any, owe any money to **Miami-Dade Cardiology Consultants, LLC.** for the medical services provided to me or on my behalf.

I authorize my insurance carrier to release information regarding my claim to **Miami-Dade Cardiology Consultants, LLC.**

I agree to be responsible for payment of any denied claims and for any unpaid balance of any claim for services rendered to me or on my behalf by **Miami-Dade Cardiology Consultants, LLC.**

_____ _____
Patient Signature **Date**

Rev. November 2016

General Consent for Treatment

1. I, the undersigned patient or _____ (name of authorized representative acting in behalf of patient) consent to examination, care and treatment from the physicians and other healthcare professionals of Miami-Dade Cardiology Consultants (MDCC), including but not limited to necessary tests, treatments and other procedures.
2. I have been told the name of the physician who has primary responsibility for my care, as well as the names, professional status and professional relationships of the other individuals who will be involved in my care.
3. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me by a MDCC doctor as to the results of diagnosis, examinations or treatments in a MDCC facility, or in a hospital, or other tertiary facility.
4. I hereby grant to members of MDCC medical staff and other medical researchers access to my medical records for the purposes of bona fide medical research. I further authorize them to use my medical records and results for bona fide medical research. However, my records may not be identified as pertaining to me specifically, without my express written permission.
5. I hereby understand that my medical records will be assessed by senior management of MDCC for the specific purpose of evaluating the ongoing quality and efficiency of career rendered at MDCC and by its staff. I further understand the senior management may use portions of my medical records as necessary for educational and disciplinary purposes, provided that the records will not be identified as pertaining to me specifically without my express written consent.
6. I understand that medical information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. I further understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers, and their respective agents, for purposes including, but not limited to, payment, Utilization Review and Quality Assurance Review, and to support applications for patient assistance programs.
7. I hereby authorize payment directly to MDCC and such other entities as may be authorized by MDCC of any benefits due to me in any pending claim and/or any health insurance coverage otherwise payable to me, provided that such direct payments do not exceed the amount then due and owing.
8. I hereby agree that a photostatic, digital or faxed copy or transmission of this authorization is as valid as the original.

_____ _____ _____
Signature of patient | Date | Time

_____ _____
Authorized representative, sign and print | Indicate relationship to patient

_____ _____
Witness, sign and print, include title | Interpreter's signature

_____ _____
Witness of Interpreter, sign and print

MINOR'S CONSENT: Patients who are unemancipated minors (patients who are under the age of eighteen, who have never been married) must have parent's or guardian's signature.

_____ _____
Parent signature | Interpreter's signature

_____ _____
Guardian, or authorized representative, sign and print | Witness of interpreter, sign and print

_____
Indicate relationship to patient

_____ _____ _____
Witness, sign and print, include title | Date | Time

MIAMI-DADE CARDIOLOGY CONSULTANTS
Miami, FL 33137

GENERAL CONSENT FOR TREATMENT

Miami-Dade Cardiology Consultants, LLC
Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____

_____ (Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ (Patient/Representative initials) I **consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/ Representative Initials) I decline to receive communication via text.

_____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Revocation (I do not consent to use my cell or email any longer)

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

Records Release Form

Doctor:

☐ Bazzi	☐ Bryan	☐ Cerami	☐ Correa
☐ Coy	☐ Davenport	☐ Elias	☐ Hernandez
☐ Hurwit	☐ Lister	☐ Mejia	☐ Rechani
☐ Smithson	☐ Zide		

To: _____

I, _____ hereby authorize the release of all my medical records or copies such as labs, EKGs, HIV, CXRs, test results including echocardiograms, reports, exams, procedures, etc. and request that they be transferred to:

☐ **AVENTURA OFFICE - MDCC**
21097 NE 27th COURT, SUITE 100
AVENTURA, FL 33180
O. (305) 792-0012 F. (305) 792-0030

☐ **BISCAYNE OFFICE - MDCC**
3801 BISCAYNE BOULEVARD, SUITE 300
MIAMI, FLORIDA 33137
O. (305) 571-0620 **F. (305) 576-8099**

☐ **KENDALL OFFICE – MDCC**
11760 SW 40th Street, SUITE 352
Miami, FL 33175
O. (305) 552-1005 F. (305) 552-1035

☐ **MIAMI LAKES OFFICE - MDCC**
15100 NW 67 AVENUE, SUITE 104
MIAMI LAKES, FL 33014
O. (305) 571-0671 F. (305) 362-9823

☐ **PEMBROKE PINES OFFICE - MDCC**
400 N. HIATUS ROAD, SUITE 200
PEMBROKE PINES, FL 33026
O. (954) 433-5666 F. (954) 433-5592

_____ Patient name (print)

_____ Patient signature

_____ Patient date of birth

_____ Social Security number

_____ Date

_____ Witness

Do not write below this line. Office use only.

Requested by: _____ Date: _____ Received by: _____

Sent on: _____ By: _____ Via: _____